ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC022269
Case Name	GONZALEZ, GABRIEL v. SUNSOURCE
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0205
Number of Pages of Decision	10
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	DAVID BARISH
Respondent Attorney	Patrick Morris

DATE FILED: 6/1/2022

/s/ Deborah Simpson, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gabriel Gonzalez,

Petitioner,

vs. NO: 19 WC 22269

SunSource,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 13, 2021, 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 $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.

June 1, 2022
o5/25/22
DLS/rm
046

/s/*Deborah L. Simpson*
Deborah L. Simpson

/s/*Stephen J. Mathis*
Stephen J. Mathis

/s/*Deborah J. Baker*
Deborah J. Baker

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC022269
Case Name	GONZALEZ, GABRIEL v. SUNSOURCE
Consolidated Cases	No Consolidated Cases
Proceeding Type	19(b) Petition
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	7
Decision Issued By	Gerald Granada, Arbitrator

Petitioner Attorney	David Barish
Respondent Attorney	Patrick Morris

DATE FILED: 10/13/2021

THE INTEREST RATE FOR THE WEEK OF OCTOBER 13, 2021 0.05%

/s/Gerald Granada, Arbitrator

Signature

22IWCC0202

STATE OF ILLINOIS)
)SS.
COUNTY OF DU PAGE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Gabriel Gonzalez
Employee/Petitioner

v.

SunSource
Employer/Respondent

Case # **19** WC **22269**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **Wheaton**, on **August 9, 2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **7/3/19**, Respondent ***was*** operating under and subject 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 $**47,840.00**; the average weekly wage was $**920.00**.

On the date of accident, Petitioner was **51** years of age, ***married*** with **1** 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 $613.33/week for 106 1/7 weeks, commencing 7/29/19 through 8/9/21, as provided in Section 8(b) of the Act and Respondent shall receive a credit for any disability benefits it has already paid in accordance with Section 8(j) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $2100.00 to Western Touhy Anesthesiology, $45,580.88 to Lake Shore Surgery Center Facility, $490 to Lakeshore Surgery Center Physicians, $1046 to Lakeshore Open MRI, $6957.80 to Delaware Physicians, $47,200 to River North Pain Management, $6243 to Grandview Health Partners, $3710.51 to Matrix Medical Supply, $102.84 to Injured Workers Pharmacy, $2265.43 to Hydra Pharmacy, $1800 to Imaging Centers of North America, $974 to Dr. Salehi, $645 to Aurora Emergency Physicians and $909.30 to Rush Copley Medical Center, as provided in Sections 8(a) and 8.2 of the Act. Any expenses related to Petitioner's discogram are denied.

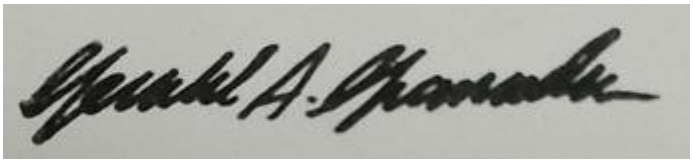
Respondent shall authorize and pay for the lumbar fusion proposed by Dr. Salehi along with any medical care during the recuperation from said procedure and shall pay temporary total disability compensation while Petitioner recovers from said procedure.

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

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

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

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



Signature of Arbitrator Gerald Granada

OCTOBER 13, 2021

FINDINGS OF FACT

This case involves Petitioner Gabriel Gonzalez, who alleges to have sustained injuries arising out of and in the course of his employment with Respondent SunSource on July 3, 2019. Respondent disputes Petitioner's claims with the issues being: 1) accident; 2) causation; 3) medical expenses; 4) TTD; and 5) prospective medical care. Petitioner testified in Spanish via a translator.

Petitioner, worked for GHX for twenty years. GHX has had a few owners over time, and Respondent was the owner on July 3, 2019 and has been the owner for about a year. Petitioner was a lead man in the hose department with physical and supervisory duties that included welding and cutting hoses weighing up to 70 lbs., and sorting and picking up metal. Petitioner testified that he had no prior problems with his low back before July 3, 2019 and had undergone no prior treatment for his low back. He had been diagnosed with Parkinson's disease in early 2018 but had no low back pain associated with the disease. He had tremors and problems with his hands and legs, and those symptoms had been become a source of discussions with his employer over his ability to perform his job.

On July 3, 2019 Petitioner was attempting to straighten out a metal hose weighing between 30 and 40 pounds, when he felt a sharp pain in his lower back. He testified that it was difficult to pull the hose. He was working alone at the time and sat down for about 20 minutes. This did not draw attention as Petitioner had taken some rest periods over the past year due to his Parkinson's disease and the company attempted to accommodate the Parkinson's disease - as per a June 4, 2019 memo sent by Respondent to Petitioner limiting his lifting to no more than 50 pounds (his job normally required lifting up to 70 pounds), restricting him from driving a forklift, allowing him more frequent breaks. Petitioner did not report this injury because he thought his back pain might be related to his Parkinson's disease. He continued to work over the next few weeks, felt more tired, and took more breaks. There was no evidence offered to rebut this testimony.

On July 23, 2019, Petitioner received a memo indicting that he would be placed on a leave of absence because of continuing problems performing the job. This was Petitioner's last day of work. Petitioner testified that on July 29, 2019, he called and spoke with Respondent's Operations Manager Kim Heis and notified him that he had injured himself lifting a hose on July 3, 2019. According to Petitioner, Mr. Heis told him there was nothing that he could do, and he transferred Petitioner to speak with somebody in HR, where a report was taken.

On July 29, 2019 Petitioner went to Grandview Health Partners and saw chiropractor Dr. Davis. Petitioner reported injuring his low back when bent over to pick up a large metal hose on July 3. A course of treatment began, and Petitioner testified that he was taken off work that day. On August 3, 2019, an MRI was performed revealing a broad-based herniation at L4/5 and at L5/S1. Dr. Davis referred Petitioner to Dr. Vargas at Delaware Physicians. Dr. Vargas noted a history of manipulating a heavy metal hose and experiencing a sudden jolt to his back. He was aware of Petitioner's Parkinson's disease and noted a typical Parkinson's shuffle. Petitioner testified that he had told all his doctors about his Parkinson's disease. Dr. Vargas diagnosed a discogenic radiculopathy and lumbosacral axial facet pain syndrome. He planned a series of epidural steroid injections, medial branch blocks and physical therapy. He found Petitioner unable to work. Petitioner underwent epidural steroid injections on August 23, September 6, and September 27, 2019. Petitioner testified that he had no relief from these injections. A lumbar discogram was performed on October 31, 2019 and revealed concordant pain at L4/5 and L5/S1.

Dr. Vargas referred Petitioner to neurosurgeon Dr. Sean Salehi. Dr. Salehi noted that every position was painful for Petitioner and that bending made things worse. He diagnosed a herniated lumbar disc and

recommended a fusion given the failure of conservative care. The surgery was never authorized. Dr. Salehi renewed his prescription for surgery on February 12, 2020. Petitioner returned to see Dr. Salehi on July 7, 2020. There was a paucity of care between the visits presumably due to the outbreak of the coronavirus pandemic. Dr. Salehi again prescribed the lumbar fusion.

On October 6, 2020, Petitioner underwent a Section 12 examination with Dr. Babak Lami at Respondent's request. Dr. Lami testified via evidence deposition on December 10, 2020. He opined that the mechanism of bending over to move a hose was trivial and felt that there was no good explanation for Petitioner's pain. He felt that no more than three weeks of physical therapy was indicated. Dr. Lami wrote a second report dated February 22, 2021 where he disagreed that the L4/5 and L5/S1 discs were aggravated and there was no evidence to support a fusion or the epidural injections for axial back pain. Dr. Lami testified that absent a neurocompressive pathology, he did not see an indication for surgery. He also felt that Parkinson's can present as back pain. He did admit that straightening a 30 to 40 pound flexible hose and flexing forward could be competent cause for a back strain. He also admitted that the medical records did not show any abatement of the low back pain after the first visit to the chiropractor. He disagreed that there was a herniated disc per the MRI.

Dr. Salehi testified via evidence deposition on January 5, 2021. He agreed with Dr. Lami that the discogram was unnecessary as the diagnosis was not a radiculopathy but mechanical low back pain due to the annular tears at L4/5 and L5/S1. Dr. Salehi testified that he disagreed that lifting a 40 pound hose was trivial. He agreed with Dr. Lami that the findings at L4/5 and L5/S1 were degenerative. However, he disagreed with Dr. Lami insofar as a man with no prior low back pain can aggravate that preexisting condition after lifting and attempting to straighten a 40 pound hose. He agreed that most people with annular low back pain can heal without surgery but with the lack of response to conservative care, Petitioner is a surgical candidate.

Kim Heis, the Operations Manager, testified on behalf of Respondent. Heis was the Branch Manager at the facility where Petitioner worked on July 3, 2019. Mr. Heis testified to having three conversations by telephone following the Petitioner's alleged accident date. He could not date these conversations and produced no notes of these conversations. Heis testified that in their discussions, Petitioner never mentioned a back injury at work. Heis testified that he informed Petitioner that he could no longer work for Respondent because of his Parkinson's disease. He testified that during the first conversation, Petitioner expressed concern over what he would be paid while on leave. Heis was not aware that Petitioner was receiving disability through the company for his Parkinson's disease.

Petitioner testified that he did not report his work accident sooner because he thought it might be related to his Parkinson's disease. He further testified to having ongoing low back pain that has gotten worse over time, and for which he takes pain medication. He has pain going down his leg and has the most difficulty getting out of the bed in the morning. He testified that there is a difference between his Parkinson's symptoms and his back pain that he can identify. Petitioner wants to have the surgery recommended by Dr. Salehi and wants his medical expenses paid.

CONCLUSIONS OF LAW

1. Regarding the issue of accident, the Arbitrator finds that the Petitioner has met his burden of proof. In support of this finding, the Arbitrator relies on the Petitioner's testimony and the preponderance of the medical evidence. Petitioner credibly testified that on July 3, 2019, he lifted a 30-40 pound metal hose and hurt his back. Although Respondent questions this incident because it was not immediately reported,

there was no other evidence offered to rebut Petitioner's testimony on this issue. All of Petitioner's treating records contain a history of accident consistent with the Petitioner's testimony. Petitioner's explanation of his delay in reporting his accident because of his Parkinson's disease is very reasonable given the physical challenges Petitioner experienced due to this unrelated disease. Accordingly, the Arbitrator concludes that the Petitioner sustained an accident arising out of his employment with Respondent on July 3, 2019.

2. With regard to the issue of causation, the Arbitrator finds that the Petitioner has met his burden of proof. In support of this finding, the Arbitrator relies on the Petitioner's unrebutted testimony and the medical evidence from Petitioner's treaters. Petitioner testified that he did not have back pain prior to this injury and explained that from his Parkinson's disease he experienced loss of balance and numbness and trembling in his hands. He also explained that when he injured his back at work, he did not report it immediately because he was not sure of whether his back pain may have been due to his Parkinson's disease. The Arbitrator finds persuasive the testimony of Dr. Salehi, who confirmed that Petitioner did not have any significant prior low back pain and that his back problems have not diminished since the accident. Dr. Salehi diagnosed Petitioner with an annular tear. While Respondent disputes this issue based on the opinions of their IME, Dr. Lami - who did not believe Petitioner had a herniated disc condition, found no good explanation for Petitioner's complaints of pain, and opined that Petitioner should be at MMI - the Arbitrator does not find Dr. Lami's opinions persuasive when compared to the preponderance of the medical evidence which did reveal a broad based herniation at L4/5 and at L5/S1, and would explain Petitioner' continued complaints of back pain. As such, the Arbitrator concludes that the Petitioner's current condition of ill-being in his back is causally connected to his July 3, 2019 work accident.

3. Consistent with the Arbitrator's conclusions on the issues of accident and causation, the Arbitrator further finds that the treatment provided by Drs. Davis, Vargas and Salehi was reasonable and necessary with the exception of the lumbar discogram – which Dr. Salehi testified was not necessary. All bills in Petitioner's Exhibit 5 other than those in conjunction with the discogram are awarded pursuant to the Fee Schedule in Section 8.2 of the Act.

4. Consistent with the Arbitrator's findings above, the Arbitrator further finds that the Petitioner's request for prospective medical care is reasonable and necessary to address his work-related back condition stemming from his July 3, 2019 accident. Accordingly, Respondent shall authorize and pay for the prospective medical treatment recommended by Dr. Salehi, including his recommendation for surgery and any related follow-up medical care.

5. Based on the findings above, the Arbitrator further finds that the Petitioner was temporarily totally disabled from July 29, 2019 – the date he was authorized off work due to his back condition by Dr. Davis – through the date of hearing. Therefore, the Arbitrator awards the Petitioner TTD from the July 29, 2019 through the date of this hearing. Petitioner has received long term disability benefits from Respondent for his Parkinson's and Respondent shall receive a credit for any disability benefits it has paid pursuant to Section 8(j) of the Act.

22IWCC0202

Illinois Workers' Compensation Commission
Arbitrator Decision Receipt Form

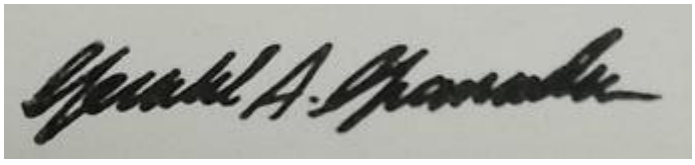
Please list all decisions on this form and complete all fields. Print three copies of this form and submit with your decisions to Arbitration Support Staff. One signed copy will be returned to you.

Arbitrator Gerald Granada			Date sent **10/13/21**	
	Case Number	**Petitioner's Name**	**Respondent's Name**	**Proofs Closed Date**
1	**19 WC 22269**	**Gonzalez**	**SunSource**	**8/9/21**
2				
3				
4				
5				
6				
7				
8				
9				
10				

Total number of decisions: **1**

By signing below I hereby verify that for each of the decisions listed above I have double-checked for accuracy each of the following:

- The correct form has been used;
- The case name and number are correct;
- The correct boxes for funds have been checked;
- The rates for TTD, TPD, PPD, PTD, and fatal benefits are correct in relation to both the AWW listed and the applicable maximum and minimum rates;
- The correct number of weeks is listed in relation to the percentage(s) of disability awarded;
- The correct number of weeks is listed in relation to the period of TTD awarded;
- The findings and conclusions attached to the decision correctly match the findings and order portion of the Commission's decision form;
- I have properly signed and dated the decision.



_____
Arbitrator signature

ARBITRATION SUPPORT SECTION

Date received: _____

Number of decisions received: _____

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC028672
Case Name	PENNINGTON, LORI v. STATE OF ILLINOIS, EPA
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0206
Number of Pages of Decision	22
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	William LaMarca
Respondent Attorney	Kayla Koyne

DATE FILED: 6/1/2022

/s/ Deborah Simpson, Commissioner

Signature

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

Lori Pennington,
Petitioner,

vs. NO: 18 WC 28672

State of Illinois, EPA,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 6, 2021, 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.

Pursuant to §19(f)(1) of the Act, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

June 1, 2022
o5/25/22
DLS/rm
046

/s/*Deborah L. Simpson*
Deborah L. Simpson

/s/*Stephen J. Mathis*
Stephen J. Mathis

/s/*Deborah J. Baker*
Deborah J. Baker

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC028672
Case Name	PENNINGTON, LORI v. STATE OF ILLINOIS EPA
Consolidated Cases	
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	20
Decision Issued By	Maureen Pulia, Arbitrator

Petitioner Attorney	William LaMarca
Respondent Attorney	Kayla Koyne

DATE FILED: 12/6/2021

THE INTEREST RATE FOR THE WEEK OF NOVEMBER 30, 2021 0.09%

/s/ Maureen Pulia, Arbitrator
Signature

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

December 6, 2021

/s/ Brendon O'Rourke
Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

LORI PENNINGTON,
Employee/Petitioner

v.

STATE OF ILLINOIS, EPA,
Employer/Respondent

Case # **18** WC **28672**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Springfield**, on **11/19/21**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **8/29/18**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**60,492.12**; the average weekly wage was $**1,163.31**.

On the date of accident, Petitioner was **56** years of age, ***married*** with **1** dependent children.

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

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

Respondent shall be given a credit of $**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 temporary total disability benefits of $775.54/week for 4 weeks, commencing 12/18/18 through 1/3/19, and 6/4/21 through 6/16/21, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services related to petitioner's bilateral carpal tunnel and cubital tunnel syndrome from 8/29/18 through 6/16/21, as provided in Section 8(a) and 8.2 of the Act.

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

Respondent shall pay Petitioner permanent partial disability benefits of $697.99/week for 7.6 weeks, because the injuries sustained caused the net loss of 2% loss of the petitioner's right hand, and the net loss of 2% loss of the petitioner's left hand, as provided in Section 8(e) of the Act, after taking into consideration respondent's credit of 17.5% loss of use of the right hand, and 18.5% loss of use of the left hand pursuant to Section 8(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $697.99/week for 50.6 weeks, because the injuries sustained caused a 10% loss of the petitioner's right arm, and a 10% loss of the petitioner's left arm, as provided in Section 8(e) of the Act

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

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

Maureen H. Pulia

_____ **DECEMBER 6, 2021**

Signature of Arbitrator

ICArbDec p. 2

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 56 year old Facilities ID Unit Manager, alleges she sustained accidental injuries to her bilateral upper extremities, due to repetitive work activities, that arose out of and in the course of her employment by respondent, and manifested itself on 8/29/18. Petitioner has worked for the State of Illinois for 30 years in different agencies.

On 11/1/17 petitioner had presented to Dr. Kevin Hazard for her uncontrolled diabetes Mellitus type 2, with neuropathy, as well as other conditions. They discussed treatment options. Dr. Hazard noted microvascular complication of peripheral neuropathy affecting her feet in the form of tingling and paresthesias. Various management programs were discussed. On 1/28/18 she returned to Dr. Hazard for her uncontrolled diabetes and the option of adding prandial insulin was discussed, but petitioner did not want to pursue it. On 8/27/18 she again followed-up with Dr. Hazard and she was continued on GLP-1 agonist therapy. Weight loss was again recommended.

On 8/29/18 petitioner was working in the EPA Department. She testified that for seven years her duties involved mainly typing all day long. Petitioner would assign ID numbers to all documents that were imaged, such as all records, files, and applications. During any given shift petitioner would use her keyboard/mouse at least 6 hours in her 7 ½ hour day. She testified that her work would in come in through emails or the database. Prior to performing this position for 7 years, petitioner worked as a supervisor of the administration staff that was over the Bureau of Air. In that job she answered all emails and instructed workers. She also had her own typing tasks then. Petitioner testified that her typing hours per day were the same in both positions.

On 8/16/18 petitioner presented to her primary care physician, Dr. Widicus. She reported that it felt like her carpal tunnel was back in her right wrist. Petitioner had surgery for her carpal tunnel 14 years ago. Dr. Widicus diagnosed carpal tunnel syndrome and diabetes mellitus. Petitioner testified that she was diagnosed with diabetes 8 years ago.

On 8/29/18 petitioner underwent an EMG/NCS of her bilateral arms performed by Dr. Trudeau. Dr. Trudeau noted that petitioner was right hand dominant and suspected of having recurrent carpal tunnel and/or even possibly cubital or other conditions. Dr. Trudeau was of the opinion that petitioner has diabetes mellitus, but that diabetic neuropathy tends to show up first and worst in the feet, and less so in the upper extremities. Dr. Trudeau noted that petitioner's symptoms in the left 5th digit and the right 3rd and 4th digits would not tend to follow the stocking glove pattern of diabetes mellitus, which tends to be diffuse. He noted that diabetes mellitus tends to attack all digits and it tends to be equal and

symmetrical. Dr. Trudeau noted that petitioner gave a very clear history that her work activities bring on and aggravate her symptoms. He noted that she reported that by the end of the work day after using her upper extremities repetitively her symptoms were much worse. Based on this information, Dr. Trudeau was of the opinion that it certainly seemed less likely that her problems were diabetic related, but were more likely related to discreet entrapment neuropathy. The results of the bilateral EMG/NCS revealed bilateral carpal tunnel syndrome, moderately severe on the right side, and mild on the left; bilateral cubital tunnel syndrome, mild and neuropathic on either side, left greater than right; and, no current evidence of proximal neuropathy, distal neuropathy, other entrapment neuropathy, cervical radiculopathy, or brachial plexopathy.

On 9/13/18 the Supervisor's Report of Injury or Illness was completed by Tom Reuter. He noted that petitioner was the Supervisor of the Facility ID Management Group who oversees and participates in maintenance of the Agency's site inventory system. The activity at the time of the accident/incident was identified as typing and data input.

That same date petitioner completed an Employee's Notice of Injury Report. She noted that the duty she was performing at the time of injury was keyboard typing and data inputting in her office/cubicle. She noted that the injury occurred with constant daily typing and data inputting for several years. She noted prior surgery in 2007 for a right carpal tunnel syndrome, and a surgery on 2004 for a left carpal tunnel syndrome.

On 9/26/18 petitioner presented to Dr. Michael Neumeister for recurrent bilateral carpal tunnel syndrome and a new onset of bilateral cubital tunnel syndrome. Dr. Neumeister noted that petitioner had a release of her bilateral carpal tunnels approximately 10 years ago. Petitioner noted that paresthesias in her radial sided digits approximately 6 months ago, with new ulnar sided symptoms. She reported that her left side ulnar neuropathy was the most bothersome to her. Dr. Neumeister noted that petitioner reported that she worked at a desk job which requires frequent typing. Following an examination Dr. Neumeister assessed bilateral recurrence of carpal tunnel, and a new onset of bilateral cubital tunnel, confirmed by EMG. He recommended nighttime splinting of her wrists and elbows.

On 10/29/18 petitioner followed up with Dr. Neumeister. Her chief complaint was numbness and tingling in her left hand. She reported that the splints had not helped her hands and that she wanted to proceed with a surgical release. Dr. Neumeister recommended a decompression of the left side first.

On 12/18/18 petitioner underwent a left carpal tunnel and cubital tunnel release performed by Dr. Neumeister. Petitioner was authorized off work. Petitioner followed-up post-operatively with Dr. Neumeister.

On 1/3/19 petitioner followed up with Dr. Neumeister. She was doing quite well and the sutures were removed. Dr. Neumeister was of the opinion that petitioner could return on an as needed basis. Petitioner was released to full duty work without restrictions.

On 5/22/19 Dr. Neumeister drafted a letter in response to some correspondence he received with regards to petitioner. He noted that petitioner told him she worked as a desk personnel and it required frequent typing, but had no documentation that the symptoms got worse while she was doing those activities. However, he also noted that on a new outpatient intake form she did indicate that she is a smoker of about ½ package of cigarettes per day, and is diabetic, both of which are risk factors for compression neuropathies. Dr. Neumeister noted that although he did not have it documented in his notes, if while doing the work petitioner did (such as typing or any other particular activity), it brought on the symptoms of numbness and tingling in her hands and upon discontinuation of those activities the symptoms resolved, that he would believe the work aggravated her symptoms. Dr. Neumeister was of the opinion that the exact cause of petitioner's carpal tunnel was likely multifactorial with contribution from the smoking, diabetes, and potential scarring from the previous surgery, except as it relates to the cubital tunnel.

On 12/12/19 petitioner underwent a Section 12 examination performed by Dr. James Williams. Petitioner reported that she works for the Illinois Department of EPA from 8 am-5pm Monday through Friday, with two 15-minute breaks and a 30 minute lunch. She reported that she worked for the EPA for 30 years, and IDOT for 6 years. Petitioner gave a history of her symptomatology to date and her treatment.

As far as her work is involved, petitioner stated that she had been a supervisor for the last 5 years. She stated that she cross references all databases into 1 database at ASES. She further stated that her and her staff, which is 4 people, are transferring data and assigning all ID numbers for every document/site in the state. She noted that she types on the computer all day long regarding all data from each site. She stated that there are paper and emails which she has to go through on the computer. She does 6 hours of typing per day at minimum. She also reviews all staff's work for accuracy. She stated that her workstation is on a counter, and she has a split keyboard (ergonomic keyboard). She also noted that she

has a pull out tray, but it is broken so she does not use it. Her chair is adjustable. She denied resting her wrists or elbows on the counter. Petitioner demonstrated her typing for Dr. Williams.

Dr. Williams reviewed her medical history and records and performed a physical examination. Dr. Williams assessed uncontrolled diabetes, now on insulin, with a 5 year history of non-insulin dependent diabetes, which was uncontrolled; a 30+ year smoking history of ½ pack per day; postmenopausal for over 6 years; and BMI greater than 42. He assessed carpal and cubital tunnel on the right with normal sensation, and no further findings of carpal tunnel or cubital tunnel on the left. Dr. Williams did not find that petitioner had a non-ergonomic workstation, although he had no pictures of it. Dr. Williams found petitioner's typing to be intermittent, but the question was how much. He noted that she claimed to type 6 hours a day, but it sounds like it is mainly data entry. Based on this he did not find petitioner's work activities would either be aggravating and/or causative of her condition. Dr. Williams felt that her uncontrolled diabetes for several years, where her hemoglobin A1c's were markedly elevated even at times in the 11s with blood sugars consistently in the 200s and 300s, would be more the cause of her condition, instead of her work duties. He noted that petitioner was right handed and her nerve study showed that the right side was worse than the left, yet she had more symptoms on the left, which he found inconsistent. He was of the opinion that her condition would be more related to her medical comorbidities being her obesity, her postmenopausal status, her uncontrolled diabetes, rather than her work duties. Dr. William was of the opinion that petitioner did not need any further medical treatment for her left side, but she may need surgery for her right side, being a right carpal and right cubital release. He was of the opinion that petitioner had reached MMI for her left side when Dr. Neumeister released her in January of 2019.

On 3/24/20 Dr. Williams drafted an Addendum report after viewing pictures of petitioner's workstation. He noted that it appeared as petitioner had indicated. Based on what he saw in the pictures he was of the opinion that the workstation was ergonomically correct.

On 10/1/20 the evidence deposition of Dr. Williams, an orthopedic surgeon with CAQ in hand and upper extremity and microvascular surgery, was taken on behalf of the respondent. Dr. Williams was of the opinion that 15% of patients that have had carpal tunnel release surgeries need revision surgery down the road. Dr. Williams noted that in a note from Dr. Hazard it was noted that petitioner had microvascular complications of peripheral neuropathy affecting her feet in the form of tingling and paresthesias. He said it was significant because it showed the extent of her diabetes in regards to the fact that it was bad enough that it was affecting the blood supply to the nerves. He stated that it can also affect her hands. Dr.

Williams opined that petitioner's work duties did not cause or contribute to her carpal tunnel syndrome or cubital tunnel syndrome. He opined that her insulin dependent diabetes, 30 year history of smoking ½ pack a day, her postmenopausal status of over six years, and her BMI greater than 42, were bigger contributing factors than her work activities would be. Dr. Williams opined that her medical treatment was reasonable and necessary, but not related to her work activities.

On cross-examination Dr. Williams noted that the EMG of 8/29/19 did not reveal the presence of diabetic neuropathy. He also testified that petitioner did not have evidence of a stocking-glove type pattern. Dr. Williams noted that the symptoms in her feet that Dr. Hazard noted in his office notes on 11/1/17, she did not complain of the same to him, and he was opinion that it might be because her blood sugar value was improved. Dr. Williams admitted that there can be more than one cause to the development of carpal tunnel and cubital tunnel syndrome. Dr. Williams was of the opinion that petitioner's typing was intermittent because she was viewing papers on a computer, which she explained was when they are inputting them in the system she is checking things. He was of the opinion that if someone is typing a few keys, scanning documents and then typing again, that's a different activity, and different amount of activity than it is when someone is constantly typing. Dr. Williams was of the opinion that if petitioner is typing 6 hours a day, instead of intermittently, that would be constant, and possibly a contributing factor to the development of her conditions. He also testified that if she did more than data entry, his opinion may change. Dr. Williams was of the opinion that if petitioner's arms are held in a flexed position for a prolonged period of time, that can stretch the nerve and bring about symptomatology.

On redirect examination, Dr. Williams testified that when petitioner demonstrated how she holds her arms and hands when she types that it was essentially ergonomic. He noted that petitioner did not rest her forearms, elbows, or wrists on the table when she typed.

On 11/18/20 the evidence deposition of Dr. Neumeister, a plastic surgeon, board certified with an additional qualification in hand surgery, was taken on behalf of petitioner. Dr. Neumeister testified that petitioner gave him a brief history of her job duties regarding her work at a desk job which required frequent typing. Dr. Neumeister was of the opinion that the symptoms petitioner described to him in her hands were related to a peripheral neuropathy as opposed to diabetic neuropathy. He was also of the opinion that if petitioner's typing activities brought on her symptoms, then it could aggravate her conditions of carpal tunnel and cubital tunnel. Dr. Neumeister was told that while typing, petitioner's keyboard was on the top of the table, and while operating her keyboard, her arms are in a flexed position

of about 45 to 60 degrees. Dr. Neumeister opined that this position puts the nerves at risk and can contribute to the development of cubital tunnel syndrome. Dr. Neumeister was of the opinion that when typing or doing activities where the fingers are extending and flexing, those tendons are gliding back and forth around the nerve over a period of time that could result in inflammation and swelling around the nerve giving symptoms of carpal tunnel. He was also of the opinion that if a person rests their wrists on a pad or the edge of the desk while typing, that direct compression over the carpal tunnel could actually result in the symptoms of carpal tunnel syndrome. Dr. Neumeister opined that if petitioner was typing 6 hours a day, that in combination with her other conditions that place her at an increased risk of developing carpal tunnel, could lead to the development of carpal tunnel syndrome. Dr. Neumeister opined that petitioner's work activities were at least a contributing factor of developing her bilateral carpal tunnel and cubital tunnel syndrome.

On cross examination, Dr. Neumeister was of the opinion that a person's sleeping position can possibly aggravate their carpal or cubital tunnel syndrome, or aggravate the symptoms. Dr. Neumeister testified that petitioner only discussed with him her typing duties at work, but did not report how much time per day she spent doing that, or if it was broken up by any other job duties. He further testified that she did not indicate where her keyboard was located; did not indicate if her work chair was adjustable; did not provide him with photos of her work station; did not demonstrate how she would hold her hands and arms at her desk when performing her job duties; did not describe exactly what she was typing at work; and, did not indicate whether she types repetitively or consistently. Dr. Neumeister was of the opinion that it is not common for people who have carpal tunnel release surgeries to need revision surgeries in the future. Dr. Neumeister was of the opinion that petitioner had other risk factors for carpal tunnel that included diabetes, being a smoker, and thyroid disorder. He was also of the opinion that as people age they have an increased chance of developing carpal tunnel or cubital tunnel surgery, and that women, and especially those who are peri or postmenopausal, have a higher chance of developing cubital and carpal tunnel. Dr. Neumeister noted that petitioner made no mention of anything outside of work causing her symptoms.

On 2/3/21 petitioner presented to Dr. Mark Greatting for numbness and tingling in her right arm. She gave a history of her previous surgeries on her bilateral arms and hands. She reported that she did well after the left carpal tunnel and cubital tunnel release in 2018. She complained of numbness and tingling in the index and middle fingers of her right hand, symptoms in the ulnar side of her hand and thumb. She noted a twitching type sensation involving her thumb. She reported some discomfort in her

medial elbow area, and minimal symptoms at night. On her intake form she reported that continuous typing and writing made her symptoms worse. She reported that her symptom bother her while she is at work, and while sleeping.

She gave a history of being employed by the State of Illinois for 40 years, and was currently a supervisor at the EPA. She reported that she uses the keyboard and mouse on a regular basis and does this for most of her time during her workday. She also reported that she also has to lift some mail bins full of files and take them to various employees. She noted a significant increase in her symptoms while doing her daily activities and as a result has to frequently stop and shake her hands to get the symptoms to resolve. She felt her symptoms were getting worse over time. She also reported increased symptoms with writing activities. Petitioner gave a history of her diabetes mellitus and ½ pack a day smoking history.

Following an examination and review of the EMG performed 8/29/18, Dr. Greatting was of the opinion that petitioner had a history and exam findings consistent with right carpal tunnel syndrome and recurrent right carpal tunnel syndrome. Dr. Greatting recommended an updated EMG.

On 3/24/21 petitioner underwent a repeat EMG/NCS performed by Dr. Trudeau. Petitioner reported that she uses the keyboard and mouse on a regular basis and does this for most of her time during her work day. He noted that petitioner was very specific that her work activities both bring on and aggravate her symptomatology. She noted that she has had continued difficulties in her upper extremities, and still has symptoms on the left side, as well as particularly with paresthesias about the left elbow. The results of the EMG/NCS revealed right carpal tunnel syndrome, moderately severe, and increased since study on 8/29/18; right cubital tunnel, mild; left carpal tunnel syndrome, mild and similar to the previous study, and likely persistent/residual lesion, not unusual given the timeframe since the surgery; resolution of the left cubital tunnel syndrome; and, no current evidence of cervical radiculopathy or brachial plexopathy.

On 4/14/21 petitioner followed-up with Dr. Greatting to review the results of the updated EMG/NCS. Following an examination, Dr. Greatting assessed right chronic cubital and carpal tunnel syndrome. He noted that the carpal tunnel syndrome was recurrent. Dr. Greatting recommended a right carpal and cubital tunnel release.

On 6/4/21 petitioner underwent a right carpal tunnel release and a right cubital tunnel release performed by Dr. Greatting. Petitioner followed up post-operatively with Dr. Greatting.

On 6/8/21 Dr. Greatting authorized petitioner off work through 6/16/21 due to surgery on 6/4/21.

On 6/16/21 petitioner followed-up with Dr. Greatting. She reported that she was doing well. She felt that the numbness and tingling was resolving. Her sutures were removed. Dr. Greatting released petitioner on an as needed basis, and returned her full unrestricted work duties.

On 6/21/04 Arbitrator Stephen Mathis approved a Settlement Contract for case 03 WC 41603. This Contract involved an injury to petitioner's right hand and wrist due to repetitive work activities. It was settled for 17.5% of the right hand.

On 1/7/08 Arbitrator Stephen Mathis approved a Settlement Contract for case 07 WC 6843. This Contract involved an injury to petitioner's left hand carpal tunnel syndrome due to repetitive work activities. It was settled for 18.5% of the left hand.

At trial, petitioner testified that for about 6 months prior to her alleged injury date she noticed numbness in her fingers, and her pinky and elbows ached. She also reported cramping and pain in her elbows. When this occurred she would have to take a break and shake out her arms/hands. She denied any problems prior to this 6 month period preceding her alleged date of injury.

Petitioner testified that following the surgery to her left upper extremity all the pain, tingling and numbness in her left upper extremity resolved. For awhile she still had some numbness in her left elbow, but that eventually resolved. After she returned to work following her surgery on her left upper extremity petitioner did not need to take as many breaks.

Petitioner testified that she had to delay the treatment on her right upper extremity due to personal reasons involving medical issues and surgery her husband had to deal with, as well as delays due to COVID. Petitioner testified that she needed to be there for him, and once he was better, and COVID restrictions on elective surgery had been lifted, she proceeded with treatment for her right upper extremity. During this delay petitioner's symptoms in her right upper extremity continued. She stated that she had to stop, pause, and take breaks. Following her return to work after the surgery on her right upper extremity, petitioner testified that she no longer had numbness in her fingers, or any pain in her elbow. She testified that all her symptoms had resolved.

Petitioner testified that she is a diabetic that uses insulin and other medications to control her blood sugar. She testified that she is currently controlling her diabetes with this treatment. Petitioner denied any numbness in her feet or hands.

Petitioner testified that when working on the keyboard her wrists and palms rest on the bottom part of her keyboard, and her elbows are bent at approximately 45 degrees at chest level. Petitioner testified that she also uses a numeric keypad and mouse. Petitioner stated that when she is typing her elbows do not rest on her chair arms, but rather are unsupported.

Currently, petitioner has no numbness in her fingers or elbows, and no pain in her elbows. She denied any problems with her upper extremities while working, and no longer has to stop working while typing. Petitioner can perform all her job duties without issue, and has no issues with her upper extremities.

Petitioner testified that the only job duties she has that do not require typing are going to the copier, and answering phone calls from the company. Petitioner testified that she assigns ID numbers; processes emails and requests from compliance section when the company has a violation; processes requests for permit applications by assigning ID numbers. Petitioner testified that the typing she does all day involves filling in forms and memo typing. Petitioner testified that 90-95% of her workday is spent typing, with the remaining 5-10% spent copying, answering phones, or helping one of her employees. She also testified that the Job Description does not accurately reflect the time she spends on the keyboard.

Petitioner testified that the ergonomic keyboard she works on does not fit on the keyboard tray attached to her desk and that is why she has to work with her keyboard on her desk, which is 20 years old.

Respondent offered into evidence petitioner's Job Description which listed the percentage of time she spends on large groups of activities. The actual amount of keyboard time associated with these specific activities is not noted in the job description.

B. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?

Petitioner alleges that she sustained an accidental injury to her bilateral hands and arms, due to repetitive work activities, that arose out of and in the course of her employment by respondent, that manifested itself on 8/29/18. Respondent disputes this claim.

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

detailed information concerning the petitioner's work activities, including the frequency, duration, manner of performing, etc. It is also equally important that the medical experts have a detailed and accurate understanding of the petitioner's work activities.

Since petitioner is claiming injuries to her bilateral hands and arms, in Illinois, recovery under the Workers' Compensation Act is allowed, even though the injury is not traceable to a specific traumatic event, where the performance of the employee's work involves constant or repetitive activity that *gradually* causes deterioration of or injury to a body part, assuming it can be medically established that the origin of the injury was the repetitive stressful activity.

Pursuant to the Supreme Court's holding, petitioner must first place into evidence specific and detailed information concerning her work activities, including the frequency, duration, manner of performing, etc. In the case at bar, petitioner testified that she types on her computer 6 hours of her 7 ½ hour day. She testified that although she types on an ergonomic keyboard, the keyboard is on her desk, due to a broken keyboard tray under her desk. When typing on the keyboard her wrists and palms rest on the bottom part of her keyboard, and her elbows are at a 45 degree angle about her chest, and do not rest on her desk or the arms of her chair. In addition to her keyboard, petitioner also uses a numeric keypad and a mouse.

Petitioner testified the she spends 90-95% of her work day typing on the keyboard, with the remaining 5-10% of her work day copying, answering phones, or helping her employees. Petitioner testified that the typing she does do involves assigning ID numbers, processing emails, and requests from the compliance section when a company has a violation. She also processes requests for permit applications by assigning ID numbers. She testified that her typing does not only involve filling in forms, but also involves memo typing.

Respondent offered into evidence a Job Description for petitioner that outlined the percentage of time she spent on specific groups of activities. However, this job description does not include how much time was spent using the keyboard. Petitioner even confirmed that this Job Description does not accurately reflect the time she spends keyboarding per day. Although the arbitrator agrees the Job Description is detailed, she also finds it significant that this Job Description does not accurately reflect which duties require the use of the keyboard, and for how long.

The arbitrator also finds it significant that when petitioner completed the Employee's Notice of Injury Report, she noted that the duty she was performing at the time of injury was keyboard typing and data inputting in her office/cubicle. She also reported that the injury occurred with "constant" daily typing and data input for several years.

In addition, the arbitrator finds it significant that other than the Job Description, respondent offered no evidence to rebut the time petitioner spent keyboarding per day, the information she was typing, the manner in which she performed her typing, and her workstation setup.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner placed into evidence specific and detailed information concerning her work activities, including the frequency, duration, and manner of performing her work duties.

In addition to the petitioner placing into evidence specific and detailed information concerning her work activities, including the frequency, duration, manner of performing, etc., the Supreme Court held that it is also equally important that the medical experts have a detailed and accurate understanding of the petitioner's work activities.

In the case at bar, Dr. Trudeau noted in his report that petitioner gave a very clear history that her work activities bring on and aggravate her symptoms in her upper extremities. He also noted that she told him that by the end of the work day, after using her upper extremities repetitively, her symptoms were much worse.

Dr. Neumeister treated petitioner for her left upper extremity. Petitioner reported to Dr. Neumeister that she worked at a desk job that required frequent typing. In a letter to petitioner's attorney, Dr. Neumeister again reiterated that petitioner told him she worked as a desk personnel and it required frequent typing. During his deposition Dr. Neumeister was told that while typing petitioner's keyboard was on the top of the table, and while operating her keyboard, her arms are in a flexed position of about 45-60 degree. Dr. Neumeister was also told that petitioner types 6 hours a day.

Petitioner reported to Dr. Greatting that she uses the keyboard and mouse on a regular basis and did those for most of her time during the workday. She also reported that she had to lift some mail bins full of files and take them to various employees. She also reported to Dr. Greatting that she had a significant increase in her symptoms while doing her daily activities, and as a result has to frequently stop and shake out her hands to get her symptoms to resolve.

Petitioner was also examined by Dr. Williams on behalf of the respondent. Petitioner reported to Dr. Williams that she cross references all databases into 1 database at ASES; transfers data and assigns ID numbers for every document/site in the State; and types on the computer all day long (6 hours at minimum). She also told Dr. Williams that her workstation is on a counter, and she has an ergonomic keyboard. She noted that her workstation has a pullout keyboard tray, but it is broken, and even if fixed, the ergonomic keyboard does not fit on it. Petitioner demonstrated how she types for Dr. Williams.

Based on the above, as well as the credible evidence, in addition to finding the petitioner placed into evidence specific and detailed information concerning her work activities, including the frequency, duration, and manner of performing her work duties, the arbitrator also finds the medical experts had a detailed and accurate understanding on petitioner's work activities. Therefore, the arbitrator finds the petitioner has proven by a preponderance of the credible evidence that she sustained an accidental injury to her bilateral hands and arms due to repetitive work activities, that arose out of and in the course of her employment by respondent, and manifested itself on 8/29/18.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

Having found the petitioner has proven by a preponderance of the credible evidence that she sustained an accidental injury to her bilateral hands and arms due to repetitive work activities, that arose out of and in the course of her employment by respondent, and manifested itself on 8/29/18, the arbitrator next looks at whether or not her current condition of ill-being as it relates to her current condition of ill-being as it relates to her bilateral hands and arms is causally related to the injury on 8/29/18. The arbitrator notes, and case law has held, that the petitioner's work activities need not be the sole cause of her current condition of ill-being as it relates to her bilateral hands and arms, but merely "a cause" of her current condition of ill-being.

In the case at bar, it is unrebutted that on or about the date of injury petitioner had been diagnosed, and was treating for diabetes mellitus. Approximately one year before the injury, she had seen Dr. Hazard for microvascular complication of peripheral neuropathy affecting her feet in the form of tingling and paresthesias. On or about the alleged date of injury on this case, petitioner underwent an EMG/NCS of her bilateral arms that showed bilateral carpal tunnel syndrome, moderately severe on the right, and mild on the left, as well as bilateral cubital tunnel, mild on both sides, left greater than right. Dr. Trudeau was of the opinion that although petitioner has diabetes mellitus, diabetic neuropathy tends to show up first and worst in the feet, and less so in the upper extremities. He was also of the opinion that petitioner's symptoms in the 5th digit and the right 3rd and 4th digits would not tend to follow the stocking glove pattern of diabetes mellitus, which tends to be diffuse. He noted that diabetes mellitus tends to attack all digits and tends to be equal and symmetrical, which is not what the EMG/NCS showed. Dr. Trudeau was of the opinion that petitioner gave a very clear history that her work activities is what brought on and aggravated her symptoms, and that by the end of the work day, after using her upper extremities repetitively, her symptoms were much worse. Based on this information, Dr. Trudeau was of the opinion that it certainly seemed less likely that petitioner's problems were diabetic related, but were more likely related to discreet entrapment neuropathy.

Petitioner also treated with Dr. Neumeister. She gave a history of frequent typing. Although Dr. Neumeister indicated that petitioner smoked ½ pack of cigarettes a day, and was a diabetic, and both are risk factors for compression neuropathies, he was of the opinion that if petitioner's typing at work brought on the symptoms of numbness and tingling in her hands and upon discontinuation of those activities the symptoms resolved, that he would believe her work activities aggravated her symptoms. The arbitrator finds it significant that petitioner did in fact testify that her typing would aggravate her hands to the point where she had to stop, and shake them out so her symptoms would subside.

When Dr. Neumeister was deposed he opined that the symptoms petitioner described were due to a peripheral neuropathy, as opposed to a diabetic neuropathy. He further opined that if petitioner's typing activities brought on her symptoms, which petitioner testified that they did, then her work activities could aggravate her conditions of carpal and cubital tunnel. Dr. Neumeister also opined that petitioner's position on the keyboard put her nerves at risk and could contribute to the development of cubital tunnel syndrome. He opined that when typing or doing activities where the fingers are extending and flexing, as petitioner described, the tendons are gliding back and forth around the nerve over a period of time that could result in inflammation and swelling around the nerve giving symptoms of carpal tunnel. Dr. Neumeister opined that if petitioner was typing 6 hours a day, as she testified to, that in combination with her other conditions, that placed her at an increased risk of developing carpal tunnel, and could lead to the development of carpal tunnel syndrome. He further opined that petitioner's work activities were at least a contributing factor in the development her bilateral carpal tunnel and cubital tunnel syndrome.

When Dr. Williams examined petitioner, she described her work duties and stated that she types on the computer all day long, which she indicated was a minimum of 6 hours a day. She also described her workstation and the fact that she could not put her ergonomic keyboard on the keyboard tray because it was broken. After discussing her work duties with her, examining her, and reviewing her medical history, Dr. Williams determined petitioner's typing to be intermittent, even though that is not what petitioner described. He also assumed petitioner's only performed data entry, even though credible evidence supports a finding that petitioner typed memos in addition to her data entry. Based on these inaccurate assumptions, Dr. Williams opined that petitioner's work duties did not aggravate or cause her current condition of ill-being as it related to her bilateral upper extremities. He opined that her condition would be more related to her medical comorbidities of obesity, postmenopausal status, uncontrolled diabetes, rather than her work duties.

When Dr. Williams was deposed he noted that petitioner did not have evidence of a stocking glove type pattern of numbness in her hands, and did not have symptoms in her feet that she had reported to Dr. Hazard

nearly one year prior. He believed this was probably due to her sugar level being improved. Dr. Williams also opined that if petitioner was typing 6 hours a day, instead of intermittently, that would be constant, and possibly a contributing factor to the development of her conditions. He opined that if she did more than just data entry, which petitioner testified she did, his causal connection may change.

Based on the above, as well as the credible evidence, the arbitrator finds the opinions of Dr. Neumeister and Dr. Trudeau more persuasive than those of Dr. Williams. The arbitrator finds that Dr. Williams opinions were based in part on incorrect assumptions, that in turn, led to opinions not supported by the credible evidence. For these reasons, the arbitrator finds the petitioner has proven by a preponderance of the credible evidence that the her current condition of ill-being as it relates to her bilateral carpal tunnel syndrome and cubital tunnel syndrome, are causally related to her work injury that manifested itself on 8/29/18.

J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?

Having found the petitioner sustained an accidental injury to her bilateral hands and arms due to repetitive work activities that arose out of and in the course of her employment by respondent on 8/29/18, and that her current condition of ill-being as it relates to her bilateral hands and arms is causally related to the injury she sustained on 8/29/18, the arbitrator finds all medical services that petitioner received from 8/29/18 through 6/16/21, related to her bilateral carpal tunnel and cubital tunnel syndromes, were reasonable and necessary to cure or relieve petitioner from the effects of her injury on 8/29/18.

Based on the above, as well as the credible evidence the arbitrator finds the respondent shall pay reasonable and necessary medical services related to petitioner's bilateral carpal and cubital tunnel syndrome from 8/29/18 through 6/16/21, 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.

K. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

The petitioner claims she is entitled to temporary total disability benefits for the periods 12/18/18 through 1/3/19, and 6/4/21 through 6/16/21, for a total of 4 weeks. Respondent's sole objection is liability.

Having found the petitioner sustained an accidental injury due to repetitive work activities that arose out of and in the course of her employment by respondent on 8/29/18, and that her current condition of ill-being as it relates to her bilateral hands and arms is causally related to the injury she sustained on 8/29/18, the arbitrator

finds the petitioner is entitled to temporary total disability benefits for the periods 12/18/18 through 1/3/19, and 6/4/21 through 6/16/21, for a total of 4 weeks.

Respondent shall pay petitioner the temporary total disability benefits that have accrued from 12/18/18 through 1/3/19, and 6/4/21 through 6/16/21, and shall pay the remainder of the award, if any, in weekly payments.

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

The nature and extent of petitioner's injury, 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.

Neither party submitted an AMA rating pursuant to Section 8.1b of the Act into evidence. For this reason, the arbitrator gives no weight to this factor.

With respect to factor (ii), the occupation of the injured employee, the petitioner was a Facilities ID Unit Manager for respondent, who ultimately returned to her regular duty job on 6/16/21 and continued working without incident through the date of trial. For these reasons, the arbitrator gives less weight to this factor.

With respect to factor (iii), the age of the employee. Petitioner was 56 years old at the time of the injury. Following the left carpal tunnel and cubital tunnel release surgery petitioner was off work for 2 weeks before returning to regular duty work. Following her right carpal tunnel and cubital tunnel release on 6/4/21, petitioner was off work through 6/16/21, after which she returned to her regular duty job without restrictions and still works in this capacity full time. Petitioner testified that since being found to have reached MMI on 6/16/21 she has worked without incident through the date of trial. For these reasons, the Arbitrator gives less weight to this factor.

With respect to factor (iv), the future earnings of the petitioner, the petitioner returned to regular duty work for respondent on 6/16/21. There was no evidence entered on the record regarding her future earnings. For these reasons, the Arbitrator gives no weight to this factor.

With respect to factor (v), evidence of disability corroborated by the treating medical records, the Arbitrator notes that as result of the injury on 8/29/18 petitioner underwent bilateral carpal tunnel and cubital tunnel releases. She was ultimately released to full duty work without restrictions on 6/16/21 and found to have

reached maximum medical improvement. Petitioner testified that since undergoing the surgeries she no longer has any problems tingling and numbness in her hands or elbows.

Prior to the injury on 8/29/18 petitioner had settled a prior claim related to case 03 WC 41603, that involved an injury to her right hand in the amount of 17.5% loss of use of the right hand pursuant to Section 8(e) of the Act, for which respondent is entitled to credit.

Petitioner also settled a prior claim related to case 07 WC 6843, that involved an injury to her left hand in the amount of 18.5% loss of use of the left hand pursuant to Section 8(e) of the Act, for which respondent is entitled to a credit.

The Arbitrator gives greater weight to this factor.

Based on the above as well as the credible evidence, the arbitrator finds the petitioner sustained a net loss of 2% loss of use of her right hand, and a 2% loss of use of her left hand pursuant to Section 8(e) of the Act, after respondent's credit of 17.5% loss of use of the right hand, and 18.5% loss of use of the left hand pursuant to Section 8(e) of the Act, as well as a 10% loss of use of her right arm, and a 10% loss of use of her left arm pursuant to Section 8(e) of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	11WC019848
Case Name	KULACH, PAWEL v. CHRIS CARPENTRY AND KRZYSZTOF KOWALKOWSKI & IWBF
Consolidated Cases	
Proceeding Type	Remand
Decision Type	Commission Decision
Commission Decision Number	22IWCC0207
Number of Pages of Decision	3
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	David VanOverloop
Respondent Attorney	Will Dimas, William Meyer

DATE FILED: 6/2/2022

/s/ Deborah Simpson, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Pawel Kulach,

Petitioner,

vs. NO: 11 WC 19848
20 IWCC 563

Chris Carpentry Co.,
Krzysztof Kowalkowski, and
State Treasurer as *Ex-Officio* Custodian of the Injured Workers' Benefit Fund,

Respondents.

DECISION AND OPINION ON REMAND

This matter comes to the Commission on Petitioner's Motion for Modification of Award Pursuant to Order on Judicial Review, on remand from the Circuit Court of Cook County. Petitioner worked as a carpenter for Chris Carpentry Co and Krzysztof Kowalkowski. Those respondents did not have Workers' Compensation insurance coverage and the Illinois Workers' Benefit Fund was joined as a respondent. On April 8, 2011, Petitioner sustained a severe injury to his left hand. He had eight surgeries which resulted in various degrees of amputations of the fingers of Petitioner's left hand. The Arbitrator awarded Petitioner $572,419.08 in medical expenses, 81&1/7 weeks of temporary total disability benefits, 16&2/7 weeks of maintenance benefits, and 414 weeks of permanent partial disability benefits representing loss of the use of 50% of the thumb, 50% of the index finger, 50% of the middle finger, 50% of the ring finger, 100% of the little finger, and 60% of the person-as-a-whole for loss of occupation. On remand the Commission affirmed and adopted the Decision of the Arbitrator.

Respondent, IWBF, appealed the Decision of the Commission to the Circuit Court of Cook County. The Circuit Court vacated the Arbitrator's/Commission's permanent partial disability awards because it determined that the awards under both 820 ILCS 305/8(e) and 820 ILCS 305/(d)(2) were mutually exclusive. On remand the Circuit Court directed the Commission "to modify the Decision and Order eliminating that portion of the order awarding benefits pursuant to 820 ILCS 305/8(d)(2) and 820 ILCS 305/(e) and substituting an award pursuant to 820 ILCS 305/(e)(9) for the complete loss of the Claimant's left hand." Therefore, the Commission hereby modifies its decision in accordance with the mandate of the Circuit Court of Cook County.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's/Commission's permanent partial disability awards are hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay Petitioner temporary total disability benefits of $343.84 per week for 81&1/7 weeks commencing April 19, 2011, through November 6, 2012, as provided in Section 8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay Petitioner maintenance benefits of $343.84 per week for 16&2/7 weeks commencing November 7, 2012, through February 28, 2013, as provided in Section 8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay necessary and reasonable medical expenses of $572,419.08, under section 8(a), subject to the applicable medical fee schedule in Section 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay Petitioner $309.46 per week for 205 weeks because the injuries sustained resulted in the loss of the use of 100% of the left hand.

IT IS FURTHER ORDERED BY THE COMMISSION The Illinois State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund was named as a co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under §4(d) of the Act, in the event of the failure of 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.

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

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

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

June 2, 2022

/s/*Deborah L. Simpson*
Deborah L. Simpson

o:05/25/22
DLS/dw
46

/s/*Stephen J. Mathis*
Stephen J. Mathis

/s/*Deborah J. Baker*
Deborah J. Baker

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC035696
Case Name	GAY, JASON F v. KNAPHEIDE
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0208
Number of Pages of Decision	13
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Matthew Brewer
Respondent Attorney	Terry Schroeder

DATE FILED: 6/6/2022

/s/Stephen Mathis, Commissioner

Signature

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

Jason Gay,

Petitioner,

vs. NO. 18WC 35696

Knapheide Manufacturing,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 1, 2021, is hereby affirmed and adopted.

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

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

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

June 6, 2022

/s/ *Stephen J. Mathis*
Stephen J. Mathis

/s/ *Deborah J. Baker*
Deborah J. Baker

/s/ *Deborah L. Simpson*
Deborah L. Simpson

SJM/sj
o-5/11/2022
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ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC035696
Case Name	GAY, JASON v. KNAPHEIDE
Consolidated Cases	No Consolidated Cases
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	10
Decision Issued By	Edward Lee, Arbitrator

Petitioner Attorney	Matthew Brewer
Respondent Attorney	Terry Schroeder

DATE FILED: 10/1/2021

THE INTEREST RATE FOR THE WEEK OF SEPTEMBER 28, 2021 0.05%

/s/Edward Lee, Arbitrator

Signature

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jason Gay
Employee/Petitioner

v.

Knapheide
Employer/Respondent

Case # **18** WC **35696**

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 **Springfield**, on **8/9/21**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **7/16/18**, Respondent ***was*** operating under and subject 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 $**47,965.32**; the average weekly wage was $**922.41**.

On the date of accident, Petitioner was **49** years of age, ***single*** with **1** dependent children.

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

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

Respondent shall be given a credit of $**0.00** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**3,866.69** for other benefits, for a total credit of $**3,866.69**.

Respondent is entitled to a credit of $**3,221.27** under Section 8(j) of the Act.

ORDER

The Arbitrator finds that the Petitioner has met his burden of proof that he sustained accidental injuries that arose out of and in the course of his employment with the Respondent.

The Arbitrator finds that the Petitioner has met his burden of proving that his current condition of ill being is causally connected to the injury of 7/16/18.

The Arbitrator orders the Respondent pay all reasonable and necessary medical services as set forth in the Petitioner's exhibits, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay the Petitioner temporary total disability benefits of $614.94 per week for 16 and 2/7 weeks, commencing 2/26/19 through 6/20/19, as provided in Section 8(b) of the Act.

Respondent shall the Petitioner permanent partial disability benefits of $553.45 per week for 60 weeks, because the injuries sustained caused a 12% loss of use of the person as a whole, as provided in Section 8(d) 2 of the Act.

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

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

Edward Lee
Signature of Arbitrator

OCTOBER 1, 2021

FINDING OF FACT

The Petitioner was born on 6/19/69. The Petitioner has a Bachelor of Science in Physical Education and Sociology from Eastern New Mexico University. (AT 6) The Petitioner currently lives in Quincy, Illinois and has lived there since approximately 2002. (AT 7)

On 7/16/18 the Petitioner was employed by Knapheide Manufacturing as a washer/prepper. (AT 7) As of July 2018 the Petitioner had been working in that position for approximately 3 months. (AT 8) Prior to the washer/prepper position the Petitioner worked for the Respondent in the fabrication department. (AT 8) The Petitioner was hired on by Knapheide approximately 9/12/11. (AT 8)

The Petitioner described his job duties as a washer/prepper. Aluminum bodies would be pushed into a bay where they would look over it to see if any rivets were left from the body being built. Then the Petitioner would put on a hazmat suit and begin washing the bodies. The Petitioner described the bodies as kind of the bed of a truck. (AT 8-9) When the Petitioner would wash the bodies with a power wash system which included a lancer or wand attached to a hose.

On 7/16/18 the Petitioner testified that he was washing the cargo (a body) when the wand that he was holding with his right arm suddenly kicked his right upper extremity back. (AT 10) The Petitioner described his body mechanics at the time. The Petitioner was bent at the time of the accident. The Petitioner was bent over at the waist using his left arm to hold open one of the doors on the body and using his right arm which was bent approximately 90 degrees to hold the lancer or wand and he was spraying out one of the compartments of the body. (AT 10-12) The Petitioner testified that he was spraying inside of the box trying to get the caulking loose when his right upper extremity was shot backwards. (AT 12) The Petitioner believed that the reason that arm was shot back was due to the fact that he and his partner who were spraying out the same body although on different sides had stopped using his wand. (AT 12) The Petitioner testified that at the time of the accident he noticed a little pop in his right shoulder. (AT 15)

The Petitioner testified that the hose that goes into the lance or wand is about 2 inches in diameter. The Petitioner testified that the lance or wand that he was using was 14 inches long. (AT 15) The Petitioner testified that there are two different wands that the use. (AT 16) Once is 14 inches which is what the Petitioner was using at the time of the accident, and the other wand is 42 inches long. (AT 16) The Petitioner testified that one key difference between the 14 inch and 42 inch wand is that the 14 inch wand does not give the user the ability to adjust the power and pressure. (AT 17) On the other hand, the 42 inch wand has a handle that can be adjusted to raise or lower the power and pressure. (AT 17) The wand the Petitioner was using at the time of the accident does not give the user the ability to raise or lower the power and pressure. (AT 18)

The Petitioner again testified that at the time of the accident he noticed a pop and developed a kind of numbness in his right hand. (AT 18) The Petitioner continued working and when he finished the stage he reported the accident to the Respondent. (AT 18) The Petitioner reported the incident to his coach Andrew Wilson and explained to him what had happened. (AT 19) The Petitioner testified that he was then sent to complete an accident report which he did on the date of the accident. (AT 19)

The Petitioner testified that he did not seek medical care right away and he took some Aleve after the accident and hoped that it would simply go away. (AT 19) The Petitioner testified that he thought he just had a sprain however the numbness did continue. (AT 19) The Petitioner testified that he was able to continue to do his prepper job with one hand. The Petitioner is right hand dominant. (AT 19-20)

In the weeks following the accident, the Petitioner began to notice weakness in his right upper extremity with difficulty keeping stuff in his hands, gripping, and keeping his arm elevated for longs periods of time when standing. (AT 20)

Leading up to 7/16/18, the Petitioner was not on any work restrictions relative to his right upper extremity. The Petitioner testified that his job duties as a washer/prepper can include all different types of physical demand levels. Depending upon what station or bay in at the moment will dictate the type of work he's doing light, medium or heavy. (AT 20-21)

The Petitioner was able to do all of his job duties as a washer/prepper leading up to 7/16/18. The Petitioner did not have any problems doing any of his job duties as a washer/prepper leading up to 7/16/18. The Petitioner did not have any numbness in his right upper extremity leading up to 7/16/18. (AT 21)

The Petitioner did have prior surgeries on his right shoulder prior to July of 2018. The Petitioner underwent a right shoulder arthroscopy procedure with Dr. Derhake in 2012. (AT 21) The Petitioner then had a second arthroscopic surgery in 2014 with a Dr. Milne. (AT 22 & PX 5, p. 20-22) On 2/19/14 Dr. Milne performed a right shoulder arthroscopic revision rotator cuff repair with 3 anchors, revision subacromial decompression and extensive glenohumeral and subacromial debridement. (PX 5, p. 20-22) Subsequent to the February 2014 surgery, the Petitioner received a full duty release from Dr. Milne on 7/29/14. (PX 5, p. 14) That office visit which was admitted into evidence indicates that the Petitioner looked great and was happy with his progress. The Petitioner was able to do Crossfit workouts and was able to tolerate them well. The Petitioner was working full duty and Dr. Milne indicated the Petitioner did not require any additional medical treatment and was considered at maximum medical improvement relative to his right shoulder. (PX 5, p. 14)

Between July 2014 and July 2018 the Petitioner was not taking any medications for his right shoulder, was not on any work restrictions for his right shoulder and was able to his job with the Respondent full duty during this time period. (AT 22-23) The Petitioner did not have any problems doing his job duties being July 2014 and July 2018 nor did he have any diminished function regarding his right shoulder or right upper extremity. (AT 23)

Following the 7/16/18 work accident the Petitioner presented to the occupational medicine facility at the Quincy Medical Group at the request of the Respondent. On 9/18/18 the Petitioner indicated that the had sustained a right shoulder injury while working at Knapheide on 7/16/18. The Petitioner reported that he is a washer at Knapheide and while using a pressure washer, his partner let go of his side causing all the force toward the Petitioner's right arm. The Petitioner indicated that his right arm was jerked back and he felt a pop in the right shoulder. The Petitioner has continued to work since the date of the accident without restrictions but has developed numbness and weakness in the shoulder. The Petitioner described his two prior rotator cuff surgeries performed by Dr. Derhake and Dr. Milne. An examination was taken and it was recommended the Petitioner have a right shoulder MRI. The Petitioner was also placed on light duty. (PX 2, p. 2-5)

On 10/8/18 the Petitioner underwent an MRI of the right upper extremity without contrast at Quincy Medical Group. This revealed post-surgical changes compatible with prior rotator cuff repair; supraspinatus full width re-tear with tendon retraction to the mid-humeral head with mild fatty atrophy of the muscle belly; no evidence of a full thickness tear of the infraspinatus with mild fatty atrophy of the muscle belly; subscapularis moderate tendinosis without definite evidence of tearing; and moderate acromial clavicular osteoarthritis. (PX 2, p. 25-26)

The Petitioner then followed up with the occupational medicine clinic at Quincy Medical Group on 10/16/18. The Petitioner reported some improvement while working light duty. The MRI was reviewed with the

Petitioner and he was referred to an orthopedic surgeon. It was also noted that the Petitioner had an upcoming Independent Medical Examination with Dr. Nathan Mall. (PX 2, p. 8-12)

The Petitioner then saw Dr. Mall for an IME on 10/17/18. The Petitioner testified that Dr. Mall spent about 5-7 minutes with him. (AT 26)

The Petitioner followed up with the occupational medicine clinic at Quincy Medical Group on 11/26/18. The Petitioner indicated that his case was now denied based upon the IME of Dr. Mall, however Quincy Medical Group continued to refer the Petitioner to an orthopedic surgeon. Quincy Medical Group continued to recommend the Petitioner be placed in a light duty position. (PX 2, p. 15-19)

The Petitioner then presented to Dr. Mark Greatting at the Springfield Clinic on 1/16/19. The Petitioner provided a history to Dr. Greatting of the 7/16/18 accident as well as informed Dr. Greatting of his prior surgeries from 2010 and 2012 with Dr. Derhake and Dr. Milne respectively. Dr. Greatting performed an extensive examination and recommended shoulder arthroscopy with rotator cuff repair. Dr. Greatting's office note of 1/16/19 indicated that he believed that the Petitioner's rotator cuff tear as evidenced by the MRI of 10/28/18 is a new tear and directly related to the injury of 7/16/18. Dr. Greatting continued the Petitioner on light duty work. (PX 3, p. 2-4)

On 2/26/19 the Petitioner underwent a right shoulder arthroscopy with subacromial decompression and repair of recurrent rotator cuff tear performed by Dr. Greatting. Pre and post-operative diagnosis was recurrent right rotator cuff tear. The Petitioner was taken off of work at the time and after his surgery. (PX 3, p. 11-12)

The Petitioner followed up with Dr. Greatting post-operatively on 3/11/19. Incisions were well healed and the Petitioner's sutures were removed. The Petitioner was primarily taking narcotic pain medication at night. The Petitioner was given an immobilizer and was kept off work at this time. It was indicated that 6 weeks post-operatively the Petitioner could begin physical therapy. (PX 3, p. 17)

The Petitioner followed up with Dr. Greatting on 4/16/19. The Petitioner's immobilizer was removed for the examination. The Petitioner's pain was well controlled and he was able to comfortably forward flex and abduct to and 120-130 degrees. The Petitioner was instructed to continue using his shoulder immobilizer until 8 weeks post-operatively. Physical therapy was ordered and the Petitioner was kept off of work at this time. (PX 3, p. 37)

The Petitioner began physical therapy on 4/17/19 at First Choice Physical Therapy in Quincy. (PX 4)

The Petitioner followed up with Dr. Greatting on 5/22/19. The Petitioner indicated that he was doing well and had increased range of motion and strength with minimal pain. The Petitioner was to continue in physical therapy for another month to continue working on strengthening and would be re-evaluated at that time. The Petitioner was placed on light duty with no lifting, pushing, pulling over 5 lbs, no reaching above shoulder level, and no forceful or repetitive pushing, pulling or gripping. (PX 3, p. 32-33)

The Petitioner followed up with Dr. Greatting on 6/20/19. The Petitioner was continuing to do well and had further increased his range of motion and strength in his shoulder. Dr. Greatting indicated the Petitioner would be released to return without restrictions and will follow up in 2 months. (PX 3, p. 30-31) The Petitioner testified that he did return to his regular job full duty with the Respondent as of 6/21/19. (AT 32) The Petitioner testified that when he returned to work at that time he did notice it took him a while to adjust back to being more right hand dominant. He did have a difficult time initially with the rate and speed as to which he needed to perform his job duties, but he was able to handle the workload at that time. (AT 32-33)

The Petitioner last saw Dr. Greatting on 8/21/19. The Petitioner was back to his normal job activities and having essentially no pain. The Petitioner felt his strength was good as well as his range of motion. The Petitioner was released from care at MMI by Dr. Greatting. (PX 3, p. 28-29) The Petitioner has not seen Dr. Greatting since 8/21/19. (AT 33)

The Petitioner testified that he is still working in the washer/prepper job full duty and has maintained this status since his release on 6/21/19. (AT 33) The Petitioner testified that he is able to handle all of his current job duties but does have to use his left hand more as opposed to his dominant right hand. (AT 33-34) The Petitioner believes that he does have some limitations with his range of motion and his strength in his right upper extremity. (AT 34) The Petitioner does not recall having any issues as far as his range of motion and his strength leading up to the July 2018 accident. (AT 34)

The Petitioner testified as of the time of trial that his right shoulder feels pretty good but he does notice he has difficulty from time to time with various tasks included carrying groceries, holding his son. (AT 34) The Petitioner testified that he has to sleep on his left side more or on his back which he did not do in the past. (AT 34-35) The Petitioner notices difficulty cutting grass or weed eating, things like that. (AT 35) The Petitioner also notices difficulty at times at work when he is required to move heavier objects. (AT 35-36)

The Respondent admitted into evidence a video of an employee (not the Petitioner) using the hose and wand system the Petitioner was using at the time of the accident. (RX 2) However, on cross-examination the Petitioner confirmed that the lancer/wand in the video was not the same one he was using at the time of the accident. (AT 39-40) The lancer/wand in the video was the 42 inch lancer/wand, whereas the Petitioner was injured while using the 14 inch lancer/wand. (AT 40). The Petitioner also confirmed that the pressure can be adjusted with the 42 inch lancer/wand used in the video, whereas the pressure cannot be adjusted on the 14 inch lancer/wand he was using at the time of the accident. (AT 40)

The Respondent called Michael Dailing to testify on their behalf at trial. Mr. Dailing is the corporate safety manager at Knapheide. Mr. Dailing testified that he in aware of the basics of how the equipment at Knapheide operates. (AT 57) Mr. Dailing is the individual depicted in the video admitted as Respondent's Exhibit 2. Mr. Dailing did not take the video that is a total of about 20-30 seconds. (AT 63)

Mr. Dailing testified that a job safety analysis of Petitioner's job has been prepared by Respondent, however non was admitted at trial by the Respondent. (AT 64) Mr. Dailing also confirmed the Petitioner completed an accident report the day he was injured, but the Respondent did not admit that into evidence. (AT 64-65) Mr. Dailing also confirmed the history Petitioner gave Knapheide about how the accident occurred in the accident report that was completed on the date of the accident was essentially the same as his in-trial testimony. (AT 65-66)

Mr. Dailing confirmed he did not prepare the diagram of the wand, which is labeled as Respondent's Exhibit 4. (AT 67) Mr. Dailing did not draw the diagram, nor conduct any testing to confirm the PSI of the unit in Respondent's Exhibit 4. (AT 67) Mr. Dailing confirmed that Respondent Exhibit 4 was only in Petitioners file at Knapheide because Petitioner was injured while using the lancer/wand depicted in Respondent's Exhibit 4. (AT 68)

Mr. Dailing confirmed he was using the 42 inch lancer/wand in the video and not the 14 inch lancer/wand. (AT 70) Mr. Dailing does not use the lancers/wands in his daily duties with Knapheide, or even at all. (AT 71) Mr. Dailing does not know whether the pressure can be adjusted on the 42 inch lancer/wand. (AT 71) Mr. Dailing also confirmed that he was not in the same body position in the video that the Petitioner was when Petitioner was injured using the lancer/wand. (AT 72-73)

The Respondent's EX #5, a Short Term Disability Claim Form, was admitted into evidence by the Arbitrator as a busines record over a hearsay objection by the Petitioner. On the Form Petitioner wrote work related accident and Dr. Greatting checked a box indicating not work related.

The evidence deposition of Petitioner's treating surgeon, Dr. Mark Greatting, was conducted on September 14, 2020. Dr. Greatting is board certified in Orthopedic Surgery with an Added Qualification in hand surgery. (PX 7, p. 8-9) Dr. Greatting performs 15-30 surgeries a week, 20-25% of which are shoulder surgeries. (PX 7, p. 10-11) Dr. Greatting has focused exclusively on upper extremity work since he began practicing in 1991. (PX 7, p. 11)

Dr. Greatting testified that Petitioners accident of 7/16/18 was directly related to his diagnosis of a recurrent right rotator cuff tear. (PX 7, p. 17) The basis of Dr. Greattings opinions was the fact that Petitioner's right shoulder was functioning normally leading up to the 7/16/18 accident, and then immediately thereafter Petitioner suffered from pain, weakness, and decreased range of motion. (PX 7, p. 17-18)

The evidence deposition of the Respondent's IME physician, Dr. Nathan Mall, was conducted on April 12, 2019. Dr. Mall is board certified in Orthopedic Surgery. (RX 7, p. 5) Dr. Mall examined the Petitioner one time on 10/17/18. Dr. Mall diagnosed Petitioner with a chronic right rotator cuff tear. Dr. Mall questioned whether the mechanism of injury caused the Petitioner's problems despite no knowing the amount of force exerted on Petitioner's arm at the time of the accident. (RX 7, p. 23-24) Dr. Mall also confirmed that the Petitioner had not sought medical care on his right shoulder for several years leading up the 7/16/18 accident and had been working full duty in a laborious job for the Respondent. It should also be noted that the Respondent did not provide the video they admitted at trial to Dr. Mall.

CONCLUSIONS OF LAW

In regard to disputed issue C: Did an accidental occur that arose out of and in the course employment?

At trial the Petitioner credibly testified that he injured his right shoulder while washing a cargo body with a pressure washer wand that pushed back. He stated he felt "a little pop in my right shoulder, TX pp 15, ln 7 and "Numbness in my right hand." TX pp 18, ln 14 & 15. Its not disputed he reported the accident the same day.

The Petitioner testified that he and his co-worker were both spraying with pressure washers and "when he (co-worker) stopped spraying, it shot me back, all the pressure came back to me at once he let go of the trigger. "TX pp 12, ln 6-10. This was the same history given to Dr. Mall and Dr. Greatting.

This relationship of the co-workers pressure washers is corroborated by the Respondent's safety officer, Michael Dailing's testimony, "Pulling the wand, spraying it, another person has the other wand and is spraying it. They let go of their trigger and that's when you see the tip of the wand raise up, then push it again and it goes down.

Based on the above the Arbitrator finds the Petitioner did sustain an accident that arose out of and in the course employment with the Respondent.

In regard to the disputed issue F: Is the Petitioner's current condition of ill-being causally related to the injury?

The Petitioner was examined by Dr. Nathan Mall, Respondent's Section 12 examiner and was treated by Dr. Mark Greatting. The doctors had opposing opinions on causal connection. Dr. Mall's opinion suggested the mechanism of accident was insufficient to cause the injury and that the Petitioner's condition pre-existed the accident because of the extent of tendon retraction, muscle atrophy and fatty build up.

Dr Greatting testified that that Petitioner's accident of 7/16/18 was directly related to his diagnosis of a recurrent right rotator cuff tear. (PX 7, pp 17). The Doctor also opined that tendon retraction, muscle atrophy and fatty build up could occur within three months of an injury which is the time between the accident and the MRI demonstrating the degeneration.

The Arbitrator notes that in Respondent's EX 5, dated March 14, 2019, Dr. Greatting checked the box indicating not work related which is inconsistent with the Doctor's opinion set forth in his Deposition dated September 14, 2019. The Arbitrator gives considerably more weight to the Doctor's opinion in the deposition because the Doctor gives the basis for his opinion regarding causal connection whereas in the R EX 5 Form he does not. Moreover, the checked box on R EX #5 may have been a mistake or possibly a preliminary position.

The Arbitrator finds Dr. Greatting to be more credible than Dr. Mall because a basis for Dr. Greeatting's opinion on causal connection was the fact the Petitioner's right shoulder was asymptomatic and functioning normally leading up to the July 7, 2018 accident, and then immediately thereafter, Petitioner experienced pain, weakness, and decreased range of motion.(PX 7, pp 17-18)

Therefore, based upon Dr. Greattings opinions and the Petitioner's testimony, the Arbitrator finds the Petitioner's condition to be causally related to his injury.

G. What were the Petitioner's earnings?

According to R EX 1 the Petitioner's earnings the 52 weeks preceding the accident were $43,198.63 with overtime counted at straight time. Petitioner worked 46 4/5 weeks. Therefore, the Arbitrator finds the Petitioner's average weekly wage to be $ 922.42.

J. and K. Is the Petitioner entitled medical benefits and TTD benefits?

Based upon Dr. Greatting's testimony, the medical records, Petitioner's Exhibits and testimony, the Arbitrator finds the Petitioner is entitled to medical and TTD benefits

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 record reveals that Petitioner was employed as a washer/prepper at the time of the accident. The Arbitrator notes that Petitioner's washer/prepper job is laborious in nature and Petitioner is required to lift, push and pull heavy weights/objects on a daily basis. The Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 49 years old at the time of the accident. The Petitioner has a work-life expectancy of another 18 years. The Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes the Petitioner has not suffered a loss of earning capacity. The Arbitrator therefore 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 notes the Petitioners history and complaints have been consistent throughout the record. 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 12% loss of use of man as a whole pursuant to §8(d)(2) of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	21WC000957
Case Name	JONES, CHARLES v. KINCAID GENERATION LLC
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0209
Number of Pages of Decision	12
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Matthew Brewer
Respondent Attorney	Neil Giffhorn

DATE FILED: 6/6/2022

/s/Stephen Mathis, Commissioner

Signature

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

Charles Jones,

Petitioner,

vs. NO. 21WC 000957

Kincaid Generation,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by both parties herein and notice given, the Commission, after considering the issues 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 January 3, 2022 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 $49,600.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

June 6, 2022

SJM/sj
o-4/13/2022
44

/s/ *Stephen J. Mathis*
Stephen J. Mathis

/s/ *Deborah J. Baker*
Deborah J. Baker

/s/ *Deborah L. Simpson*
Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	21WC000957
Case Name	JONES, CHARLES v. KINCAID GENERATION LLC
Consolidated Cases	
Proceeding Type	Request for Hearing - Nature and Extent Only
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	9
Decision Issued By	Dennis OBrien, Arbitrator

Petitioner Attorney	Matthew Brewer
Respondent Attorney	Neil Giffhorn

DATE FILED: 1/3/2022

/s/ Dennis OBrien, Arbitrator
Signature

INTEREST RATE WEEK OF DECEMBER 28, 2021 0.21%

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

CHARLES JONES
Employee/Petitioner

v.

KINCAID GENERATION
Employer/Respondent

Case # **21** WC **000957**

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 **Dennis O'Brien**, Arbitrator of the Commission, in the city of **Springfield**, on **October 27, 2021**. By stipulation, the parties agree:

On the date of accident, **September 2, 2019**, 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 $**129,900.72**, and the average weekly wage was $**2,478.88**.

At the time of injury, Petitioner was **66** years of age, ***married*** with **no** dependent children.

Necessary medical services and temporary compensation benefits have been provided by Respondent.

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

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury, and attaches the findings to this document.

ORDER

Respondent shall pay Petitioner the sum of $**836.69**/week for a further period of**. 59.125** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **a 27 ½% loss of use of the left leg.**.

Respondent shall pay Petitioner compensation that has accrued from **September 2, 2019** through **October 27, 2019**, 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

January 3, 2022

FINDINGS OF FACT:

TESTIMONY AT ARBITRATION

Petitioner

Petitioner testified that on September 2, 2019 he was employed by Respondent as Shift Supervisor 1, having held that position since November of 2008. His duties in that position began about 15 minutes prior to the start of the shift when he would do a post-job brief with the previous shift to see what they had noticed while walking their rounds that needed attention during his shift. He would then dismiss them to go home and he would at that point do a pre-job brief with his crew, explaining what needed to be done that day and ask if they had any concerns or problems that needed to be addressed, concluding by telling them no service or urgency of service could ever justify their endangering their health or safety. He normally had seven people working for him, two in the control room and five on the floor.

Petitioner said he would then go back to his office and enter things into his shift log that were needed, he would take phone calls and he would go out and about to make sure the jobs assigned were being performed. He said doing that would encompass about two miles, both inside and outside the plant. He would sometimes have to climb ladders or go up or down an incline.

Petitioner testified that on September 2, 2019 he had done the work in the office on his shift log and about 9 a.m. he went to walk down inside the coal handling area where a job had been assigned. He said there was a piece of machinery, the S4 tripper, that people would have to walk around, so they had put in a step bridge. He had gotten up to the platform and was beginning to descend when his boot got caught on the step and his right foot slipped and his left stayed on the step causing him to bend the left leg all the way behind him while the right leg went out in front of him. He said he could hear the muscles ripping. He said his buttock went all the way down to the left leg. He said he was holding the railing and couldn't move. He said he could not bend his leg and it became swollen. He collected himself, straightened out and limped to the elevator. He took it from the seventh elevation down to the third floor where his office was and he told his control room operator that he had hurt himself. That person went and got ice and propped Petitioner's foot up, as he could see it was swollen.

Petitioner said he called Respondent's safety person, George, and informed him that he was hurt but did not want to file an accident report. He was told that having told George, he had filed an accident report, now they needed to fill out the paperwork. He said he did fill out the accident report. Petitioner said he initially tried staying at work, and he finished his shift, but he could not take it and George called MOHA and got him in.

Petitioner said he went to MOHA the next day, September 3, 2019. They sent him back to work with a cane and with restrictions. He eventually got crutches. He said people would transport him from the parking lot to the main building and he would work in his office all day, he did not walk around the plant as he normally would. He said MOHA ordered a Doppler study to make sure he did not have deep venous thrombosis, and he was sent for physical therapy. He had an MRI in October of 2019, and MOHA then referred him to Dr. Sharma, an orthopedist at Springfield Clinic. Dr. Sharma then referred him to an orthopedic surgeon, Dr.

Wolters. Petitioner said he saw Nurse Practitioner (NP) Cheney, who worked with Dr. Wolters, on October 16, 2019, and she scheduled him for surgery with Dr. Wolters. Dr. Wolters performed surgery on October 23, 2019.

Petitioner said that after the surgery he was in a cast which went to his mid-thigh. He said he was off work after the surgery and had regular follow up visits with Dr. Wolters and NP Cheney. He said the swelling in his leg went down after surgery and the cast became loose. He saw NP Cheney on November 19, 2019, and he believed she removed the cast at that time. Physical therapy was also ordered during that visit. He began physical therapy on November 25, 2019, and when he started he could not bend his knee, and the therapy was painful. He said he continued doing therapy until MOHA had to close down due to COVID in March. He said physical therapy was very helpful, it got range of motion back in his leg. They also gave him exercises to do.

Petitioner testified that he got the immobilizer brace around Christmas. He said it helped as he was then able to drive as he could bend his leg and lock it in place. He said he returned to work on December 30, 2019. Respondent had filled his position but they had created a position for him called Operation Production Specialist, where he would go through and rewrite procedures, send out morning reports to the Vice-President of the parent company in Houston, Texas, as well as to other managers at Respondent in regard to the status and availability of their units. This new position did not require him to walk around as his old position did. In the beginning they were adamant that he stay in his office on the administration floor, he would only leave to go to his boss's office around the corner or the plant manager's office down the hall.

Petitioner said he last saw Dr. Wolters on May 8, 2020, at which point he was released at maximum medical improvement, and he could do his new job without limitations. Petitioner said he retired as of January 1, 2021. He said that as of the day of arbitration his leg still felt like a shot of novacaine and there is some tightness and on some days a dull throb. He said he could hear a noise when he bends it, and he could feel it then, too, right over the patella. He said the leg was tight and would not let him lower his leg all of the way when walking down stairs, that his foot basically dropped the last half inch. He said he does not have full range of motion, but he is satisfied that he can get into a car and drive. He also did not think it was as strong. He said he had tried to climb a ladder but had intense pain, and he can no longer lift his grandchildren up on his ankle. He said he had also gained about 35 pounds as he is afraid to walk out and about. He said he did not walk long distances as he was afraid it would buckle, it was just a mental block he had.

On cross-examination Petitioner agreed that he was released to return to his current job with no restrictions on March 20, 2020. He agreed that prior to the accident he had scheduled his retirement for April 15, 2020 but he delayed it due to the injury. He said he was declared at maximum medical improvement on Mary 8, 2020 and released from Dr. Wolters care on that date. Petitioner testified that he had not sought medical treatment for his knee since that date.

MEDICAL EVIDENCE

Petitioner was seen by NP Pope on September 3, 2019. He gave a consistent history and advised them his pain was 8/10. He advised them his knee felt unstable. Physical examination on that date revealed significant, diffuse edema of the left knee which extended two inches up into the thigh. He had exquisite pain right above the patella. His range of motion with flexion was reduced due to pain and stiffness. Petitioner's x-

rays on that date showed soft tissue swelling and joint effusion and suggested an MRI be performed. Petitioner was given a soft brace to wear for comfort and support. Petitioner was released to perform all duties of his regular work, but with caution. (PX 2 p.5,7-9)

Petitioner was seen by NP Pope on September 10, 2019. Petitioner reported some improvement in the knee pain, but it continued to be swollen. He rated his pain at 5/10. Physical examination again showed the knee to have significant edema which extended up into the thigh and down into the calf. He was now tender over the medial joint line as well as over the patella. Anterior drawer sign was positive as was the McMurray's test. Petitioner right calf was quite swollen from the knee to the ankle. Because of his objective abnormalities an MRI was ordered, as was a venous Doppler of the left leg, to rule out a DVT. Petitioner was again released to perform his job duties with caution. (PX 2 p.22-24)

Petitioner received physical therapy at Memorial Industrial Rehabilitation Center from September 16, 2019 through October 7, 2019. Petitioner made minor improvement at first but regressed entirely after another aggravating injury at work, then feeling just as bad or worse than he had when he began treatment. (PX 3 p.121-146)

When seen on September 24, 2019, Petitioner reported his knee was still swollen, but better. His pain was down to 3/10, but constant and aching. His complaints were the same as during his last visit. Physical examination did reveal the swelling had improved but Petitioner continued to be tender along the lateral joint line. Otherwise his exam was unchanged. He was again released to perform his job without restrictions, but with caution. (PX 2 p.25-28)

An MRI of the left knee was performed on October 12, 2019. It found a near complete tear of the distal quadriceps tendon with only a few tendon fibers remaining intact. (PX 4 p.116,117)

Petitioner saw NP Pope for a final time on October 15, 2019. He reported his symptoms were worse, that he had been working with a circuit breaker at work and had tripped backwards, reinjuring his knee, he is now unable to extend it, and the swelling was much worse, with a nodule on the outer thigh. Physical examination showed significant edema which was diffusely tender to palpation, especially superior to the patella. Range of motion was greatly decreased and Petitioner was unable to extend his knee. A nodule was palpable on the lateral thigh. Strength was now quite decreased. A referral was made to orthopedics and Petitioner was released to sit down work only. (PX 2 p.30-33)

Petitioner was seen by Dr. Sharma on October 15, 2019 and after getting a history and reviewing the MRI, he performed a physical examination which resulted in a diagnosis of left quadricep rupture, and Petitioner's care was transferred to orthopedic surgery. (PX 4 p.80)

NP Cheney saw Petitioner in orthopedics on October 16, 2019 to provide a surgical consultation for his left knee injury. She received a history of his accident and subsequent medical care. His pain when seen was 2/10, but he noted it could get as bad as 8/10. Her physical examination found moderate swelling about the knee and a palpable defect over the left distal quadricep. Petitioner was unable to fire his quadriceps on the left or perform a straight leg raise on the left. She reviewed the MRI of the knee and diagnosed a left knee distal quadricep tendon rupture, consulted with Dr. Wolters who recommended a left knee open repair of the quadricep tendons as soon as possible. Petitioner agreed and the surgery was to be scheduled at the earliest possible time in order to have the best chance of a good outcome. (PX 4 p.74,75)

Dr. Wolters performed a left quadriceps tendon repair on October 23, 2019. He found a full-thickness tear of the quadriceps tendon from the patella and it was reattached using FibreWire sutures through holes drilled in the patella. (PX 4 p.54,544)

Petitioner was seen post-operatively by NP Cheney on October 29, 2019. Petitioner was restricted from all work. Petitioner's long leg cast was noted to be irritating the back of his heel and a Band-Aid with antibiotic on it was applied. Recovery otherwise was going well. (PX 4 p.50,51)

Petitioner returned to see NP Cheney on November 19, 2019. He was in his long leg cast and he felt he was having some skin breakdown and pain on his heel. Petitioner was using crutches and was not taking pain medication. NP Cheney removed the cast and found skin to be intact with mild swelling of the knee. He did have superficial skin breakdown over the left heel and Achilles. An immobilizer brace was provided and physical therapy ordered. It was noted he needed a 3-D rehabilitation brace. (PX 4 p.39-41)

Petitioner again received physical therapy at Memorial Industrial Rehabilitation Center post-operatively, commencing on November 25, 2019. During this therapy he slowly but continually progressed in his strength and range of motion and his pain decreased as well. By the time of his last visit on March 16, 2020 Petitioner was reporting 0/10 pain in his left knee and quadriceps, stating he was having no problems at work and was able to stand or sit to perform his desk work. He had a home exercise plan which he was to continue. (PX 3 p. 5-118)

Petitioner's had a follow up office visit with Dr. Wolters on December 18, 2019. He had been attending physical therapy and felt he was doing well. He was not taking any pain medication. He had not yet gotten his knee brace, so he could not drive. He was found to have slight swelling throughout the knee and had full extension. He was advised that once his brace arrived he could return to sedentary work. (PX 4 p.33-35)

Petitioner saw NP Cheney on January 17, 2020. He was not having any pain and swelling and numbness were getting better. He felt he was advancing in physical therapy. Mild swelling was noted on physical examination, he had some restriction in flexion and mild pain on forced flexion. While he had good quadricep control, his strength was still only 4/5. He was told he could start unlocking his knee range of motion brace for short periods of time, that his physical therapist could give him guidance on that. He was to perform sedentary work only. (PX 4 p.28,29)

When seen by Dr. Wolters on February 21, 2020 Petitioner reported that his strength was gradually improving, he was wearing his brace and attending physical therapy. He denied any radicular pain. He was found to have good quadriceps function and full range of motion of both knees. He was to continue physical therapy and was given restrictions of no climbing of ladders and no lifting over 25 pounds. (PX 4 p.23,24)

Petitioner saw NP Cheney on March 20, 2020. He told her he really was not having too much pain except when he was sitting, at which time he had some behind the patella. He had been working a sedentary job at home but advised NP Cheney that he felt he was ready to go back to work full duty. Physical examination showed a small reduction in knee flexion on the left when compared to the right, but no pain on range of motion and the quadriceps were nontender on palpation. He did not have a limp. Petitioner was released to full duty work. (PX 4 p.19,20)

On May 8, 2020 Petitioner was seen for the last time by Dr. Wolters. At eight months post-op he told the doctor that he was doing very well but still had a little trouble with ladders and a small amount of weakness

in his leg, but felt he was still improving. He noted occasional discomfort on the outside of his knee. His physical examination revealed 5/5 quadricep strength bilaterally and Petitioner was walking without a limp. Petitioner was working without restrictions but was performing a lighter duty job. Petitioner was found to have reached maximum medical improvement and was released on a PRN basis. (PX 4 p.14,15)

ARBITATOR'S CREDIBILITY ASSESSMENT

Petitioner testified in a straightforward manner, answering all questions put to him with no apparent attempt to evade or deceive. His testimony in regard to his injuries and treatment was corroborated by the medical records introduced into evidence. He did not appear to exaggerate his complaints in any way. The Arbitrator finds Petitioner to have been a credible witness.

CONCLUSIONS OF LAW

In support of the Arbitrator's decision relating to the nature and extent of the injury the Arbitrator makes the following findings:

The findings of fact, above, are incorporated herein.

The summaries of medical evidence and deposition testimony, above, are incorporated herein.

As the accident occurred after September 1, 2011, the nature and extent of the injury must be determined through the five-factor test set out in §8.1b(b) of the Act.

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 Shift Supervisor 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 Petitioner did not return to his previous position as Respondent had placed another employee in that position while Petitioner was recovering from the injuries he incurred in this accident. Respondent did, however, create a new position for Petitioner which was sedentary in nature, while his previous position would have required him to walk about two miles per shift and climb ladders and stairways to accomplish his tasks. Petitioner did not need restrictions in the job he returned to, and it is unknown whether or not he would have required restrictions had he returned to his previous position. Because of his ability to return to work for Respondent following his recuperation, the Arbitrator therefore gives *lesser* 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 the accident. Prior to the date of this accident Petitioner had already decided to retire effective April 15, 2020. Because of this accident Petitioner chose to extend his employment with Respondent and instead retired on January 1, 2021. The Arbitrator therefore gives *lesser* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator again notes that Petitioner had intended to retire on April 15, 2020, seven-and-a-half months after this accident, but instead retired on January 1, 2021, approximately 12 months after he returned to work on restricted duty, nine months after he returned to unrestricted work. His work life expectancy was therefore not shortened by this accident. In addition, no evidence was introduced indicating any loss of earnings during the period of time he worked prior to his retirement. Because of his planned, but postponed, but later realized retirement and the lack of evidence showing any change in earnings, the Arbitrator therefore 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 notes Petitioner's complaints at arbitration that his leg still felt like a shot of novacaine, that there is some tightness and on some days a dull throb in his leg, that he could hear a noise when he bends the leg, and that he could feel it then, also, right over the patella. He said the leg was tight and would not let him lower his leg all of the way when walking down stairs, that his foot basically dropped the last half inch. Petitioner said he did does not have full range of motion of the left leg, but he is satisfied that he can get into a car and drive. He also said he did not think the leg was as strong. He said he had attempted to climb a ladder, but he had intense pain. He said he did not walk long distances as he was afraid the leg would buckle, noting that was just a mental block he had. The medical records indicate that Petitioner had a nearly complete tear of the distal quadriceps tendon, as shown on an MRI and seen by Dr. Wolters at surgery. Dr. Wolters performed a left quadriceps tendon repair on October 23, 2019, repairing the full-thickness quadriceps tendon using FibreWire sutures through holes drilled in the patella. Petitioner received nearly four months of physical therapy following that surgery and was instructed to continue a home exercise program thereafter. When Petitioner saw Dr. Wolters for the last time, eight months after the surgery, he told the doctor that he was doing very well but still had a little trouble with ladders and a small amount of weakness in his leg. He also noted occasional discomfort on the outside of his knee. His physical examination revealed 5/5 quadricep strength bilaterally and Petitioner was walking without a limp. Because of the extensive damage done to Petitioner's quadricep tendon, his lengthy treatment following the surgical repair and his continuing moderate complaints, 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 27 1/2% loss of use of the left leg pursuant to §8(e) of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC029695
Case Name	SMITH, TIM v. AMERICAN COAL
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0210
Number of Pages of Decision	17
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Roman Kuppart
Respondent Attorney	Julie Webb, Kenneth Werts

DATE FILED: 6/6/2022

/s/Stephen Mathis, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tim Smith,

Petitioner,

vs. NO. 17WC 29695

American Coal Company,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of occupational disease, permanent disability, causal connection, sections 1(e) – (f), and 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 4, 2021, 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 $19,000.00. 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.

June 6, 2022

/s/ *Stephen J. Mathis*
Stephen J. Mathis

SJM/sj
o-5/11/2022
44

/s/ *Deborah J. Baker*
Deborah J. Baker

/s/ *Deborah L. Simpson*
Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC029695
Case Name	SMITH, TIM v. AMERICAN COAL COMPANY
Consolidated Cases	
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	14
Decision Issued By	Linda Cantrell, Arbitrator

Petitioner Attorney	Roman Kuppart
Respondent Attorney	Kenneth Werts

DATE FILED: 8/4/2021

THE INTEREST RATE FOR THE WEEK OF AUGUST 3, 2021 0.05%

/s/ Linda Cantrell, Arbitrator

Signature

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

TIM SMITH
Employee/Petitioner

v.

AMERICAN COAL COMPANY
Employer/Respondent

Case # **17** WC **029695**

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 **Linda J. Cantrell**, Arbitrator of the Commission, in the city of **Collinsville**, **Illinois** on **May 17, 2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Sections 1(d)-(f) of the Occupational Diseases Act**

FINDINGS

On **August 28, 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 $**82,582.24**; the average weekly wage was $**1,588.12**.

On the date of accident, Petitioner was **57** years of age, ***single*** with **0** dependent children.

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

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

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

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

ORDER

Respondent shall pay Petitioner the sum of $**755.22 (Max rate)**/week for a period of **25** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused a **5% loss of Petitioner's body as a whole.**

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

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

AUGUST 4, 2021

Arbitrator Linda J. Cantrell

STATE OF ILLINOIS)
) SS
COUNTY OF MADISON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

TIM SMITH,	)	
	)	
Employee/Petitioner,	)	
	)	
v.	)	Case No.: 17-WC-029695
	)	
AMERICAN COAL COMPANY,	)	
	)	
Employer/Respondent.	)	

FINDINGS OF FACT

This claim came before Arbitrator Linda J. Cantrell for trial in Collinsville on May 17, 2021 on all issues. An Application for Adjustment of Claim was filed on October 12, 2017 wherein Petitioner alleges he sustained an occupational disease of his lungs and/or heart as the result of inhaling coal mine dust, including, but not limited to, coal dust, rock dust, fumes, and vapors for a period in excess of 38 years. The Application alleged a date of last exposure of August 28, 2015. The issues in dispute are accident, causal connection, the nature and extent of Petitioner's injuries, and Sections 1(d)-(f) of the Occupational Diseases Act. All other issues have been stipulated.

TESTIMONY

Petitioner is 63 years old, recently married, and has no dependent children. Petitioner attended high school through the 11th grade and received his GED. He testified he performed underground coal mining for 37 years where he was regularly exposed to coal dust, rock dust, fly ash, diesel fumes, and silica dust. His last date of employment for Respondent was August 28, 2015. On that date he was 58 years old and his job classification was an examiner, pumper, and laborer jobs. Petitioner testified he was exposed to and breathed coal dust on that day.

Petitioner testified he was laid off by Respondent after 8/28/15 when the Galatia, Illinois mine closed. He has not worked since and applied for Social Security Disability for conditions related to his knees and back. Petitioner testified he did not indicate black lung on his Social Security Disability Application because he did not know he had the disease when he filed in 2015. Petitioner testified he knew he had breathing problems and his breathing had been noticeably declining for quite some time.

Petitioner testified he lived in Duluth, Minnesota before he moved to Southern Illinois in 1977. From 1977 to 1979 he worked for the Job Corps in Golconda, Illinois. He then worked six months at Harrisburg Truss Company. In October 1979, Petitioner was hired by Sahara Coal

Company and worked at Mine #20 until 1983. Petitioner then worked at Sahara Coal Company Mine #7 from 1983 to 1984. In 1984, Petitioner began working for American Coal Company and worked there until he was laid off in August 2015.

Petitioner started as a utility man at Sahara and moved to roof bolting, pulling pillars, and shuttle cars. He was a pumper for nine years and a part-time examiner. In 2007, Petitioner was a support foreman and a pump foreman where he made sure water was out of the mine and the work areas and belt line, and he hung pipe and set pumps. He had to walk the belt lines and faces. Petitioner testified he breathed a lot of black mold that grew on the wood. He classified his job duties as medium to heavy labor and many of his jobs were in coal returns and he hung pipes and set pumps. His job duties required him to bend, stoop, and squat. He worked in areas from 36 inches to five and a half feet in height and traversed through mud and water while carrying equipment.

Petitioner testified he worked around the longwall and could not see beyond 8 to 9 feet in front of him due to thick dust. He testified that bending, stooping, and squatting caused breathing problems while working in those conditions. He first noticed a change in his breathing around 15 to 16 years ago while working in the mines. He covered a lot of territory in order to examine the intake, returns, shafts, and slope of the mines. Petitioner testified he really noticed breathing problems when walking up the slope going out of the mine. He estimated the slope to be 17 degrees in elevation and half a mile long. He could walk between 50 to 100 feet before he needed to take a break. Petitioner estimated he walked 10 miles per shift as an examiner. He walked in water and mud up to his waist at times. He stated some of the terrain was rough and sometimes his boots would come off his feet because the mud would stick to them. He walked over rocks and between cribs and the pumper dover. He hung pipe measuring 2 to 8 inches in diameter and 20 foot long. He used a ram car and two or three people assisted in hanging pipe. Petitioner testified the ram car would only take supplies so far and they had to physically carry them. He stated he set the pumps himself on occasion. The smallest pump weighed between 25-30 pounds and the biggest pump required equipment to lift it.

Petitioner testified that as a laborer for Respondent he was required to shovel coal and break rock on the slope. He would break the rocks with a 10-pound sledgehammer and shovels. Petitioner testified the cribs he built were approximately 40 to 60 pounds. He stated sometimes they were wet and frozen. He testified that the timbers he set were 6 by 8 inches and 7 feet long, some as long as 12 to 14 feet. Petitioner testified he built bridges underground so the equipment could get through. The bridges were about 4 to 5 inches by 18 foot long or 4 to 5 inches thick and 12 to 14 inches wide of roughcut lumber. Petitioner testified they had to use two people to move the timber. He used 12-inch spikes and sledgehammers to build them. Petitioner testified that swinging a sledgehammer caused him breathing problems.

Petitioner testified the dust conditions varied throughout the mine. He worked in heavy dust conditions on the slope and longwall. He testified that from the time he entered the mine until the time he left he was exposed to coal dust and his breathing progressively worsened. He can currently walk 100 to 200 feet before his breathing gets heavy and difficult. His breathing issues affect his daily life. He used to run and was athletic and now his walking is very limited. He used to run in high school and six miles every day in Job Corps which he can no longer do.

After working for the mines he used to take 1 to 2 mile walks. Petitioner testified he mows most of his yard with a riding mower and uses a push mower for trimming. Petitioner testified that back in the 80's and 90's he would push mow most of his yard.

Petitioner testified his hobbies include working around his home which he does for 2 to 3 hours per day and then does paperwork. He testified that while working in the mines he had to take breaks because of his breathing and his co-workers sometimes had to finish his job. He stated there was several months he could not finish his job duties during one shift or cover the territory required.

Petitioner testified that Dr. Ewell was his primary care physician for many years and Dr. Swayze has been his physician for one year. Petitioner testified he cannot use a computer, nor can he type. He has never smoked. He received injections for his bilateral knee conditions. He stated he has several bulging discs and two herniated discs but has not undergone surgery. He has high cholesterol. He takes Naprosyn for inflammation and Lipitor and fish oil for his cholesterol. He testified he could not currently perform any of his job duties he last performed while working for Respondent. He testified that toward the end of his employment he was in bad shape and had to wear two back braces and knee braces and tape up every day.

On cross-examination, Petitioner testified he walked on the slope every day. He had to walk out of the mine rather than take the elevator because it was part of his job. Petitioner testified he had to inspect the slope and follow company policies, as well as state and federal guidelines. He stated he may have carried a shovel or a sledgehammer while walking up the slope. Otherwise, he wore and carried standard gear that weighed about 40 pounds. Petitioner testified there was a concrete surface in the mine, but it had a lot of rock and coal spillage that made is slick and sometimes froze in the winter.

Petitioner testified he would have reported for his next shift had he not been laid off. Petitioner then applied for and collected unemployment benefits and then received social security disability partially related to his knees and back. He testified he stopped going to Dr. Ewell because he was seeing Brian Hester for physical therapy for his knees. He reported to Dr. Hester his breathing problems and wheezing and was referred to Dr. Robert Swayze. Petitioner testified he was sent to Dr. Istanbouly to be examined for black lung in April 2018. From time to time he would undergo examinations from NIOSH but denied receiving any test results.

He testified he generally worked eight-hour shifts but worked ten hours and double shifts which was required for his position. He stated that at the end of his career he worked a lot of hours and on most of his double shifts he walked 15 to 6 miles. Petitioner testified he worked seven days on and one day off, seven days on and two days off, seven days on and three days off and that would be his long break.

Petitioner testified he uses his time socializing with neighbors and performing small repairs around the house. He no longer gardens like he used to do. He does not drive long distances.

MEDICAL HISTORY

On September 8, 2017, Dr. Henry K. Smith reviewed a chest x-ray taken on September 1, 2017. Dr. Smith is board-certified in radiology and is a NIOSH certified B-Reader and has maintained his certification status continuously over 32 years. Dr. Smith found that the chest film was a quality 1 film. His impression was of simple coal workers' pneumoconiosis with small opacities, primary p, secondary p, all zones involved bilaterally, of a profusion 1/1.

On June 8, 2018, Dr. Cristopher A. Meyer, reviewed a chest x-ray of Petitioner dated September 1, 2017. Dr. Meyer is a board-certified radiologist and a NIOSH certified B-reader. Dr. Meyer indicated the film was a quality 2 film because of mottle. He found no radiographic findings of coal workers' pneumoconiosis on the film. On September 25, 2018, at Respondent's request, Petitioner underwent pulmonary function testing performed by Dr. Jeff Selby that was normal.

On July 22, 2018, Dr. Istanbouly testified via evidence deposition. Dr. Istanbouly is board-certified in critical care medicine and pulmonary medicine. Dr. Istanbouly performs black lung examinations for the U.S. Department of Labor. He has been the medical director of the pulmonary department at Herrin Hospital since 2005. Dr. Istanbouly is also the director of the Intensive Care Unit at Carbondale Memorial Hospital and is a former director of the Intensive Care Unit at Herrin Hospital.

Dr. Istanbouly performed a physical examination of Petitioner on April 16, 2018 and took a detailed history and reviewed the pulmonary function test and chest x-ray. Dr. Istanbouly testified that the pertinent aspects of Petitioner's history were that he was 66 years of age and worked as a coal miner for 38 years, he last worked in the mines in August 2015, and he never smoked. He testified that Petitioner mentioned having a cough on and off for the past six years, which was mild in intensity, more prominent in the morning, triggered by inhaling irritating smells, including coal dust. The cough was productive of thick greenish sputum, two to three tablespoons a day, which Dr. Istanbouly found to be significant. Dr. Istanbouly testified that Petitioner was getting frequent upper respiratory infections and mentioned exertional dyspnea. On the day of the examination, Petitioner was getting short of breath after walking a quarter of a mile.

Dr. Istanbouly testified that it is not unusual for miners with simple coal worker's pneumoconiosis to be asymptomatic and a coal miner can have the condition and not know it. Dr. Istanbouly testified that Petitioner's physical examination of his chest was normal which is not unusual for someone with early stages of coal workers' pneumoconiosis. He testified that Petitioner's pulmonary function studies suggested a mild obstruction and opined that a person with coal workers' pneumoconiosis could have a completely normal pulmonary function test in the early stages of the disease. He opined that a miner does not have to have either an obstruction or restriction in order to have coal workers' pneumoconiosis. Dr. Istanbouly testified that spirometry is a measure of the global impairment of both lungs rather than a focal impairment of a portion of the lungs. He testified that a person could have a certain amount of their lung with focal impairment, yet the global overall function be normal. Dr. Istanbouly testified that a person could even have shortness of breath and daily cough, but have a normal pulmonary function test.

Dr. Istanbouly also testified that a person could have a normal diffusing capacity and have mild coal workers' pneumoconiosis.

Dr. Istanbouly testified that the chest x-ray taken on September 1, 2017 was of diagnostic quality and revealed mild bilateral interstitial changes involving upward, mid, and lower lung zones. Dr. Istanbouly testified that the B-reader read the film and found the profusion was 1/1. He stated a person does not have to be a B-reader in order to diagnose coal workers' pneumoconiosis. He testified there are no B-readers in any of the hospitals he is affiliated and the closest B-reader is approximately 100 miles away. He stated that B-reading is not taught in medical school and it is used for legal purposes not medical reasoning.

Dr. Istanbouly testified that coal workers' pneumoconiosis is caused by the inhalation of coal dust that causes irritation and inflammation that ultimately forms tiny scars called fibrosis. He stated the scarring and fibrosis are permanent and cannot carry on the function of normal healthy lung tissue. Dr. Istanbouly testified that, by definition, if you have coal workers' pneumoconiosis then you have an impairment of the function of the lungs, at least at the site of the scar or fibrosis. He stated that only exposure to coal dust can cause coal workers' pneumoconiosis and there is no cure for the condition. He testified there is a certain amount of coal dust that is trapped in the miner's lungs, which remains there for life.

Dr. Istanbouly testified that, based upon on a reasonable degree of medical certainty, Petitioner's coal workers' pneumoconiosis was caused by his long-term coal dust inhalation. He also diagnosed Petitioner with mild chronic obstructive pulmonary disease (COPD), which he relates to Petitioner's long-term coal dust exposure as he is a lifelong non-smoker. Dr. Istanbouly testified that based on Petitioner's x-ray and breathing tests it is not advisable for Petitioner to ever return to work in the coal mines and any additional exposure to coal dust could worsen his lung condition.

Dr. Istanbouly testified that a person with chronic lung diseases such as COPD and coal workers' pneumoconiosis are more susceptible to pulmonary infections and pneumonias making it more difficult to recover from infections and pneumonias. He testified that Petitioner did not have any further coal dust exposures according to the history that was provided to him. Based on the nature of the disease of coal workers' pneumoconiosis and Petitioner's 38 years of coal mine employment it is more likely than not that his COPD and coal workers' pneumoconiosis would have been in existence when Petitioner was last occupationally exposed to coal dust.

Dr. Christopher A. Meyer testified via evidence deposition. Dr. Meyer is a board-certified radiologist who has a B-Reading certificate. Dr. Meyer is currently the Vice Chair of Finance and Business Development and professor of diagnostic radiology at the University of Wisconsin Hospital and Clinics in Madison, Wisconsin. Dr. Meyer testified that he reviewed a PA and lateral chest x-ray of Petitioner dated September 1, 2017 and found the film to be a quality 2 film because of quantum mottle. He testified it was his impression there were no radiographic findings of coal workers' pneumoconiosis on the film. Dr. Meyer agreed that experts with similar credentials may disagree on the reading of chest films, especially those in Category 1 of pneumoconiosis.

On cross-examination, Dr. Meyer agreed that a negative chest x-ray for coal workers' pneumoconiosis does not necessarily rule out the disease. Dr. Meyer testified he became a B-reader in January,1999; however, he had taken the test before and did not pass. Dr. Meyer further agreed that many coal miners have had negative chest x-rays for coal workers' pneumoconiosis, but on biopsy or autopsy it is shown they had the condition pathologically. He agreed with the Laney and Petsonk study which stated, "[i]ndividual coal macules are generally too small to be appreciated on chest x-rays". Dr. Meyers explained that "[m]ost of the nodules that we see on chest x-rays are actually what are known as summation shadows, which means that multiple coal macules superimposed on one another form a shadow that's big enough for us to see."

On June 12, 2020 and May 4, 2021, Dr. David Rosenberg testified via evidence deposition. Dr. Rosenberg is board-certified in internal medicine and pulmonary diseases. He obtained a Master's of public health and is board-certified in occupational medicine. Dr. Rosenberg became a B-reader in 2000 and is licensed in Ohio, Kentucky, Tennessee, and Florida. Dr. Rosenberg has examined coal miners for Petitioner's and Respondent's attorneys, with 95% of the examinations being done for industry.

Dr. Rosenberg reviewed Petitioner's treatment records from Harrisburg Medical Center. He testified that on October 23, 2015, Petitioner presented with bronchitis, coughing, fever, and stuffy nose. He reviewed Petitioner's records from Primary Care and it was noted on October 6, 2008 that Petitioner had been coughing up blood for two to three months. Dr. Rosenberg testified that both the pulmonary function studies performed in April 2018 and October 2018 showed no obstruction. Dr. Rosenberg testified that according to the AMA Guides to the Evaluation of Permanent Impairment, Sixth Ed., Table 5-4, Petitioner fell into Class O based on his pulmonary function testing.

Dr. Rosenberg reviewed Petitioner's chest x-ray dated September 1, 2017 and found it to be a quality 2 film being somewhat mottled and showed no evidence of coal workers' pneumoconiosis. He stated the film of June 27, 2016 was a quality 1 and negative for coal workers' pneumoconiosis with some scattered granulomatous changes. Dr. Rosenberg did not find any evidence of emphysema on the chest film.

Dr. Rosenberg noted that Petitioner worked in the coal mines for over 30 years, was a non-smoker, had multiple musculoskeletal complaints and treatment for same, and had several episodes of acute bronchitis over the years and a history of influenza. Chronic respiratory complaints were not outlined in the records. He noted Petitioner did not have chest x-ray evidence of a pneumoconiosis and his pulmonary function tests were normal.

Dr. Rosenberg testified he performs 5 or 6 records reviews a week for coal worker's litigation. He has treated approximately 10 to 20 patients for black lung, which is a very small percentage of the patients he has treated. Dr. Rosenberg testified that he performed black lung examinations for the Department of Labor from 1979 to 1984. He stopped performing DOL examinations when he left his hospital-based position. Dr. Rosenberg testified he became a B-reader in 2000 at the hospital's request and contracted his services to companies such as General Electric, steel mills, and private occupational medicine services.

Dr. Rosenberg agreed that scarring and fibrosis occur with coal workers' pneumoconiosis which adversely affects lung function. He stated there is no cure for coal workers' pneumoconiosis and the scarring and fibrosis is permanent. Dr. Rosenberg indicated that coal workers' pneumoconiosis could progress but it is unusual. He agreed that the best treatment is to remove the person from the exposure. He agreed that a person could have coal workers' pneumoconiosis without having chest x-ray evidence of the disease or know they have it. He agreed that a person could have shortness of breath despite normal pulmonary function. He agreed that a person could have normal pulmonary function and have coal workers' pneumoconiosis, stating it would not be unusual and most would have normal pulmonary function. He agreed that a person could have a certain amount of their lungs with focal areas of impairment, yet normal global function. He testified that a person could have a lobe of their lung removed and still have normal pulmonary function. He testified that a person could have a normal diffusing capacity and have simple coal workers' pneumoconiosis.

Dr. Rosenberg did not take a patient history of Petitioner. He did not speak with or examine Petitioner or perform any testing. Dr. Rosenberg did not speak with Petitioner's treating doctors. Dr. Rosenberg testified that the reading of chest x-rays for coal workers' pneumoconiosis is very subjective. He agreed that similarly qualified, educated physicians can and do disagree as to the findings on chest x-rays and that would especially be true in borderline cases of 0/1 or 1/0. Dr. Rosenberg agreed that a physician does not have to be a B-reader to diagnose someone with coal workers' pneumoconiosis and the B-reading system was never designed for and should never be used for diagnosis purposes. Dr. Rosenberg stated that according to the American Thoracic Society there is no safe dust level for someone with coal worker's pneumoconiosis.

Dr. Rosenberg testified that even though Petitioner did not have symptoms, did not have abnormal pulmonary function, and did not have an abnormal diffusing capacity, he could still have coal worker's pneumoconiosis. He testified that Dr. Istanbouly was the only doctor in the records that he reviewed that did an examination for the presence or absence of an occupational lung disease.

On November 5, 2020, Dr. Henry K. Smith testified via evidence deposition. Dr. Smith has been board-certified in Radiology since 1973 and has been a Certified NIOSH B-reader continuously since 1987. Dr. Smith holds medical licensure in five states. Dr. Smith is affiliated with or has privileges at numerous hospitals and clinics but discontinued seeing walk in patients in 2016. He continues to do consulting work.

Dr. Smith reviewed a chest film of Petitioner dated September 1, 2017 that he found to be quality 1 and noted the presence of interstitial fibrosis classification p primary, secondary p, upper, middle and lower zones bilaterally involved of a profusion of 1/1. Dr. Smith opined that Petitioner has coal worker's pneumoconiosis and has damage to his lungs as a result of his coal worker's pneumoconiosis. Dr. Smith testified he did not see any mottle of the film he read.

Records from the NIOSH coal workers' surveillance program contain a chest film dated 5/03/07 read as a category 0/1, a film dated 4/03/13 read as a category 1/1, and a film dated 5/27/17 read as a category 1/1.

Medical records from Eldorado Primary Care were entered into evidence. The office note dated 7/23/18 states under "Respiratory" there is chronic cough, decreased exercise tolerance, and difficulty breathing. Under "Assessment" there is a diagnosis of coal workers pneumoconiosis. On 8/25/17 under "History" it lists shortness of breath and wheezing. Under "Assessment" it lists cough and coal workers' pneumoconiosis. On 10/25/15, Petitioner presented with cough with onset of two weeks ago. Under "Chest and Lung Exam" it lists prolonged expiration – both lung fields. No adventitious sounds. Assessment was acute bronchitis. On 12/26/13, Petitioner reported productive cough that began three days ago. Petitioner presented on 2/24/12 with a cough and sputum production. Fine rales were found on examination of the chest. Assessment was pneumonia. On 2/20/12, Petitioner presented with a productive cough that started eight days ago. Cough and sputum production were noted with no difficulty breathing. Physical examination of the chest found fine rales in the right and left lower lobes. Assessment was pneumonia. On 2/08/11, Petitioner reported coughing up green phelm and chest congestion that began three days ago. Cough was present, not present were chronic cough and decreased exercise intolerance. Physical examination of the chest was normal. Assessment was acute bronchitis.

Medical records from Harrisburg Medical Center were entered into evidence. On 8/25/17, Petitioner presented for allergic rhinitis and cough and coal workers' pneumoconiosis were noted. On 12/07/16, Petitioner presented with cough and wheezing and was assessed with cough and acute sinusitis. On 10/23/18, Petitioner presented for influenza and strep test and was diagnosed with bronchitis. On 10/23/15, Petitioner presented for cough with no difficulty breathing. Physical examination of the chest revealed prolonged expiration in both lung fields, no adventitious sounds. Assessment was acute bronchitis. On 2/24/12, Petitioner presented with a hacking cough; shortness of breath has improved but still present on exertion. Under Respiratory it lists cough with sputum production (a little green) and difficulty breathing on exertion. Not present difficulty breathing. Physical examination of the chest revealed fine rales in left lung field on expiration only. Assessment was pneumonia. On 2/20/12, Petitioner stated he had been sick for a week but started feeling worse yesterday. Cough with sputum production was reported with no difficulty breathing. Physical examination of the chest revealed fine rales in both right and left lower lobes. Assessment was pneumonia. On 2/08/11, Petitioner was admitted to the hospital with bronchitis. On 2/08/11, Petitioner reported coughing up green phlegm and chest congestion. Cough was present. Not present chronic cough and decreased exercise intolerance. Physical examination of the chest was normal. Assessment was acute bronchitis. On 2/15/02, Petitioner presented with many complaints including a productive cough. Physical examination of the chest showed bilateral rhonchi on expiration. Assessment is not legible. On 1/19/01, Petitioner presented with a productive cough with thick green/brown phlegm for the last week. Physical examination of the lungs was clear. Assessment was Influenza with secondary otitis media.

Medical records from Primary Care were entered into evidence. The records contain results from a bronchoscopy due to Petitioner's complaints of coughing up blood, an upper endoscopy, a colonoscopy, and an abscess on his neck.

Records from Petitioner's Social Security Disability File were admitted into evidence. The Disability Determination Transmittal noted Petitioner's claim for disability benefits was

filed on July 6, 2016. Determination was made that his disability began on August 29, 2015. The primary diagnosis was osteoarthrosis and allied disorders. Secondary diagnosis was disorders of back (discogenic and degenerative). On his Function Report, Petitioner indicated that his illnesses, injuries, or conditions limited his ability to work as follows: weight limit on lifting of 25 pounds or less, avoid bending over as much as possible, both knees need replaced, two herniated discs, several bulged discs in his back, 37 years of mining, 47 years of hard work, landscaping, construction, etc., pain levels at times are unbearable.

CONCLUSIONS OF LAW

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

Issue (F): Is Petitioner's current condition of ill-being casually related to his occupational exposure?

The Arbitrator finds that Petitioner was last exposed to an occupational disease that arose out of and in the course of his employment with Respondent. Section 1(d) of the Illinois Workers' Compensation Diseases Act states, in pertinent part:

> "A disease shall be deemed to arise out of the employment if there is apparent to the rational mind, upon consideration of all the circumstances, a causal connection between the conditions under which the work is performed and the occupational disease. The disease needs not to have been foreseen or expected but after its contraction it must appear to have had its origin or aggravation in a risk connected with the employment and to have flowed from that source as a rational consequence. An employee shall be conclusively deemed to have been exposed to the hazards of an occupational disease when, for any length of time however short, he or she is employed in an occupation or process in which the hazard of the disease exists...If a miner who is suffering or suffered from pneumoconiosis was employed for 10 years or more in one or more coal mines there shall, effective July 1, 1973 be a rebuttable presumption that his or her pneumoconiosis arose out of such employment." 820 ILCS 310/1(d)

On September 8, 2017, Dr. Henry Smith, a board-certified B-Reader for over 32 years, performed a film interpretation and B-Reading of Petitioner's chest x-ray. Dr. Smith's impression was of simple coal workers' pneumoconiosis with small opacities, primary p, secondary p, all zones involved bilaterally, of a profusion 1/1. Dr. Istanbouly testified he physically examined Petitioner and took a detailed medical and occupational history. Dr. opined that the cause of Petitioner's coal worker's pneumoconiosis was exposure to coal mine dust.

The Arbitrator finds the opinions of Drs. Smith and Istanbouly more persuasive than those of Drs. Meyer and Rosenberg. Although they disagree as to the diagnostic findings and diagnosis of Drs. Smith and Istanbouly, Dr. Meyer agreed that a negative chest x-ray for coal workers' pneumoconiosis does not necessarily rule out the disease. He agreed that many coal miners have had negative chest x-rays for coal workers' pneumoconiosis, but on biopsy or autopsy it is shown they actually had the condition pathologically. Dr. Meyers further agreed

with the Laney and Petsonk study which stated, "[i]ndividual coal macules are generally too small to be appreciated on chest x-rays".

Dr. Rosenberg conceded that he had never met, spoken to, or physically examined Petitioner. He testified that 95% of the examinations he performs for black lung are for industry. He agrees that a person can have coal workers' pneumoconiosis without having chest x-ray evidence of the disease. He also agreed that a person can have coal workers' pneumoconiosis and not know they have the disease. Dr. Rosenberg agreed that a person could have shortness of breath despite normal pulmonary function. He also agreed that a person could have normal pulmonary function and have coal workers' pneumoconiosis, stating that it would not be unusual, and most would have normal pulmonary function. He agreed that a person could have a certain amount of their lungs with focal areas of impairment, yet have a normal global function. He agreed that a person could have a normal diffusing capacity and have simple coal workers' pneumoconiosis.

Given the totality of the evidence, the Arbitrator finds Petitioner has satisfied the requirements of Section (d) of the Act and that Petitioner's coal workers' pneumoconiosis arose out of and in the course of his employment with Respondent. The Arbitrator further finds that Petitioner's condition of ill-being is causally connected to this exposure.

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 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).

(i) **Level of Impairment**: Neither Party submitted an AMA rating. Therefore, the Arbitrator gives no weight to this factor.

(ii) **Occupation**: Petitioner was laid off in August 2015 and has not been employed since. Petitioner is currently receiving social security disability benefits. The Arbitrator places no weight on this factor.

(iii) **Age**: Petitioner was 57 years old at the time of his last exposure. Petitioner is receiving social security disability benefits. The Arbitrator places some weight on this factor.

(iv) **Earning Capacity**: There is no evidence of reduced earning capacity contained in the record and Petitioner was laid off in August 2015 due to mine closure. Petitioner did not obtain subsequent employment and is currently receiving social security disability benefits. The Arbitrator places some weight on this factor.

(v) **Disability**: As a result of his work exposure, Petitioner testified he continues to have breathing problems that affect his daily life. He testified his walking is very limited. Following his employment with Respondent he walked 1 to 2 miles per day. Dr. Istanbouly reported that at the time of his examination on 4/16/18, Petitioner was getting short of breath after walking a quarter of a mile. Petitioner testified that he works around the house for 2 to 3 hours per day and then does paperwork. He no longer gardens like he used to. The Arbitrator places greater weight on this factor.

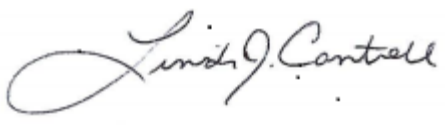
Based upon the foregoing evidence and factors, the Arbitrator orders Respondent to pay Petitioner the sum of $**755.22 (Max. rate)/**week for a period of **25 weeks**, as provided in Section 8(d)2 of the Act, because the injuries sustained caused **5% loss of the body as a whole.**

Issue (O): Sections 1(d)-(f) of the Occupational Diseases Act.

Section 1(e) of the Occupational Diseases Act states, in pertinent part, "{d}isablement" means an impairment or partial impairment, temporary or permanent, in the function of the body or any of the members of the body." 820 ILCS 310/1(e). The Arbitrator finds Petitioner has satisfied the requirements of Section (e) of the Act. Petitioner testified to increased respiratory difficulty with his activities of daily living. Dr. Istanbouly also testified that the inhalation of coal dust that causes irritation and inflammation will ultimately form tiny scars. Dr. Istanbouly testified there is no cure for coal workers' pneumoconiosis and the condition is chronic. Dr. Rosenberg agreed that the scarring and fibrosis that occurs in the lungs from pneumoconiosis is irreversible and permanent. Dr. Rosenberg testified that the scarring and fibrosis is an alteration of the lung tissue.

Section 1(f) of the Occupational Diseases Act states, in pertinent part, "[n]o compensation shall be payable for or on account of any occupational disease unless disablement, as herein defined, occurs within two years after the last day of the last exposure to the hazards of the disease." 820 ILCS 310/1(f). Petitioner last worked a day of coal mine employment on August 28, 2015. Petitioner has not worked in the coal mines and has not had any other exposure to coal mine dust since that date. On September 1, 2017, Petitioner underwent an x-ray with PA & Lateral views of the chest for pneumoconiosis at Ferrell Hospital. Dr. Smith's impression of that chest x-ray was of simple pneumoconiosis, category p/p, 1/1. Since the Petitioner obtained the coal workers' pneumoconiosis diagnosis within two years of leaving Respondent's employment, he meets the requirement under Section 1(f) of the Act. Petitioner also had positive NIOSH chest x-rays while still working in the mines.

Based on the totality of the evidence, and the factual findings above, the Arbitrator finds that Petitioner met the requirements of Sections 1(d)-(f) of the Occupational Diseases Act.



Arbitrator Linda J. Cantrell DATE

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC019580
Case Name	RENFROW, JASON R v. PRAIRIE STATES WAREHOUSE
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0211
Number of Pages of Decision	28
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Gary Stokes
Respondent Attorney	Jay Lory

DATE FILED: 6/6/2022

/s/Stephen Mathis, Commissioner

Signature

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

Jason Renfrow,

Petitioner,

vs. NO. 18WC 19580

Prairie States Warehouse,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of 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. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 26, 2021 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 $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.

June 6, 2022

SJM/sj
o-5/11/2022
44

/s/ *Stephen J. Mathis*
Stephen J. Mathis

/s/ *Deborah Simpson*
Deborah L. Simpson

/s/ *Deborah Baker*
Deborah J. Baker

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC019580
Case Name	RENFROW, JASON R v. PRAIRIE STATES WAREHOUSE
Consolidated Cases	No Consolidated Cases
Proceeding Type	19(b) Petition
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	25
Decision Issued By	Dennis OBrien, Arbitrator

Petitioner Attorney	Gary Stokes
Respondent Attorney	Jay Lory

DATE FILED: 10/26/2021

THE INTEREST RATE FOR THE WEEK OF OCTOBER 26, 2021 0.06%

/s/ Dennis OBrien, Arbitrator

Signature

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

JASON R. RENFROW
Employee/Petitioner

v.

PRAIRIE STATES WAREHOUSE
Employer/Respondent

Case # **18** WC **019580**

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 **Dennis O'Brien**, Arbitrator of the Commission, in the city of **Springfield**, on **September 7, 2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **January 19, 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 $**61,187.54**; the average weekly wage was $**1,176.68**.

On the date of accident, Petitioner was **43** years of age, ***married*** with **one** dependent child.

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

Respondent shall be given a credit of $**28,704.96** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**28,704.96**.

Respondent is entitled to a credit of $**29,643.56** under Section 8(j) of the Act.

ORDER

Petitioner has proven that he suffered an accident on January 19, 2018 which arose out of and in the course of his employment by Respondent.

Petitioner's medical conditions, torn rotator cuff of the left shoulder, surgically repaired with an acromioplasty to get more space for the rotator cuff, as well as aggravation and acceleration of preexisting osteoarthritis in the left shoulder are causally related to the accident of January 19, 2018.

Petitioner's medical condition, os acromiole, is not causally related to the accident of January 19, 2018.

Petitioner is entitled to prospective medical treatment as recommended by Dr. Eubanks, to wit, a left total shoulder replacement.

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

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

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

Signature of Arbitrator

OCTOBER 26, 2021

ICArbDec19(b)

FINDINGS OF FACT:

TESTIMONY AT ARBITRATION

Petitioner

Petitioner testified that he was employed by Allerton Propane as the manager of sales and service. He worked with setting up residential and agriculture propane, including setting the tanks in people's yards and running lines. He said he had worked for the company for 15 years. He was 46 years old on the date of arbitration. He said he is left handed.

Petitioner said that on January 19, 2018 he was delivering propane and was trying to open the back door of his truck. He said the door was the width of the truck. The shocks on it that held the door up were broken, so he wedged it up, putting a bar in to hold the door up. While taking the 20-foot, 1 ¼ inch hose off the truck he felt a pop in his left shoulder. He said it felt like a rubber band snapping. While the shoulder was noticeably irritated, he finished his work that day and reported the incident to the office. He said he told the office he would probably have to have somebody with him until he was able to see a doctor.

Petitioner said he had not had any injuries to his left shoulder that he could recall, nor had he seen a doctor, a nurse, a physician assistant or any other medical professional for complaints relative to his left shoulder. He said he had not, prior to January 19, 2018, had any pain, discomfort, numbness or tingling in his left shoulder.

Petitioner testified that his duties including installing the concrete pads that tanks were set on. Each concrete pad weighed 74 pounds, as the pads have to support a tank which weighs 2,600 pounds when full, and two to four pads are set for each tank. The pads have to be leveled out, which involves spade digging. He said it is a very physical job. He said the hose that is pulled out weighs a pound a foot, and the truck has a 125 foot hose on a reel. The reel is greased, but it is a lot easier to pull in the summer than in the winter.

Petitioner said he did not go to see a doctor on the day of accident. He reported the accident and then did not hear anything from his employer. He said by the following Monday he could not even climb into the truck, so he had a man in the shop put the shocks for the door/lid on his truck. He said he contacted the office again and they told him to set something up with Carle Occupational Medicine.

Petitioner said he saw a Carle doctor on February 20, 2018. He said his left shoulder pain did not get better in the month between the accident and his seeing Dr. Scott. He said he had to climb in and out of his truck 20 to 25 times per day, and the arm became more irritated. He demonstrated the pain was from the top of the shoulder towards the AC joint. He said he had not suffered any new injury between the date of this accident and the time he saw Dr. Scott. When he saw Dr. Scott that physician placed restrictions on him. He could not

remember what those restrictions were, and he observed them when he worked. He said Respondent finally got an assistant for him on most days.

Petitioner testified that Dr. Scott ordered an MRI and it was performed. He was then referred to Dr. Gurtler in orthopedics on April 17, 2018. Dr. Gurtler almost immediately scheduled him for surgery, and that surgery to the left shoulder was performed by Dr. Gurtler on June 8, 2018.

Petitioner said he attended physical therapy from July of 2018 through November of 2018 which involved stretches, pulling rubber bands and pull-down machines with weights. He said he never progressed past 20 pounds with that, and at the end of his therapy he did not think he had reached his potential in regard to comfort in movement and lifting, based on his prior experience after right shoulder surgery in 2014.

Petitioner said he was released to return to work light duty on approximately October 28 or 29, 2018, and he did so. He was doing the same job as before, but he was able to do it with some modifications.

Petitioner said he recalled telling the doctor's office in January of 2019 that he was having pain regularly, that even the motion of pulling on a comforter was very painful. He said reaching out to the left with his left arm caused a lot of pain. Using his right arm he demonstrated that his arm became painful when it was raised to the top of his shoulder blade level, with a bent elbow, his hand a little bit higher and a little in front of his body. Petitioner said his pain at that time was 3/10 and it was to the point where at the end of the day his climbing in and out of the truck caused it to be inflamed and he had to put ice packs on it when he got home. He said it got to where he could not sleep at night, despite having had two steroid injections.

Petitioner said Dr. Gurtler ordered another MRI in May of 2019, as well as a functional capacity evaluation. He said he continued working with modifications, which was a person being with him to make sure he could get the job done, with that person pulling the hose, doing the heavy lifting, setting blocks and doing the digging. He said in December of 2019 he had another discussion with Dr. Gurtler about a possible shoulder replacement. He said his pain had never resolved in the previous 18 months, not had it improved significantly, especially when he was active.

Petitioner said he last saw Dr. Gurtler in December of 2019 as the doctor retired and moved to Colorado. He said that at the time he retired in 2020, Dr. Gurtler set up a second opinion with a doctor in St. Louis. That doctor also injected his shoulder, that being the third injection he had undergone since the time f his surgery. Petitioner said he saw a pain management specialist, Dr. Santiago in 2020 as well. Dr. Santiago then referred him to another orthopedist, Dr. Eubanks, and Petitioner said he had been treating with that doctor through the date of arbitration. He said Dr. Eubanks recommended a shoulder replacement for him even though he was 44 or 45 at the time. Petitioner said he did not know if he could go another 20 years in the condition he was in. It was his desire that the arbitrator order that surgery take place.

Petitioner said he had not had any accidents either at home or at work involving his left shoulder since January 19, 2018. He said that compared to the recovery from his prior right shoulder surgery, the left shoulder had never recovered to the point the right shoulder had, he could do his day to day activities with his right shoulder, but the left shoulder had not gotten to that point. That is what he meant in physical therapy when he said the left shoulder felt new and different.

Petitioner said he went to St. Louis to be examined by Dr. Frisella at Respondent's request. He said that examination was 13 minutes long and that he answered every question the doctor asked of him, other than the exact work restriction he had, saying he could not remember if it was 20 or 25 pounds, so he did not answer that as he did not want to be wrong.

Petitioner testified that the doctors, including Dr. Eubanks, had all indicated that he might have to have more than one surgery, having another when he was older. He said that did not give him pause as he felt he was at the point where he wanted to feel normal again.

Petitioner said that he had a son who was 10 and in a wheelchair, and there was currently not much he could do for him, he would watch his wife do it. He said he did not even want to try because if his son fell he would not be able to catch him. He had learned how to wash his hair with his right arm, and drying off was a challenge. He said he could not put a belt on, he would either put it on before or have his wife do it, as he could not reach to the middle of his back. He said he had gone to wearing bibs as some days he could not button his jeans or shorts. Petitioner said he would only get three to four hours of sleep without tossing and turning and he had moved to his own bed in his son's bedroom as his flip flopping was keeping his wife up.

Petitioner testified that the only thing that seemed to help the pain was sitting, and sometimes that did not help. He said he did not take painkillers because he had a commercial drivers license and he was under the impression that he could not take painkillers and still drive.

Petitioner said he had been working with a 20 pound work restriction and that with assistance with physical tasks he had been able to do his duties at work and get his work done. He said Respondent had left it up to him to hire someone to do that work that he knew he could not do.

Petitioner said that on an average day his pain would probably be a six on a scale of one to ten, that it would be higher on a busy day and a five or six on a slower day.

On cross examination Petitioner said his personal doctor for the past couple of years has been Dr. Martinez. He said he did not have a personal doctor at the time of this accident. He said Dr. Martinez has treated him for his low back, and a chiropractor, Dr. Oxendine, had treated his neck. He said he had never seen Dr. Oxendine for his left shoulder, just for his neck and back.

Petitioner said that during the month after the accident while waiting for his employer to get back to him and send him somewhere, he did not seek medical care elsewhere. He said he was familiar with Dr. Gurtler as that is who had performed the earlier surgery on his right shoulder in 2014. He said Dr. Gurtler had not examined or treated his left shoulder when treating him in 2014.

Petitioner agreed he had physical therapy after this left shoulder surgery. He said he would not disagree if the physical therapist's notes and Dr. Gurtler's records reflected he was improving and getting better, saying he would never disagree with a physician's opinions. He said when he saw Dr. Gurtler in December of 2018 physical therapy had ended in November 2018 and he was to do a home exercise program.

Petitioner said when he next saw Dr. Gurtler on January 10, 2019 he told the doctor of catching and snagging in his shoulder. He said he had experienced that previously and had probably told the doctor then that the shoulder was still aching, as it was not a new complaint. He said nothing had happened to his left shoulder

between the December 2018 and the January 2019 Dr. Gurtler visits, he had not shoveled snow or set up decorations for Christmas or put lights on trees.

Petitioner testified that when he told Dr. Gurtler on May 9, 2019 that his pain was new and different he was referring to it in comparison to his right shoulder, nothing had happened at that time. He said he told Dr. Gurtler that he was comparing it to his right shoulder.

Petitioner said that while surgery had been mentioned in his visits with Dr. Gurtler, Dr. Gurtler would not perform surgery on him, he referred him down to Dr. Keener's office in St. Louis. Petitioner said it was not because he wanted to see a doctor in St. Louis, he did not know doctors in St. Louis. He said he saw Dr. Keener twice. He said Dr. Keener would not perform the surgery on him, either, as he was too young.

Petitioner said he did not know how he got Dr. Santiago's name. Dr. Santiago referred him to Dr. Eubanks, and Petitioner said he had only seen Dr. Eubanks on one occasion, on November 5, 2020. He said he did not take any medical records with him when he saw Dr. Eubanks, but that Dr. Eubanks took x-rays that day, and he did not know if Dr. Eubanks already had the medical records. He said he gave a history of his surgeries and therapy to Dr. Eubanks.

Petitioner said he did not participate in any sports, and he went fishing occasionally, the most being three times in 2021. He said he did not drive an ATV or a motorcycle, and he did no off-roading. He said he had not had any motor vehicle accidents since January 19, 2018. He said he had not seen any chiropractors for his left shoulder, received physical therapy anywhere but Carle Clinic or been seen in any urgent care facility, emergency room or hospital for left shoulder problems that had not been discussed during his testimony.

On redirect examination Petitioner said the physical therapists would ask his pain level at the beginning of his appointment, but the pain would escalate during the therapy.

Petitioner said that when he last saw Dr. Gurtler in December the doctor said "something is going to have to be done." No recommendations short of a total shoulder replacement have been made to him by anyone, other than Dr. Santiago's recommending he see Dr. Eubanks.

MEDICAL EVIDENCE

Petitioner initially saw Dr. Scott on February 20, 2018 with a history of dragging/pulling a gas line hose while propping up the lid to the reel with his left shoulder. He said he heard and felt a pop in the left shoulder and he had immediate pain, though it being 15 degrees outside, that numbed it. This was his first medical visit since then, and Petitioner told him that he had difficult in the weeks since then and that it hurt to lie on the shoulder. He decided to seek medical care because of the persistent pain. He said the left shoulder felt similar to how the right shoulder felt in 2013. Physical examination at that time showed decreased range of motion of the left shoulder in abduction and forward flexion with limited internal range of motion, with pain on range of motion testing. He had tenderness over the anterior portion of the left shoulder. Dr. Scott felt the possibility of internal derangement of the left shoulder was high and that they needed to rule out a rotator cuff tear versus a labral tear. He ordered x-rays and an MRI and restricted his work to 15 pounds with the left arm, avoiding overhead work, and no overhead lifting. He was told to keep work between his waist and chest level. (PX 1)

The MRI was performed on March 14, 2018. It was interpreted as showing a undersurface partial-thickness tear of the supraspinatus tendon at its insertion. A small amount of fluid in the subacromial/ subdeltoid bursa was also thought to indicate a poorly demonstrated tiny focal full-thickness tear at that location. Degenerative arthritis was noted, including a moderate sized osteophyte on the humeral head with thinning of articular cartilage in the glenohumeral joint and associated degeneration of the glenoid labrum, including a probable posterior labral tear. (PX 2)

Petitioner saw Dr. Scott again on March 20, 2018. He said the x-rays which were performed showed no fractures but mild-to-moderate left shoulder osteoarthritis. The MRI had been performed and showed partial a thickness tear of the supraspinatus tendon at its insertion, an abnormality of the glenoid labrum with a probable posterior labral tear, as well as the osteoarthritic changes to the joint. His physical examination was unchanged and his pain remained about the same, 7/10. Dr. Scott's assessment was new onset of left shoulder internal derangement, at least a partial rotator cuff tear of the supraspinatus tendon as well as a possible posterior labral tear. He referred him to Dr. Gurtler who had treated Petitioner's right shoulder in the past. His restrictions were continued. (PX 1)

Dr. Gurtler saw Petitioner on April 17, 2018. He described the prior injury to the right shoulder and its treatment in detail. In regard to the new left shoulder condition he gave a history of holding the door up and, while propping the door, feeling a pop in his left shoulder. He said he had done the same maneuver 20 times that day, without injury. He said it hurt for the rest of the day as he worked, he reported the injury, but felt it would get better on its own. On the date of examination Petitioner said he was in constant pain, which was worse at night, and that any movement of the shoulder away from his body was painful. His maximum pain was reported at 8/10. He showed Petitioner the MRI images of the torn rotator cuff. That day's physical examination showed reduced active range of motion, and positive Hawkins, empty can, speed's and O'Brien's tests. Dr. Gurtler thought Petitioner could live with his arthritic pain, but they needed to deal with the rotator cuff pain. He discussed a rotator cuff repair with Petitioner and noted that his not continuing to perform the heavy propane work for the rest of his life, as he was only 43, would be a good idea. Petitioner told him he was probably going to be doing office work in the future as he was training his replacement. (PX 3)

Dr. Gurtler performed left shoulder arthroscopic and open surgery on June 8, 2018, finding bare bone lesions on the bottom and anterior portions of the glenoid and on the ball of the articular surface of the humeral head.excising the os acromiale, performing an acromioplasty to get more space for the rotator cuff tissue and repairing the rotator cuff. (PX 4)

Dr. Gurtler saw Petitioner post-operatively on June 21, 2018. He advised Petitioner that during his surgery a congenital deformity, an Os Acromialis, was excised, that it was loose and would most likely cause him pain. He also said the rotator cuff repair would result in a slow healing due to the tendons having a very poor blood supply, that it would be six months before he could resume activities. He noted Petitioner had moderately severe degenerative joint disease in the shoulder with marked erosion and defects to the humeral head, that the arthritis was very advanced, with bare bone areas. He advised Petitioner to find work that was less stressful on his shoulder as the left shoulder was headed toward a total shoulder replacement in not too many years if he did not put less stress on the shoulder. Physical therapy was ordered at that time. (PX 3)

Physical therapy was provided at Carle's Danville facility from July 9, 2018 through November 27, 2018. Initial treatment was for passive range of motion and progressed to add active range of motion, resistance exercises and, finally, strengthening exercises . While Petitioner had pain and discomfort throughout, he progressed in ability and his pain lessened. By October 29, 2018 Petitioner's QuickDash testing reflected a 41 percent perceived disability. On that date seven of Petitioner's nine physical therapy goals had been met, one, being able to lift a gallon of milk without increased pain was improving (Petitioner was only allowed to lift 5 pounds), and Petitioner had not met the return to full duty work goal. He met the gallon of milk goal without any issues on November 13, 2018 as his weight restriction was raised to 15 pounds. In his last nine physical therapy visits he reported a pain level of 0/10. (PX 4)

When seen on July 12, 2018 Dr. Gurtler noted that Petitioner had to heal before he could go back to his work duties, and it would likely take six months. He felt Petitioner was doing well, and his pain was markedly reduced. Petitioner said he did have discomfort in the arm, and Dr. Gurtler explained that they had to release the long head of the biceps in the surgery and that discomfort would probably go away with time. Dr. Gurtler felt Petitioner was making progress in physical therapy and his range of motion was improving. He noted Petitioner should not go back to work until he was completely healed. When he saw Petitioner next on August 9, 2018 Petitioner's pain was diminishing and his range of motion was improving. Physical therapy was to continue, and Petitioner was to remain off work. Petitioner was seen again on September 7, 2018 with very little pain except after physical therapy sessions. Physical therapy was to continue but to add very light strengthening activities. He was kept off work with anticipated release to desk work in a month. (PX 3)

On October 5, 2018 Petitioner was seen by Physician Assistant (PA) Cummings. Physical therapy was continued with light strengthening and he was released to "very restricted duty," no lifting over 5 pounds, overhead work, just right hand work only. When seen by PA Cummings on November 5, 2018 his findings were similar, Petitioner was doing well, and his restrictions were increased to 15 pounds, with physical therapy to continue. PA Cummings saw him again on December 4, 2018 and Petitioner had continued to improve. His range of motion was considered to be good, comparable to his right side, and he was able to lift the arm against gravity and moderate resistance. Petitioner reported being subjectively improved since his last visit. Physical therapy was stopped, with Petitioner transitioning to a home exercise program. Petitioner reported that he had been able to do a significant amount of his work duties with his restrictions so his lifting limit was increased to 25 pounds, and he was allowed to do some non-prolonged overhead work. (PX 3)

When seen by PA Cummings on January 10, 2019 Petitioner said that overall he was doing okay, but still regularly had pain in his shoulder as well as a catching and snagging sensation deep in the shoulder. Even simple activities such as pulling the comforter over his body at night was very painful and difficult. He was continuing to do his work with restrictions. On this date he was found to have strongly positive Hawkins and empty can tests, and his strength was 4+/5. PA Cummings left his restrictions the same, but noted that overhead work was to be brief. A subacromial Cortisone injection was performed at this visit. (PX 3)

On February 11, 2019 PA Cummings noted that the Cortisone injection had provided quite a bit of relief, but Petitioner was still reporting a lot of catching and snagging, especially when the arm was up above shoulder height. Petitioner was found to have a lot of difficulty in the last 30-40 degrees of range of motion.

His strength was 5-/5 but he had ongoing stiffness and a feeling of resistance within the shoulder. His restrictions continued. (PX 3)

PA Cummings noted that on April 9, 2019, 30 weeks after Petitioner's surgery, Petitioner was still struggling, had pain with motion, adduction and extension and motion above the shoulder height in abduction. Petitioner on this date was describing a feeling of sharp stabbing or catching sensation in the top of the lateral shoulder. On physical examination it appeared the pain was localized to the AC joint. O'Brien testing was positive and Hawkins, and Neer's testing was weakly positive, while the empty can test was negative. X-rays that day did not identify the cause of Petitioner's discomfort. Another Cortisone shot was provided and he was to see Dr. Gurtler at his next visit. (PX 3)

Petitioner saw Dr. Gurtler on May 9, 2019. Dr. Gurtler noted that Petitioner was in significant pain which was rated at 3/10, and he said it interfered with his activities of daily living and sleep and interfered dramatically with his work. Physical examination revealed tenderness in the anterior shoulder as well as the anterior lip of the acromion. He had decreased range of motion and Dr. Gurtler felt his strength was, at best, 4/5, with even less strength with his arm out away from his body. The x-rays which had previously been taken were found by Dr. Gurtler to show significant degenerative joint disease in the glenohumeral joint with articular surface damage and joint space narrowing. Petitioner felt his symptoms had escalated dramatically and were interfering more than ever with his life. He was very worried about the loss of strength. Dr. Gurtler recommended a new MRI. (PX 3)

The left shoulder MRI of May 22, 2019 was interpreted as showing a rather significant artifact related to a small piece of metal along the posterior lateral margin of the humeral head. No evidence of a large re-tear of the rotator cuff was seen. Worsening glenohumeral arthritis was observed with posterior decentering of the humeral head, cartilage loss of the posterior glenoid with subchondral sclerosis and spurring and a prominent spur had developed along the inferior margin of the humeral head. (PX 6)

Dr. Gurtler saw Petitioner on July 9, 2019. He reported that the new MRI of May 22, 2019 had not shown a new tear, but there was posterior subluxation of the humeral head with erosion of the articular surface posteriorly, and a goat beard osteophyte was beginning to develop. He noted there was not much they could do for a 44 year old with this much arthritis. Petitioner advised him that it was getting harder and harder to work, that his constant pain was 4/10 but would spike much higher, and that he felt he was losing motion. Physical examination did show a reduction in range of motion, Petitioner could not get his hand behind his back at all. He noted that Petitioner was in quite a bit more pain while trying to move it during the examination. Dr. Gurtler said they talked about how they could not do shoulder replacements in a 44 year old, he was just too young, even though it would take away his pain. He indicated doing more surgery in the back to repair where it was bone on bone was useless and not worth it for Petitioner. He said Petitioner was "stuck with trying to find a way to live with this." Dr. Gurtler noted, "We both understand that shoulder replacement would likely relieve his pain it is just the longevity is difficult to predict. Certainly if he had a shoulder replacement he could not do the job he is doing now where he is doing lifting. He just would not be able to do that. If he had a shoulder replacement he had (sic) restricted to about 5 lb. That would not be consistent with his job." Dr. Gurtler felt a functional capacity evaluation was necessary to determine what Petitioner could and could not do, and one was ordered. (PX 3)

A functional capacity evaluation was performed at Carle Therapy Services on July 18, 2019. The therapist who performed the testing found Petitioner to have given maximal effort as determined by physical observations as well as physiological responses such as increased heart rate, and similar tests resulting in similar performance. Petitioner was found to be functioning at a medium physical demand level which would allow him to lift 60 pounds floor to waist, 30 pounds waist to crown and 60 pounds front carry, each on a rare basis. It was noted that Petitioner had limited mobility of both shoulders, left worse than right, and demonstrated weakness of both shoulders. (PX 7)

Dr. Gurtler on July 30, 2019 noted that Petitioner was trying to work but said it was getting more difficult. He discussed a reverse total shoulder replacement with Petitioner, and noted that at age 44 it was very difficult as it would be a permanent change in his shoulder and in his life, with a 5 pound restriction for life. He also told Petitioner that his shoulder was a problem, and it was not going to get much better. Dr. Gurtler noted the functional capacity evaluation which had been done which noted he could not do any overhead work, could not do any heavy lifting, and had weakness in both of his shoulders, worse on the left. Much of Dr. Gurtler's notes reference the FCE are unintelligible as a result of apparent poor transcription. (PX 3)

Petitioner was seen by Dr. Martinez on August 1, 2019 for a routine check-up, but he was also reporting having had low back pain for a year, producing left leg numbness and tingling. Dr. Martinez's physical examination on that date found marked atrophy around the left shoulder girdle and quite poor range of motion. Petitioner was reporting pain to be 6/10. Dr. Martinez did not think either a hemiarthroplasty or a total shoulder replacement was a good idea and he made a referral to a doctor in St. Louis to try to find a solution other than prostheses. He said there were very poor options down the road. (PX 3)

December 17, 2019 x-rays of the left shoulder were compared to April 9, 2019 x-rays and revealed Petitioner's surgical changes to be stable, as were the mild-moderate degenerative changes of the glenohumeral joint with osteophyte formation at the inferior aspect of the humeral head. (PX 8)

Petitioner was seen at Washington University in St. Louis Physicians by Dr. Mo (Resident) and Dr. Keener on February 19, 2020. Petitioner's history to Dr. Mo was consistent with his testimony and treatment history. His voiced complaints to her on that date were of pain in the anterolateral aspect of his left shoulder which was sharp and aching and moderate to severe in nature. He noted he was currently working, but with significant restrictions, and was no longer able to do heavy loading and unloading. Her physical examination on that date showed decreased range of motion on the left in forward elevation, external rotation to the side and internal rotation behind the back. He had a positive impingement test, speed's test and was tender to palpation over the biceps. Dr. Keener noted Petitioner had modest global loss of range of motion. He felt there was a disconnect between Petitioner's objective findings and his subjective complaints. Both doctors recommended fluoroscopic guided glenohumeral steroid injection. Dr. Keener did not think an arthroplasty was indicated at this point. He felt Petitioner's work restrictions should continue, noting a 5 pound lifting restriction and avoiding overhead work. (PX 9)

Petitioner was seen again by Dr. Keener on May 27, 2020. Dr. Keener noted that a fluoro guided glenohumeral injection had been performed and it given Petitioner no relief, not even temporarily. Physical examination on this date showed focal tenderness at the AC join, reduced range of motion, and a mildly painful AC joint with cross-body motion and terminal elevation. Mild abduction and external rotation weakness was

noted. Dr. Keener did not believe Petitioner was a good candidate for total shoulder arthroplasty. He felt Petitioner's pain was related to his AC joint, which he injected. He did not believe Petitioner required any surgery at this point, he would just have to live with chronic pain at this point. He gave him permanent restrictions of 20 pound lifting below shoulder height, 20 pound push-pull limit and no overhead lifting. He released Petitioner from his care with no further follow-up. (PX 9)

On September 21, 2020 Petitioner was seen by Dr. Santiago, a pain specialist. He said the injection performed by Dr. Keener gave him about 30 percent relief for three days, and that a steroid injection had not helped. After reviewing the MRI from May of 2019 and performing a physical examination Dr. Santiago's diagnoses were chronic left shoulder pain and osteoarthritis of the left glenohumeral joint. He referred Petitioner for another opinion in regard to possible shoulder replacement and after discussing other treatment modalities including low-dose opioids for quality of life with his family it was decided to hold off on that at present. (PX 10)

Petitioner was seen by Dr. Eubanks on November 18, 2020. At that time Petitioner was complaining of 4/10 pain. On physical examination Petitioner had pain to palpation of the left shoulder, crepitus of the left glenohumeral joint, decreased range of motion of the left shoulder and reduced left rotator cuff strength. X-rays taken that date showed mild arthritic changes of the left shoulder joint. No diagnosis or treatment recommendation is included in this note. (PX 11)

DEPOSITION TESTIMONY OF DR. AARON C. EUBANKS

Dr. Eubanks was called as a witness by Petitioner and testified that he was a board certified orthopedic surgeon, treating all areas of the body other than the spine, performing an average of fifteen surgeries per week. He said 20 to 25 percent of his surgeries involved the shoulder. He said he performed 25 to 30 shoulder replacement surgeries per year, with all of them reporting improvement in pain following surgery, and approximately 75 percent reporting improvement n function following the surgery. He said the predominant reason for shoulder replacement surgery was arthritis complaints and the second most common reason was failure of the rotator cuff to heal or a failed rotator cuff repair. (PX 12 p.4-9)

Dr. Eubanks said he had seen Petitioner on one occasion, November 5, 2020. He said he was aware Petitioner had previously had surgery. When seen Petitioner was complaining of moderate, four out of ten, pain in the left shoulder, despite the use of non-steroidal anti-inflammatories. Petitioner reported that the pain prevented him from sleeping through the night. Petitioner reported pain upon palpation during his physical examination, and he was found to have a limited range of motion of the left shoulder as well as a strength loss in the left shoulder. X-rays taken that day disclosed arthritis in Petitioner's left shoulder. (PX 12 p.9,10)

Dr. Eubanks diagnosed Petitioner with posttraumatic arthritis of the left shoulder. Dr. Eubanks testified that trauma can cause the development of arthritis, can aggravate preexisting arthritis and can accelerate the progression of arthritis in an affected joint. He said trauma could include the fracturing of bone or tearing of muscles, tendons and ligaments but could also include the dissection of tissue, excising or sawing of bone in surgery. (PX 12 p.11,12)

Dr. Eubanks then was asked a hypothetical question generally describing Petitioner's left shoulder accident, complaints, testing and treatment since January 19, 2019 as well as a pre-morbid state of no left shoulder complaints or treatment. Based upon those hypothetical facts Dr. Eubanks said that in his opinion the injury that occurred started a process that had led to the development of advanced shoulder arthritis at an early age, that the accident and injury of January 19, 2018 was either a cause or significant exacerbating factor in Petitioner's current condition. (PX 12 p. 12-16)

Dr. Eubanks testified that he had recommended a total shoulder replacement for Petitioner as it was the only reasonable treatment that he or anyone else could provide to return Petitioner to a level of good function and reduce his pain to a comfortable level, that no other treatment could achieve those goals. He said Petitioner had received sufficient conservative treatment. He felt Petitioner would continue to suffer pain levels at least equal to those he had when seen in November of 2020 if he did not have the total shoulder replacement. (PX 12 p.16,17)

Dr. Eubanks said age was a good question in shoulder replacements, as no orthopedic surgeon wanted to do a shoulder replacement on a younger person, but there were young people, even teenagers, who have congenital problems that required joint replacement surgery. Age did not matter for a person with cancer whose bone had to be removed, their condition dictated the treatment. He shared that feeling in regard to Petitioner, his arthritis was limiting his function and his only good option was a joint replacement. So even though they did not like to do that procedure at an early age, he felt it was appropriate. He said he would tell Petitioner that he would get 15 to 20 years of good function, but know that the replacement would wear out and would require another surgery in his sixties, but that he would have a better quality of life from age 45 to 65 than would otherwise be possible. (PX 12 p.17,18)

On cross examination Dr. Eubanks said Petitioner's complaints on November 5, 2020 were 4/10, moderate to severe, and he was looking for an answer which would allow him to function at a higher level. He said Petitioner reported he was able to perform activities of daily living. He said he did not recall discussing Petitioner's mechanism of injury with him. It was his understanding that Petitioner had a pull injury or a traction type injury to the shoulder. He did not recall Petitioner describing his job duties to him. He knew Petitioner had undergone a rotator cuff repair surgery, and he said it took an average of about six months for pain from such a surgery to resolve. He said it had been about two and a half years after the surgery when he saw Petitioner. He attributed Petitioner's ongoing complaints to be from his arthritis. (PX 12 p.19-22)

Dr. Eubanks said the x-rays he took on the day of his examination did not show acute findings, but did show arthritis. He said while the radiologist felt the arthritis was mild, he felt it was moderate, a little more severe than what the radiologist described. He said he had reviewed Petitioner's MRI films, but he did not remember if he did that on the day of the examination. He did not include the MRI findings on his report. He said he had not reviewed the pre- or post-operative medical records, injection records, or the operative report and did not know the opinions of Petitioner's prior physicians. He could not recall if Petitioner had told him of having had injections, but he did not record having been told that. He did not know if the injections had been effective, but they were not effective as of the time he examined Petitioner. (PX 12 p.22-25)

Dr. Eubanks testified that his indications for total shoulder replacement surgery were glenohumeral arthritis that had failed conservative care and/or a rotator cuff that had failed surgical or nonsurgical care, that

irreparable rotator cuff and glenohumeral arthritis were the two main reasons for that surgery, with fracture being the third reason. He said he certainly had patients who might benefit from a total shoulder replacement but who he did not recommend the surgery, often geriatric patients who had severe arthritis but were treated conservatively as they were not candidate for surgery. For those patients, medical comorbidities were the reason surgery was not indicated. (PX 12 p.25,26)

Dr. Eubanks said age was a factor to be considered when recommending total shoulder, hip and knee replacements, but it was not a hard "no." It was just one factor, and it is discussed in detail as is the potential need for another surgery in the future if the first did not last as they were young. He said he would tell Petitioner that the surgery would probably help a lot for 20 years and that he would expect it would have to be redone in 20 years, with potentially not as good a result the second time. He said he liked to see severe arthritis when doing the surgery, but it doesn't always show up on x-ray, you get pretty good information from an MRI, and really good information when you are looking right in the joint. He said his review of the MRI indicated moderate to severe arthritis. He said response to injections were helpful guidelines, but the shots sometimes did not last very long because the arthritic disease was too severe for the shots to be helpful, but response to injections was not a hard "yes" or a hard "no," either. With injections you look for someone to have a shot last six months, the second shot will last four or five months, and over time the shots begin to be ineffective. A patient's failing to respond to injections would be another factor indicating total shoulder replacement. (PX 12 p.26-28)

In regard to his physical examination Dr. Eubanks said he found pain to palpation, grinding or crepitus to the left shoulder. He assumed the crepitus was caused by the arthritis that was grinding when he rotated Petitioner's arm back and forth, although another cause could be the knots from the rotator cuff repair rubbing. Dr. Eubanks said he did not know at the deposition, and potentially not at the time of the examination, whether Petitioner had arthritis prior to the date of this accident. Despite that, he was still of the opinion that if he had it, the accident accelerated or worsened it, and if he did not have it, the accident would have directly caused it. He testified that if Petitioner had at least some degree of arthritis prior to the date of accident, then he would say that the accident did not cause the arthritis, but that it instead aggravated or accelerated the arthritis. He said damage to the joint structure, in Petitioner's case the labral and rotator cuff tears he had, basically set up the situation where the ball is not seated properly in the socket and it has abnormal sheer force, rubbing, in layman's terms, and the extra rubbing rubs the cartilage down and away. He said going in and doing surgery occasionally, not a lot, has bumps or bruises or local damage, and in some people this causes degenerative change rapidly after the surgery and fast tracks the development of arthritis. (PX 12 p.28-31)

Dr. Eubanks said a rotator cuff tear was not an injury to cartilage, it was an injury to a tendon, four muscles attach to the top of the humerus and the almost blend into one another like a baseball cap. The "cap" sits on top of the bone, and moves in different directions depending on which muscle is fired. When a tendon pulls off the bone, that is called a rotator cuff tear. The repair of the rotator cuff is to the tendon and bone, not to cartilage. During Petitioner's surgery the surgeon would have looked into the joint as he documented in the operative report seeing, in the surgeon's words, "severe arthritis." (PX 12 p.31,32)

Dr. Eubanks was familiar with the natural progression of arthritis, and he would have expected Petitioner's arthritis seen in the surgery to cause ongoing and progressing arthritic complaints. He said

Petitioner's presentation when he saw him in November of 2020 did not seem surprisingly or way out of line from a natural progression of complaints since June of 2018. But he said Petitioner's natural progression was not natural, he had been functioning well, then had an injury, then really deteriorated in the year or so after the surgery before he examined him. He felt this made sense as a natural progression of posttraumatic arthritis. He said this was based on his usual findings with patients who had a rotator cuff tear, then a rotator cuff repair, and then do well without daily complaints. (PX 12 p.32-34)

Dr. Eubanks said some patients are not necessarily symptomatic, that they can become symptomatic due to repetitive activity or idiopathically, and their symptoms can wax and wane. He said people with arthritis can get by with their arm by using it less and by keeping their arm closer to their body and doing less with the hand extended. (PX 12 p.35,36)

DEPOSITION TESTIMONY OF DR. W. ANTHONY FRISELLA

Dr. Frisella was called as a witness by Respondent and testified that he was a board certified orthopedic surgeon whose clinical practice primarily involved shoulder and elbow surgery, having been fellowship-trained in shoulder surgery. Dr. Frisella said he performed an independent medical examination of Petitioner on January 21, 2021 at the request of Respondent's attorney. The history Dr. Frisella said he received from Petitioner was different from his testimony at arbitration and what he reported to Petitioner's treating physicians following the accident, as he told Dr. Frisella he was pulling on a hose he was dragging behind him with his left arm, yanking it forward, when he felt a pop in the left shoulder like something had snapped in the shoulder. Petitioner told him that he continued to have significant pain and problems in his left shoulder. He said Petitioner would not really tell him what his current problems were. He said Petitioner did not seem to be in severe pain during his examination. (RX 1 p.4-8)

Dr. Frisella said he reviewed the operative report of Dr. Gurtler of June 8, 2018. He said during his physical examination of Petitioner he thought his findings were consistent with Petitioner having had a successful rotator cuff repair as he had fairly good range of motion, his rotator cuff strength was normal and he had a little bit of tenderness to palpation. He said the exam was reasonably good considering the arthritis shown in the x-rays and MRI as well as the operative report. (On cross examnation he noted he did not review the MRI films, only the radiologist's report.) He said the x-rays he took on January 21, 2021 showed changes to the bone from the time of surgery, a few metallic artifacts from the rotator cuff repair, and moderate to severe degenerative osteoarthritis at the glenohumeral joint, wear and tear of the ball and socket joint in the shoulder. (RX 1 p.9,10,29)

Dr. Frisella said that osteoarthritis can occur months or years after an acute injury, it does not occur immediately. But a rotator cuff tear should not cause arthritis even later as a tear to a tendon typically does not turn into arthritis at any point in the future. (RX 1 p.11,12)

Dr. Frisella's diagnosis after examining Petitioner was one of multiple shoulder problems going on at once, Petitioner had a rotator cuff tear caused by the 2018 injury and multiple degenerative or preexisting conditions, arthritis of the glenohumeral joint, osteoarthritis of the acromioclavicular joint, and an os acromiale, a congenital piece of bone on the top of the shoulder that did not fuse to the shoulder blade and had been

hanging out free above the rotator cuff. He did not believe the last three diagnoses were related to the injury at work. He said the glenohumeral osteoarthritis, in his opinion, was not related as Petitioner had arthritis from the first imaging, that imaging from January 20, 2018 showed arthritis. He said the March 2018 MRI noted that the degenerative arthritis was advanced for Petitioner's age, and the arthritis seen at the surgery four months after the accident had not had enough time for an acute injury to cause that arthritis. He said arthritis was a wear and tear condition, and Petitioner was pretty young to get it, but it was not unheard of for a 45 year old to have it. (RX 1 p.12-15)

As far as treatment was concerned, Dr. Frisella said that given Petitioner's age and his moderate to severe arthritis, he felt Petitioner should live with it, though he might get to a place where a shoulder replacement would be an option. (RX 1 p.15)

Dr. Frisella said Petitioner had "a shoulder that was completely nude of cartilage, there is no cartilage on it at all, not through the whole thing. It would be really unusual for him to have never felt pain in the shoulder before given the findings on the x-ray and especially at the time of the surgery several months later for him to say I never had any shoulder pain prior to the injury." (RX 1 p.16)

Dr. Frisella felt Petitioner had reached maximum medical improvement. He said he would go with the restrictions from the functional capacity examination as they did the work to figure that out, and he felt the restrictions they set were due to the osteoarthritis, as a person with a successful rotator cuff repair did not require any restrictions. He felt Petitioner's current complaints were due to the arthritis. (RX 1 p.16-18)

Dr. Frisella said his indications for total shoulder replacement surgery were typically moderate to severe osteoarthritis, an intact rotator cuff and pain that was not responsive to conservative treatment in a patient who was in their sixties, typically, and not before. He said he did not recommend it for Petitioner because he still had some cartilage left and he was only 45 years old. (RX 1 p.18)

Dr. Frisella said that based on the AMA guides, sixth edition, he assigned Petitioner an 11 percent of an upper extremity impairment rating. (RX 1 p.19)

On cross examination Dr. Frisella said that he had no indication that Petitioner had treated for left shoulder problems before but could not say that he had never complained of them, as it would be unusual for Petitioner to not have had prior pain. When asked why Petitioner would have not indicated he had prior problems Dr. Frisella did not answer, saying that would be speculation on his part, that he had no opinion on what someone's motivation would be. (RX 1 p.20,21)

Dr. Frisella said he had been providing testimony in workers' compensation cases and personal injury cases for about ten years, and 95 percent of his testimony had been given for the defense side of the bar and insurance companies. He said he grossed about $100,000.00 per year doing this work, charging $1,200.00 per hour for examinations and $1,500.00 for the first hour of depositions and $1,200.00 per hour thereafter. (RX 1 p.22,23)

Dr. Frisella agreed Respondent had not provided him with any medical records indicating prior complaints or treatment to Petitioner's left shoulder. He agreed that he examined Petitioner almost exactly three years after the accident and that at that time Petitioner was still having ongoing problems with pain despite having undergone successful rotator cuff surgery, distal clavicle resection and the excision of the acromion,

having received four months of physical therapy, and despite at least three injections. He cited Dr. Keener's comments about Petitioner's subjective complaints being out of proportion to his subjective findings, but then admitted that nowhere in their records did Mr. Cummings, Dr. Scott, Dr. Gurtler or any other doctor suggest or imply that Petitioner's complaints were in excess of his objective findings. (RX 1 p.23-26)

Dr. Frisella said that the pain complaints Petitioner was making to PA Cummings 34 weeks after surgery could be from both the rotator cuff and from arthritis, as it was less than the year it took to recover from rotator cuff surgery, and that for people with arthritis it took longer to recover from that surgery. He said by the 11 month point when Petitioner was complaining of pain to Dr. Gurtler significant pain interfering with activities of daily living, night pain and pain interfering dramatically with his work, it was his opinion it was arthritis pain at that point, but he was just guessing. (RX 1 p.27,28)

When asked if the accident of January 19, 2018 appeared to have aggravated Petitioner's arthritis that was evident in the March 2018 MRI, Dr. Frisella said it was a matter of semantics, but that it did not permanently structurally change the arthritis, and that it was impossible to say it even temporarily changed the arthritis. Dr. Frisella acknowledged that the tearing of tendons in the shoulder was a trauma, that surgery to the shoulder itself was a trauma, and that using saws and burring machines to cut off portions of the distal clavicle and acromion were trauma, but that there was no objective evidence that suggested there was some permanent aggravation of the arthritis. (RX 1 p.33,34)

While saying it was not his job to decide if people were telling the truth he did not hesitate to say that it was his opinion, more likely than not, that Petitioner's shoulder was bothering him before this accident. When asked if it was bothering Petitioner to the degree he was complaining of in January of 2018 and January of 2019 Dr. Frisella said, "clearly he had a super – additional trauma as we agreed on that caused it to hurt more and now several years later it's still bothering him but I can say someone with arthritis like that, you see them a couple years later and it's probably going to be bothering him. You know, when you say did it aggravate it, it's hard to agree with that." When asked why it continued to hurt more if it was not aggravated Dr. Frisella said, "Because time passes, arthritis progresses. It did progress." Dr. Frisella said he did not know if it was just a coincidence that Petitioner's pain progressed with wear and tear of arthritis. He said that the fact he did not know if it was coincidental or not meant the accident might or could have been a factor in causing, lighting up the arthritis and making it symptomatic, Dr. Frisella said he certainly could not exclude that possibility. (RX 1 p.35-37)

Dr. Frisella said that some traumas could accelerate, aggravate, cause and contribute to arthritis, make it progress at a faster pace than it had been developing at. (RX 1 p.37)

While Dr. Frisella said he would not do shoulder replacement surgery on Petitioner if he walked in his office, he felt there was a reasonable chance in the future that Petitioner would choose to proceed with a shoulder replacement or that someone would offer that to him and Petitioner would agree. He said the shoulder would inevitably progressively deteriorate. (RX 1 p.38)

Dr. Frisella said the life expectancy of a replacement shoulder is at least 10 years, but for a 45 year old who did physical work it would be less. He put 20 pound lifetime lifting restrictions on his patients who had the surgery. He said if Dr. Gurtler had already put five pound permanent weight restrictions he would disagree with that. He said if Dr. Keener had given permanent 20 pound restrictions he had obviously not looked at the FCE.

Dr. Frisella agreed that Dr. Keener's restrictions were the same without a shoulder replacement as he would impose with a shoulder replacement. (RX 1 p.40,41)

Dr. Frisella agreed that if someone is significantly symptomatic and you and is willing to accept the possibility of early failure, "then it is not completely out of the question to consider a shoulder replacement. I wouldn't recommend it for him but not every 45 year old is the same." He said that post shoulder replacement surgery 30 percent of his patients have no pain whatsoever, 30 percent fell that it is "way better," and are glad that they did it, even though their shoulder still bothered them, 20 percent say "it's better, I guess, you know, I'm glad I did it but it's really not that great," and five percent will say it did not help at all, I wish I had not done it. (RX 1 p.43,45,46)

Dr. Frisella said he had performed shoulder replacement surgery on patients that had Petitioner's gradation of arthritis, moderate to severe. Dr. Frisella said he was not suggesting that undertaking a shoulder replacement on Petitioner would violate a standard of care. (RX 1 p.48,49)

ARBITATOR'S CREDIBILITY ASSESSMENT

Petitioner at arbitration answered all questions asked of him in a clear, understandable manner and with no apparent attempt to evade the questions. He did not appear to exaggerate his complaints or his work duties. Petitioner appeared to be a credible witness.

Dr. Eubanks answered all questions put to him in a straightforward manner, even those which tended to minimize or contradict his opinions. Dr. Eubanks appeared to be a credible, unbiased witness.

Dr. Frisella did not answer questions put to him in a straightforward manner. He was often asked questions that would call for a yes or no answer and he would answer in a narrative, often changing the subject or direction of the question. He had to be asked several questions repeatedly to obtain an answer. He made it clear that he took umbrage and judged Petitioner unreliable as he did not want to answer the doctor's historical or physical complaint questions. While he said he did not speculate, or guess why Petitioner acted in such a manner, he made it clear, nevertheless, that he felt Petitioner had ulterior motives. Dr. Frisella appeared to be a biased witness and his testimony as an examining physician was therefore given less credibility.

CONCLUSIONS OF LAW:

In support of the Arbitrator's decision relating to whether an accident occurred which arose out of and in the course of Petitioner's employment by Respondent on January 19, 2018 and whether Petitioner's current condition of ill-being, torn rotator cuff, excision of the os acromiale, need for an acromioplasty, and glenohumeral arthritis, is causally related to the accident of January 19, 2018, the Arbitrator makes the following findings:

The findings of fact, above, are incorporated herein.

The summaries of medical evidence and deposition testimony, above, are incorporated herein

The credibility findings, above, are incorporated herein.

Petitioner said that on January 19, 2018 he was trying to open the back door of his truck. He said the door was the width of the truck. The shocks on it that held the door up were broken, so he wedged it up, putting a bar in to hold the door up. While taking the 20-foot, 1 ¼ inch hose off the truck he felt a pop in his left shoulder. He said it felt like a rubber band snapping. Petitioner's testimony at arbitration as to the events of January 19, 2018 was consistent with the history given in all of the subsequent medical records. Petitioner's uncontradicted testimony is that he reported the accident that day, and waited for the company to tell him what to do before going for treatment. He said by the following Monday he could not even climb into the truck. He said he contacted the office again and they told him to set something up with Carle Occupational Medicine. Petitioner saw Dr. Scott on February 20, 2018. From that date until the date of arbitration all of Petitioner's complaints and treatment have been in regard to his left shoulder.

After obtaining an MRI, Dr. Scott referred Petitioner to Dr. Gurtler, who, years earlier, had operated on Petitioner's right shoulder. Dr. Gurtler saw Petitioner on April 17, 2018. Petitioner on that date described a feeling of sharp stabbing or catching sensation in the top of the lateral shoulder. He showed Petitioner the MRI images of the torn rotator cuff. That day's physical examination showed reduced active range of motion, and positive Hawkins, empty can, speed's and O'Brien's tests. Dr. Gurtler thought Petitioner could live with his arthritic pain, but they needed to deal with the rotator cuff pain.

Petitioner was found to have arthritis soon after he began being treated for these injuries. An MRI was performed on March 14, 2018 and in addition to a partial-thickness tear of the supraspinatus tendon, degenerative arthritis was noted, including a moderate sized osteophyte on the humeral head with thinning of articular cartilage in the glenohumeral joint. Dr. Gurtler on April 17, 2018 showed Petitioner the MRI images of the torn rotator cuff. Dr. Gurtler thought Petitioner could live with his arthritic pain, but they needed to deal with the rotator cuff pain. Dr. Gurtler performed left shoulder arthroscopic and open surgery on June 8, 2018, repaired the rotator cuff tear, excised the os acromiale, which he said was a congenital deformity, performed an acromioplasty to get more space for the rotator cuff and found that Petitioner had bare bone lesions on the bottom and anterior portions of the glenoid and on the ball of the articular surface of the humeral head.

After the left shoulder surgery Petitioner followed up with Dr. Gurtler and received physical therapy as well as multiple Cortisone shots to the shoulder. Petitioner was eventually allowed to return to work with significant restrictions, which were accommodated.

Petitioner continued to make left shoulder complaints from the time of this accident through his surgery, recovery from surgery, physical therapy and up to the date of arbitration. Petitioner was off work for numerous months following the surgery and then worked with restrictions, and at no time did he ever get released to return to work without restrictions. As early as May 9, 2019 Petitioner was complaining to Dr. Gurtler of significant pain which was rated at 3/10, and he said it interfered with his activities of daily living and sleep and interfered dramatically with his work. On that date Petitioner had decreased range of motion and Dr. Gurtler felt his strength was, at best, 4/5, with even less strength with his arm out away from his body. The x-rays which had previously been taken were found by Dr. Gurtler to show significant degenerative joint disease in the glenohumeral joint with articular surface damage and joint space narrowing. Dr. Gurtler recommended a new MRI. The new left shoulder MRI was performed on May 22, 2019 and was interpreted as showing worsening

glenohumeral arthritis with posterior decentering of the humeral head, cartilage loss of the posterior glenoid with subchondral sclerosis and spurring and a prominent spur had developed along the inferior margin of the humeral head.

On September 21, 2020 Petitioner saw Dr. Santiago, a pain specialist. After reviewing the MRI from May of 2019 and performing a physical examination, Dr. Santiago's diagnoses were chronic left shoulder pain and osteoarthritis of the left glenohumeral joint.

Dr. Eubanks saw Petitioner on November 5, 2020. Petitioner was complaining of moderate, four out of ten, pain in the left shoulder, saying the pain prevented him from sleeping through the night. Petitioner reported pain upon palpation during his physical examination, and he was found to have a limited range of motion of the left shoulder as well as a strength loss in the left shoulder. X-rays taken that day disclosed arthritis in Petitioner's left shoulder. Dr. Eubanks diagnosed Petitioner with posttraumatic arthritis of the left shoulder. Dr. Eubanks testified that trauma can cause the development of arthritis, can aggravate preexisting arthritis and can accelerate the progression of arthritis in an affected joint. He said trauma could include the fracturing of bone or tearing of muscles, tendons and ligaments but could also include the dissection of tissue, excising or sawing of bone in surgery.

Dr. Eubanks was asked a hypothetical question generally describing Petitioner's left shoulder accident, complaints, testing and treatment since January 19, 2019 as well as a pre-morbid state of no left shoulder complaints or treatment. Based upon those hypothetical facts Dr. Eubanks said that in his opinion the injury that occurred started a process that had led to the development of advanced shoulder arthritis at an early age, that the accident and injury of January 19, 2018 was either a cause or significant exacerbating factor in Petitioner's current condition.

At Respondent's request Petitioner was examined by Dr. Frisella on January 21, 2021. Dr. Frisella's diagnosis after examining Petitioner was one of multiple shoulder problems going on at once, a rotator cuff tear caused by the 2018 injury and multiple degenerative or preexisting conditions, arthritis of the glenohumeral joint, osteoarthritis of the acromioclavicular joint, and an os acromiale, a congenital piece of bone on the top of the shoulder that did not fuse to the shoulder blade. He did not believe the last three diagnoses were related to the injury at work. He said the glenohumeral osteoarthritis, in his opinion, was not related as Petitioner had arthritis from the first imaging, that imaging from January 20, 2018 showed arthritis. He said the March 2018 MRI noted that the degenerative arthritis was advanced for Petitioner's age, and the arthritis seen at the surgery four months after the accident had not had enough time for an acute injury to cause that arthritis. He said arthritis was a wear and tear condition. When asked on cross examination if the accident of January 19, 2018 appeared to have aggravated the arthritis that was evident in the March 2018 MRI, Dr. Frisella said it was a matter of semantics, but that it did not permanently structurally change the arthritis, and that it was impossible to say it even temporarily changed the arthritis. Dr. Frisella acknowledged that the tearing of tendons in the shoulder was a trauma, that surgery to the shoulder itself was a trauma, and that using saws and burring machines to cut off portions of the distal clavicle and acromion were trauma, but that there was no objective evidence that suggested there was some permanent aggravation of the arthritis. Dr. Frisella said that some traumas could accelerate, aggravate, cause and contribute to arthritis, make it progress at a faster pace than it had been developing at.

Dr. Frisella also testified on cross examination that, "clearly (Petitioner) had a super – additional trauma as we agreed on that caused it to hurt more and now several years later it's still bothering him but I can say someone with arthritis like that, you see them a couple years later and it's probably going to be bothering him. You know, when you say did it aggravate it, it's hard to agree with that." When asked why it continued to hurt more if it was not aggravated, Dr. Frisella said, "Because time passes, arthritis progresses. It did progress." Dr. Frisella said he did not know if it was just a coincidence that Petitioner's pain progressed with wear and tear of arthritis. He said that the fact he did not know if it was coincidental or not meant the accident might or could have been a factor in causing, lighting up the arthritis and making it symptomatic, Dr. Frisella said he certainly could not exclude that possibility.

The Arbitrator finds that Petitioner has proven that he suffered an accident on January 19, 2018 which arose out of and in the course of his employment by Respondent. This finding is based upon Petitioner's unrebutted testimony as to the events of that date, the popping of his left shoulder while pulling on the hose, and the immediate onset of severe pain. All contemporaneous histories in medical records are consistent with Petitioner's testimony.

The Arbitrator further finds that Petitioner's medical conditions, torn rotator cuff of the left shoulder, surgically repaired with an acromioplasty to get more space for the rotator cuff, as well as aggravation and acceleration of preexisting osteoarthritis in the left shoulder are causally related to the accident of January 19, 2018. This finding is based on the medical records of Dr. Scott, Dr. Gurtler, and Dr. Santiago, as well as the testimony of Dr. Eubanks. The Arbitrator gives greater weight to the opinions of the treating physicians than to the opinions of Dr. Frisella as Dr. Frisella did his best to avoid answering questions on cross examination and appeared to show a bias against Petitioner as Petitioner did not answer his questions reference history and complaints to Dr. Frisella's liking. In addition, even Dr. Frisella, when pressed on cross examination, had to admit that it was possible that Petitioner's arthritic pain progression may not have just been a coincidence following this accident and his surgery to the left shoulder.

The Arbitrator further finds that Petitioner's medical condition, os acromiole, is not causally related to the accident of January 19, 2018. This finding is based upon the medical records of Dr. Gurtler which indicate that condition was congenital and the bone simply had not fused to the scapula.

In support of the Arbitrator's decision relating to whether Petitioner is entitled to any prospective medical treatment, the Arbitrator makes the following findings:

The findings of fact, above, are incorporated herein.

The summaries of medical evidence and deposition testimony, above, are incorporated herein.

The credibility findings, above, are incorporated herein.

The findings in regard to accident and causal connection, above, are incorporated herein.

Petitioner is requesting the surgery recommended by Dr. Eubanks, a left total shoulder replacement, be ordered.

When Dr. Gurtler saw Petitioner on July 9, 2019 Petitioner advised him that it was getting harder and harder to work, that his constant pain was 4/10 but would spike much higher, and that he felt he was losing motion. Physical examination did show a reduction in range of motion, Petitioner could not get his hand behind his back at all. He noted that Petitioner was in quite a bit more pain while trying to move it during the examination. Dr. Gurtler said they talked about how they could not do shoulder replacements in a 44 year old, he was just too young, even though it would take away his pain. He said Petitioner was "stuck with trying to find a way to live with this." Dr. Gurtler noted, "We both understand that shoulder replacement would likely relieve his pain it is just the longevity is difficult to predict. Certainly if he had a shoulder replacement he could not do the job he is doing now where he is doing lifting. He just would not be able to do that. If he had a shoulder replacement he had (sic) restricted to about 5 lb. That would not be consistent with his job."

Dr. Gurtler again saw Petitioner on July 30, 2019 and noted that Petitioner was trying to work but said it was getting more difficult. He discussed a reverse total shoulder replacement with Petitioner, and noted that at age 44 it was very difficult as it would be a permanent change in his shoulder and in his life, with a 5 pound restriction for life. He also told Petitioner that his shoulder was a problem, and it was not going to get much better.

Petitioner saw Dr. Keener on February 19, 2020, voicing complaints of pain in the anterolateral aspect of his left shoulder which was sharp and aching and moderate to severe in nature. Petitioner noted he was currently working, but with significant restrictions, and was no longer able to do heavy loading and unloading. Dr. Keener did not think an arthroplasty was indicated at this point. Petitioner was seen again by Dr. Keener on May 27, 2020. Dr. Keener did not believe Petitioner was a good candidate for total shoulder arthroplasty.

On September 21, 2020 Petitioner was seen by Dr. Santiago, a pain specialist. After reviewing the MRI from May of 2019 and performing a physical examination Dr. Santiago's diagnoses were chronic left shoulder pain and osteoarthritis of the left glenohumeral joint. He referred Petitioner for another opinion in regard to possible shoulder replacement.

Dr. Eubanks saw Petitioner on November 5, 2020. Dr. Eubanks testified that after examining Petitioner he recommended a total shoulder replacement as it was the only reasonable treatment that he or anyone else could provide to return Petitioner to a level of good function and reduce his pain to a comfortable level, that no other treatment could achieve those goals. He said Petitioner had received sufficient conservative treatment. He felt Petitioner would continue to suffer pain levels at least equal to those he had when seen in November of 2020 if he did not have the total shoulder replacement. Dr. Eubanks said age was a good question in shoulder replacements, as no orthopedic surgeon wanted to do a shoulder replacement on a younger person, but there were young people, even teenagers, who have congenital problems that required joint replacement surgery. He said in regard to Petitioner, that his arthritis was limiting his function and his only good option was a joint replacement. So even though they did not like to do that procedure at an early age, he felt it was appropriate. He said he would tell Petitioner that he would get 15 to 20 years of good function, but know that the replacement would wear out and would require another surgery in his sixties, but that he would have a better quality of life from age 45 to 65 than would otherwise be possible.

Dr. Eubanks testified that his indications for total shoulder replacement surgery were glenohumeral arthritis that had failed conservative care and/or a rotator cuff that had failed surgical or

nonsurgical care, that irreparable rotator cuff and glenohumeral arthritis were the two main reasons for that surgery, with fracture being the third reason. He said he certainly had patients who might benefit from a total shoulder replacement but who he did not recommend the surgery, often geriatric patients who had severe arthritis but were treated conservatively as they were not candidate for surgery. For those patients, medical comorbidities were the reason surgery was not indicated. (PX 12 p.25,26)

Dr. Eubanks said age was a factor to be considered when recommending total shoulder, hip and knee replacements, but it was not a hard "no." It was just one factor, and it is discussed in detail as is the potential need for another surgery in the future if the first did not last as they were young. He said he would tell Petitioner that the surgery would probably help a lot for 20 years and that he would expect it would have to be redone in 20 years, with potentially not as good a result the second time. He said he liked to see severe arthritis when doing the surgery, but it doesn't always show up on x-ray, you get pretty good information from an MRI, and really good information when you are looking right in the joint. He said his review of the MRI indicated moderate to severe arthritis.

As far as treatment was concerned, Dr. Frisella said that given Petitioner's age and his moderate to severe arthritis, he felt Petitioner should live with it, though he might get to a place where a shoulder replacement would be an option. Dr. Frisella said Petitioner had "a shoulder that was completely nude of cartilage, there is no cartilage on it at all, not through the whole thing." Dr. Frisella said his indications for total shoulder replacement surgery were typically moderate to severe osteoarthritis, an intact rotator cuff and pain that was not responsive to conservative treatment in a patient who was in their sixties, typically, and not before. He said he did not recommend it for Petitioner because he still had some cartilage left and he was only 45 years old.

While Dr. Frisella said he would not do shoulder replacement surgery on Petitioner if he walked in his office, he felt there was a reasonable chance in the future that Petitioner would choose to proceed with a shoulder replacement or that someone would offer that to him and Petitioner would agree. He said the shoulder would inevitably progressively deteriorate. Dr. Frisella agreed that if someone is significantly symptomatic and is willing to accept the possibility of early failure, "then it is not completely out of the question to consider a shoulder replacement. I wouldn't recommend it for him but not every 45 year old is the same." He said that post shoulder replacement surgery 30 percent of his patients have no pain whatsoever, 30 percent fell that it is "way better," and are glad that they did it, even though their shoulder still bothered them, 20 percent say "it's better, I guess, you know, I'm glad I did it but it's really not that great," and five percent will say it did not help at all. Dr. Frisella said he had performed shoulder replacement surgery on patients that had Petitioner's gradation of arthritis, moderate to severe. Dr. Frisella said he was not suggesting that undertaking a shoulder replacement on Petitioner would violate a standard of care.

The Arbitrator finds that Petitioner is entitled to prospective medical treatment as recommended by Dr. Eubanks, to wit, a left total shoulder replacement. This finding is based upon the testimony of Petitioner in regard to his subjective complaints, which are accepted as true and accurate by the Arbitrator, the medical findings of Dr. Gurtler and Dr. Eubanks. While shoulder replacement surgery is preferably performed at an older age, Petitioner has bone on bone findings and a great deal of pain. Shoulder replacement should relieve him of much or most of his pain during up to twenty of his most productive years. No other alternative to

lessen his pain and increase his quality of life has been suggested by any physician. Even Dr. Frisella said Petitioner had "a shoulder that was completely nude of cartilage, there is no cartilage on it at all, not through the whole thing," and he had performed shoulder replacement surgery on patients that had Petitioner's gradation of arthritis, moderate to severe. In addition, Dr. Frisella said he was not suggesting that undertaking a shoulder replacement on Petitioner would violate a standard of care. While Petitioner may need additional surgery in approximately twenty years, a shoulder replacement at this time may improve his life and working ability for twenty of his peak working years.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC023828
Case Name	MANTZKE, STEVEN P v. STATE OF ILLINOIS/ DEPT OF HUMAN SERVICES
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0212
Number of Pages of Decision	44
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Matthew Brewer
Respondent Attorney	Chelsea Grubb

DATE FILED: 6/6/2022

/s/Stephen Mathis, Commissioner

Signature

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

Steven Mantke,

Petitioner,

vs. NO. 18WC 23828

State of Illinois/DHS,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by both parties herein and notice given, the Commission, after considering the issues of benefit rates, medical expenses, causal connection, necessary treatment, disputed causation as to PTSD, disputed causation as to anxiety disorder, permanent disability, temporary disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 7, 2021, 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.

Pursuant to §19(f)(1) of the Act, this Decision and Opinion on Review of a claim against the State of Illinois is not subject to judicial review.

June 6, 2022

SJM/sj
o-5/11//2022
44

/s/ *Stephen J. Mathis*
Stephen J. Mathis

/s/ *Deborah J. Baker*
Deborah J. Baker

/s/ *Deborah L. Simpson*
Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC023828
Case Name	MANTZKE, STEVEN v. STATE OF ILLINOIS/TREATMENT & DETENTION CENTER
Consolidated Cases	
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	41
Decision Issued By	Dennis OBrien, Arbitrator

Petitioner Attorney	Matthew Brewer
Respondent Attorney	Warren Wilke

DATE FILED: 12/7/2021

THE INTEREST RATE FOR THE WEEK OF DECEMBER 7, 2021 0.10%

/s/ Dennis OBrien, Arbitrator
Signature

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

December 7, 2021

/s/ Brendon O'Rourke
Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

STEVEN MANTZKE
Employee/Petitioner

v.

STATE OF ILLIONOIS / DHS TREATMENT & DETENTION CENTER
Employer/Respondent

Case # **18** WC **023828**

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 **Dennis O'Brien**, Arbitrator of the Commission, in the city of **Springfield**, on **September 22 ,2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **July 30, 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.

On the date of accident, Petitioner was **48** years of age, ***single*** with **no** dependent children.

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

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

Respondent shall be given a credit of $**35,459.10** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**35,459.10**.

Respondent is entitled to a credit **for all amounts paid by its group health insurer** under Section 8(j) of the Act.

ORDER

Petitioner's medical conditions of sternum contusion, aggravation of pre-existing anxiety, and post-traumatic stress disorder are causally related to the accident of July 30, 2018.

Petitioner did not suffer low back or right shoulder injuries as a result of the accident of July 30, 2018.

Petitioner's average weekly wage while working for Respondent in the 21.5714 weeks prior to his accident was $1,209.64, resulting in annual earnings of $62,901.28.

Petitioner was temporarily totally disabled as a result of the accident from July 31, 2018 to September 10, 2018, and from April 16, 2019 through May 10, 2019, a period of 9 4/7 weeks.

The medical bills included in Petitioner's Exhibit 7 are related to Petitioner's sternum and anxiety aggravation and post-traumatic stress disorder injuries, are reasonable and were necessitated to treat or cure Petitioner's injuries suffered in this accident with the exception of the following which are for unrelated treatments or unsupported by medical records or testimony introduced at arbitration:

- **Sarah Culbertson Hospital bills of November 6, 2018, November 8, 2018, and May 10, 2019 which are for unrelated lumbar spine and shoulder testing and treatment**
- **Clinical Radiologists bills of May 11, 2019, May 12, 2019, May 8, 2020, and May 28, 2020, which are for unrelated lumbar spine, shoulder, calcaneus and lower leg testing and treatment**
- **McDonough District Hospital bills of December 12, 2018, December 21, 2018, December 26, 2018, December 28, 2018, and January 4, 2019, which are for unrelated shoulder treatment**
- **Quincy Medical Group bills of September 17, 2018, September 26, 2018, December 28, 2018, January 23, 2019, March 25, 2019, May 10, 2019, May 31, 2019, June 5, 2019, August 12, 2019, November 1, 2019, May 13, 2020, June 10, 2020, and April 1, 2021, which are for either unrelated**

low back, shoulder, high blood pressure, eye, laboratory, or podiatric testing or treatment and/or are not supported by medical records or testimony introduced into evidence at arbitration

- **Springfield Clinic bills of October 2, 2018, November 9, 2018, February 6, 2019, and May 10, 2019, which are for unrelated low back and shoulder testing and treatment**

Respondent shall pay Petitioner permanent partial disability benefits, commencing 7/21/20, of $372.00 per week until the Petitioner reaches age 67, or 5 years from the date of the final award, whichever is later, because the injuries sustained caused a loss of earnings as provided in Section 8(d)(1) of the Act.

Respondent is, pursuant to agreement, entitled to credit of $35,459.00 under Section 8(j) of the Act.

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

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

Signature of Arbitrator

DECEMBER 7, 2021

FINDINGS OF FACT:

TESTIMONY AT ARBITRATION

Petitioner

Petitioner testified that he was a high school graduate. He said on July 30, 2018 he was employed by Respondent as a security therapy aide at the Rushville Treatment Detention Facility. He had started with Respondent in late 2000, took a short leave, returned to work for Respondent and had worked there for 17 or 18 years as of July 30, 2018. He said his duties were to care for the well-being of the residents, as well as their safety and the safety of others. He would provide transportation for residents to funerals, for medical care, and for court appearances. He said the residents at the facility were all sexually violent people, all rapists or pedophiles.

Petitioner said that on July 30, 2018 he was working on Fox unit, where the men with behavioral problems were, people who required more observation. He said a resident came out and Petitioner said good morning to him, and asked how he was doing. The resident then looked at him and said, "Don't talk to me. I'm a n*****." Petitioner said he and another officer looked at each other as they did not know what that was about. Petitioner said that a couple of minutes later breakfast was brought onto that unit. That is done by opening the door and yelling, "chow." The residents are then to come out of their room, get their food and then go back and eat.

Petitioner testified that the resident did not come out, but later came out yelling about not getting breakfast. Petitioner noted he had called it. The resident then said the only reason he did not get his breakfast was because he was a n*****. Petitioner advised the resident that had nothing to do with it, that if he did not come out to get his breakfast, he missed out. He said the resident went back to his room and he went into the unit to get the rest of the trays and the door shut. He said he was the only officer on the unit. He turned around to have the other officer roll the door, for while he could key the door, that would set off alarms, so he waited for the other officer to roll the door. While he was waiting for the door to roll the resident came up to him on his right and began beating on the door. Petitioner said he turned and the resident bumped into him a little bit, but not aggressively. Petitioner was not sure if the resident intended to bump into him at that time. He began to talk to the resident, saying, "I need you to …," and the resident threw an elbow at him, striking Petitioner's glasses on the side of his head. Petitioner said he backed up and was pinned up against a wall and the resident came at him, throwing punches. Petitioner said he tackled the resident. He said that while doing so he seemed to have struck his chest on one of the steel chairs bolted to the ground. Petitioner said he fell on top of the resident, kind of on his side and a little on his back. Petitioner said the resident tried to gouge his eyes, but luckily his glasses had not fallen off and they saved his eyes. He said other officers came to his aid and subdued the resident.

Petitioner said that before the day of this incident he had never had any run-ins with this resident, the resident had always been well-mannered with him. Petitioner said that he did not really have any trouble with residents.

Petitioner said that after the attack he wanted to confront the resident, he yelled obscenities at him, but another officer picked Petitioner up and walked him out of the area. He said he had a throbbing, burning chest pain, and scratches on his face which were bleeding somewhat. He filled out an accident report and was driven to the hospital by the officer who had picked him up. He was treated at Culbertson Hospital and x-rays of his ribs were taken. He was advised he had a cracked rib and a bruised chest. He said he felt drained when he left the emergency room. After getting home he had chest pains when he took deep breaths, and his mother took him to McDonough District Hospital the next day, where more x-rays were taken. They restricted him from work and told him to see his primary care physician, Dr. Schroeder.

Petitioner said he could not recall having any low back issues leading up to this accident, but a week or two after this accident he noticed low back issues. He said Dr. Schroeder sent him to an orthopedist to look at his back, and discussed his seeing a counselor or psychologist about mental issues he was having. He said his primary care doctor kept him off work in August of 2018, but on September 5, 2018 he asked his doctor to give him a full duty release to return to work. He said he did this as he needed a paycheck. He said he liked his job and believed he was good at it. He said he returned to full duty work on September 10, 2018.

Petitioner said he started seeing Danielle Mercer at Connections Family Counseling on September 11, 2018, telling her about the incident and his symptoms, which included being nervous, looking over his shoulder, as he did not want anyone behind him. He said she diagnosed him with acute PTSD at their first visit.

Petitioner said that when he saw his primary care doctor on September 17, 2018 he had leg pain radiating down his left leg, with burning and throbbing down the outside of his left thigh and calf into his foot. He said those symptoms began shortly after the accident, but he did not know the exact day. He said his doctor took him off work again as of that date. He said his doctor also ordered an MRI of the lumbar spine in late September of 2018.

Petitioner testified that he saw Dr. Payne, an orthopedist at Springfield Clinic, on October 2, 2018, and told him of his accident. He ordered a CT scan at that time and kept him off work. He said the CT scan was done on November 6, 2018, he then followed up with Dr. Payne on November 9, 2018, and he was again kept off work. On November 6, 2018 he told Dr. Payne of bilateral shoulder pain, which Petitioner said came on about three weeks after the incident. Dr. Payne ordered physical therapy for the shoulders, which he began getting on December 12, 2018 at McDonough District Hospital. He said that physical therapy helped a little.

Petitioner said he saw his primary care physician again in January of 2018 and was referred to Dr. Leutz for care of his shoulders. He said he saw Dr. Leutz on February 6, 2019. That physician ordered an MRI of Petitioner's right shoulder.

Petitioner agreed that Dr. Payne released him back to work full duty as of February 7, 2019, but he did not return to work at that time. He said he was still under the care of Danielle Mercer and his primary care doctor.

Petitioner described a March 2019 incident he was involved in where his daughter called him as she had locked her keys in her car with her child in the vehicle. He said he told her to call the cops who could come out real quick and unlock the door. He then drove quickly to where she was, a 20 – 25 minute drive, and found a policeman standing there. His daughter told him the police officer had not brought anything to unlock the door.

Petitioner said he questioned the officer who started to approach him, with his hand on his taser, pointing a finger at Petitioner. Petitioner said his brother got between the policeman and him to push Petitioner away as he was having issues with his comfort zone.

Petitioner noted that he had gone back to work Sergeant Parsons at the morning briefing was telling everyone what was going on and Petitioner said he asked a question and was told the answer was on a need to know basis. Petitioner said he did not agree with that and the sergeant started to approach him saying he would tell Petitioner what he would agree with, pointing his finger, and getting in his face. Petitioner said another officer had to grab Petitioner as Petitioner did not like the sergeant approaching him aggressively. He said he would not have acted that way prior to the July 2018 incident.

Petitioner said he continued to see Danielle Mercer into 2019, saying she had saved his life, he had not been in a good place and she helped him get through this. She said she helped him find "a happy place." He said her treatments had helped him over time, that while he was not cured, he was in a better spot.

Petitioner said on May 1, 2019 he saw his primary care physician and told her he felt like he could not go back to his job with Respondent. He said he was scared. He said attacks on employees at his workplace were rare, he had never been attacked in the 18 years he had worked there until this incident. He said he was afraid of going in and not doing his job correctly, without being scared, he felt like "a sissy."

Petitioner said his primary care doctor in May of 2019 placed him on a restriction of no contacts with residents at the prison. He said that restriction was made permanent in August of 2019.

Petitioner testified that he saw Dr. Froman, a clinical psychologist in Quincy, Illinois on April 15, 2019. He said he met with him on one occasion.

Petitioner testified that Dr. Payne released him from his care in regard to his back on May 10, 2019.

Petitioner said that he had continued to see Danielle Mercer, having seen her for the last time about one year prior to the arbitration hearing. He said his visits with her continued to give him relief and that if he had further issues down the road he would go back to her.

Petitioner testified that he had not had the issues he described, such as fear, or looking over his shoulder, prior to this July 2018 accident.

Petitioner said he had been sent by Respondent for an independent medical examination with Dr. Hartman in the Chicago area on August 8, 2019. He said when he went there he felt "smoky," pretty confused in the head. He said the exam was almost a full day, from 8:00 or 9:00 in the morning until after three o'clock. He recalled his blood pressure was an issue that day, thinking it was "like 200 something over 190 something." He said he had trouble filling out the doctor's papers as his glasses had been broken and not replaced, but the doctor loaned him some of his glasses so he could read the paperwork and fill it out. The doctor later took his blood pressure, and then did it again on his other arm. He then said he'd let Petitioner settle down and do it a third time. This time it was 198, and the doctor asked if he had high blood pressure and Petitioner told him he was on medication for it. The doctor wanted him to call his physician right them. He did and the doctor's office told him to come in when he was done to have it checked. He said Dr. Hartman then had him do things on the computer and do some testing. Petitioner said he was having headaches, and he had difficulty reading the screens and papers, but could make them out "a little bit."

Petitioner said he was no longer employed by Respondent, but he could not remember the exact date his employment ended. He said after he was terminated he began looking for work elsewhere, and he was able to find a job with INET, a boar stud farm where he collects semen from boars. He said he had worked there for a year and a half as of the date of trial, since perhaps the middle of July 2020. He said he gave his wage information from the new job to his attorney. He said he loved his new job as he likes working with animals. He said he could do the job, though he had a few issues Ms. Mercer had helped him with, such as the slamming of gates and doors, which makes him jump.

Petitioner testified that as of the date of arbitration he was doing "pretty darn good," compared to the day of the accident. He said he did not know if he would ever be 100 percent, but with the tools Ms. Mercer helped him with he is able to get through it. He said he still had issues if a person would get in his personal space or look over his shoulder, but not as often, and not as bad. He said that even feeling better he did not feel he could return to his job as a security aide for Respondent.

Petitioner said that the glasses which were broken on the date of this accident had never been replaced or reimbursed for and that they were no line bifocals which cost $600 to $800.

On cross-examination Petitioner said he did not know how his first attorney went about trying to get Petitioner's glasses paid for. When asked if he was near sighted or far sighted Petitioner said he had astigmatism.

Petitioner said he started working for the state in 2000 and took a break of less than a year before going back to work, so he worked for Respondent about 18 years.

Petitioner said he could not remember when his TTD checks stopped, but he got on the phone and called his attorney and called Kendra Robinson at Respondent. Petitioner said he did not work in the time between when his TTD checks stopped and when he started working for INET. He said he had applied for the INET job as it was posted on the Indeed search engine. He did not recall when he started that search.

Petitioner agreed that prior to the date of this accident he had been treated by Dr. Payne, that Dr. Payne had performed a lumbar fusion with a cage and rods on his back two or three years prior to this accident. He said he had some intermittent back pain issues after that surgery, with the last flare-up possibly being the December prior to this accident.

Petitioner believed his prior attorney had set up the appointment with Dr. Froman. He said he saw Dr. Froman one time. He said he had seen another person after the accident, named Bartlow, perhaps through an employee assistance program, and that person sent him to Ms. Mercer.

Petitioner said that Dr. Hartman tested everyone's blood pressure, and when his was found to be high Dr. Hartman asked him how he was feeling and he told the doctor he had a headache. Dr. Hartman implored him to call his doctor.

Petitioner said that prior to this accident he had a diagnosis of anxiety, but he did not remember a diagnosis of depression. Petitioner said he was taking Lexapro before the accident and was taking more as of the time of the arbitration. He said he had not been prescribed Cymbalta. He said he had been prescribed Buspar but he could not recall when that medication was started. He said as of the date of arbitration he was

taking Lisinopril, Atenolol and one he could not remember which might have started with "Hydro." He said he was still on high blood pressure medication.

He said that prior to the date of this accident he had never had anxiety or depression issues severe enough to warrant an emergency visit to a medical professional. He said prior to this accident all of his medication had been prescribed by Dr. Schroeder, who also gave him restrictions for his anxiety in August of 2019.

Petitioner said there had been an improvement since 2019. He said he was still having the left leg pain, it was burning and throbbing. He said he was treating with Dr. Payne again and he needed another back surgery. He said he'd been having a lot of back pain, saw Dr. Payne, had another low back MRI four or five months prior to arbitration, and he had two broken screws. He said he just started hurting, and it took a bit of time to be seen. He said he'd been hurting for about a year.

Petitioner said this was the only time he was physically attacked, though there had been many altercations.

Petitioner said he was not really having any shoulder issues, and he had only seen Dr. Leutz once.

On re-direct examination Petitioner said the anxiety issues he had prior to this accident were not comparable to what he experienced after the accident. He said he could not recall or remember if he was taking any medications for anxiety or depression in the weeks or months prior to this accident, the switched his medication and he lost track of what he was on before.

MEDICAL EVIDENCE

Pre-Accident Medical Treatment:

On August 7, 2014 Petitioner called Dr. Schroeder's office with complaints of increased back pain going down his leg and a prescription of Toradol was given (RX 9)

Petitioner called Dr. Schroeder's office on August 15, 2014 saying he felt he needed to have his anxiety medications increased, that he was having problems with anger, and when that happened his blood pressure got pretty high, that he'd had an argument with a superior at work and his blood pressure got so high he ended up in the emergency room. Dr. Schroeder saw Petitioner on August 15, 2014 for continued back problems, he was worried about surgery which had been recommended. He reported radicular symptoms in his legs. He said standing lor long periods at work bothered him, as did riding in transport to and from Chicago. He wanted to increase the Lexapro he was taking. He reported he had felt down, depressed or hopeless in the preceding two weeks. Dr. Schroeder assessed Petitioner as having back pain with radiation and depressive disorder. She increased his Lexapro dosage. (RX 9)

Dr. Schroeder did a pre-op physical on September 17, 2014 as Petitioner was scheduled for back surgery on September 22, 2014. The next office visit in the exhibit are for February 28, 2017 and reflect another pre-op examination for another lumbar surgery. He was still taking Lexapro and Buspar was added at this time, as needed. Petitioner was then seen for another pre-op physical on December 11, 2017, with surgery to occur two days later. It was noted this was to be a correction of a CAGE issue from a recent lumbar surgery, as Petitioner

was having issues with leg radiculopathy. Petitioner's blood pressure was noted to be 150/94 on this visit. Despite this, Dr. Schroeder found him to be "at medical best for intended surgical procedure." (RX 9)

Post-Accident Medical Treatment:

Petitioner was seen at Culbertson Memorial Hospital in Rushville, Illinois, on July 30, 2018. Petitioner's history was consistent with his testimony at arbitration. He was complaining of chest pain, especially when taking a deep breath. Physical examination noted abrasions on the head but ho swelling, abrasions, lacerations or tenderness to the face. His respiratory examination was normal. It was noted that there were no musculoskeletal injuries. Petitioner had blood pressure of 190/119 and said his pain was 6/10. A later history did note a complaint of back pain, but no abnormal or physical examination findings are noted. X-rays of the chest revealed no acute findings. The impression at discharge was "chest pain: on breathing." He was given a note excusing him from work on the day of the accident but to return to work on July 31, 2018. (PX 2 p.5,9,13,14)

In the late afternoon of July 30, 2018 Petitioner called Dr. Schroeder's office, advised the nurse that he had been attacked by an inmate that day, had gone to the emergency room, but was still in severe pain. He was advised to go back to the emergency room if he did not get better. (RX 9)

Petitioner was seen at McDonough District Hospital in Macomb, Illinois the next day, July 31, 2018. He advised that facility of the altercation the day before and having gone to a different emergency room the day prior to this visit, telling this ER staff that chest x-rays and rib studies had been negative. On this visit he was complaining of pain in the sternum area. He advised them he had been squeezed and struck in the chest wall. He said deep breathes were painful, as was changing position. Physical examination showed tenderness on the anterior border of the sternum and manubrium. They noted there was no external evidence of trauma. His back was not tender, and he had a normal range of motion of the back. He had no musculoskeletal complaints. X-rays were again taken of his sternum and interpreted as showing no acute bony abnormality. The diagnosis, despite a negative x-ray, was sternal fracture and chest wall contusion. He was given an excuse from work and told to follow up with his primary care physician. (PX 3 p.9-11)

Petitioner telephoned his doctor's office on August 1, 2018 complaining of continued sternum pain. He was requesting an off work extension and, it appears, additional pain medication. He noted he had an upcoming appointment with Dr. Payne. The notes for that date indicate Petitioner had been taking Buspirone (Buspar), as needed, for severe anxiety, since March 9, 2018. He was given a refill for a lower dosage hydrocodone. A letter taking Petitioner off work until August 7, 2018 was issued on August 2, 2018. (PX 4 p.7-10,93; RX 9)

On August 6, 2018 Petitioner was seen by his primary care physician, Dr. Schroeder, with noted facial scratches, but principally complaining of sternum pain. He gave her a consistent history of the altercation. He told her he was slowly getting better, but that he was still mentally "shook up" by the altercation. He already had a counselor/psychologist evaluation scheduled in a few days. He told Dr. Schroeder that he was not physically or mentally ready to return to work. He also asked to see his surgeon for a reevaluation of his back as he was having some pain, though he denied radiculopathy. Physical examination revealed him to be tender in the area of the sternum and the left rib cage. Dr. Schroeder urged him to use a minimum of hydrocodone and said an evaluation with his previous back surgeon would be set up. Dr. Schroeder issued a letter on that date restricting Petitioner's work until August 16, 2018. (PX 4 p.9,12-14,94; RX 9)

Petitioner was seen by Dr. Schroeder on August 16, 2018. He said that while he still had pain in the sternum. it had improved. He said his bigger problem was anxiety, dreams and trouble sleeping. He said he had seen a psychologist once and was to see her again on the day of this office visit. He said he was nervous about going back to work and that buspirone (Buspar) was not really helping. He was generally secluding at home, but his daughter made him go out. Petitioner was prescribed a trial of Ambien to help him sleep. He was told to remain off work until he was physically and mentally improved. Another letter taking him off work until August 24, 2018 was issued. Dr. Schroeder also signed CMS forms on that date indicating Petitioner could not work, and Tristar Workers' compensation Medical Report noting a sternum injury, anxiety and sleep disturbance. (PX 4 p.18-20,95,103-105; RX 9)

When seen on August 24, 2018 Petitioner told Dr. Schroeder he was doing better in regard to the sternum injury, but workers' compensation had not approved his seeing Dr. Payne. He said his counselor had made a referral for him to see a PTSD specialist. He said he was not mentally ready to return to work. Physical examination of the sternum showed he was still tender, but it had improved since his last visit. He gross psychiatric evaluation of him at that time was normal. She advised him to continue counseling and gave him a note for work stating he was not mentally ready to return. An off work until August 31, 2018 letter was issued, as was a CMS report showing Petitioner's symptoms were sternum injury and anxiety/insomnia. (PX 4 p.27-29,96,106,107)

On August 30, 2018 Petitioner called Dr. Schroeder's office saying he needed a note saying he would be off work until the following Wednesday. The nurse was apparently told by Dr Schroeder that he should be seen in the office on Wednesday to make it official. Petitioner then told the nurse he was planning to be back in on September 6, 2018. Later that afternoon Petitioner again phoned the doctor's office and said he was ready to go back to work and did not need any restrictions, that he felt good and was ready to return to full duty the next week. He asked they fax a note to that effect to his work. In an apparent error, Dr. Schroeder issued a letter dated August 31, 2018 saying Petitioner was to remain off work until August 25, 2018. (PX 4 p.33,34,97)

Petitioner was seen by Dr. Schroeder on September 5, 2018. He told her he was physically better as far as the sternum was concerned, had not seen Dr. Payne as workers' compensation had not approved it, had been approved to see a PTSD specialist, had called several times and had gotten no replies. He said Ambien had helped with his sleep, with no side effects. He said he now felt mentally and physically ready to return to work, full duty, on September 10, 2018. On physical examination he was found to no longer be tender over the sternum or left rib cage and her psychiatric evaluation of him was normal for mood, affect, behavior, judgment and thought content. He was released to return to work on September 10, 2018 in a letter of September 5, 2018. (PX 4 p.36,38,98)

When Petitioner saw Dr. Schroeder on September 17, 2018 he told her that he had been sent home from work on that date due to left leg pain, in the buttock, knee, down the shin to his foot. He told her his return to work had been without difficulty until the left leg pain that day. There had been no new injury per Petitioner, he thought it was just due to his standing. He did tell her that his father had to cut his lawn the previous weekend as the vibration of the mower bothered his back. The doctor noted that Petitioner did not ask for any pain medication at this appointment. During the physical examination that day Petitioner's blood pressure was found to be markedly elevated at 160/110. His musculoskeletal examination notes only one abnormality, swelling of

the left knee. All other left knee, left thigh, left ankle and left foot findings were normal, which begs the question whether the office notes had a typographical error and were meant to state "no swelling," as no other comments about the leg were included in the physical examination or in the diagnosis portion of the office visit. The only diagnosis on this date was lumbar radiculopathy, and an injection was given for that. An off work until September 24, 2018 letter issued by Dr. Schroeder on September 17, 2018. Dr. Schroeder's office called Dr. Payne's office the next day and got an appointment for Petitioner for October 2, 2018. Dr. Schroeder also filled out a CMS report showing the diagnosis of lumbar back pain with radiculopathy. (PX 4 p.41-43,48,99,108,109)

Dr. Schroeder saw Petitioner on September 26, 2018 with continued complaints of his back hurting. Petitioner told her he could not perform his job duties. No physical or psychiatric abnormalities on examination are included in the office notes of that day. Dr. Schroeder issued a letter that same date saying Petitioner could not perform his job until October 2, 2018. (PX 4 p.50-52,100)

Petitioner was seen by his orthopedic surgeon, Dr. Payne, on October 2, 2018. His blood pressure was noted to be 162/86. It noted that he had a previous L4/5, S1/2 fusion with his last surgery being on December 13, 2017. He gave a history of an incident at work where he was assaulted by an inmate, fell into the inmate and hurt his back He said he had been having pain down his left leg. X-rays were taken of the lumbar spine and Dr. Payne noted he did not see any broken hardware, fractures or migrating cages. The radiologist also felt the hardware was unchanged. Dr. Payne noted that Petitioner's foot drop had actually improved from his last visit, that all other motor groups were 5/5, reflexes were normal and he had painless range of motion of the hips, knees and ankles bilaterally. Petitioner did have a positive straight leg raising test on the left at 40 degrees. Dr. Payne's impression was low back pain and left lumbar radiculopathy. He ordered a CT scan of the low back to make sure there were no fractures of the lumbar spine caused by the fall. Dr. Payne restricted Petitioner from work until October 15, 2018, until CT results were obtained. (PX 6)

A CT of the lumbar spine was performed on November 6, 2018. It was noted that the reason for the study was, "Low back pain for several years. Prior lumbar spine fusion procedure. Pain radiating down the left leg." The radiologist's impression was an instrumented fusion from L4 through S1, bilateral neural foraminal narrowing at L3-4 and no evidence of hardware failure being seen. (PX 2 p.28)

Dr. Payne saw Petitioner again on November 9, 2018. He noted the CT scan showed no broken or displaced hardware. Dr Payne took a new history on this date of pain in the shoulder, and his having trouble sleeping on the right side as well as pain with overhead activities. The pain was in the anterior portion of his shoulder, radiating down to the biceps. His physical examination showed a mild impingement sign, tenderness over the biceps, tenderness proximally, and minimal tenderness over the AC joint. He found no instability in the right shoulder. His working diagnosis at that time was impingement of the right shoulder. He ordered physical therapy of both shoulders, as Petitioner was voicing complaints of mild symptoms on the left as well, and wanted both shoulders to get therapy while he was there. Petitioner was to return in 6 months, but sooner if his shoulder bothered him. (PX 6)

On November 15, 2018 Dr. Payne filled out and signed a CMS disability leave form for Petitioner based on his November 9, 2018 examination. The form deals principally with Petitioner's 2017 lumbar revision

surgery at L4-5 on December 13, 2017. On this form Dr. Payne noted Petitioner was to be off work until his next appointment on May 10, 2019. (PX 6)

On November 19, 2018 Dr. Payne signed a certification form for medical marijuana, stating Petitioner had residual limb pain. (PX 6)

Petitioner saw Dr. Schroeder again on December 28, 2018, telling her he had been seeing Dr. Payne about his back, "since it reportedly exacerbated since the incident." He now reported right shoulder issues, which Petitioner believed also stemmed from the work incident, but was just now an issue. He said Dr. Payne had ordered therapy for his shoulder as well. Petitioner told her he thought Cymbalta was helping. Dr. Schroeder's physical and psychiatric examinations on that date showed no abnormalities. (PX 4 p.55,56)

When seen by Dr. Schroeder on January 23, 2019 Petitioner told the doctor that he was being forced to return to work as his injury claims were being denied by workers' compensation. He said he could take disability, but he did not want to live with the pay cut, that he would go back to work. He did give the doctor a State Retirement System form to fill out, however. While taking Cymbalta, he said it "tears up his gut." He also talked about other foods, and the doctor noted he had previously had a gastrostomy, a feeding tube. Petitioner again brought up his right shoulder pain and limited range of motion, blaming poor documentation on Dr. Payne's part for the shoulder not being included in his evaluation, noting physical therapy had been ordered. Petitioner said he wanted to see an orthopedist for the shoulder. Petitioner continued to have high blood pressure, at 152/98. While Dr. Schroeder wanted to add another medication to help with the Cymbalta tolerance, Petitioner did not want to change medications. A referral to Dr. Leutz was made. Dr. Schroeder issued a letter releasing Petitioner to full duty work effective February 7, 2019. (PX 4 p.60,62,101)

Dr. Leutz saw Petitioner in regard to his right shoulder on February 6, 2019. X-rays on that date of the right shoulder showed bones and soft tissue to be within normal limits, with no fractures or dislocations, but cystic changes were consistent with impingement. There was evidence of a prior excision of the distal clavicle consistent with a Mumford procedure. Petitioner gave Dr. Leutz a history of having a normal shoulder until he was attacked by an inmate. Physical examination on this date revealed the left shoulder to be non-tender on palpation with normal range of motion, stability and strength. The right shoulder revealed no swelling of the shoulder, normal sensation, tenderness to several areas of the right shoulder, normal passive range of motion of the shoulder, but with pain, and moderate crepitation of the shoulder, with pain. Numerous positive test signs were noted, but Petitioner was also found to have normal stability of the shoulder. Dr. Leutz's assessment included, "shoulder pain, SLAP tear of the shoulder, a rotator cuff strain, rotator cuff tear and right shoulder pain." He recommended an MRI of the shoulder and a home exercise program. Dr. Leutz's record reflect Petitioner had a prior history of shoulder surgery but no mention of what type of surgery was performed or what maladies were treated. (PX 6)

Dr. Payne released Petitioner to return to work on February 7, 2019 without restrictions. (PX 6)

On March 4, 2019 Petitioner called Dr. Schroeder's office asking for a work release for February 27 and 28, saying he had to miss work due to anxiety. Dr. Schroeder issued an off work letter for those two days but noted she had not seen him on those days. (PX 4 p.66,67,102)

Petitioner saw Dr. Schroeder on March 15, 2019 stating that he had been off work since March 8, 2019 after a heated exchange with an authority. He said that after his return to work he found his co-workers, administration and inmates made him anxious. He said he had been seen in counseling for PTSD since the original incident. He said he could not sleep, his blood pressure was high, he was having headaches and dizziness. He asked her for a leave from work while he sorted out his anxiety/PTSD. Petitioner's blood pressure on this date was 192/102. No physical or psychiatric abnormalities were noted in the examination portion of this visit. Dr. Schroeder's diagnoses following this visit were PTSD, anxiety, and hypertension. She signed FMLA forms that day to give him leave from March 8, 2019 until May 1, 2019 as he needed time for medication adjustments and counseling. She doubled his blood pressure medication and said that should improve once stress issues were alleviated. Dr. Schroeder filled out a CMS report that day noting Petitioner was not capable of work. (PX 4 p.68,70,110,111)

Petitioner was seen by Dr. Schroeder on May 1, 2019. He told her he did not think either the Buspar or the Cymbalta were helping. He said his sleep was fair. He had seen a psychologist as well as his counselor, and he was not sure what he was going to do for an occupation as he did not feel he could go back to his current job. Dr. Schroeder prescribed Zoloft for Petitioner's PTSD, while continuing his Buspar and Ambien. She filled out a CMS form on that date and noted that Petitioner could not work, and the reason was psychological. She filled out another form on that date for the Department of Human Services noting Petitioner's disability was post-traumatic stress disorder , that he had anxiety, especially with crowds and with symptoms on the job site. She noted that interactions with superiors and inmates caused anxiety and he should have no contact with the prison system. (PX 4 p.73,75,113,114,116)

Petitioner returned to see Dr. Schroeder on May 10, 2019 as he took his blood pressure after having a headache for two days. His blood pressure at the doctor's office was highly elevated, 172/104. Petitioner told her he had been compliant in taking his medication. Dr. Schroeder added a prescription of Lisinopril. (PX 4 p.78,80)

On May 14, 2019 Dr. Schroeder filled out a SRS Non-Occupational Disability Medical Report noting a psychologist evaluation/diagnosis of post-traumatic stress disorder was the diagnostic study she was relying on in arriving at her PTSD diagnosis and noting he had not been released to return to work. (PX 4 p.118)

On May 23, 2019 Petitioner told Dr. Schroeder's nurse that his blood pressure was still high, but better, about 150/80-90. Petitioner said his machine at home saved his readings but he was not near the machine. He was told to call back when with the machine. He did not call back and repeated attempts to call him, with messages left to call the office, were unsuccessful. The office finally gave up on contacting him. Dr. Schroeder's medical records were provided on May 20, 2021, and no treatment records of Dr. Schroeder for the nearly two years preceding that date were introduced into evidence, though she continued to issue accommodation reports and/or work restriction reports for him on August 15, 2019, and November 1, 2019. (PX 4 p.3,85,85,120,124,125)

Petitioner received physical therapy to his bilateral shoulders at McDonough District Hospital commencing on December 12, 2018. Petitioner gave a history on December 12, 2018 of having injured his shoulders when attacked by an inmate four months earlier. He said his pain had gradually gotten worse since the injury. Petitioner's complaints as of this date were of pain being worse on the right side more than the left,

pain with moving his arm quickly or if reaching behind his back, when trying to hold his arm up or when pushing or pulling a heavy object. He said he had pain all the way down to his fingertips. Petitioner was to attend physical therapy one to two times per week for six weeks. He did not attend his sessions on December 14, 2018 and January 2, 2019. Petitioner did attend four physical therapy sessions, on December 21, 26, and 28, 2018, and on January 4, 2019. A discharge note was entered on June 14, 2019 noting he did not return after January 4, 2019. (PX 3 p.28,29,44,50-60,74)

Petitioner had x-rays of his right shoulder and an MRI of his lumbar spine performed on May 10, 2019. The x-rays showed no acute osseous abnormalities, and the MRI showed mild diffuse degenerative disc disease, evidence of his previous fusion of L4-5 and L5-S1 with the hardware intact, but no acute abnormalities. Petitioner saw Dr. Payne that same date for a post op followup, a year and a half after he had undergone left back surgery with fusion of L4-5 and L5-S1. Dr. Payne noted that his hardware looked fine, with no loosening of the screws or broken hardware, with the cages well positioned in the disc spaces. The doctor noticed weakness of the anterior tib, which he said was best described as 4-/5 He noted Petitioner was on medical marijuana for pain control, but no narcotics, and he noted that Petitioner's back was probably as good as it was going to get. He released him from his care on that date, but told him he could return if things worsened. (PX 2 p.41,44,45)

Post-Accident Psychological Treatment:

Petitioner was seen by Ms. Mercer at Connections Family Counseling for approximately 50 sessions beginning on September 11, 2018 and ending on October 13, 2020. On September 11, 2020 her diagnostic impression was acute PTSD. She planned weekly sessions with Petitioner. The notes for these sessions included the complaints Petitioner had in the previous days or weeks and the counselor's suggested insights he might get from those and guidance on self-care. On November 15, 2018 Petitioner reported feelings of serenity after being placed on paid leave. In her notes Ms. Mercer would often note that she validated Petitioner's complaints, while giving him ideas of how to address them. The counselor tied almost of complaints voiced by Petitioner back to his diagnosis, empathizing with him when he voiced fear of loss of benefits or having to return to work. It is noted that Ms. Mercer, a social worker, did not address Petitioner's ability to work in her session notes, perhaps because her reports were filled in on an apparent template, and that template did not call for her to address work status, while it is also possible she did not address it as social workers may not be qualified to issue such opinions.(PX 5)

On February 16, 2019 Petitioner saw Ms. Mercer after his February 2019 return to work. She said he was distraught and he said upon his return to work his trauma symptoms rose significantly, he felt unsafe at work and he was unsure how he would respond if triggered at work. Again, she empathized with him, telling him his responses were normal. He did not feel support at work. Ms. Mercer felt Petitioner was showing ambivalence towards his return to work. When he complained on March 6, 2020 about having to work in areas that triggered him, Ms. Mercer suggested he speak to his attorney about what options he had legally. She noted Petitioner was in grave danger for irreparable harm if he was not provided support in his workplace. She said this was increasing his PTSD symptoms. (PX 5)

On March 7, 2019 Ms. Mercer wrote a To Whom It May Concern letter noting her opinions on diagnosis of post traumatic stress disorder as a result of this accident, his symptoms, her opinion that he remains in a

reactive state and her recommendation that he not return to work until evaluated by a psychologist to determine if that was appropriate, as she felt his returning would place him and others at an immediate risk. (PX 5)

On March 12, 2019 Petitioner told Ms. Mercer that he had an incident at work, and felt fear and frustration. No description of this incident is included in her notes. She told him this was a common response for a person with PTSD. On March 19, 2019 Ms. Mercer noted Petitioner looked sullen. Petitioner said his anxiety symptoms had decreased. When asked why, Petitioner said he was no longer working, so he was at home, his safe place. She felt he was showing ambivalence towards his PTSD symptoms. (PX 5)

Petitioner mentioned having seen a psychologist at the request of his work when he saw Ms. Mercer on April 18, 2019. He told Ms. Mercer that the psychologist had suggested transferring him to a different department at work. Ms. Mercer said Petitioner was ambivalent, but relieved that his symptoms were valid, but a sense of loss as his work was a part of his identity. On April 23, 2019 Petitioner gave Ms. Mercer a copy of the report received from Dr. Froman. Talking about the report seemed to trigger Petitioner and his physical appearance changed, with his face turning red, his body tightening and his becoming more anxious. (PX 5)

In many, if not most, of her notes Ms. Mercer stated that Petitioner was showing growth and "showing improvements in his ability to cope in the moment." These improvements are not obvious when reading his session complaints and descriptions of how he was doing in his life activities. On June 25, 2019 she administered the UCLA-PTSD assessment to evaluate Petitioner's progress in trauma related symptoms. His score supported Petitioner's assessment that he was more confident in his ability to manage his symptoms, though he still would find himself reactive and hyper vigilant. (PX 5)

Petitioner on August 6, 2019 advised Ms. Mercer that another attack had occurred where he formerly worked. He discussed it in detail and told Ms. Mercer that he thought about the fear he would have if he returned to that environment and his accepting that he might never be emotionally ready to return to work, as it did not feel safe. Petitioner in late September and early October of 2019 spoke about his having been examined by a psychologist who was assessing his disability. He gave a copy of the psychologist's report to Ms. Mercer on October 8, 2019 and told her that he was perceived as a liar and a cheat, which is not how he saw himself. He had been thinking of resigning his employment, and Ms. Mercer indicated to him that might be an impulsive decision based upon his emotional state. (PX 5)

On November 26, 2019 Ms. Mercer ran a PCL-5 test on Petitioner and the assessment revealed Petitioner's symptoms appeared to be decreasing, though he continued to meet the criteria of "partial PTSD," and he did not meet the criteria for re-experiencing. On December 10, 2019 Petitioner appeared distraught at his therapy session and advised Ms. Mercer that he had made a big mistake the previous week and felt horrible about it. He had a physical altercation with his son-in-law, who had kicked a pet dog. Petitioner said he blacked out and was "coming to" when his daughter came out screaming. He did not realize he had become physical. Ms. Mercer suggested to Petitioner that he had experienced a dissociative state due to being retriggered. (PX 5)

The gaps between sessions gradually lengthened, starting in June of 2020. On August 12, 2020 Petitioner advised Ms. Mercer that he had obtained employment at a pig farm and was enjoying the experience of working. He liked the structure of the job, saying it was similar to a prison system, but without the people. Even when asked about triggers he might experience with the job, Petitioner was not able to identify any

potential triggers. While Petitioner said he had some struggles transitioning to full time work, he said he quickly got into a routine. He said he was physically tired, but was experiencing more emotional energy. On August 25, 2020 Petitioner told Ms. Mercer there were similarities with his old job, without the stress, which provided him comfort. He said he was working with animals instead of people and he was able to maintain calm in his workplace. He said he had a feeling of control with the animals that he did not feel with people, that he felt more confident due to his calmness and the control he felt. He said his symptoms had decreased, he was managing more effectively and he wanted to reduce the frequency of his sessions, which was agreed upon. Ms. Mercer noted that Petitioner's confidence in himself had resulted in a decrease in mental health symptoms and they planned on sessions every six weeks. (PX 5)

Ms. Mercer's final visit with Petitioner contained in Petitioner Exhibit #5 was on October 13, 2020. The session was to focus on coping skills, as Petitioner's shed had been broken into, which confused and frustrated him. Petitioner said he had physiological symptoms when this happened, but not negative thoughts or emotions. Petitioner when asked about future sessions reported that he was overall feeling better, though participated helped him maintain this. Ms. Mercer recommended they decrease the frequency of his session and Petitioner agreed. At that point he had attended approximately 50 sessions with Ms. Mercer. He was scheduled to be seen in two months, on December 15, 2020, but no further visits were documented in the medical records which were certified on May 18, 2021. (PX 5)

DEPOSITION TESTIMONY OF DR. FRANK FROMAN

Dr. Froman was deposed as a witness for Petitioner. He testified that he was a clinical psychologist, having been licensed in Illinois in 1972. As of the date of his deposition he was doing less treatment than he had in the past, and more assessments, with assessments taking up 80 to 83 percent of his time. Those assessments were for the courts, competency for trial and psychological status, and for the Social Security Administration, testing applicants for disability, seeing 10 to 20 patients per week for those assessments. He also would evaluate people for workers' compensation cases, though not very many as of the time of his deposition. He said he had treated people with PTSD. (PX 8 p.9-12)

Dr. Froman said he did a psychological evaluation of Petitioner on April 15, 2019. He received a history from Petitioner, who told him a prisoner threw him to the ground, hurting his ribs and his back, and trying to gouge his eyes out. He said about 15 guards came to get the prisoner off of him. He had Petitioner tell him his background, including work background, alcohol and drug history, prior work accidents, and he observes them as they do this, trying to obtain information which is included in the DSM-5 criteria for PTSD. (PX 8 p.12-15)

Dr. Froman said his evaluation of Petitioner took about two hours. He said Petitioner appeared anxious, and if Dr. Froman got closer to him Petitioner became more anxious. He was normal in appearance. He said Petitioner was taking Duloxetine, an antidepressant often given by doctors for patients with depression mixed with anxiety and physical symptoms. Petitioner told him he had been getting care at Connections Family Services in Quincy. Petitioner told him he was using medical marijuana. Dr. Froman said his patients with pain and those with anxiety appeared to be helped with medical marijuana, as did people with PTSD. Dr. Froman

had no objection to medical marijuana being used, and Petitioner told him it helped tremendously. (PX 8 p.16-21)

Dr. Froman said Petitioner's speech was good, he was articulate, and he had no hesitations. His eye contact was also good. He discussed Petitioner's work history with Respondent and said Petitioner liked the job and thought it would be his career. After the accident Petitioner tried going back to work, per Petitioner, and it did not go well, it was anxiety provoking, and he was initially to be given a different assignment transporting prisoners, which Petitioner thought would be easier. He told the doctor that being back at the facility was scary because he could get hurt, and because his having been compromised on the job had caused him hurt his self-image, and made him feel uncomfortable with himself. Petitioner told him he was tasked with transporting a prisoner with MRSA, and he had an objection to doing that, and he and his leader had words. Dr. Froman said he was of the opinion that Petitioner was looking for a reason not to go back to work, it could have been anything else he would have reacted to, he needed a reason, "because he did not want to have to be there," he did not want to be anywhere near Rushville, he was even avoiding getting his groceries or gasoline there. (PX 8 p.22-29)

Dr. Froman said Petitioner was experiencing hyperarousal, always being on the lookout for something bad to happen, constantly scanning for danger. He said that is common for PTSD, it is your body giving you symptoms to try to protect you, that soldiers get it, it is a protective layer telling you not to go back to a war-like place where you could get hurt or killed. (PX 8 p.29,30)

Dr. Froman, used a PCL-5, a list of things to be discussed in PTSD cases, to insure that during their conversation the doctor covered certain items. He said he was able to formulate a diagnosis for Petitioner, which was PTSD, as he had many, but not all, of the classic symptoms, avoidance, fear, not feeling good about himself, sense of alienation, and sleep disturbance, as well as the duration nad the severity of the symptoms. (PX 8 p.33-35)

Dr. Froman was of the opinion that Petitioner's PTSD was caused directly by the event Petitioner described as having happened at the prison. That opinion was based upon the clear causal line between the event and Petitioner's reactions from the time of the event onwards. Dr. Froman felt Petitioner's prognosis was pretty good depending on where he went to work, and his not going back to the prison. He did not believe Petitioner should go back to the prison as he would not feel comfortable, would not be able to relax, he had to go somewhere else to work, but the closer he was to where he could have the same type of experience, the worse it would be, going to another prison would wind up replicating many of the same feelings and conditions he would have at his prior facility. He said it would be better if he was working someplace that did not have anything to do with the justice system. (PX 8 p.36-39)

Petitioner needed ongoing psychological or psychiatric care in the opinion of Dr. Froman. Dr. Froman felt that Petitioner's counseling care that he had received thus far was reasonable and necessary, but he did not believe straight counseling would be totally effective in most cases because unless the counselor was particularly skilled in dealing with PTSD cases and had tools and techniques available, PTSD could be very difficult to wind up eradicating. In many cases medication was necessary. He said there had been advances made in PTSD treatments and people who used those advanced treatments tended to wind up getting much better results. (PX 8 p.40,41)

On cross-examination Dr. Froman noted that he was a psychologist and that differed from a psychiatrist as psychiatrists were medical doctors with different training who used a great deal of medication in their practices. He said few psychiatrists currently do counseling, they do evaluations and medication checkups, as well as admitting and treating patients in hospitals. Psychologists study on the doctorate level what makes people tick and function, how they learn and develop, how to undo things which have happened to them, how to repair them, using therapy, using almost exclusively the spoken word. He noted some psychologists, particularly in Illinois at present, are now medication eligible, taking a master's degree in psychopharmacology, which takes two years, learning about medication prescriptions and what a nurse would know about medical management. He said he was not a pyschophamacologist, he was "just a plain old psychologist." (PX 8 p.42-45)

Dr. Froman said he felt Petitioner's PTSD was moderately severe at the time he evaluated him at the request of Petitioner's attorney. Petitioner only told him of taking Duloxetine, Propanol and Atenolol, he did not mention taking Buspar, a minor tranquilizer for anxiety. When asked if Buspar was prescribed for someone who was unwell, Dr. Froman said he would never use that expression, but it would not be given to someone doing perfectly, it would be given to someone who was feeling anxious to calm themselves. He said it was not addictive, and therefore suitable for long term use. He said it would not be sufficient for someone suffering from severe anxiety. (PX 8 p.46-49)

To the best of Dr. Froman's knowledge, Petitioner was being treated by a master's level clinician at Connections Family Counseling. He said there were three levels of clinicians and that master's level was the lower level. He said a licensed clinical social worker would be at the master's level. He said he did not know who prescribed medical marijuana for Petitioner, how much Petitioner used, how he used it, or how long it had been prescribed. He said marijuana, like alcohol, was a depressant, they are good for anxiety and panic attacks and helps people get to sleep. They are self-comforters. (PX 8 p.50-59)

Dr. Froman said the only psychological or psychiatric records he had for Petitioner were the two days of reports from Ms. Mercer dated September 11, 2018 and September 20, 2018. Dr. Froman said that Petitioner told him he was not taking any antidepressants or antianxiety medication, and he denied suffering from depression or anxiety before this accident. Dr. Froman said that if Petitioner had been diagnosed with severe anxiety before this accident that would affect his opinion, but he could not say how it would affect it without seeing the records. He said if a person suffers from anxiety for five or more years it would be considered a chronic condition, that conditions which last more than a year or two are more difficult to treat as they have become entrenched in the people who have learned to live with them.. (PX 8 p.59-62,113)

Dr. Froman listed several different potential triggering events Petitioner should avoid going back to work, such as being in a similar situation again, being in a room by himself and seeing someone who resembled the individual who hurt him, or witnessing a fight. He did not think Petitioner should seek or obtain jobs which would expose him viewing or being subject to violence. He said it would be okay if it were animals as he would not see them as a threat, unless they were wild and rabid. He thought Petitioner could work well with animals. He did not think Petitioner should be employed as a security guard who carried a weapon, as he might overreact to low levels of provocation without thinking it through first. (PX 8 p.66-69)

Dr. Froman was of the opinion that Petitioner had very little progress in ameliorating his symptoms, which had become imbedded in his psyche, in fact that, "if anything, he was probably worse off," saying that if the people who treated him did not know what they were doing with PTSD, a highly specific, highly specialized area of treatment, the person will either not get better, or will get worse. (PX 8 p.72,73)

When asked, Dr. Froman listed the criteria from the DSM-5 for PTSD and noted how some things would not be considered to meet those criteria. Dr. Froman noted that he did no testing of Petitioner in his evaluation, just screening and interview. (PX 8 p.78,79)

Dr. Froman was asked about Petitioner's high blood pressure and, after noting he was not a medical doctor, noted that there are many reasons for hypertension, one of the biggest being overweight and under exercised. (PX 8 p.81,82)

Dr. Froman said that Petitioner's depression was pretty much right down the middle of what Dr. Froman's patients had, and his anxiety was pretty typical, perhaps a little higher than average. When asked about Petitioner possibly malingering Dr. Froman explained how he asks questions to help determine that, saying the biggest such question was "What do you do if this goes away. How does that affect you?" He said Petitioner's answers showed no interest in monetary items other than he needed to go back to work because he had no income, that he had to go back to work. (PX 8 p.92,95,96)

On re-direct examination Dr. Froman was asked about Petitioner possibly having severe anxiety prior to this accident and how that would affect his opinions. He stated that anxiety was a multiplier, that when a person who is already is anxious has a bad event happen, the bad event was worse because anxiety amplifies, or multiplies, whatever happens in life, making good things better and bad things worse. He said a person with preexisting severe anxiety would be more susceptible to the development of PTSD following an incident such as the one on July 30, 2018. He said he did not think Petitioner was feigning his PTSD based on the questions he asked Petitioner, the quality of the interview and his 50 years of doing evaluations. (PX 8 p.98-100)

DEPOSITION TESTIMONY OF DANIELLE MERCER

Ms. Mercer was deposed as a witness for Petitioner. She testified she was a Licensed Clinical Social Worker, having graduated from the University of Illinois in 2009 and began practicing at Chaddock Residential Center that same year. She said Chaddock specialized in trauma and attached disorders. She said she was certified in trauma focus, cognitive behavior therapy and Theraplay, which is a trauma based treatment for children. At Chaddock she started as a Clinical Therapist in a residential program working with female adolescents between the ages of 12 and 18 who were suffering from significant trauma and attachment related disorders. She said some of those adolescents were internationally adopted, were in foster care and been victims of or witnessed sexual abuse, domestic violence, or physical abuse, very significant trauma. She said she did that work for six to seven years. She was promoted to Clinical Supervisor at Chaddock School, but said school really was not her forte, so when a job opened up as a Clinical Supervisor in residential position, working with both residential students as well as students age 6 to 21 in the local area, she went to that, training therapist in trauma-related interventions so they could provide those services to the students and their families. (PX 9 p.6-10)

Petitioner resigned that position to provide for her children, but after 6 to 12 months a part-time position became available and she began working as an outpatient therapist for the two years preceding the deposition of July 28, 2020. She said she saw five to ten clients per week. She said she did couple-based counseling and a small percentage of her clients were PTSD patients. (PX 9 p.10,11)

Ms. Mercer first saw Petitioner for treatment on September 11, 2018. He gave her a history of a physical altercation with an inmate and since that time began to feel incredibly anxious, fidgety, and struggled with attention. After meeting with him over a period of 30 days she felt the appropriate diagnosis was post-traumatic stress disorder. She said she used the UCLA PTSD assessment questions to arrive at her diagnosis. Her treatment plan for him was Trauma Focused Cognitive Behavioral Therapy, a practice effective for not only children, but for adults as well. She said she used that method throughout her entire treatment period with Petitioner. (PX 9 p.13-17)

Petitioner's triggers which might cause flare-ups included physical proximity, he would get fidgety if someone was in his "bubble," especially African-Americans, as the person who assaulted him was African-American. Another was when he would feel things were unjust, such as when he confronted police officers aggressively on a number of occasions about people speeding near his home, resulting in his being confined to his home. She said his hyperarousal was very high and he minimized it by not going out, by avoiding. She said these are the types of things seen with PTSD. (PX 9 p.18-21)

She said after trauma a person can almost "live" in their back brain, which controls fight-fright-freeze responses, so she used Eye Movement Desensitization and Reproducing technique to get the left and the right sides of the brain communicating again. She said she really could not do that technique, however, as Petitioner's glasses had been broken in the incident and he did not have the finances to replace them. She said she taught Petitioner coping skills to accept he had a mental health problem, that his life was changed and that his life might not be what he wanted it to be, so she taught him some deep breathing and self-soothing skills. (PX 9 p.21-24)

Ms. Mercer said one of Petitioner's triggers was that his brother still worked at the detention center, and whenever the two of them or he and other former colleagues spoke about the center or whenever Petitioner picked his brother up at the center and would have to be in the parking lot he would feel an intense sensory overload in his body, his blood pressure would rise, and he would feel increased heart palpitations. (PX 9 p.25)

Ms. Mercer testified that during the time she treated Petitioner he had progressed, that after a while he accepted his situation and would talk more about the experience and his distorted thought. He was able to recognize that it was not his fault, and reduced his shame feelings. She said she did not see any signs of Petitioner malingering, and she felt his reported symptoms and complaints were credible. She said the last time she saw Petitioner was June 23, 2020. She said her diagnosis had changed in December of 2019 as Petitioner's symptomology had decreased to where he no longer met the criteria for post-traumatic stress disorder, that instead he met the criteria for adjustment disorder, another stressor related disorder. (PX 9 p.26-29)

Ms. Mercer said that while she treated Petitioner she did not feel he could work in his previous position due to the risks the residents presented as well as the risks Petitioner himself presented. She said those risks were slightly decreased by December of 2019. She said the risks if he returned to work there still existed,

however, that returning to that environment would heighten his symptomology and he would subconsciously digress (sic). (PX 9 p.29-31)

Ms. Mercer was of the opinion that the work incident where Petitioner was attacked had a causative or aggravating effect on his diagnosis of post-traumatic stress disorder, saying that everyone experiences trauma differently and that this specific attack impacted Petitioner's ability to function. She said the treatment she provided was related to the accident, as were Petitioner's work restrictions. (PX 9 p.31-33)

Ms. Mercer planned to continue the same type of treatment going forward, but would meet with him less frequently. (PX 9 p.33,34)

On cross examination Ms. Mercer said she was not a doctor and her recommendations regarding restrictions were based upon her experience working with clients who had experienced trauma symptoms. She does not have a doctor sign off on that as it is merely a recommendation, not something that has to be followed, just what is in their best interest. (PX 9 p.35,36)

Ms. Mercer said Petitioner advised her that he had mild anxiety before this incident occurred, but not severe anxiety. She knew what Buspar was, that it was used to treat some of her clients, but not being a psychiatrist she could not speak about it as it was outside of her expertise, though she thought it was for mood related issues. (PX 9 p.39,40,41

Ms. Mercer said she was a licensed clinical social worker, not a psychiatrist, and had no education in psychiatry. She said if she believed medication was needed she would refer a client to a psychiatrist, she works on counseling and therapy and anything else is outside her realm. She said she did not know what a psychophamacologist was, and she did not know if psychologists prescribed medicine. She said her opinions were within a reasonable degree of therapeutic certainty, not a medical, psychiatric or psychological certainty. (PX 9 p.43,44,60,61)

Ms. Mercer did not know if the UCLA testing she performed with Petitioner was incorporated or referred to in the DSM-5, and she did not know what version of the UCLA PTSD index she used. While she knew there was an adult version she did not know if she used that or the version for children and young adults. (PX 9 p.45,46)

Ms. Mercer testified that she used checklist tools when interviewing clients but she had no training on using standardized testing used by psychologists or psychiatrists, and was not familiar with the Shipley Intelligence Test, the Word Memory or Wisconsin Card Sorting Tasks, the Brief Battery for Health Improvement-2, the Minnesota Multiphasic Personality Inventory QRF, the Personality Assessment Inventory or the Structured Inventory of Malingered Symptomology tests. (PX 9 p.52-54)

Ms. Mercer said Petitioner was capable of performing tasks of daily living as of the date of the deposition. (PX 9 p.55,56)

On recross examination Ms. Mercer said her opinions would not change if he had previously been diagnosed with severe anxiety as she thought the symptomology he was presenting with was a direct result of the attack. (PX 9 p.62)

DEPOSITION TESTIMONY OF DR. DAVID HARTMAN

Dr. Hartman was deposed as a witness for Respondent. He testified that he was a licensed psychologist, board certified in clinical psychology and neuropsychology. Dr. Hartman said he had a doctorate in psychology, and had received a master's degree in psychopharmacology after receiving that doctorate. He said he was in the full-time private practice of forensic neuropsychology and clinical psychology. He explained that neuropsychology was a more advanced subset of psychology involving the relationship between brain function and psychological status, and there is a further subset of that which he practices in, medical neuropsychology, which examines the relationship of medical disorders and behavior states and mood states produced by various medical disorders. He explained that psychopharmacology is the relationship of drugs and medications on brain function, interactions between other medications, and if he were to take the national examination in psychophamacology he would be able to prescribe in Illinois and several other states. (RX 3 p.5-7)

Dr. Hartman said he was asked to examine Petitioner by TriStar, and he did so on August 8, 2019, and issued a report based on that day-long examination as well as reviewing 500 pages or so of records. He said his examination is different than a treating psychologist's examination as he does an interview and then administers tests to objectively measure various kinds of symptoms, problems and patterns that a person might produce. If he was examining a person with a severe head injury he would include tests which measured emotional or pattern of mood and behavioral disturbances, and then compare the results with hundreds of other people to decide whether this is the normal pattern for people with that symptomatology. He said you can't do that if you are just listening to a person one-on-one. He said his examination is therefore more scientific. (RX 3 p.8-10)

Dr. Hartman said Petitioner underwent a number of screening tests for cognitive function, one or two tests to examine the plausibility of his claims, and general symptom inventory and personality inventory tests. He said in Petitioner's case most of the tests were related to both medical and emotional and behavioral symptom patterns and what they might mean. The tests he gave are the type that, if given by someone in another state, would score in exactly the same way. The scoring is determined by the test developer, not by the psychologist giving the test, and it is given in a standard fashion. He said Petitioner on the day of the exam would have answered 800 to 900 questions, more than any clinician would ever ask him, so Dr. Hartman felt this gave him a much broader scope of inquiry, a bigger window on what might be happening with the person. (RX 3 p.10-12)

Petitioner took a variety of tests during his full day examination, including the Shipley-2 Intelligence Test, which is a brief IQ screening test, the Word Memory Test, a performance validity test, the Wisconsin Card Sorting Test, a reasoning test of executive function, the Brief Battery for Health Improvement-2 which is a psychological and symptom endorsement test, the Minnesota Multiphasic Personality Inventory-2RF (MMPI), a personality test in clinical and neuropsychology, with about 338 true-false questions with a combination of scales and will show whether it is a valid profile or an exaggerated profile, the Personality Assessment Inventory, which was similar to the MMPI, and the Structured Inventory of Malingered Symptomatology (SIMS). Petitioner also filled out a Medical History Questionaire and a Morel Emotional Numbing Test, where the examinee is led to believe that people with PTSD will do poorly on the test when, in fact, people with PTSD do well on the test, so if the person makes a lot of errors on the test, they are not behaving as PTSD people do. Dr. Hartman said these tests were common in his field of practice, they are standard tests. (RX 3 p.13-20)

In regard to the 544 pages of medical records he reviewed, Dr. Hartman said the notations of high blood pressure, which he also had in Dr. Hartman's office, concerned him, he did not see anyone really being in charge of Petitioner's hypertension, He felt other medical problems were not being taken care of as well, such as his history of anxiety and labile mood (mood which goes strongly up and down), which he felt should be receiving psychiatric treatment, including low heart rate, bradycardia, which should involve treatment by a cardiologist. He said Petitioner's counselor was throwing all of her treatment into the PTSD, emphasizing Petitioner to pay attention to triggers of stress on visits where he was reporting he was doing well without much stress. He said that was similar to what was called critical incident debriefing where the person is asked to rehash the trauma over and over again thinking that would somehow be helpful to the patient. Dr. Hartman said doing this is not helpful, that if the patient is a person with a long history of some form of anxiety disorder or mood disorder, they need to see a psychiatrist or a prescribing psychologist, as all the therapy in the world was not going to eliminate that mood instability. He said he felt badly for the scope of Petitioner's treatment as it did not address a lot of major concerns that Petitioner objectively had, such as his anxiety, his high blood pressure and his hyperlipidemia. (RX 3 p.20-24,39,40)

Dr. Hartman said that during his interview Petitioner did not seem anxious or depressed, as he would expect from a traumatized person, but was instead a cheerful, casual person. He said when speaking to people who have had a traumatic experience it usually hurts them to talk about it, but Petitioner did not show that. He felt Petitioner's use of marijuana card was a good first step, but that someone should be monitoring it so he would be taking the right amount, see how it interacted with his other medications and adjust them effectively. (RX 3 p.32,34,35)

Dr. Hartman said Petitioner did not make any kind of a fuss while completing the tests, but the tests showed a fairly consistent degree of exaggeration and noncredible performance. He said Petitioner's answers on the validity scale for the MMPI was so high that it required throwing out the rest of the test as being invalid. He said Petitioner's answers on the SIMS test was three times the cutoff to be considered exaggerated, showing elevated unrealistic PTSD admissions that were off the chart for any PTSD patient, that if he really had all of those symptoms he would be unable to care for himself, a person who did not clearly understand what he was doing, while his interview showed him to be a chatty person with no obvious disturbance in mental status. (RX 3 p.35-38)

Dr. Hartman said that this did not mean Petitioner did not have a long-term history of mood problems, of chronic pain, of anxiety, and of high blood pressure. He said the tests did not rule out Petitioner having chronic mood-related disorders, as he did have them. He said Petitioner's malingering in his office did not mean he did not have a chronic mood disorder, he did, and he needed to be seen for it. He said Petitioner's exaggerations in his answers caused Dr. Hartman to not be able to diagnose PTSD because "he's kind of spoiled the possibility of somebody diagnosing him in that way with the extreme level of exaggeration that he's showing here." (RX 3 p.39,41)

Dr. Hartman appeared to blame Petitioner's test answers in part on his therapist who said he had PTSD and nothing else was of interest to her, making it impossible to see clear evidence of PTSD, saying he thought the therapist was "trying to make him into a PTSD patient." He said that if Petitioner had been treated by a competent psychiatrist and got his chronic mood instability calmed down, Petitioner's might have a more

realistic view of how he feels and not feel like he had to be over the top and just indiscriminately tell everyone how bad he was. (RX 3 p.43,44)

Dr. Hartman said that a person with anxiety who is put in a position that would make them acutely more anxious would at least temporarily be more anxious. He said Petitioner's therapist was trying to make Petitioner's anxiety permanent, she was only interested in his being anxious. Dr. Hartman said if he were directing Petitioner's care he would pull Petitioner away from that therapist as soon as possible. He described what would normally see in a PTSD patient, withdrawal, not wanting to talk to people, blaming themselves, losing pleasure in what they do, and perhaps heavy drinking. He said he did not see those things in Petitioner. (RX 3 p.45-47)

Dr. Hartman said his treatment plan for Petitioner would be getting his high blood pressure under control so he did not have a stroke, having him seen by a cardiologist, get him the care of a psychiatrist, and then pull Petitioner away from his current therapist and get him to a cognitive behavior therapist to teach him how to do the opposite of what his current therapist was doing, ways to stop thinking about the incident and how to relax, focus and not obsess about triggers. (RX 3 p.50,51)

He did not believe Petitioner's treatment by Ms. Mercer was reasonable or necessary saying it was "actually iatrogenic and causing him to be worse." He said the only way Petitioner would get reasonable and necessary treatment would be if he was treated by a psychiatrist. (RX 3 p.52)

Dr. Hartman felt Petitioner could work if he passed a physical, that the assault would not make him psychologically incapable of working again at his previous position. (RX 3 p.52,53)

On cross examination Dr. Hartman agreed that if Petitioner were to return to the type of work he was performing when this accident occurred he could very well be exposed to a similar situation involving an altercation with an inmate, saying that parts of that job cannot be predicted and risks cannot be avoided. He said that it would be reasonable for a person with chronic anxiety "not to put themselves in situations that will worsen it even further." He said it certainly could at least acutely aggravate Petitioner's anxiety symptoms, but he could not predict whether it would materially change it in any way. (RX 3 p.57)

Dr. Hartman said that by law he could not send Petitioner's attorney the actual tests Petitioner took, even with a signed authorization from Petitioner, but he could send them to a licensed psychologist expert. He said the Illinois Confidentiality Act prevented him from sending it to anyone else, but he would PDF them in a day to any psychologist. Dr. Hartman admitted that even with his test results there was a possibility that the accident caused an aggravation to Petitioner's chronic anxiety condition. (RX 3 p.59-61)

Dr. Hartman said he knew nothing about Ms. Mercer other than what he read in her records, he had never met her, all he knew was that she was a licensed social worker. He was sure she was trying to help Petitioner, but was making him worse. He said he had performed therapy for decades and what she did is not what should be done. He said his current practice was all differential diagnosis, seeing one or two patients a weeks for day long examinations, and reviewing records. He said he did see patients referred by the FAA to determine if they were competent as pilots, and he had been referred patients by the ARDC to determine if they were competent to practice as an attorney, but all of his current practice was as a consultant, not in as a treating psychologist, and that had been true for about 15 years. He said about 10 percent of his practice was of the

FAA or ARDC type and the rest was medical/legal. He said he performed an independent medical examination about twice per month. He said he did other examinations for civil litigation as well. He said he charges $595 per hour for time associated with consultations, examinations, and report preparation and $695 an hour for depositions and trials. He said he spent six to seven hours with Petitioner on the day of this examination. He believed all of the workers' compensation examinations he performed were from insurance companies or respondents, not from petitioners. He said he had probably done a dozen IMEs for TriStar in the past year. He said in his 35 years of practice he may have done 100 or more examinations for TriStar. (RX 3 p.62-66,79-82)

Dr. Hartman agreed that to the best of his knowledge Petitioner had not been diagnosed with PTSD prior to this incident. (RX 3 p.67)

Dr. Hartman said TriStar made the referral to him of Petitioner, that he was not referred by Petitioner or his attorney. He said TriStar also sent him all of the medical records he reviewed. (RX 3 p.67)

Dr. Hartman said that while people have good days and bad days, their answers on the tests he administered do not change very much from day to day. He admitted that medical conditions, like chronic pain or medications which impaired cognitive efficiency or attention could interfere with the testing, as could drinking a great deal of coffee, which could make a person irritable. He said Petitioner's blood pressure was found to be quite high in the mid-afternoon and he insisted Petitioner contact a medical professional or go to the emergency room. Petitioner had done most of his testing by that time. He said high blood pressure has an affect on mood, increasing anxiety and depression. He said Petitioner's blood pressure at that time was malignant hypertension. He said people with long-term malignant hypertension can have memory problems, cognitive impairment, and can have personality changes secondary to cerebral vascular problems. He said Petitioner was able to finish all of the testing they needed to do. (RX 3 p.70-76)

On redirect examination Dr. Hartman said that in his opinion Petitioner's high blood pressure would not have affected the validity of the tests, but it might have affected his general perception of well-being or ill-being. (RX 3 p.84,85)

DEPOSITION TESTIMONY OF DR. PATRICK O'LEARY

Dr. O'Leary testified by deposition on behalf of Respondent. Dr. O'Leary testified that he was a board certified orthopedic surgeon. On November 29, 2018 he examined Petitioner at the request of Respondent in regard to an alleged low back injury. He said he conducted a physical examination of Petitioner. He said Petitioner had negative straight leg raising tests from either the L4 or L5-S1 nerve distributions, which indicated he did not have a pinched nerve from a potential herniated disk. He felt Petitioner was guarding with shoulder elevation, meaning that when the doctor tried to raise his shoulder Petitioner exhibited restraint. Dr. O'Leary said he did not find significant impingement signs, meaning he did not find rotator cuff tendinitis. He said that basically he did not find any significant abnormalities. (RX 4; RX 5 p.5-11)

Dr. O'Leary said he reviewed medical records including the emergency room records from the day of the accident and the day after the accident. On the day of the accident he was seen in the emergency room at Sarah Culbertson Memorial Hospital where they noted chest pain and abrasions to the face, and an EKG and chest x-ray showed no acute abnormalities. The next day he was seen at McDonough District Hospital

complaining of sternal discomfort with tenderness along the anterior border of the sternum and noting that he had chronic low back pain. X-rays did not show a fracture of the sternum. (RX 5 p.13.14)

Dr. O'Leary said he also reviewed the records of Dr. Schroeder, Petitioner's primary care doctor. The initial history to her was of being attacked, thrown against a bolted table and that he was concerned about his back due to prior lumbar back surgeries. In follow up visits his primary issue was anxiety. He was released to return to work on September 10th and a week later he was sent home as his left leg was hurting and he now was having progressive pain in the left buttock, knee and down the shin to his foot. He told his doctor that he had no difficulties after returning to work until September 10 when he developed the pain which Petitioner thought was from standing, though the previous weekend he had his father cut his grass because the vibration bothered his back. Dr. Schroeder took him off work to see Dr. Payne. He said Petitioner did not report radiculopathy symptoms until September 17. (RX 5 p.14-17)

Dr. O'Leary said Petitioner did not have radicular complaints when he examined him at the end of November, though he did make some complaints of leg pain, which were not accompanied by specific examination findings which concerned him for impingement of any nerves. Dr. O'Leary said having symptoms come on almost three months after an injury is unusual. (RX 5 p.17,18)

Dr. O'Leary when asked if Petitioner had previous back fusions said he did not know what had been done to Petitioner, though Petitioner told him he had undergone three fairly significant prior back surgeries, but the doctor did not have any real imaging or operative reports to review. He said Petitioner indicated to him that he had a two-level fusion, then a third level fused, and then there was a problem with that surgery and it had to be redone. Dr. O'Leary said that a person with a two or three level spinal fusion, in their forties, would be expected to have daily complaints of pain and/or leg pain. Chronic complaints are not unusual for a person with that condition, it is very unusual for a patient like that to be symptom free. In his report Dr. O'Leary noted that Petitioner took hydrocodone two to three times per day before the accident, doing so chronically, meaning for more than three to six months. (RX 5 p.21-24)

Dr. O'Leary said that his diagnosis for Petitioner was bilateral shoulder pain, chest pain which was resolving, and chronic low back pain, status post lumbar fusion. He said that given his extensive prior spinal fusion his prognosis was fair. He did not have any restrictions for Petitioner, nor did he advise any treatment. He did not believe Petitioner's back complaints were related to the July 30th accident or that there was anything of significance to his back that required any treatment related to this accident. He said Petitioner had a very extensive preexisting condition which required him to take Norco (hydrocodone) chronically, and Petitioner just seemed to want to have his back checked. He said the mechanism of injury for the back did not make sense, though he could have perhaps twisted his back, though that did not really appear to have occurred. Neither emergency room had imaged his lumbar spine as there was no immediate development of pain related to the injury in his lumbar spine. He did not think maximum medical improvement could be stated in this case as there really was no low back injury in this case. (RX 5 p.28-31)

Dr. O'Leary testified he performed 325 to 350 spinal surgeries a year. He said he performed one or two IMEs per week, sometimes doing none and sometimes doing three. He said his group practice set the flat fee of $2,500 for the examination, review of records and the report. He said he and his physician assistant see 60 to 80 postoperative patients per week. (RX 5 p.32-34)

On cross examination Dr. O'Leary said he had not been provided with any medical records for prior to July 30, 2018. He agreed that the records he was provided indicated Petitioner was off work from July 20 (sic), 2018 until approximately September 5, 2018 and that after being back to work for a few days he began to notice left leg pain. (RX 5 p.34,35)

He said he knew the State of Illinois sent patients to him for IMEs, but he did not know how many, though it would be less than a third. (RX 5 p.35)

ARBITATOR'S CREDIBILITY ASSESSMENT

Petitioner's testimony appeared to be truthful and accurate for the most part. Much of his testimony as to sternum pain and anxiety is corroborated by contemporaneous medical records admitted into evidence, but his testimony in regard to the time of onset of low back and shoulder complaints is not corroborated by the contemporaneous medical records and is in part contradicted by them. Petitioner testified that his left leg and back pain began a week or two following the accident, but such complaints are not included in the emergency room records or in the initial office visit records of Dr. Schroeder. The first mention of such complaints to Dr. Schroeder was on September 17, 2018, nearly seven weeks after the accident. On that date Petitioner told the doctor that the left leg and low back complaints began the day before his visit with her, September 16, 2018, that there had not been an accident at that time, it just came on, probably from standing. Similarly, while Petitioner testified that he had shoulder complaints beginning about three weeks after the accident, the first mention of shoulder pains in the medical records was when he told Dr. Payne of shoulder problems on November 6, 2018, over 13 weeks after the accident. The Arbitrator finds Petitioner's testimony to be credible in regard to his sternum and anxiety complaints but not to be credible in regard to his low back and shoulder complaints. He is therefore only found to be somewhat credible overall.

Drs. Froman, Hartman and O'Leary as well as Ms. Mercer all appeared to testify truthfully in regard to their findings and opinions. Their opinions varied in some respects, largely based upon their experience and expertise, but they did not appear to have any bias for or against the parties and appeared cooperative in the testimony regardless of who called them as a witness or was asking the questions. The Arbitrator finds all four to have testified credibly.

CONCLUSIONS OF LAW:

The parties stipulated that Petitioner suffered an accident on July 30, 2018 which arose out of and in the course of his employment by Respondent.

In support of the Arbitrator's decision relating to whether Petitioner's current condition of ill-being, aggravation of pre-existing anxiety, post-traumatic stress disorder, sternum contusion, low back pain and left lumbar radiculopathy, and shoulder pain, are causally related to the accident of July 30, 2018, the Arbitrator makes the following findings:

The findings of fact, and credibility assessments, above, are incorporated herein.

The summaries of medical evidence and deposition testimony, above, are incorporated herein.

Petitioner testified that at the time of the assault he struck a bolted down piece of furniture made of steel and he immediately had a throbbing, burning chest pain, and scratches on his face which were bleeding somewhat from the resident's attempts to gouge out his eyes. That day and the next day he was seen in emergency rooms and chest and rib x-rays were taken on both occasions which radiologists interpreted as negative. On the earlier visit the diagnosis was "chest pain on breathing," and on the second the diagnosis, despite a negative x-ray, was sternal fracture and chest wall contusion. No low back or shoulder abnormalities were noted at either of these visits. Petitioner was given a note excusing him from work and told to see his primary care physician after that second emergency room visit. The records do not reflect shoulder or low back complaints or findings on that date.

Petitioner called his primary care physician's office that same day, August 1, 2018, asked for additional pain medication and said he had an upcoming appointment with his back surgeon, Dr. Payne. It is noted by the Arbitrator that at the arbitration hearing Petitioner said he could not remember having any back problems prior to the date of this hearing, but this indicates he had an appointment scheduled prior to the accident date to see his back surgeon. It was noted in Dr. Schroeder's records of that date that Petitioner was already taking Buspar for severe anxiety. He was given a prescription for a lower dosage pain medication and a letter excusing him from work until August 7, 2018. Petitioner saw Dr. Schroeder on August 6, 2018, told her he had an appointment scheduled with a counselor, saying he was mentally shook up by the incident. Her records don't reflect shoulder or low back complaints or findings on that date. On August 16, 2018 Petitioner told Dr. Schroeder his sternum was better but he was having anxiety, dreams and trouble sleeping, he was nervous about going back to work and Buspar was not really helping. Again, her records don't reflect shoulder or low back complaints or findings on that date. Dr. Schroeder kept him off work.

While Petitioner told Dr. Schroeder on September 5, 2018 that workers' compensation had not approved a visit with Dr. Payne, Dr. Schroeder's records don't reflect shoulder or low back complaints or findings on that date. It was on September 17, 2018 that Petitioner first complained of left leg pain to Dr. Schroeder, radiculopathy from the buttock to the knee and down the shin to his foot. No medical record from the date of this accident seven weeks earlier until this date reflect any complaints of this nature. On September 17, 2018 Petitioner advised Dr. Schroeder that there had been no new injury, that he had his father cut his lawn the previous weekend as the vibration of the mower had bothered his back, and that he thought the radiculopathy symptoms were just due to his standing. This was the first date Dr. Schroeder had treated Petitioner's back in any manner, giving him a low back injection on that date. She kept him off work on that date and her office called Dr. Payne's office the next day and got him an appointment for October 2, 2018. She saw Petitioner again on September 26, 2018 with complaints of back pain and she again restricted him from work. No shoulder complaints are contained in any of the September 2018 medical records.

When Petitioner saw Dr. Payne on October 2, 2018, 9 ½ months following his last lumbar surgery, he told him of being assaulted at work and hurting his back, and having pain down his left leg. No mention of when Petitioner first had back pain or left leg pain following his accident is contained in Dr. Payne's office note. X-rays showed no broken hardware in his previous operative area, no fractures, and no migrating of the cages. No complaints of shoulder problems were made at this visit. Petitioner's physical examination on that

date actually showed some improvement, according to Dr. Payne, with his foot drop having improved to 4/5. On that date Dr. Payne gave Petitioner his prescription for medical marijuana as Petitioner had "chronic nerve pain." Dr. Payne wanted a CT scan done to rule out any fractures of the lumbar spine. That was done on November 6, 2018 and the radiologist wrote that found no evidence of hardware failure or any other non-surgical abnormalities.

When Dr. Payne saw Petitioner on November 9, 2018 he reviewed the CT scan and agreed it showed no broken or displaced hardware. Petitioner's complaints on this date, over three months after the accident, were really in regard to his right shoulder, a new complaint of having trouble sleeping on his right side and with activities overhead. After finding tenderness is several areas of the right shoulder, Dr. Payne's impression was right shoulder impingement, and he ordered physical therapy for both shoulders, as Petitioner told him of mild symptoms in the left shoulder as well. Petitioner was to return to see Dr. Payne in six months.

Petitioner received physical therapy to both shoulders on four occasions from December 12, 2018 through January 4, 2019. Petitioner did not attend subsequent scheduled physical therapy sessions.

Dr. Schroeder saw Petitioner on December 28, 2018 and Petitioner told her of his shoulder problems and also told her he thought they were from his accident. When Petitioner saw her again on January 23, 2018, he told her he had been forced to return to work. He told her he wanted to see an orthopedist for his shoulder and she referred him to Dr. Leutz. She also gave him a release to return to full duty work that day.

Dr. Leutz saw Petitioner on February 6, 2019 and noted Petitioner had previously undergone right shoulder surgery as there had been a prior excision of the distal clavicle consistent with a Mumford procedure. No records for prior right shoulder problems or treatment were introduced into evidence at arbitration. No definitive diagnosis was made at this visit, and Dr. Leutz recommended an MRI of the shoulder. There is no evidence Petitioner ever returned to see Dr. Leutz.

Dr. Payne released Petitioner to return to work without restrictions on February 7, 2019, though there is no evidence he had seen him in almost three months.

Dr. Schroeder saw Petitioner on March 15, 2019 saying that after his return to work his co-workers made him anxious, and he had in the week since returning to work had an argument with an authority. The doctor signed papers that day to give him FMLA leave from March 8, 2019 until May 1, 2019 for medication adjustments and counseling.

On May 1, 2019 Petitioner told Dr. Schroeder that his Buspar and Cymbalta were not helping and a history of seeing a psychologist. Dr. Schreoder prescribed Zoloft for PTSD while continuing Petitioner's Buspar and Ambien. She filled out disability forms indicating Petitioner could not work due to PTSD, noting Petitioner should not have contact with the prison system. On May 10, 2019, Petitioner saw Dr. Schroeder due to high blood pressure. Dr. Schroeder wrote a non-occupational disability medical report that her PTSD diagnosis was based on a psychologist's evaluation, and noted Petitioner had not been released to return to work.Petitioner spoke to Dr. Schroeder's nurse by telephone on May 23, 2019.

None of the March or May 2019 visits with Dr. Schroeder included complaints in regard to his low back or shoulders.

Petitioner received x-rays of his right shoulder and an MRI of his lumbar spine on May 10, 2019. The x-rays showed no acute abnormalities, and the MRI showed evidence of his previous fusions, no acute abnormalities and the hardware was intact. He saw Dr. Payne for a 1 ½ year post-op follow up for his fusion of L4-5 and L5-S1. He said Petitioner's back was probably as good as it was going to get and he released him at maximum medical improvement.

Petitioner saw a clinical social worker, Ms. Mercer, on 50 occasions between September 11, 2018 and October 12, 2020. Ms. Mercer impression was PTSD. Petitioner's complaints waxed and waned until such time as he got a new job not involving the prison. Ms. Mercer was deposed, and the vast majority of her experience was in counseling children. In fact, it appears she began counseling adults only two months prior to beginning treatment of Petitioner, and the five to ten adult clients she saw on a part-time basis during the period she saw Petitioner were principally couple-based counseling, with a small percentage of her clients being seen for PTSD. It would appear that since she was only seeing five to ten clients per week, a small percentage could possibly be only Petitioner, though that was not made clear in her deposition. After Petitioner began working at INET, the boar stud farm, in July of 2020, Petitioner's treatments became less frequent, apparently ending on October 13, 2020. She testified that what she did was not signed off on by any physician, that she was not a doctor, and that what she made were merely recommendations, not something that had to be followed. She said she said Petitioner told her he had mild anxiety prior to this accident but he did not tell her he had severe anxiety before this accident. She obviously had little to no knowledge of pharmaceuticals used to treat anxiety or depression, though she said that if she believed medication was needed she would refer a client to a psychiatrist. There is nothing in the record indicating Ms. Mercer ever referred Petitioner to a psychiatrist.

Dr. O'Leary is an orthopedist. He performed an orthopedic examination of Petitioner on November 29, 2018 and reviewed the emergency room records for treatment following this accident as well as Dr. Schroeder's records. Dr. O'Leary said that during his examination Petitioner made complaints of leg pain but not of radicular pain, and their were no examination findings indicating nerve impingement, he had negative straight leg raising findings for L4 or L5/S1 nerve distributions, indicating he did not have a pinched nerve from a herniated disk. Petitioner resisted Dr. O'Leary's attempts to raise his arms during the examination, and he did not find any impingement signs in his examination, meaning he did not have rotator cuff tendinitis. Petitioner's muscles in the arms and legs were of normal strength. He said he did not find any abnormalities during his examination. He said back pain complaints coming on three months after an accident would be unusual. He diagnosed bilateral shoulder pain, chest pain which was resolving and chronic low back pain, status post lumbar fusion. He did note recommend any restrictions or treatment for Petitioner's orthopedic conditions. Dr. O'Leary did not believe Petitioner's low back complaints were related to this accident, that the mechanism of injury did not make sense for Petitioner's complaints, nor was any of the lumbar treatment related to this accident.

Dr. Froman is a psychologist who examined Petitioner on April 15, 2019 at the request of Petitioner's attorney. He said his examination took about two hours, and the only medical records he reviewed were notes of Ms. Mercer from two of her earliest sessions with Petitioner. He said Petitioner appeared anxious during his examination. Petitioner reported he was taking Duloxetine, an antidepressant ordered by doctors for depression mixed with anxiety and physical symptoms. Petitioner also advised him he was taking medical marijuana. Dr. Froman said that often helped his patients who had pain as well as those patients with anxiety. Dr. Froman was of the opinion that Petitioner's PTSD was caused by the event which occurred at the prison, based on

Petitioner's reactions from the time of the event onwards. He said depending on where he went to work, and his not going back to the prison, Petitioner's prognosis was good. Dr. Froman did not think the kind of counseling Ms. Mercer was giving Petitioner would be totally effective in most cases unless the counselor was particularly skilled in dealing with PTSD cases, that in many cases medication was necessary. He said that there were three levels of clinicians and Ms. Mercer's master's level was the lower level. Dr. Froman said Petitioner told him he was not suffering from anxiety or depression before this accident and that if he was, his opinions would be affected by that, though he could not say how without seeing the records. Dr. Froman did not think Petitioner had gotten better with treatment, that if anything, he had gotten worse, and that if the people treating him did not know what they were doing with PTSD, a highly specific, highly specialized area of treatment, the person would not get better, and might get worse.

Dr. Hartman examined Petitioner at the request of the Respondent. He is a licensed board certified clinical psychologist and neuropsychologist. In addition to his doctorate in psychology he had gone back and received a master's in psychopharmacology. His examination of Petitioner was on August 8, 2019, and he had reviewed 544 pages of Petitioner's medical records. His examination took nearly a full day and involved Petitioner taking numerous tests to objectively measure various kinds of symptoms, problems and patterns. After reviewing the medical records Dr. Hartman was very concerned that Petitioner had medical problems which were not being adequately dealt with, including his high blood pressure and hyperlipidemia, saying he should see a cardiologist. He said Petitioner was cooperative during the testing. He said Petitioner's answers strongly showed malingering, but Dr. Hartman blamed that in part on Petitioner's therapist, Ms. Mercer, who he said was concentrating on the PTSD alone, not addressing other issues, and "trying to make him into a PTSD patient." He said he was sure Ms. Mercer was trying to help Petitioner, but she was making him worse. He said if Petitioner had been treated by a competent psychiatrist and gotten his chronic mood instability calmed down, he might have had a more realistic view of how he felt and not feel like he had to be over the top, indiscriminately telling everyone how bad he was. He said Petitioner's exaggerated answers caused Dr. Hartman to not be able to diagnose PTSD because the diagnosis was not possible due to the extreme level of exaggeration he was showing. He was of the opinion that Petitioner's therapist was trying to make Petitioner's anxiety permanent, that if Petitioner were his patient he would pull Petitioner away from Ms. Mercer as soon as possible. He did not believe her treatment was reasonable and necessary, he thought it was "actually iatrogenic and causing him to be worse." He felt reasonable treatment for Petitioner would be by a psychiatrist.

The Arbitrator finds that Petitioner's medical conditions of sternum contusion is causally related to the accident of July 30, 2018. This finding is based on the testimony of Petitioner, the emergency room records of July 30 and August 1, 2018 and the medical records of Dr. Schroeder. The symptoms of said condition had resolved within a few months following the accident.

The Arbitrator further finds that Petitioner's medical conditions, aggravation of pre-existing anxiety and post-traumatic stress disorder, are causally related to the accident of July 30, 2018. These findings are based upon the testimony of Petitioner, the pre-accident medical records showing severe anxiety, the emergency room reports, the first three months of Dr. Schroeder's reports, the pre- and post-accident medical records of Dr. Payne, the medical opinions of Dr. O'Leary, Dr. Hartman, and Dr. Froman, and to a much lesser degree, the therapeutical opinions of Ms. Mercer. Dr. Hartman was not able to render a diagnosis of PTSD based upon Petitioner's greatly exaggerated complaints on the objective tests Dr. Hartman had

administered. Dr. Hartman did not blame those exaggerations on Petitioner, however, he blamed them on Ms. Mercer, and her method of treatment. Both Dr. Froman and Dr. Hartman agreed Ms. Mercer's treatment was not the type which would help Petitioner, it would probably make him worse. Dr. Hartman said it basically trained him to give over the top exaggerated complaints, that was what Ms. Mercer wanted to hear. Both psychologists said people with PTSD need to be treated by specially trained psychologists or psychiatrists. Both agreed that it was imperative that Petitioner be treated by someone with great experience and skills with people who had suffered trauma. It is clear Ms. Mercer is not such a person, that she had minimal, almost no experience treating adults with those types of problems. Indeed, when she began treating Petitioner she had only been treating adults for two months, and that on a part-time basis, with the vast majority of her clients being seen for family counseling.

The Arbitrator further finds that Petitioner did not suffer low back or right shoulder injuries as a result of the accident of July 30, 2018. This finding is based upon Petitioner's pre-existing low back condition, having two or three lumbar surgeries, the most recent being less than eight months prior to the date of this accident, and the gap of time between the accident and the complaints and treatment for those conditions. Petitioner's had few, if any, low back complaints in the weeks and months immediately following this accident, Petitioner's first complaining of left leg pain on September 17, 2018 when Petitioner told Dr. Schroeder that he had been sent home from work on that date due to left leg pain, in the buttock, knee, down the shin to his foot. He told her his return to work had been with no difficulties until the left leg pain that day, that there had been no new injury, and Petitioner thought it was just due to his standing. When Petitioner saw Dr. Payne on October 2, 2018, 9 ½ months following his last lumbar surgery, he told him of being assaulted at work and hurting his back, and having pain down his left leg. No mention of when Petitioner first had back pain or left leg pain following his accident is contained in Dr. Payne's office note. X-rays showed no broken hardware in his previous operative area, no fractures, and no migrating of the cages. No complaints of shoulder problems were made at this visit. Petitioner's physical examination on that date actually showed some improvement, according to Dr. Payne, with his foot drop having improved. Subsequent radiographic testing showed no acute findings and all hardware from his previous surgeries was in good order. Petitioner's first mention of shoulder pain was to Dr. Payne on November 9, 2018. Dr Payne took a new history on this date of pain in the shoulder, and his having trouble sleeping on the right side as well as pain with overhead activities. This would have been over three months after the accident of July 30, 2018.

In support of the Arbitrator's decision relating to Petitioner's earnings in the year preceding July 30, 2019, the Arbitrator makes the following findings:

No testimony was given in regard to Petitioner's earnings other than his saying he gave some wage records to his attorney. On the Request for Hearing Petitioner claims to have earned $80,000.00 in the 52 weeks before his accident, yielding a claimed $1,538.46 average weekly wage. (Arb Exh. 1) No evidence supporting that figure was submitted by Petitioner.

In denying Petitioner's claimed earnings on the Request for Hearing Respondent contended that Petitioner's average weekly wage was $1,147.20. In support of that assertion Respondent submitted a wage statement with regular earnings from the pay period ending February 15, 2018 through the pay period ending

July 15, 2018. (RX 6) That document, titled "Wage Statement," shows earnings from 2/15/18 through 7/15/18 and states that Petitioner was on a leave of absence for the remainder of the period in question. Petitioner had testified that he had worked for Respondent for a number of years, had left and had recently returned to work for Respondent, explaining why a full year's wages were not reported. There is no evidence in the record reflecting what day Petitioner returned to work, so it is impossible to determine what portion of a week the initial $947.64 represents. That period of time and the $947.64 are therefore being deducted from the earnings and the divisor for number of weeks will not reflect the period of time up to February 15, 2018. After that deduction the wage statement indicates that Petitioner had $26,093.60 from February 16, 2018 through the final pay period preceding this accident, July 15, 2018. That is a period of 21 4/7 weeks.

Dividing $26,093.60 by 21.5714 results in an average weekly wage of $1,209.64. That is also consistent with the hourly wage stated on Respondent Exhibit 6 of $29.95. The wage statement entered into evidence does reflect overtime pay totaling $7,162.55 over the course of two pay periods ending on June 30, 2018 and July 15, 2018. The earlier pay period was for an extremely high amount, $6,520.12. Again, no testimony was given to explain these amounts, whether they were some type of bonus, a payment for raises contractually obligated in the past for periods of time in previous years but not paid until that date, or whether he had somehow been able to work nearly 150 hours of overtime during that one pay period on top of his regular time worked. Petitioner was credited with some overtime on that wage statement, but there was no evidence introduced indicating that the overtime was mandatory, and inasmuch as the unexplained overtime was earned in only two of ten pay periods, it is not deemed to have been regular, and the overtime is not included in calculating average weekly wage.

The Arbitrator finds that Petitioner's average weekly wage while working for Respondent in the 21.5714 weeks prior to his accident was $1,209.64, resulting in annual earnings of $62,901.28. This finding is based upon the wage statement introduced into evidence by Respondent.

In support of the Arbitrator's decision relating to what temporary benefits Petitioner is entitled to as a result of the accident of July 30, 2018, the Arbitrator makes the following findings:

The findings of fact, above, are incorporated herein.

The summaries of medical evidence and deposition testimony, above, are incorporated herein.

The findings in regard to causal connection, above, are incorporated herein.

Petitioner claimed to have been temporarily totally disabled from December 20, 2018 to July 20, 2020, a period of 82 3/7 weeks. Respondent disputed all temporary total disability "due to restrictions, lack of specific medical restrictions, and/or evidence shows that Petitioner's condition stabilized prior (to) 7/20/2020." (Arb. Exh. 1)

Restrictions were given at various times by different medical providers, and for varying maladies, psychological and physical.

In his testimony at arbitration Petitioner testified that he was taken off work when seen at the emergency rooms and, Dr. Schroeder continued to keep him off work, he asked her to release him to work and she gave

him a full duty release. He said he returned to full duty work on September 10, 2018. He said he then returned to Dr. Schroeder on September 17, 2018 due to leg pain radiating down his leg, and that Dr. Schroeder took him off work as of that date. He said he then saw Dr. Payne on October 2, 2018 for his back and left leg, and Dr. Payne took him off work again on that date. Petitioner testified that Dr. Payne continued to keep him off when he saw him on November 9, 2018, when he also told the doctor of bilateral shoulder problems which he said had come on three weeks following the accident. He said Dr. Payne continued to keep him off work. Petitioner said he saw Dr. Leutz for his shoulder on February 6, 2019 and then saw Dr. Payne on February 7, 2019, and Dr. Payne released him to full duty work on that date, but he did not go back to work at that time.

Petitioner did not testify as to the date he then returned to work with Respondent, but he said that after he had gone back to work he and Sergeant Parson got into a disagreement and the sergeant approached him aggressively. It is not clear from Petitioner's testimony when Petitioner again went off work, but he testified that on May 1, 2019 he told Dr. Schroeder that he felt he could not go back to work for Respondent. He said Dr. Schroeder in May of 2019 placed him on a restriction of no contacts with residents at the prison, a restriction he said was made permanent in August of 2019.

Petitioner testified that he was no longer employed by Respondent, but that he could not remember the exact date his employment ended. He said after he was terminated he began looking for work elsewhere, but again, he did not mention when that was. He said he eventually began working for INET, a boar stud farm, in the middle of July 2020. He said he had applied for the INET job as it was posted on the Indeed search engine. He said he did not know when he started that search.

The Culbertson Memorial Hospital emergency room records do reflect their restricting him from work on July 30, 2018, due to his sternum pain, with a return to work on July 31, 2018. The McDonough District hospital records of July 31, 2018 note Petitioner again made sternum complaints, and he was given an excuse from work and was told to follow up with his primary care physician. Dr. Schroeder's office notes indicate Petitioner spoke to her staff on August 1, 2018, asking for an off work extension, and they issued a letter taking him off work until August 7, 2018. Petitioner saw Dr. Schroeder on August 6, 2018 complaining of sternum pain and she gave him a letter restricting him from work until August 16, 2018. On that date Petitioner told Dr. Schroeder that he was nervous about going back to work. She gave him another letter on that date restricting his work until August 24. On August 24, 2018 Petitioner told Dr. Schroeder that he was doing better in regard to the sternum injury but he did not feel he was mentally ready to return to work. Dr. Schroeder once again issued him a letter taking him off work until August 31, 2018.

The records indicate that on August 30, 2018 Petitioner called Dr. Schroeder's office saying he needed a note saying he would be off work until the following Wednesday. Later that day he again called the doctor's office, this time saying he was ready to go back to work and that he did not need any restrictions, that he felt good and was ready to return to full duty work the next week. He asked her to fax a note to that effect to his work. In an apparent error, Dr. Schroeder issued a letter dated August 31, 2018 saying Petitioner was to remain off work until August 25, 2018.

Petitioner saw Dr. Schroeder again on September 5, 2018 and told her he now felt mentally and physically ready to return to work full duty, effective September 10, 2018. On that date Dr. Schroeder's physical examination found no tenderness over the sternum or rib cage and her psychiatric examination of him

was normal for mood, affect, behavior, judgment and thought content, and she issued another letter on September 5, 2018 noting Petitioner was released to return to work effective September 10, 2018. Petitioner apparently did return to work as he told Dr. Schroeder on September 17, 2018 that he had been sent home that day due to left leg pain, in the buttock, the knee, the shin, and into his foot. He told Dr. Schroeder that his return to work had been with no difficulties until the left leg pain that day, that he had not suffered any new injury and that he thought his problem that day was just due to his standing. The only diagnosis in Dr. Schroeder's records for September 17, 2018 was lumbar radiculopathy, and she provided him with an injection for that during the visit. Petitioner's low back condition is not causally related to this accident per the finding on causal connection, above. Dr. Schroeder issued a letter on that date taking Petitioner off work until September 24, 2018. Dr. Schroeder's office called Dr. Payne's office on September 18, 2018 and an appointment with Dr. Payne was made for Petitioner for October 2, 2018.

The Arbitrator finds that Petitioner's sternum injury had resolved as of September 17, 2018 based upon Dr. Schroeder's physical examination findings of September 10, 2018 and Petitioner's history that his return to work had been without difficulties.

Dr. Payne saw Petitioner for his non-causally connected low back complaints on October 2, 2018. His impression at that time was low back pain and left lumbar radiculopathy. He restricted Petitioner from work until October 15, 2018, until CT scan results were obtained. The CT scan was performed on November 6, 2018. Dr. Payne saw Petitioner on November 9, 2018 and received a new history of shoulder pain. Petitioner's shoulder conditions were found not tp be causally related to this accident per the finding on causal connection, above. Petitioner was told to return in six months. On November 15, 2018 Dr. Payne, based on his November 6, 2018 examination of Petitioner, noted Petitioner was to be off work until his next appointment on May 10, 2019.

When Dr. Schroeder saw Petitioner on December 28, 2018 complaining about his shoulder, Dr. Schroeder made no comment on Petitioner's ability to work.

Petitioner saw Dr. Schroeder on January 23, 2019 and told her that he was being forced to return to work. Petitioner again made right shoulder pain and range of motion complaints during this visit and Dr. Schroeder made a referral in regard to the shoulder to Dr. Leutz. She also issued a letter noting Petitioner was released to full duty work effective February 7, 2019.

Dr. Leutz saw Petitioner in regard to his right shoulder on February 5, 2019. He made no mention of work restrictions in his office notes of that date.

Dr. Payne released Petitioner to full duty work, with no restrictions, on February 7, 2019.

Petitioner saw Ms. Mercer on February 16, 2019, after his February 2019 return to work. She felt he was showing ambivalence towards his return to work.

On March 4, 2019 Petitioner called Dr. Schroeder's office asking for a work release for February 27 and 28 due to anxiety and the doctor issued such a letter, but noted she had not seen him on those dates.

Ms. Mercer wrote a To Whom It May Concern letter on March 7, 2019 stating it was her recommendation that he not return to work until evaluated by a psychologist to determine if that was appropriate. It does not appear that Ms. Mercer ever, at any time, referred Petitioner to a psychologist.

When Dr. Schroeder saw Petitioner on March 15, 2019 he advised her that he had been off work since March 8, 2019 after an apparent a heated exchange with a supervisor. On this date he asked her to give him a leave from work while he sorted out his anxiety/PTSD. Per his request she signed an FMLA form that day to give him leave from March 8, 2019 until May 1, 2019 as he needed time for medication adjustments and counseling. She doubled his blood pressure medication on this date. She also filled out a CMS form that day saying Petitioner was not capable of working.

Dr. Froman examined Petitioner at his attorney's request on April 15, 2019. He took a history from Petitioner that he had tried going back to work, but, according to Petitioner, it did not go well, it was anxiety provoking. Dr. Froman testified he was of the opinion that Petitioner was looking for a reason not to go back to work, he would have reacted to anything that happened at work, "because he did not want to have to be there." Dr. Froman

When Petitioner saw Dr. Schroeder on May 1, 2019 he told her he did not feel he could go back to his current job. She prescribed Zoloft for him and filled out a CMS form saying Petitioner could not work, and the reason was psychological. On a DHS form of that same date she noted interactions with superiors and inmates caused him anxiety and he should have no contact with the prison system.

No office notes for examinations of Petitioner by Dr. Schroeder were introduced for dates after May 10, 2019, when Petitioner saw her for blood pressure issues, and no mention of work restrictions was made.

Dr. Schroeder filled out an SRS form on May 14, 2019 noting she had not released Petitioner to return to work. She had not seen Petitioner since May 1, 2019 at that time.

Dr. Hartman examined Petitioner at the request of Respondent on August 8, 2019. As of that date Dr. Hartman felt Petitioner could work if he passed a physical (because of high blood pressure and the danger of a stroke), saying the accident did not make Petitioner psychologically incapable of working again at his pervious position.

While Dr. Schroeder apparently issued accommodation reports and/or work restrictions reports for Petitioner on August 15, 2019 and November 1, 2019, there were no records introduced indicating she examined Petitioner on either of those dates or on any date subsequent to May 1, 2019.

On October 8, 2019 Petitioner told Ms. Mercer that he was thinking of resigning his employment and she told him that might be an impulsive decision.

On August 12, 2020 Ms. Mercer was advised by Petitioner that he had obtained employment at a pig farm and was enjoying the experience of working.

Neither Petitioner's testimony nor the medical records admitted into evidence make it clear when Petitioner was working for Respondent and when he was not. It is not clear in the record when Petitioner was terminated by Respondent, Petitioner could not give a date for that. Petitioner was also not sure when he started seeking employment, or when exactly he started working for INET, but he thought it was the middle of July 2020.

Respondent paid "extended benefits" from August 4, 2018 through September 9, 2018, from November 1, 2018 through December 19, 2018, and paid temporary total disability from April 16, 2019 through September

30, 2019. Petitioner and Respondent stipulated on the Request for Hearing form, Arbitrator's Exhibit 1, that Respondent was entitled to a total credit of $35,459.10. (RX 7; Arb. Exh. 1)

The Arbitrator finds that Petitioner was temporarily totally disabled as a result of the accident from July 31, 2018 to September 10, 2018, and from April 16, 2019 through May 10, 2019, a period of 9 4/7 weeks.

This finding is based upon the facts noted above. Petitioner has the burden of proving he is temporarily disabled, and the period of disablement is a crucial portion of that burden. Here, the evidence introduced did not indicate in any reliable way when he was working and when he was not working. Further, starting on September 17, 2018 through at least the unknown date sometime prior to January 23, 2019 when Petitioner was seen by Dr. Schroeder, Petitioner was off work and being treated for low back and shoulder complaints which have been found to not be causally related to this accident for the reasons stated above. As of January 23, 2019 Petitioner was back to work, having returned on some unknown date, and was still complaining of shoulder injury, as Dr. Schroeder referred him to Dr. Leutz for an orthopedic consultation. Dr. Leutz saw Petitioner on February 5, 2019 but did not comment on his work status. Both Dr. Payne and Dr. Schroeder released Petitioner to return to work on February 7, 2019. Petitioner apparently worked, with the exception of February 27 and 28, 2019, until March 7, 2019, when Ms. Mercer issued a To Whom It May Concern letter saying he should not work until evaluated by a psychologist. It is noted that Ms. Mercer is not a psychologist, a psychiatrist or even a primary care medical doctor, she is a master's level clinician, and even she testified her recommendations are just that, and not orders. It is also noteworthy that Ms. Mercer at no time since undertaking the care of Petitioner referred him to either a psychologist or a psychiatrist. It should also be noted that Dr. Schroeder at no time made a referral of Petitioner to a psychologist or a psychiatrist for treatment and that her decisions in regard to Petitioner either working or not working were totally dependent on what Petitioner told her he could or could not do, whether he wanted her to restrict him from work or release him to return to work without restrictions. Ms. Mercer's recommendations and Dr. Schroeder's restrictions are therefore given very little weight. Dr. Froman did not believe Petitioner wanted to work and was looking for reasons not to work, but he did not believe Petitioner should be working in a prison-like setting, which was consistent with Ms. Mercer's recommendations as well. Dr. Hartman believed Petitioner could work from a psychological standpoint, even at a prison, but only if he got a physical release in regard to his high blood pressure. There is an absolute absence of medical proof of temporary total disability disability after May 10, 2019. There is no proof of a valid job search following that date, and neither Petitioner nor Respondent appear to have demanded, offered, or conducted vocational rehabilitation, labor market analyses or job placement assistance during the fourteen months between Petitioner's last visit with Dr. Schroeder on May 10, 2019 and Petitioner's obtaining employment in mid-July 2020. In addition, while there was no testimony or medical records introduced in regard to intervening accidents or medical conditions between May 10, 2019 and his being hired at INET, the Arbitrator notes that included in the medical bills introduced into evidence by Petitioner are radiology bills included in Petitioner's Exhibit 7 of Clinical Radiologists for a May 8, 2020 x-ray of Petitioner's calcaneus and a May 28, 2020 MRI of Petitioner's lower extremities, as well as bills from a podiatrist, Dr. Pater, of Quincy Medical Group, indicating Petitioner may have suffered an intervening injury requiring an aircast short boot and may not have been physically capable of working during that period of time for other non-accident related reasons.

In support of the Arbitrator's decision relating to whether the medical services that were provided to Petitioner were reasonable and necessary as a result of the Accident of July 30, 2018, the Arbitrator makes the following findings:

The findings of fact, above, are incorporated herein.

The summaries of medical evidence and deposition testimony, above, are incorporated herein.

The findings in regard to causal connection and temporary total disability, above, are incorporated herein.

The Arbitrator finds that all of the medical bills included in Petitioner's Exhibit 7 are related to Petitioner's sternum, anxiety aggravation, and post-traumatic stress disorder injuries, are reasonable and were necessitated to treat or cure Petitioner's injuries suffered in this accident with the exception of the following which are for unrelated treatments or unsupported by medical records or testimony introduced at arbitration:

- **Sarah Culbertson Hospital bills of November 6, 2018, November 8, 2018, and May 10, 2019 which are for unrelated lumbar spine and shoulder testing and treatment**
- **Clinical Radiologists bills of May 11, 2019, May 12, 2019, May 8, 2020, and May 28, 2020, which are for unrelated lumbar spine, shoulder, calcaneus and lower leg testing and treatment**
- **McDonough District Hospital bills of December 12, 2018, December 21, 2018, December 26, 2018, December 28, 2018, and January 4, 2019, which are for unrelated shoulder treatment**
- **Quincy Medical Group bills of September 17, 2018, September 26, 2018, December 28, 2018, January 23, 2019, March 25, 2019, May 10, 2019, May 31, 2019, June 5, 2019, August 12, 2019, November 1, 2019, May 13, 2020, June 10, 2020, and April 1, 2021, which are for either unrelated low back, shoulder, high blood pressure, eye, laboratory, or podiatric testing or treatment and/or are not supported by medical records or testimony introduced into evidence at arbitration**
- **Springfield Clinic bills of October 2, 2018, November 9, 2018, February 6, 2019, and May 10, 2019, which are for unrelated low back and shoulder testing and treatment**

These findings are based upon a review of the medical records and testimony, above, and the previously stated findings in regard to causal connection.

In support of the Arbitrator's decision relating to the nature and extent of the injury the Arbitrator makes the following findings:

The findings of fact, above, are incorporated herein.

The summaries of medical evidence and deposition testimony, above, are incorporated herein.

The findings in regard to causal connection, temporary total disability, and medical, above, are incorporated herein.

Petitioner seeks a wage differential award under Section 8(d)(1). In order to qualify for wage differential benefits under Section 8(d)(1) a claimant must prove both a partial incapacity that prevents him or her from pursuing his or her usual and customary line of employment and an impairment of earnings. 820 ILCS 305/8(d)(1). The purpose of a wage-differential award is to compensate an injured employee for his or her reduced earning capacity. Jackson Park Hospital vs. Illinois Workers' Compensation Commission, 2016 Ill.App. (1st) 142431 WC ¶ 39. The amount of a wage-differential benefit is to equal to 66 2/3 percent of the difference between the average amount the Petitioner would be able to earn in the full performance of his or her duties in the occupation he or she was engaged in at the time of the accident and the average amount he or she is earning or is able to earn in some suitable employment or business after the accident.

The testimony of Petitioner, the medical records of his treaters and the testimony of both Dr. Froman and Dr. Hartman indicate that Petitioner's earning capacity has been significantly diminished by his residual functional ability which is causally related to his accident of July 30, 2018. Ms. Mercer and Dr. Schroeder were in agreement that Petitioner's anxiety and PTSD were aggravated by his being present at or working in either his prior employment setting or a prison, that doing so brought on anxiety and change of mood. Ms. Mercer testified that she did not feel Petitioner could work in his previous position due to the risks the residents presented as well as the risks Petitioner himself presented, that returning to that environment would heighten Petitioner's symptomology and he would regress. Dr. Froman felt Petitioner's prognosis was good depending on where he went to work, and his not going back to the prison, saying Petitioner should not go back to the prison as he would not feel comfortable, and would not be able to relax. He did not think Petitioner should seek or obtain jobs which would expose him to viewing or being subject to violence. Even Dr. Hartman agreed that Petitioner had a chronic mood disorder, and later stated that if Petitioner were to return to the type of work he had been performing prior to this accident he could very well be exposed to another incident of this sort, an altercation with an inmate, as parts of the job were unpredictable, risks could not be avoided, and it would be reasonable for a person with chronic anxiety to not put themselves in situations that would worsen their anxiety further.

Pre-accident wage records for Petitioner's job with Respondent indicate an hourly wage of $29.95, and it appears that if he worked approximately 40 hours per week he would earn $1,198.00. His average weekly wage from actual earnings, however, as noted above, was $1,209.64. No evidence was introduced at arbitration as to what Petitioner would be able to earn in the full performance of his or her duties in the occupation he or she was engaged in at the time of the accident, so the hourly amount as set out in Respondent's Exhibit 6 will be used as the best evidence of what Petitioner would be able to earn as of the date of arbitration, $1,198.00.

The Petitioner is currently working for INET. Petitioner's wages from INET were admitted as Petitioner's Exhibit 10. The INET wage records show Petitioner as of his last pay periods included in Petitioner Exhibit 10 was earning $16.00 per hour. No explanation was given for different numbers of hours being worked at different times, but those records show that in the months prior to arbitration he was working approximately 40 hours per week. His current hourly wage times 40 hours equals $640.00. The difference between what Petitioner would be able to earn in his prior position, $1,198.00, and what he is earning in his present position, $640.00, is $558.00. 66 2/3 percent of that difference is $372.00.

The Arbitrator finds that the Petitioner is partially incapacitated from pursuing his usual and customary line of employment as a Security Therapy Aide, and there is a difference between the average amount which he would be able to earn in the full performance of his job duties as a Security Therapy Aide and his current earning capacity working at the boar stud farm. As such the Petitioner is entitled to wage differential benefits under Section 8(d)(1) of the Act

The Arbitrator finds that Respondent shall pay Petitioner permanent partial disability benefits, commencing July 21, 2020, of $372.00 per week until the Petitioner reaches age 67, or 5 years from the date of the final award, whichever is later, because the injuries sustained caused a loss of earnings as provided in Section 8(d)1 of the Act. The Arbitrator further finds that Respondent is, pursuant to agreement, entitled to credit of $35,459.00 under Section 8(j) of the Act.

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ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	20WC027599
Case Name	BORDNER, MARIA M v. FREEPORT MEMORIAL HOSPITAL
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0214
Number of Pages of Decision	11
Decision Issued By	Thomas Tyrrell, Commissioner

Petitioner Attorney	Kylee Miller
Respondent Attorney	Andrew Rane

DATE FILED: 6/10/2022

/s/ Thomas Tyrrell, Commissioner

Signature

22IWCC0214

STATE OF ILLINOIS)
) SS.
COUNTY OF WINNEBAGO)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maria Bordner,

Petitioner,

vs. NO: 20 WC 27599

Freeport Memorial Hospital,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b) having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issue of prospective medical treatment, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below. The Commission 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 affirms the Arbitrator's conclusion that Petitioner's current condition of ill-being regarding her lumbar spine is causally related to the April 27, 2020, work injury. The Commission also affirms the Arbitrator's conclusion that Petitioner met her burden of proving an entitlement to the pain management evaluation recommended by her treating physician, Dr. McNulty. However, the Commission makes certain modifications to the Arbitration Decision.

In the Order section of the Arbitration Decision Form, the Arbitrator wrote: "Respondent shall pay Petitioner temporary total disability benefits as needed, as provided in Section 8(b) of the Act." The Commission strikes this sentence in its entirety from the Arbitration Decision Form. A review of the record shows that the parties agreed the only disputed issues at the arbitration hearing were causation and prospective medical treatment. Temporary total disability benefits were not at issue during the arbitration hearing.

In the Order section, the Arbitrator also wrote: "Respondent shall pay Petitioner reasonable and necessary medical expenses, as provided in Section 8(a) and 8.2 of the Act." The Commission strikes this sentence in its entirety from the Arbitration Decision Form. Medical expenses were not

at issue during the arbitration hearing. Furthermore, the Arbitrator stated on the record that Petitioner was continuing to investigate the medical bills.

In the Order section, the Arbitrator wrote that Petitioner is entitled to "ongoing medical care in the form of Pain Management." A review of the record shows that Petitioner's treating doctor, Dr. McNulty, has only referred Petitioner to undergo an evaluation for pain management treatment. No doctor has prescribed any further pain management treatment. Thus, the Commission finds an award of ongoing pain management treatment is inappropriate. The Commission modifies the above-referenced sentence on the Arbitration Decision Form to read as follows:

> Petitioner is entitled to undergo an evaluation for possible pain management treatment as recommended by Dr. McNulty.

The Commission corrects certain scrivener's errors the Arbitrator made in several places throughout the Decision. On pages one (1) and two (2) of the Decision, the Arbitrator mistakenly refers to an "annual tear." The Commission hereby replaces all references to an "annual tear" with the correct phrase, "**annular tear**." Likewise, the Arbitrator mistakenly refers to Respondent's Section 12 Examiner as "Dr. Track" on pages two (2) and three (3) of the Decision. The Commission hereby replaces all references to "Dr. Track" with his correct name, "**Dr. Tack**."

In the final paragraph on page two (2) of the Decision, the Arbitrator wrote: "Petitioner treated with Respondent's choice of physician Dr. McNulty who ordered an MRI which Petitioner underwent on July 20, 2020. Both Dr. McNulty and the MRI interpreting physician (Dr?) diagnosed L5-S1 disc desiccation, disc bulging with left conjoined nerve root, disc desiccation and disc bulging and a central annual [sic] tear at L4-5." The Commission strikes these sentences and replaces them with the following:

> Petitioner treated with Respondent's initial choice of physician, Dr. McNulty, who subsequently became Petitioner's treating physician. Dr. McNulty ordered an MRI which Petitioner underwent on July 20, 2020. After reviewing the MRI results, Dr. McNulty diagnosed L5-S1 disc desiccation and disc bulging with left conjoined nerve root, and disc desiccation and disc bulging and a central annular tear at L4-L5.

On page three (3) of the Decision the Arbitrator mistakenly wrote "Perspective Medical." The Commission hereby strikes the phrase "Perspective Medical" and modifies the heading to read as follows:

> In regard to (K): **Prospective Medical**

On page three (3) of the Decision the Arbitrator wrote: "Having found that Petitioner's

condition of ill being remains causally connected to her workplace accident of April 27, 2020, Respondent is instructed to authorize ongoing medical treatment as needed to cure and/or relieve Petitioner's condition." The Commission hereby strikes this sentence in its entirety from the Decision. On page three (3) of the Decision, the Arbitrator also wrote a section with the heading: "In regard to (O): Petitioner's Entitlement to Pain Management Treatment." The Commission hereby strikes this section in its entirety from the Decision.

Finally, on page three (3) of the Decision, the Arbitrator wrote: "Respondent's choice of physician, Dr. McNulty made the recommendation clarifying that conservative treatment had not been completed and Petitioner had not reached MMI." The Commission modifies this sentence to read as follows:

> Dr. McNulty made the recommendation clarifying that conservative treatment had not been completed and Petitioner had not reached MMI.

The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 6, 2021, is modified as stated herein.

IT IS FURTHER ORDERED that Petitioner is entitled to undergo an evaluation for possible pain management treatment as recommended by Dr. McNulty.

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

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

June 10, 2022

o: 4/19/22
TJT/jds
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/s/ *Thomas J. Tyrrell*
Thomas J. Tyrrell

/s/ *Maria E. Portela*
Maria E. Portela

/s/ *Kathryn A. Doerries*
Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	20WC027599
Case Name	BORDNER, MARIA v. FREEPORT MEMORIAL HOSPITAL
Consolidated Cases	
Proceeding Type	19(b) Petition
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	6
Decision Issued By	Paul Seal, Arbitrator

Petitioner Attorney	Kylee Miller
Respondent Attorney	Andrew Rane

DATE FILED: 7/9/2021

THE INTEREST RATE FOR THE WEEK OF JULY 6, 2021 0.05%

/s/ Paul Seal, Arbitrator
Signature

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
19(b)

Maria Bordner
Employee/Petitioner

v.

Freeport Memorial Hospital
Employer/Respondent

Case # **20** WC **027599**

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 **Paul Seal**, Arbitrator of the Commission, in the city of **Rockford**, on **6/8/2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of 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. [X] Other **Is Petitioner Entitled to prospective medical**

FINDINGS

On the date of accident, **April 27, 2020**, Respondent ***was*** operating under and subject 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 $**23,512.32**; the average weekly wage was $**452.16**.

On the date of accident, Petitioner was **51** years of age, **married** with **2** dependent children.

ORDER

Respondent shall pay Petitioner temporary total disability benefits as needed, as provided in Section 8(b) of the Act.

TTD is not in dispute.

Respondent shall pay reasonable and necessary medical expenses, as provided in Section 8(a) and 8.2 of the Act.

Petitioner is entitled to ongoing medical care in the form of Pain Management.

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.

JULY 9, 2021

Signature of Arbitrator

ICArbDec19(b)

FINDINGS OF FACT

On April 27, 2020, Petitioner was a married, 51-year-old woman with two dependents under the age of 18. She was a 2-year employee working as a CNA for Freeport Memorial Hospital ("FHN"). She worked 36 hours a week making $12.56 an hour giving her an AWW of $452.16. Petitioner was tasked with caring for patients in the medical surgical unit, assisting patients with activities of daily living, and transferring patients. On the day of the injury Petitioner was asked by two technicians to assist in transferring a patient from one bed to another. Petitioner testified the patient resisted during the transfer and she held more of his weight than she was able to maintain. She felt immediate pain and a popping in her back. Petitioner testified she took over the counter pain medication and continued to work for six more hours before the pain in her back became too great. She reported the injury to her Duty Nurse Kelly Steward and Supervisor Rachel Walker. Ms. Walker instructed Petitioner to complete an accident report and to go to the FHN emergency room for an examination.

Petitioner testified she received medical care on April 27, 2020 at the FHN Emergency room. (PX 4/130). Petitioner gave a history of her accident to the emergency room personnel. The emergency room personnel performed a brief examination and recommended Petitioner talk to her floor supervisor regarding lifting restrictions. She was diagnosed with a lumbar strain. (Id.).

On April 30, 2020 Petitioner followed up with Dr. Diana McNulty at FHN Family Health Care Center. (PX 2). Petitioner testified that Dr. McNulty was not her regular primary care physician. Instead she'd been instructed by FHN to see Dr. McNulty specifically as a "workers compensation doctor." Dr. McNulty performed a physical examination and took a history of the accident. Dr. McNulty diagnosed low back pain with left sided sciatica and SI joint dysfunction. (PX 2/120). She recommended Petitioner undergo chiropractic care and that she may also benefit from physical therapy.

Petitioner began chiropractic care with Dr. Roger Sdao at Freeport Family Chiro and Acupuncture on May 4, 2020. (PX 3). She treated with Dr. Sdao through September 4, 2020. She was released from chiropractic care after Dr. Sdao felt Petitioner had plateaued and would not benefit from his ongoing treatment.

During the summer and fall of 2020 Petitioner continued to treat with Dr. McNulty. Dr. McNulty placed Petitioner on lifting and durational shift limitations. (PX 2/160). FHN was initially unable to accommodate these restrictions and TTD benefits were paid. Petitioner underwent two physical therapy visits on June 2, 2020 and on June 4, 2020 but testified these were discontinued when workers' compensation would not authorize both chiropractic care and physical therapy simultaneously.

On July 20, 2020 Petitioner underwent an MRI at FHN. (PX 4/168). The MRI diagnosed L5-S1 disc desiccation, disc bulging with left conjoined nerve root, disc desiccation and central annual tear at L4-5. (*Id.*). Dr. McNulty continued Petitioner's restrictions.
On September 10, 2020 Petitioner reported to Dr. McNulty that she continued to have significant pain in her lower back extending down her left leg that had developed into numbness in the left

leg and left big toe. (PX 2/176). Dr. McNulty noted petitioner needed to shift from sitting to standing several times during the visit. On examination Petitioner was able to fully flex forward but was unable to extend. Dr. McNulty requested a referral to the FHN pain clinic for consideration of a steroid injection.

On October 22, 2020 Dr. McNulty increased Petitioner's restrictions from 4 hours a shift to 6 hours a shift with 20 pound lifting restrictions and a need to walk, stand, and sit at will. (PX 2/ 180). Dr. McNulty continued to list annual tear of lumbar disk and low back pain with left sided sciatica as the diagnosis. (*Id.*).

Petitioner testified that in October of 2020 FHN was able to place her at a light duty position taking patient temperatures as a covid precaution. Eventually she was transitioned to a customer relations position that remained within her light duty limitations. She testified that she has been unable to return to her full position as a CNA since her accident on April 27, 2020.

On November 12, 2020 Dr. McNulty drafted a letter documented Petitioner's condition, limitations, and need for ongoing treatment. (PX 5). Dr. McNulty opined Petitioner had not yet reached MMI and that a steroid injection was a necessary next step in Petitioner's treatment. She issued an addendum including updated restrictions on November 18, 2020. (PX 6).

Petitioner continued to follow up with Dr. McNulty in December 2020 and January 2021.

At Respondent's request Petitioner was examined by Dr. Stanford Tack who issued a report on May 5, 2021. Dr. Track diagnosed a lumbar sprain/ strain. He opined Petitioner's MRI was remarkable for age related degeneration at L4-L5 and L5-S1 only. He opined Petitioner was required no further medical treatment.

To date Respondent has not authorized Petitioner's treatment or evaluation for pain management.

CONCLUSIONS OF LAW

In regard to Issue (F) – IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELEATED TO THE INJURY?, the Arbitrator finds the following:

Neither party disputes Petitioner injured her back on April 27, 2020. Petitioner credibly testified that she felt pain and a pop in her lower back when transferring the patient. She immediately sought out medical treatment and has cooperated with all medical care. Petitioner treated with Respondent's choice of physician Dr. McNulty who ordered an MRI which Petitioner underwent on July 20, 2020. Both Dr. McNulty and the MRI interpreting physician (Dr?) diagnosed L5-S1 disc desiccation, disc bulging with left conjoined nerve root, disc desiccation and disc bulging and a central annual tear at L4-5. (PX 4/168). Petitioner also credibly testified that she had not injured her back prior to the accident. The medical evidence supports Petitioner's testimony. There is no evidence that Petitioner was involved in any intervening accident.

Petitioner has been unable to return to her regular line of work. Further the opinions of Dr. Tack make no mention of the annual tear and therefore render no opinion as to treatment needed to alleviate that condition.

There has been no break in the causal chain, therefore the Arbitrator find Petitioner's condition of ill being remains casually connected to her accident of April 27, 2020.

In regard to (K): Perspective Medical

Petitioner has been referred to Pain Management for a possible steroid injection. Respondent's choice of physician, Dr. McNulty made the recommendation clarifying that conservative treatment had not been completed and Petitioner had not reached MMI. Dr. McNulty is not a spinal surgeon or pain management expert. Therefore, her referral to an expert in pain management in an effort to rule out all conservative options is reasonable.

Dr. Track's finding that Petitioner only suffered a lumbar sprain/ strain is not supported by the evidence of record. Dr. Track has not treated Petitioner. He reviewed Petitioner's MRI report finding Petitioner had a degenerative condition. Even if Petitioner did have a degenerative condition, the accident and resultant pain is undisputed. Two treating physicians have opined Petitioner suffered an annual tear of the lumbar spine. Further, Dr. Track's opinion that Petitioner does not require any additional medical treatment and has reached MMI is incorrect. In weighing Dr. Track's opinion against Respondent's choice of physician Dr. McNulty, the Arbitrator favors Dr. McNulty. She has followed Petitioner from the beginning and is recommending ongoing conservative care with an expert at this time.

Having found that Petitioner's condition of ill being remains casually connected to her work-place accident of April 27, 2020, Respondent is instructed to authorize ongoing medical treatment as needed to cure and/or relieve Petitioner's condition.

In regard to (O): Petitioner's Entitlement to Pain Management Treatment

The Arbitrator finds that Petitioner's referral to Pain Management to complete conservative treatment is both reasonable and necessary to cure and/ or relieve Petitioner's condition of ill being.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC006862
Case Name	SMITH, AUDREY v. CORNERSTONE SERVICE
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0215
Number of Pages of Decision	22
Decision Issued By	Kathryn Doerries, Commissioner

Petitioner Attorney	Kenneth Lubinski
Respondent Attorney	William Dewyer

DATE FILED: 6/10/2022

/s/Kathryn Doerries, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

AUDREY SMITH,

Petitioner,

vs. NO: 15 WC 006862

CORNERSTONE SERVICES,

Respondent.

DECISION AND OPINION ON REVIEW

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

Petitioner filed two Applications for Adjustment of Claim (AAC) on March 3, 2015. One AAC was filed on behalf of the Petitioner, alleging a date of accident on April 30, 2014, and injury to Petitioner's right foot and was assigned case number 15 WC 006858. On the same date, a second AAC was filed on behalf of the Petitioner, alleging a date of accident on July 12, 2013, and a disfigurement injury to the left and right arms from a human bite and was assigned case number 15 WC 006862.

The Decision that the Arbitrator designated for case number 15 WC 006858, for date of accident April 30, 2014, and for Petitioner's alleged right foot injury, was published under case number, 15 WC 006862 and conversely, the Decision that the Arbitrator designated for case number 15 WC 006862 for date of accident on July 12, 2013, was published under case number 15 WC 006858.

The Commission modifies the Arbitrator's Decision solely to correct this case number scrivener's error and to set the record straight going forward. The Commission modifies the Arbitrator's Decision regarding the date of accident of July 12, 2013, for injuries to Petitioner's face, left elbow and right forearm, by changing the case number on this Decision, so that the Review Decision corresponds to the date of accident assigned on the Application for Adjustment of Claim. Any references to the date of filing of the Arbitrator's Decision will be referring to the Decision that is written for the accident date and body part that corresponds to the AAC, not the case number.

The Commission has now changed the two case numbers, so that the Commission Decision on review of the Arbitrator's Decision reflects the AAC's respective dates of accident and case numbers.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Decision filed on July 13, 2021, for the date of accident on July 12, 2013, is hereby modified for the reasons stated herein, changing the case number for this Decision to 15 WC 006862, and the Decision is otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner sustained accidental injuries which arose out of and in the course of her employment with Respondent on July 12, 2013. Petitioner sustained injuries to her face, left elbow and right forearm as a result of the July 12, 2013, accident.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner has failed to prove that she is entitled to temporary total disability benefits as a result of the July 12, 2013, accident.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $252.00 per week for a period of seven (7) weeks, as provided in §8(c) of the Act, for the reason that the injuries sustained caused the disfigurement of the right forearm.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the reasonable and necessary medical expenses contained within Petitioner's Exhibit 8 which are causally related to the July 12, 2013, accident, as provided in §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit for any awarded medical bills that have been paid by Respondent prior to the 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 §8(j) of the Act.

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

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 $510.00. 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.

June 10, 2022
KAD/bsd

O041922
42

/s/*Kathryn A. Doerries*
Kathryn A. Doerries

/s/*Thomas J. Tyrrell*
Thomas J. Tyrrell

/s/*Maria E. Portela*
Maria E. Portela

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC006862
Case Name	SMITH, AUDREY v. CORNERSTONE SERVICES
Consolidated Cases	
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	18
Decision Issued By	Paul Cellini, Arbitrator

Petitioner Attorney	Kenneth Lubinski
Respondent Attorney	Kelly Kamstra

DATE FILED: 7/13/2021

THE INTEREST RATE FOR THE WEEK OF JULY 13, 2021 0.05%

/s/ Paul Cellini, Arbitrator

Signature

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

AUDREY SMITH
Employee/Petitioner
v.
CORNERSTONE SERVICES
Employer/Respondent

Case # **15** WC **06862**

An *Application for Adjustment 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 **May 12, 2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

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

In the year preceding the injury, Petitioner earned $**21,840.00**; the average weekly wage was $**420.00**.

On the date of accident, Petitioner was **33** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**280.00** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**280.00**.

Respondent is entitled to a credit of $**4,943.04** under Section 8(j) of the Act.

ORDER

The Arbitrator finds that the Petitioner sustained accidental injuries which arose out of and in the course of her employment with Respondent on April 30, 2014.

The Arbitrator finds that the Petitioner's right foot/ankle condition from April 30, 2014 through May 9, 2014 was causally related to the April 30, 2014 accident. The Arbitrator further finds that the Petitioner's bilateral foot and ankle conditions after May 9, 2014 were not causally related to the April 30, 2014 accident.

Respondent shall pay Petitioner temporary total disability benefits of $280.00 per week for 6/7 weeks, commencing May 4, 2014 through May 9, 2014, as provided in Section 8(b) of the Act. Pursuant to Section 8(b) of the Act, the first three days of temporary total disability benefits are not payable given that the Petitioner was off work for less than 14 days.

Respondent shall be given a credit of $280.00 for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical expenses incurred between April 30, 2014 and May 9, 2014 which are included in Petitioner's Exhibit 8, as provided in Sections 8(a) and 8.2 of the Act.

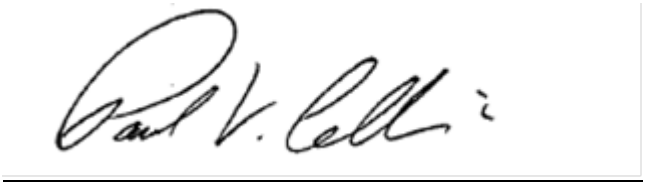
Respondent is entitled to credit for any awarded medical expenses that were paid by Respondent prior to the hearing date, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $252.00 per week for 25 weeks, because the injuries sustained caused the loss of use of 5% of the right foot, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner compensation that has accrued from **April 30, 2014** through **May 12, 2021**, 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

JULY 13, 2021

STATEMENT OF FACTS

Petitioner testified that in July 2013 she was employed by Respondent as a Direct Service Professional at a children's group home in Minooka, Illinois for the developmentally disabled. Her building housed five such residents aged 13 to 18. Her work duties included tending to the residents' activities of daily living, including assistance with ambulation, physical transfers, meals, bathing, cleaning, transportation and leisure activities. She testified this often involved being on her feet, and that the resident children tended to be unpredictably aggressive and would act out.

While working on 7/12/13, Petitioner testified she was called to a resident's (Michael) room. He couldn't articulate what he wanted, so he pulled her down the hallway by her arm to the living room, wanting to move the living room TV to his room. When she indicated he could not do so, the resident became aggressive and began to hit and claw at her, scratching at her face and biting both the back of her left elbow and right forearm. Petitioner sought treatment at Provena St. Joseph's and was diagnosed with human bite wounds and facial lacerations. She received a Tetanus shot and pain medication. The MedWorks (the company occupational health facility) records indicate bites to the right forearm and lateral left elbow, which were healing. Petitioner was treated with antibiotics and a Hepatitis B vaccination. She subsequently had a negative HIV test on 1/12/14 at MedWorks, and she followed up about a year later and underwent further blood work in January 2015. She had no further treatment related to this incident. (Px2).

The Petitioner identified photographs of her face, left elbow, right forearm submitted into evidence as Px13, Px14 and Px15. However, these photos were all taken in 2013. A fourth photo was taken of her chest, where she indicated the resident slapped her with a closed hand. The Arbitrator notes that he determined that these photos are relevant for purposes of pinpointing the locations of the bite and scratch marks, they otherwise are not relevant to the issues in this case, in particular the issue of permanency, given that they are from almost eight years prior to the hearing date. Petitioner testified the only remaining marking/scarring on her skin from the 7/12/13 incident is on her right forearm. She indicated she has no pain at this location, but that the bite mark area appears brighter when she has warm or cold skin. The Arbitrator had an opportunity to view the

Petitioner's right forearm at the hearing and saw minimal evidence of any ongoing visible scarring. Petitioner also testified she lost no time from work as a result of injuries related to this incident.

Petitioner suffered a subsequent injury at work on 4/30/14. While making her evening rounds of the residents' rooms following her lunch break, around 7 p.m., two residents, Robbie and Michael, were fighting over a blanket. She tried to separate them as they were tugging on and fighting for the blanket and was knocked to the ground. She testified that Michael and Robbie fell on top of her as they continued to fight, and her right foot became twisted underneath her body. Her left leg was extended, causing her left foot to be jammed hard into the corner of a computer desk with a twisting motion. She testified that while she went to St. Joseph's Hospital with the residents that night, she did not seek treatment there for herself. She indicated she didn't initially have much pain in the left ankle until she was getting out of bed the next morning. While she acknowledged that she'd undergone prior treatment for plantar fasciitis, she testified that this pain was a different type of pain, in a different area on the outside of the ankle going up into the calves, and she denied any prior treatment to her left or right ankles. She testified she also had right ankle pain with swelling and a feeling of tightness.

A Staff Accident/Injury Event Form, which is undated, indicated that on 4/30/14 the Petitioner was pushed down while trying to separate two residents involved in a physical altercation, and one of them fell on top of her while one of her feet were underneath her body. The report notes the injury was to the right foot, and the report notes co-worker witness Jessica Adams indicated Petitioner's ankle was "swollen and red." The report further noted the Petitioner iced it that night, called her supervisor the next day and went to MedWorks for treatment. The report also notes Petitioner was off work for 6 days and then returned to work. (Px1). Petitioner testified that Respondent's HR representative, Amanda Progress, referred her for treatment at MedWorks.

The history stated in the 5/1/14 report from MedWorks was of Petitioner trying to separate two clients in an altercation and being pushed down to the floor, with her right foot turned underneath her body while the clients fell on top of her, injuring her right ankle. She reported significant pain and swelling along both ankles. She denied any prior injuries to these body parts. Swelling and erythema was noted at the right ankle on exam. She had limited dorsiflexion and difficulty with weightbearing. Right ankle x-ray was normal other than medial and lateral soft tissue swelling. Petitioner was diagnosed with right bimalleolar right ankle sprain, given an air cast and was limited to sedentary work duties. (Px2).

Petitioner testified that her preexisting left-sided plantar fasciitis was worse after the 4/30/14 injury, but the right-sided plantar fasciitis was basically unchanged. Petitioner also testified that she had left ankle pain at this time but not as bad as the right ankle, and that she remained off work because the Respondent could not accommodate the sedentary duty restriction.

At her 5/6/14, follow up, Petitioner reported being much improved, but had some ongoing pain with standing and ambulation. The report corroborates she was off work due to no light duty availability. It was noted: "She has not been using the Ace wrap or applying ice or heat to the affected region since she states she does not have problems all the time." Petitioner was advised to start weight bearing and to use the Ace wrap. Light duty restrictions were continued, and the plan was to release her at the next visit. (Px2). Petitioner testified Respondent continued to be unable to accommodate her restrictions.

A 5/9/14 MedWorks report notes Petitioner had been pain free until that day other than minor pain (1 out of 10) she attributed to the damp weather. She was ambulating without difficulty and was not using the Ace wrap or anti-inflammatories. Examination was normal and Petitioner was released from care and advised to return to work without restrictions. (Px2). As to her indication of only 1/10 level pain at this visit, the Petitioner testified she was on crutches and non-weightbearing at that time, and her pain would come and go depending on weightbearing, activity and use of pain medication.

Petitioner testified she received a call from the Respondent's house manager on 5/10/14 indicating they were short staffed and needed her to come back to work, which she did. She did not recall if she had been receiving temporary total disability benefits or not at that time.

On 5/15/14, Petitioner sought treatment with Dr. Shanholtzer, who she testified was a podiatrist/orthopod specializing in the foot/ankle. The intake form notes complaints of ankle pain, cramps in the feet and legs, heel pain and, swelling and tired feet. The medical report documents complaints of pain in both legs and feet and plantar fasciitis, left greater than right: "She has about 2 years of problems with this and also with her right foot. She has seen [Dr. Caneva] and had injections and several different kinds of orthotics and still has problems. She is on her feet all the time with Cornerstone patients, taking them from place to place and standing for long periods of time." The report goes on to note Petitioner was taking cortisone, had an x-ray of her heel and wore a tall or short boot at times and an elastic wrap. Several injections had provided only temporary relief and "it has come back. Mostly this time the left one is also bothering her but she is concerned about her legs also. The swelling seems to be going up to her knee area." The assessment was bilateral plantar fasciitis, and she was advised to see a family doctor for swelling in her lower leg for a possible diuretic. Dr. Shanholtzer wanted her to see Dr. George for her ankle area, and an orthopedic surgeon at George's office for her lower leg. He stated: "Patient has plantar fasciitis, left and right foot, aggravated by a maximal amount of edema in both legs and feet." She was prescribed Cataflam for pain, noting she already used biofreeze, and she was advised to soak in epsom salts. (Px3).

Petitioner testified that at this point her left ankle felt worse than the right, which she believed was due to favoring her right ankle, and she was using two crutches. At a 5/30/14 visit to her general physician, Dr. Chourdry, the doctor's PA documented a medical history that included "various foot issues (including plantar fasciitis, pronation deformity of foot – sees podiatry)." (Px6).

On 6/17/14, Petitioner saw podiatrist Dr. George, testifying this was the first treatment she sought after her return to work. She reported bilateral foot pain, left greater than right, in the plantar fascia and over the medial calcaneal tubercle: "States pain with the first few steps out of bed." Petitioner noted she had treated with Dr. Caneva for foot issues that had been going on for two years, including heel pain with multiple treatments (injections, orthotics, night splints, etc.), but was unhappy with the lack of improvement. X-rays revealed no acute findings. Pain was palpated over the left plantar medial tubercle of the Achilles, no significant pain on the right side. Given two years without improvement, Dr. George prescribed a left ankle MRI. The 6/18/14 radiologist's impression was: 1) medial band plantar fasciitis at its origin (differential diagnoses for this included high grade partial thickness and complete nonretracted tears of the medial band of origin with aponeurotic swelling), 2) Stieda process without Stieda process syndrome, 3) short segment longitudinal fraying juxtamalleolar peroneus brevis tendon. The report indicates there was moderate to severe plantar fasciitis at its origin evident with at least a partial thickness tear, possibly a full thickness tear, without retraction. At 6/24/14 follow up, Dr. George noted the partial plantar fascia tear along with peroneal tendon longitudinal tear, and some tibiotalar capsulitis with impingement. Dr. George noted that given the ongoing problem, arthroscopic surgery would be beneficial, including debridement, possible syndesmotic repair with peroneal tendon and 10 X fasciotomy of the left plantar fascia. (Px4). Left ankle surgery was performed by Dr. George on 7/9/14, involving arthroscopic debridement, peroneal tendon repair, syndesmotic repair using stainless steel tightrope and plantar fasciotomy with a Tenex. Post-surgical diagnoses included left ankle impingement with peroneal tendinopathy, syndesmotic insufficiency and recalcitrant plantar fasciitis. (Px5). A 7/14/14 note of Dr. George kept Petitioner off work. On 7/24/14, Petitioner reported she had tripped and fallen the night before, putting full weight on her left foot, but her pain remained well controlled. On 8/12/14, Dr. George noted Petitioner had progressed with therapy but had shooting pain at night and ongoing swelling. She was advised to discontinue

the use of crutches and advance out of the boot. She was to continue therapy and remain off work for approximately a month. (Px4).

Petitioner attended physical therapy from 7/29 to 8/22/14, which she testified involved range of motion exercises, massage, and electrotherapy. The initial evaluation noted complaints of pulling sensation in the inner left ankle. On 8/6/14, Petitioner reported she was still sore and tight, but was better overall. On 8/11/14, Petitioner had better range of motion and less overall pain but had ongoing swelling. On 8/12/14, it was noted that Dr. George was happy with her progress, and on 8/18/14 he indicated Petitioner was returning to her job the next day. On 8/22/14, she indicated she was feeling good but was frustrated by ongoing swelling, which the therapist indicated remained elevated. On 8/26/14, Petitioner noted she was having problems getting physical therapy authorized, reporting pain and intense swelling in the ankle, and that she was beginning to have right sided pain "following an ankle sprain at work 5/1/14. She is having increased swelling and bruising and pain at times, though no pain currently." Petitioner testified her right sided pain had "returned", as she had been putting more weight on the right leg. On 9/2/14, Petitioner reported she would be re-starting therapy on 9/3/14. (Px4).

On 9/16/14, Petitioner reported stubbing her 5th toe, and x-rays showed a minimally displaced 5th proximal phalanx fracture, so the 4th and 5th toes were taped together. On 9/25/14, Petitioner reported improvement even after discharge from therapy. She was using her old orthotics for her plantar heel pain and wanted to discuss a release to return to work, which Dr. George medically cleared her to do. (Px4).

Petitioner testified that when she returned to work following this release, she would have intermittent left ankle pain and swelling depending on her activities. She denied receiving TTD following her left ankle surgery. She testified that her right ankle pain never resolved, was worse with activity, and that over time she developed constant swelling.

Petitioner testified that on 9/27/14, a resident pushed a chair into a table, which hit her left foot. The 9/27/14 report from Presence St. Joseph's ER noted Petitioner's prior left foot surgery and that a resident at work hit the bottom of her left foot that day and hurt it. She was able to walk without pain but indicated she was sent for evaluation by Respondent due to the recent surgery. Exam was benign and x-ray showed no fracture or change in bone structure. Petitioner indicated she felt fine and was able to return to work. (Px5). The Arbitrator notes that the x-ray states the films showed evidence of a prior operative fusion of the distal talofibular joint, as well as scattered degenerative changes throughout the midfoot and forefoot and a small plantar calcaneal spur. (Px5).

On 11/10/14, Petitioner saw Dr. Chourdry and reported complaints of bilateral knee pain, right greater than left, and bilateral foot pain, noting she hadn't improved following left foot surgery: "Twisted Rt ankle in May (fell with foot underneath)." Petitioner was requesting a referral to orthopedics, noting she had treated with podiatrist Dr. Caneva in the past with orthotics, which she reported didn't fit well and which she believed was causing her knee pain. She reported the incident in May involved twisting her right ankle when she fell with her foot rolled inward underneath her. She reported off and on swelling of the lateral ankle and muscle spasms of the right foot. She noted she had undergone prior 2012 knee x-rays. No edema was noted in the feet or ankles on exam. She was referred back to Dr. George for her foot/ankle issues and to Dr. Pizinger for her knees. (Px6).

Petitioner returned to Dr. George on 11/13/14, reporting right ankle and foot pain similar to what she had on the left: "Pain to heel plantarly and lateral ankle." Dr. George prescribed right foot and ankle MRIs. The 12/11/14 right foot MRI reflected: 1) Moderate FHL tendon tenosynovitis proximal to the master knot of Henry, 2) a focal region of nonspecific mild subchondral bone marrow edema in the plantar aspect of the first metatarsal head, and 3) mild first and second intermetatarsal bursitis. The right ankle MRI from the same date noted a history of right ankle instability and history of injury. The impression was of 1) mild to moderate subcutaneous edema about the ankle, 2) mildly attenuated appearance of the anterior talofibular ligament compatible with

sequelae of a prior partial thickness tear, and 3) small ganglion cyst along the dorsal aspect of the talar head. (Px4).

Petitioner followed up with Dr. George on 12/12/14, at which time he stated: "This is an old injury that has gotten more symptomatic. She relates that this happened at work." Noting the MRI finding, he recommended arthroscopic right ankle surgery with debridement and Tenex procedure of the plantar fascia if she did not respond to conservative treatment, including a cortisone injection, which was performed at this visit. Petitioner testified this was performed for plantar fasciitis. Dr. George was not optimistic given the failure of the same injection previously on the left. (Px4).

On 1/4/15, Petitioner returned to the Presence St. Joseph ER, this time indicating she slipped while walking down a stairway, getting her foot caught in the railing, with pain across the top of her 2nd, 3rd and 4th toes. X-rays were unremarkable and she was advised to follow up with her podiatrist. (Px5).

On 1/13/15, Dr. George noted the right ankle problem and that "Two clients got in an altercation, the patient was trying to break up the fight when she fell down and was piled on by about 4 patients." Based on the failure to improve with the injection, Dr. George recommended surgery and issued work restrictions with ambulation as tolerated with breaks as needed. (Px4).

The next visit appears to have occurred on 6/2/15, with Petitioner telling Dr. George her claim for the right ankle/foot was being denied by Respondent and that, while she hired an attorney, she wanted to undergo the surgery through her group health coverage. Dr. George stated: "Her right ankle has gotten worse in addition to her previous issues with her pain at the ATFL ligament and the plantar fascia which is essentially unchanged from her prior visit." He noted she also had a peroneal subluxation which would also need to be addressed with the surgery. (Px4). Dr. George performed surgery on 6/8/15, involving arthroscopic debridement, peroneal stabilization and ATFL ligament repair. The diagnosis was right lateral ankle instability with ATFL instability and insufficiency, peroneal subluxation and anterior ankle lateral impingement. (Px4; Px5).

Petitioner testified that the Respondent had been unable to accommodate her work restrictions and terminated her on 6/12/15, receiving a letter on that date from HR stating that her FMLA time had expired.

At a 6/12/15 follow up, Petitioner complained of right ankle pain and tightness from swelling. She was prescribed a CAM boot and crutches and advised to stay non-weightbearing for 10 days. On 6/22/15, Petitioner reported minimal (1/10) pain and swelling was noted to be within normal limits. (Px4).

Petitioner had an initial physical therapy evaluation at ATI on 7/2/15 On 7/13/15, Petitioner reported great improvement in her symptoms. She had persistent swelling, but stiffness was improving with therapy. An 8/10/15 report from notes improvements in strength and range of motion but ongoing difficulty with SLS activities and that she remained at the sedentary level. (Px7). On 8/11/15, Petitioner told Dr. George she was doing very well with very intermittent episodes of soreness. (Px4). The Arbitrator notes that these records of Dr. George do not reflect statements regarding work status.

On 8/24/15, Dr. George indicated Petitioner was there for her *left* foot with forefoot pain to the 3rd interspace of the ball of the foot, noted to be a neuroma. An injection was performed with relief. She last saw Dr. George on 9/10/15, and she reported no complaints as to the right ankle, while the injection provided only 4 days of relief for the neuroma. It was noted that a return to work note was issued, but the Arbitrator could not locate such note in the evidentiary record. (Px4). Petitioner indicated she was returned to full work duties at this time.

On 9/16/15, Petitioner told her therapist she was doing great without any significant pain. The last therapy note from ATI, dated 9/17/15, indicated Petitioner had difficulty with prolonged standing, but otherwise had met all goals and was capable of medium duty work, which is what her regular job was rated at, and she was discharged. (Px4; Px7).

Records which predate the Petitioners alleged 4/30/14 accident from podiatrist Dr. Caneva were presented into evidence by the Respondent. An initial visit, based on an 8/7/12 referral from Dr. Chaurdry for bilateral foot pain, occurred on 8/20/12. Petitioner presented with worsening sharp bilateral heel pain she rated as 3 out of 10 (3/10) that was impacting ambulation and prolonged standing. Gel soles and athletic shoes had provided no relief. Petitioner was noted to be morbidly obese. Diagnoses included foot pain, plantar fasciitis and, based on x-ray, subtalar joint pronation. Stretching, ice, rest, elevation, over-the-counter analgesics and orthotics were prescribed. Petitioner followed up on 8/31/12 to pick up her custom orthotics. On 9/17/12, Petitioner reported moderate relief with the recommended treatment and orthotics. While steroid injections were discussed if Petitioner's pain persisted, she called in on 9/28/12 to report her orthotics were working fine and that she needed no further follow up. Petitioner next returned to Dr. Caneva on 11/22/13, again reporting 3/10 level bilateral heel pain that had been present for a year. She requested replacement orthotics, with Dr. Caneva reporting: "Pointing toes causing shin splints. Heel pain bilateral with cramping." X-rays showed subtalar joint pronation and pes valgoplanus bilaterally. Diagnoses remained the same but now included posterior tibial tendonitis and shin splints. The same treatment recommendations were made, this time along with elastic ankle wraps. While it was not specified in his report, Dr. Caneva ordered bilateral ultrasound testing as well, which was performed on 12/5/13. The radiologist's impression bilaterally was: 1) plantar fasciitis medial band origin, 2) mild peroneus brevis tendinopathy posterior to the lateral malleolus, and 3) mild posterior tibialis insertional tendinitis. At the 12/10/13 follow up with Dr. Caneva, Petitioner reported the same pain in her left foot with improvement on the right, noting she had discontinued use of the ankle wraps and was alternating use of her old orthotics and arch supports. She was again advised to use the ankle wraps and to continue the other treatments, and the left heel was injected with Depo-Medrol. (Rx3).

The next and last noted visit with Dr. Caneva was on 4/10/14. Petitioner reported increasing left heel pain and requested another injection. She noted she had a CAM walker at home, which apparently had been provided to her previously, and Dr. Caneva advised her to continue to use this device. He also performed another left heel steroid injection. (Rx3).

The Petitioner was examined by orthopedic surgeon Dr. Holmes of Midwest Orthopaedics at Rush at the request of the Respondent (see Section 12 of the Act) on 2/27/19. Petitioner related a 4/30/14 history of falling to the ground and bracing herself during a fight between two residents. She reported a previous history of bilateral heel pain "for which she was treated until the exact same month as her injury", April 2014. The doctor reviewed Petitioner's prior medical records, including those of Dr. Caneva and the operative reports. He noted Petitioner presented to him with some complains of stiffness and occasional swelling in both ankles, that she used no assistive devices for ambulation, took no medications and had returned to work. Examination appeared to be benign. Dr. Holmes diagnosed left-sided plantar fasciitis "and other conditions of the foot or ankle", and right sided plantar fasciitis, which were not causally related to the 4/30/14 accident. Dr. Holmes did not believe the conditions were caused or aggravated by the work incident given she had a long history of plantar fasciitis treatment up to and including 4/12/14, just weeks prior to the incident. He further opined that the surgical procedures performed by Dr. George were not related to the 4/30/14 incident. He believed Petitioner required no further treatment or work restrictions and had an excellent prognosis. (Rx1).

Dr. George testified via deposition on 6/5/19. A podiatric surgeon, he testified the bulk of his practice was sports medicine with surgery of the foot and ankle. Petitioner initially treated with him on 6/17/14 for the left foot and ankle, after which she was released and then later returned regarding her right foot and ankle. He had

no knowledge of the mechanism of Petitioner's 4/30/14 injury other than what was in his 10/12/14 report. Dr. George's left extremity diagnosis was recalcitrant plantar fasciitis, syndesmotic insufficiency and left ankle impingement with peroneal tendinopathy. On the right, he diagnosed lateral ankle instability with ATFL tear, ligament instability and insufficiency, peroneal tenson subluxation and anterolateral impingement. Asked about his causation opinions, Dr. George testified: "In my opinion, based on the type of injury that the patient stated that she sustained, these type of injuries to the ankle that causes a disruption of the ligament and a band of tissue called the retinaculum which also holds the peroneal tendons in place, and when that retinaculum is disrupted, it can cause instability of the ankle, but it can also cause, over time, fraying of the tendon due to the fact that the retinaculum was also damaged or injured." Dr. George also opined that the ankle injuries bilaterally could be related to "the mechanical fall" she had. He testified that plantar fasciitis is typically not a result of an acute injury but rather from a chronic issue or injury, though there was a possibility it could have been exacerbated. He testified that if Petitioner had undergone immobilization treatment prior to seeing him, it could have caused Achilles tightening, which can increase plantar fasciitis symptoms. Despite this testimony, he indicated that he was unable to opine one way or the other as to whether the 4/30/14 incident aggravated the plantar fasciitis condition. (Px9).

Dr. George opined that the surgical procedures involving left ankle debridement, peroneal tendon repair and syndesmotic insufficiency were all causally related to the 4/30/14 incident. He further opined that the right ankle arthroscopy, peroneal stabilization and ATFL ligament repair were also related to this incident. As to the causal connection bilaterally, he testified these pathologies were usually seen with a twisting injury to the ankle. Dr George's understanding was that Petitioner had undergone conservative measures, including immobilization, injections, orthotics and splinting, with no improvement prior to her seeing him. As to the left sided treatment, he discharged Petitioner on 9/9/14, and believed the treatment had been successful. She returned on 11/13/14 with right-sided complaints, approximately 7 months post-accident, and Dr. George stated his understanding is that she had undergone right sided treatment subsequent to the accident date. As to the right sided MRI findings, Dr. George opined that the ATFL ligament and the 1st metatarsal head edema conditions could have been attributed to the 4/30/14 mechanism of injury. The metatarsal head edema basically involves a deep bone bruise. On the right, post-surgery, Petitioner underwent therapy and continued to improve. On 8/24/15, she had pain in the 3rd interspace of the left foot, which he diagnosed as a neuroma and injected, and which he opined is unrelated to the work accident: "This is something that is normally related to irritation of the nerve between the two metatarsal bones." Dr. George testified that that any left foot treatment after September 2014 was unrelated to the 4/30/14 incident. He released Petitioner back to work as to the right ankle on 9/10/15. While therapy continued after that, he testified the Petitioner never followed up with him again, so he had no knowledge or opinions regarding her post-September 2015 condition or need for work restrictions, or future treatment. (Px9).

Asked what dates he had Petitioner off work due to the 4/30/14 injury, Dr. George testified: "I don't have the exact dates, especially since there were two surgical interventions, but I believe I had her return to work after her left ankle surgery on 9/25/14, and I had her off work once again from her second surgical intervention, which was 6/8/15, until 9/10/15." Dr. George acknowledged Petitioner "may have mentioned" prior treatment for bilateral plantar fasciitis when he first saw her but he never reviewed any of her prior medical records, testifying it would not have any effect on his causal connection opinions anyway. In support of this, he indicated that while plantar fasciitis was more of a chronic issue, the ankle injuries were more typically seen with mechanical falls and twisting type injuries. He had not reviewed any records indicating Petitioner had any ankle ligament injuries bilaterally prior to 4/30/14. The pathologies he diagnosed in the ankles are typically acute or subacute but can be chronic. (Px9).

On cross examination, Dr. George testified that the intake form his patients generally complete, including a description of an injury, was not part of Petitioner's medical records from his facility. He agreed that his initial 6/17/14 report mention nothing about a work accident, and that Petitioner reported to him that she stopped

treating with Dr. Caneva because she was unhappy with his treatment. He did not have knowledge of the bilateral ultrasound testing in 2013 that resulted in findings of bilateral plantar fasciitis over the medial band, mild peroneus brevis tendinopathy posteriorly to the lateral malleolus or mild posterior tibial insertional tendinitis. He agreed the Petitioner is obese and that obesity can aggravate plantar fasciitis, "and that's the reason why it would be more symptomatic or not improving." He agreed that the first time Petitioner mentioned right foot pain was 8/26/14, which she then related to a right ankle sprain on or approximately 5/1/14. He could not recall any further details regarding that injury: "I don't recall her mentioning exactly how it occurred." On 12/12/14, Petitioner did state that her right ankle injury was related to falling at work, but she did not provide any details on how exactly she fell or how she landed. When he initially saw the Petitioner, "she stated that the left caused more discomfort than the right, but she did not have any specific complaints on the right side initially." Initially, he did not treat her right ankle/foot. He testified that a bone bruise can take up to eight months to heal. On redirect, Dr. George agreed that the initial diagnosis of a bimalleolar right ankle sprain is consistent with his later diagnosis of a ligament tear, and that this could not be confirmed until an MRI was reviewed. None of the questions he was asked on cross changed any of his stated opinions. (Px9).

Dr. Holmes also testified via deposition (on 10/21/19). An orthopedic surgeon who specializes in the foot and ankle. Dr. Holmes indicated Petitioner reported her injury was falling to the ground and bracing herself. Examination on 2/27/19 was essentially normal with stable ankles and symmetrical measurements. Dr. Holmes diagnosed Petitioner as status left foot plantar fasciitis, based on her longstanding history of treatment for this condition from 2012 to 2014, supported by her medical records, and the 6/18/14 MRI. He testified this evidence also supported his opinion that the condition was unrelated to her work injury, noting there had not been any resolution of this condition prior to the injury. He further opined that she needed no additional treatment to the left foot or work restrictions, noting he saw no evidence of treatment since 2015. As to the right foot, Dr. Holmes diagnosed plantar fasciitis, again unrelated to the 4/30/14 work injury for the same reasons he opined as to the left side. He did not believe she needed any further treatment or any work restrictions related to the right extremity. Dr. Holmes testified he did not find any specific ongoing ankle pathology on exam bilaterally. As to the MRI findings and surgeries performed by Dr. George, Dr. Holmes opined that Petitioner's ankle conditions predated 4/30/14: "Specifically, she was diagnosed early on with issues of peroneus brevis tendinopathy, mild posterior tibial tendonitis bilaterally in 2013, and ultimately underwent some – something that addressed that from podiatrist, Joe George, but those were not related to the injury and did not appear to be active problems when I saw her on 2/27/19." (Rx2).

On cross, Dr. Holmes was questioned as to whether Petitioner's pre-4/30/14 complaints included ankle symptoms, and he testified "I'm not sure that's completely correct" that there were no ankle complaints. He referenced a 12/5/13 report where Dr. Caneva diagnosed bilateral peroneal brevis tendinopathy and posterior tibial insertional tendinitis and testified that these two structures are adjacent to and around the ankle. He could not reference any other reports which would support his determination that Petitioner's bilateral ankle conditions were unrelated to the 4/30/14 accident. As to there being no pre-accident evidence of a right ankle tendon tear, Dr. Holmes testified this was not correct, as the term peroneus brevis tendinopathy is sometimes used interchangeably with a tendon tear issue. He agreed there was no pre-accident MRI showing such a tear, there was no pre-accident documentation of an ATFL injury, and no pre-accident surgical recommendations. (Rx2).

As to his testimony that Petitioner's plantar fasciitis was unrelated to the accident, Dr. Holmes agreed that "theoretically" this condition can be aggravated by trauma and made more symptomatic. He agreed, again theoretically, an injury involving falling on the right foot and ankle and twisting it could be the type of trauma to aggravate plantar fasciitis. He agreed plantar fasciitis manifests as foot and heel pain while peroneal tendinitis manifests as ankle pain. He agreed, again theoretically, that an injury as described could make a pre-existing tendon injury symptomatic or more symptomatic, but still opined that this was not what occurred in this

case. Dr. Holmes disagreed that the lack of a pre-accident diagnosis or treatment for an ATFL tear, and right ankle injury complaints immediately after the injury, supported a causal connection, testifying that Dr. George initially diagnosed plantar fasciitis and did not mention ankle pain or an ATFL tear. He testified that Dr. George's 6/17/14 report did not mention any ankle injury, his exam demonstrated pain to the plantar fascia, and his MRI prescription had nothing to do with ankle symptoms. It was only after that scan that Dr. George mentioned ankle surgery, along with plantar fasciitis surgery. Dr. Holmes testified: "So it is my opinion, given the patient's height and weight and morbid obesity, and my research and knowledge of patients with tendinopathy and tendon tears, that that was the finding of the MRI that was unrelated to the injury." He referenced studies in which people with no traumatic ankle injuries or problems underwent MRIs and 35-40% of these seemingly normal people had pathologies such as ATFL tear, peroneus brevis tear/tendinopathy, loose bodies, OCDs. He further testified: "That research is directed for physicians to examine the patient, and not simply operating, go after findings that are abnormal on MRI scan." Dr. Holmes agreed he had not reviewed any MedWorks records - when asked about an initial post-accident MedWorks report diagnosing a right bimalleolar sprain and on 5/6/14 a right ankle sprain, he testified this information would not change his opinions. He disagreed with both surgeries performed by Dr. George as well as the timing – he testified: "From my standpoint and training, the patient sustained an injury on 4/30/14; and I did not see a sufficient course of conservative treatment prior to her surgery that was performed on 7/9/14, and surgery had been recommended as early as 6/24/14, which was only, approximately, two months after the date of injury. So for someone who theoretically had the issues that were being ascribed to the injury of 4/30/14, from my training/experience, to do the amount of surgery that was done, that quickly thereafter, was not appropriate from my standpoint, from that of an orthopedic foot and ankle surgeon." (Rx2).

On redirect examination, Dr. Holmes testified he had no knowledge of any pre-accident MRI testing. He testified that, "first and foremost, almost everyone who has an ankle sprain has an ATFL ligament tear." Thus, such a tear, per MRI, must be weighed with its clinical significance, including there being some instability, prior to considering surgery, and he did not see any documentation of such findings in Dr. George's records. Dr. Holmes testified that the 6/18/14 MRI also showed no evidence of the acute collateral damage that would be anticipated if the problem was the result of an injury, including effusion, hematoma or soft tissue edema. Given no such acute MRI findings, Dr. Holmes testified that even if Petitioner had sustained an ankle sprain in the accident with resulting findings in the peroneal tendons, the treatment performed was inappropriate given such patients generally undergo 3 to 6 months of conservative treatment, after which 50% of them do not require surgery. An ankle sprain, in and of itself, does not indicate instability in the ankle. It was Dr. Holmes' opinion that Petitioner did not have an acute peroneal tendon tear, but rather a chronic tear, and if she had previously undergone 3 to 6 months of physical therapy, surgery would have been reasonable. If it had been acute, as indicated by Dr. George, she should have then undergone that 3 to 6 months of therapy. (Rx2).

At the time of the hearing, the Petitioner complained of ongoing bilateral pain and swelling, but agreed she was improved following the surgeries and that any ongoing pain did not prevent her from working. Stiffness, swelling and discomfort, more so than pain, comes and goes with activity. Petitioner testified that she continues to have daily swelling in the right ankle with scarring at the surgical site and within the ankle. If she tries to stand on her toes to reach up, her feet want to collapse back down. Stairs, prolonged standing and walking are problematic for her. She testified that if she tries to kneel, the bending of the foot causes cramping behind the ankle and in the calf. She can get cramping at night. She testified she has basically the same symptoms on the left side, with more intense swelling. Petitioner reiterated that she did not have any of these problems prior to the alleged accident date and that she had never had a similar surgery previously recommended, including by Dr. Caneva. Following her 6/12/15 termination, Petitioner has worked as a receptionist for Heartland, and has performed programming and calibrating breathalyzers for Lifesafer Interlock. She testified that both were sedentary jobs. At the time of trial, Petitioner had been working for Amita Health as a front desk receptionist since 12/1/20. She has no future treatment scheduled for ankle/foot treatment. Petitioner testified she was off

work from 4/30/14 to 5/10/14, again from 7/9/14 to 9/25/14 following her first surgery, and from 6/8/15 to 9/10/15 following the second surgery. Petitioner did not recall Dr. Caneva diagnosing peroneal brevis tendinopathy and posterior tibial tendinitis on 9/5/13 and did not know why such diagnoses would be indicated in his records. She testified she believed the medical bills contained in Px8, totaling $122,616.43 total, are true and accurate.

On cross examination, Petitioner agreed she was never diagnosed with any diseases following the human bites she sustained on 7/12/13. As to the 4/30/14 incident, she agreed she was released without restrictions by MedWorks on 5/9/14. As to her 6/17/14 report of two years of foot pain, Petitioner testified this was a different type of pain than what she had following the alleged work injury. She initially started treating with Dr. Caneva for plantar fasciitis in August 2012 and had been provided with orthotics, which she wasn't wearing on 4/30/14. Petitioner agreed a pronation deformity had been diagnosed, but she denied being prescribed ankle wraps: "I had a sock." She was not wearing this on 4/30/14. She acknowledged seeing Dr. Caneva on 4/24/14 just prior to the 4/30/14 incident. She did complain of increased right ankle pain on 11/14/14, the same type of pain she had on the left side. Petitioner does not currently take any pain medications. To her recall, she was hired by Heartland shortly after Dr. George released her, and she had filed for unemployment following her termination by the Respondent. Petitioner agreed she was not working at the time she reported increased right ankle pain on 8/26/14.

The Arbitrator notes that the Petitioner also submitted photographs of her ankle that were taken no later than 2015, and as such are not of any relevance in this case. (Px12).

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 sustained accidental injury which arose out of and in the course of her employment with Respondent on 4/30/14.

Petitioner's job involved supervision of developmentally disabled children. While doing so on 4/30/14, she had to separate two residents who were physically quarreling over a blanket, and ended up being knocked down, where they fell on top of her. Her testimony in this regard was unrebutted and is supported by the contemporaneous medical records. The incident clearly occurred in the course of her employment, as she was performing her regular work duties. In doing so, it is also clear that her injuries arose out of the employment, as the risk of such injury and her exposure to same was a work-related risk, given that her duties specifically involved supervision of the resident children. Petitioner also testified that outbursts such as what occurred on 4/30/14 were not unusual in her job.

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 issue of causation in this case is of key importance and is a very difficult question. Prior to the 4/30/14 accident, the Petitioner clearly was having problems with the bilateral feet. She was diagnosed in 2012 and 2013 with bilateral plantar fasciitis. In fact, she visited Dr. Caneva with ongoing bilateral foot problems, left greater than right, on 4/10/14, just 20 days prior to the 4/30/14 accident date. She had treated from August 2012 through September 2012, indicating bilateral foot pain that she indicated resolved with new orthotics. However, when she returned in November 2013, Petitioner reported bilateral heel pain that had been present for a year.

The left heel was injected on 12/10/13. She didn't return to Dr. Caneva again until 4/10/14, but at that time reported increasing left heel pain and requested another injection, which was performed, and Dr. Caneva advised to her to wear a CAM walker. Additionally, an ultrasound was obtained of both distal lower extremities in December 2013 and reflected findings of plantar fasciitis, mild peroneus brevis tendinopathy and mild posterior tibialis insertional tendinitis.

In terms of the 4/30/14 accident itself, the Petitioner testified that her right foot became twisted underneath her when she fell, and the residents fell on top of her. She also testified that her left foot was jammed into a desk area. The Respondent's accident report (Px1) notes only an injury to the right foot. The history contained in the initial 5/1/14 MedWorks report was of her right foot turned underneath her body while the clients fell on top of her, injuring her right ankle. She also apparently reported significant pain and swelling along both ankles and denied any prior injuries to these body parts. Swelling and erythema was noted at the right ankle on exam, a right ankle x-ray was obtained, and Petitioner was diagnosed with right bimalleolar right ankle sprain. There was no indication of left ankle exam, testing or diagnosis that the Arbitrator noted. By 5/9/14, MedWorks reported Petitioner was essentially pain free and released her from care, while Petitioner testified she was on crutches and non-weightbearing at that time, and her pain would come and go depending on weightbearing, activity and use of pain medication. She then returned to work. The Arbitrator notes it is difficult to believe that the Petitioner remained on crutches and non-weightbearing at the same time she was being released to full duty work, and that she returned to full duty work on 5/10/14 if she remained on crutches and non-weightbearing. This does not impact the Petitioner's credibility in the Arbitrator's view as much as it impacts her memory, given that this occurred 7 years prior to her testimony.

Petitioner did seek further treatment after 5/9/14, seeing podiatrist Dr. Shanholtzer on 5/15/14. His report references ankle pain, cramps in the feet and legs, heel pain, swelling and tired feet, along with complaints of bilateral leg and foot pain and plantar fasciitis, left greater than right. However, interestingly, the report references two years of problems "with this and also with her right foot", noting she had treated with Dr. Caneva with injections and orthotics with no relief beyond temporary. While Petitioner noted she was on her feet all the time at work, whether ambulating or standing, nothing whatsoever was indicated with regard to the 4/30/14 accident or injuring the feet or ankles on that date. One concern about swelling in the legs appeared to be water retention, as she was referred to her family doctor to consider a diuretic. Dr. Shanholtzer did refer Petitioner to Dr. George after diagnosing Petitioner with plantar fasciitis aggravated by swelling in the lower legs and feet.

Dr. George's initial report indicates complaints of bilateral foot pain, left greater than right, in the plantar fascia and over the medial calcaneal tubercle, and that she had been treating with Dr. Caneva for foot problems for two years, including injections, orthotics and night splints, and was unhappy with a lack of improvement with Caneva. X-rays were noted to show no acute findings, and pain was palpated over the left plantar medial tubercle of the Achilles, which was not present on the right, which appears to have been the foot that was twisted beneath Petitioner when the residents fell on her on 4/30/14. As Dr. Holmes indicated in his testimony, it did not appear that there was any specific reference to Petitioner's ankle until after the 6/18/14 left ankle MRI, which indicated, in addition to plantar fasciitis, "Steida process without Stieda process syndrome", which was never explained to the Arbitrator by Dr. George, and short segment longitudinal fraying juxtamalleolar peroneus brevis tendon. Dr. George's review of the MRI also noted some tibiotalar capsulitis with impingement.

Dr. George acknowledged in his testimony that his original treatment of the Petitioner did not involve the right foot or ankle, and his records do not even reference the work accident until 12/12/14. On 11/10/14, she had seen her primary care provider, Dr. Chourdry, reporting complaints of bilateral knee pain, right greater than left, and bilateral foot pain, with no improvement following the left-sided surgery. At this time the doctor noted a statement from Petitioner: "Twisted Rt ankle in May (fell with foot underneath)." Petitioner wanted a referral to

orthopedics, as the orthotics she had received previously from Dr. Caneva didn't fit well, and she felt they were causing the knee pain. No edema was noted in the feet or ankles on exam, and she was referred back to Dr. George for her foot/ankle issues. The doctor's testimony acknowledged that he was not addressing the right lower extremity until November 2014, which is approximately 7 months post-accident.

While Dr. Holmes' testimony also left something to be desired in terms of completeness, given that he agreed he had not reviewed the initial MedWorks records referencing a right ankle sprain, his explanation of Petitioner's condition was more persuasive to the Arbitrator than that of Dr. George. First, Dr. Holmes references the fact that the training of a podiatrist is not the same as that of a medical doctor of orthopedic surgery. Secondly, Dr. Holmes explained that the findings in the ultrasound included findings related to the ankles, and that tendonitis/tendinopathy are terms that often are used interchangeably with partial tears in the ankle ligaments.

Often in circumstances like this where there is a preexisting condition that is alleged to be aggravated, the Arbitrator will look to whether the accident date in question represented a change in the claimant's condition in some fashion, which would reflect a chain of events-type finding of compensability. Here, the Arbitrator finds it difficult to find a true line of demarcation between the preexisting condition and Petitioner's ongoing condition after 4/30/14. This is particularly the case when she had last treated for her feet just a few weeks prior to the alleged accident date. The subsequent medical records paint a picture of a temporary aggravation that had essentially resolved as of the 5/9/14 visit with MedWorks, as the initial reports of Petitioner's subsequent treatment with Dr. Shanholtzer and Dr. George do not even reference the work accident, but rather reference the problems Petitioner had been having on an ongoing basis prior to 4/30/14. Additionally, Dr. George's testimony did not sufficiently explain how the ultrasound findings in December 2012 regarding how preexisting peroneus brevis tendinopathy and mild posterior tibialis insertional tendinitis may have impacted any causal relationship of the ankle conditions to the 4/30/14 accident. The December 2013 ultrasound testing identified tendinitis problems with both the peroneus brevis posterior to the lateral malleolus and posterior tibialis insertion. Further, the records of Dr. Caneva also reference subtalar joint pronation and pes valgoplanus bilaterally, the latter of which the Arbitrator understands from experience to reference "flat" feet. This certainly appears to reference problems for the Petitioner beyond just plantar fasciitis. Dr. George opined that the surgical procedures involving left ankle debridement, peroneal tendon repair and syndesmotic insufficiency were all causally related to the 4/30/14 incident. He further opined that the right ankle arthroscopy, peroneal stabilization and ATFL ligament repair were also related to this incident. However, the preexisting ultrasound findings were just not sufficiently explained by Dr. George, in the Arbitrator's view, in terms of how they interrelate with his causation opinions.

The Arbitrator also cannot ignore that the Petitioner was morbidly obese during this time period, which both Dr. George and Dr. Holmes indicate impacts the conditions of her feet. While the Respondent takes the Petitioner as it finds her, there clearly was a preexisting condition here in the Petitioner's feet before the accident occurred, and it appears that there also were ankle findings in 2013 as well. Dr. Holmes testified that even if the post-4/30/14 conditions were related to that accident, the proper treatment would have been three to six months of conservative treatment before consideration of surgery. Thus, it would appear that if this timeline is correct, Dr. George was considering Petitioner's pre-4/30/14 treatment as part of the treatment for the allegedly work-related condition, which makes no sense unless the condition was preexisting.

While Petitioner's counsel references the fact that Dr. Holmes did not review the initial MedWorks records referencing a right ankle sprain diagnosis, it is accurate to state that Dr. George also did not review the pre-accident records of Dr. Caneva. While these are deficiencies in the testimony of both doctors, the burden of proof in this case is on the Petitioner to prove her case by the preponderance of the evidence. The burden is not on the Respondent to disprove a causal connection.

Overall, it is certainly possible that the accident of 4/30/14 caused or aggravated some of the conditions in the Petitioner's distal lower extremities. However, it is difficult for the Arbitrator to say that the Petitioner was able to prove this by the preponderance of the evidence, as required, based on the evidence referenced by the Arbitrator above, and thus the Arbitrator cannot find that such a finding is probable based on the preponderance of the evidence. The Arbitrator also notes that while the more significant injury would appear to have been to the right foot/ankle, given that is the extremity the Petitioner fell onto along with the residents, the initial treatment was all directed to the left side following the release from MedWorks. As such, the Arbitrator finds that the treatment to the left lower extremity, as well as the treatment of the right lower extremity after 5/9/14, was unrelated to the 4/30/14 accident. The treatment to the right foot and ankle from 4/30/14 through 5/9/14 was causally related to the accident.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator awards all medical expenses contained in Px8 that are related to the 4/30/14 injury which were incurred through the 5/9/14 release from MedWorks. Respondent is entitled to credit for any awarded medical expenses that were paid prior to the hearing date, so long as Respondent holds Petitioner harmless with regard to same.

All other medical expenses contained in Px8, other than those awarded in the 15 WC 06858 claim and awarded in this case, are denied.

Respondent is not entitled to take any medical expense credit under Section 8(j) against any other workers' compensation benefits that may be owed, including any TTD and/or permanency.

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:

Petitioner was held off work from 5/1/14 through 5/9/14, and she testified she returned to work on 5/10/14. According to Section 8(b) of the Act, a claimant can only recover the initial three days of lost time benefits if they are off work for at least 14 days. Here, the Petitioner was off work for less than 14 days, and thus she is not entitled to the initial three days of lost time on a statutory basis. The Petitioner is entitled to TTD from 5/4/14 through 5/9/14, a total of 6/7 weeks.

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 has presented an AMA permanent partial impairment rating or report into evidence. Therefore, this factor carries 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 Direct Service Professional at a children's group home in Minooka, Illinois for the developmentally disabled at the time of the accident. She returned to that same job on 5/10/14. This factor carries some medium weight in the permanency determination.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 33 years old at the time of the accident. Neither party has submitted evidence in support of the impact of the Petitioner's age on any permanent disability condition that may exist related to the 4/30/14 accident. This factor carries no significant weight in the permanency determination.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that the Petitioner returned to her regular job following her 5/9/14 release. While she did undergo further treatment, including bilateral distal lower extremity surgeries, the Arbitrator has determined that these surgeries were unrelated to the 4/30/14 accident. The Arbitrator also notes that the Petitioner ultimately was released to return to full duty work. This factor carries moderate weight in the permanency determination.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner appears to have sustained bilateral strains of the right foot/ankle and left foot/ankle. The greater weight of the evidence supports the further finding that these conditions resolved as of 5/9/14. The greater weight of the subsequent treatment records state that the Petitioner's ongoing problems relate back to preexisting conditions bilaterally. This factor carries the most significant 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 the loss of use of 5% of the right foot pursuant to §8(e) of the Act.

WITH RESPECT TO ISSUE (N), IS THE RESPONDENT DUE ANY CREDIT, THE ARBITRATOR FINDS AS FOLLOWS:

As noted above, the parties have stipulated to the Respondent's entitlement to a $280.00 credit for TTD previously paid prior to the hearing.

As to the medical expenses, the Arbitrator notes that the Respondent's stipulated 8(j) credit may not be applied to anything other than specifically awarded medical expenses in this case, i.e. it may not be applied in any way against TTD and/or permanency.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC006858
Case Name	SMITH, AUDREY v. CORNERSTONE SERVICES
Consolidated Cases	15WC006862
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0216
Number of Pages of Decision	22
Decision Issued By	Kathryn Doerries, Commissioner

Petitioner Attorney	Kenneth Lubinski
Respondent Attorney	William Dewyer

DATE FILED: 6/10/2022

/s/Kathryn Doerries, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

AUDREY SMITH,

Petitioner,

vs. NO: 15 WC 006858

CORNERSTONE SERVICES,

Respondent.

DECISION AND OPINION ON REVIEW

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

Petitioner filed two Applications for Adjustment of Claim (AAC) on March 3, 2015. One AAC was filed on behalf of the Petitioner, alleging a date of accident on April 30, 2014, and injury to Petitioner's right foot and was assigned case number 15 WC 006858. On the same date, a second AAC was filed on behalf of the Petitioner, alleging a date of accident on July 12, 2013, and a disfigurement injury to the left and right arms from a human bite and was assigned case number 15 WC 006862.

The Decision that the Arbitrator designated for case number 15 WC 006858, for date of accident April 30, 2014, and for Petitioner's alleged right foot injury, was published under case number, 15 WC 006862 and conversely, the Decision that the Arbitrator designated for case number 15 WC 006862 for date of accident on July 12, 2013, was published under case number 15 WC 006858.

The Commission modifies the Arbitrator's Corrected Decision solely to correct this case number scrivener's error and to set the record straight going forward. The Commission modifies the Arbitrator's Corrected Decision regarding the date of accident of April 30, 2014, for injury to Petitioner's right foot, by changing the case number on this Decision, so that the Review Decision corresponds to the date of accident assigned on the Application for Adjustment of Claim. Any references to the date of filing of the Arbitrator's Decision will be referring to the Decision that is written for the accident date and body part that corresponds to the AAC, not the case number.

The Commission has now restored the two case numbers, so that the Commission Decision on review of the Arbitrator's Decision reflects the AAC's respective dates of accident and case numbers.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Corrected Decision filed on August 5, 2021, for the date of accident on April 30, 2014, is hereby modified for the reasons stated herein, changing the case number for this Decision to 15 WC 006858, and the Decision is otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner sustained accidental injuries which arose out of and in the course of her employment with Respondent on April 30, 2014. The Petitioner's right foot/ankle condition from April 30, 2014, through May 9, 2014, was causally related to the April 30, 2014, accident. The Petitioner's bilateral foot and ankle conditions after May 9, 2014, are not causally related to the April 30, 2014, accident.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $280.00 per week for a period of 6/7 weeks, commencing May 4, 2014, through May 9, 2014, that being the period of temporary total incapacity for work under §8(b) of the Act. Pursuant to §8(b) of the Act, the first three days of temporary total disability benefits are not payable given that the Petitioner was off work for less than 14 days. Respondent shall be given credit of $280.00 for temporary total disability benefits that have been paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $252.00 per week for a period of 8.35 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of use of 5% of the right foot.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay reasonable and necessary medical expenses incurred between April 30, 2014, and May 9, 2014, which are included in Petitioner's Exhibit 8, as provided in §8(a) and §8.2 of the Act. Respondent is entitled to credit for any awarded medical expenses that were paid by Respondent prior to the hearing date, 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 §8(j) of the Act.

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

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.

June 10, 2022

KAD/bsd
O041922
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/s/*Kathryn A. Doerries*
Kathryn A. Doerries

/s/*Thomas J. Tyrrell*
Thomas J. Tyrrell

/s/*Maria E. Portela*
Maria E. Portela

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC006862
Case Name	SMITH, AUDREY v. CORNERSTONE SERVICE
Consolidated Cases	
Proceeding Type	
Decision Type	Corrected Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	18
Decision Issued By	Paul Cellini, Arbitrator

Petitioner Attorney	Kenneth Lubinski
Respondent Attorney	Kelly Kamstra

DATE FILED: 8/5/2021

THE INTEREST RATE FOR THE WEEK OF AUGUST 3, 2021 0.05%

/s/ Paul Cellini, Arbitrator

Signature

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION

AUDREY SMITH
Employee/Petitioner
v.
CORNERSTONE SERVICES
Employer/Respondent

Case # **15** WC **06862**

An *Application for Adjustment 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 **May 12, 2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

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

In the year preceding the injury, Petitioner earned $**21,840.00**; the average weekly wage was $**420.00**.

On the date of accident, Petitioner was **33** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**280.00** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**280.00**.

Respondent is entitled to a credit of $**4,943.04** under Section 8(j) of the Act.

ORDER

The Arbitrator finds that the Petitioner sustained accidental injuries which arose out of and in the course of her employment with Respondent on April 30, 2014.

The Arbitrator finds that the Petitioner's right foot/ankle condition from April 30, 2014 through May 9, 2014 was causally related to the April 30, 2014 accident. The Arbitrator further finds that the Petitioner's bilateral foot and ankle conditions after May 9, 2014 were not causally related to the April 30, 2014 accident.

Respondent shall pay Petitioner temporary total disability benefits of $280.00 per week for 6/7 weeks, commencing May 4, 2014 through May 9, 2014, as provided in Section 8(b) of the Act. Pursuant to Section 8(b) of the Act, the first three days of temporary total disability benefits are not payable given that the Petitioner was off work for less than 14 days.

Respondent shall be given a credit of $280.00 for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical expenses incurred between April 30, 2014 and May 9, 2014 which are included in Petitioner's Exhibit 8, as provided in Sections 8(a) and 8.2 of the Act.

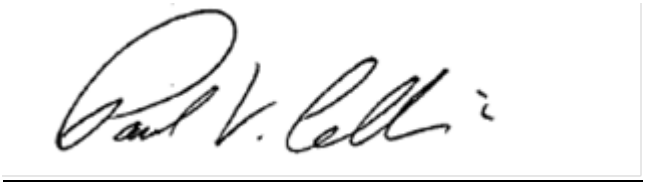
Respondent is entitled to credit for any awarded medical expenses that were paid by Respondent prior to the hearing date, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $252.00 per week for 8.35 weeks, because the injuries sustained caused the loss of use of 5% of the right foot, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner compensation that has accrued from **April 30, 2014** through **May 12, 2021**, 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

AUGUST 5, 2021

STATEMENT OF FACTS

Petitioner testified that in July 2013 she was employed by Respondent as a Direct Service Professional at a children's group home in Minooka, Illinois for the developmentally disabled. Her building housed five such residents aged 13 to 18. Her work duties included tending to the residents' activities of daily living, including assistance with ambulation, physical transfers, meals, bathing, cleaning, transportation and leisure activities. She testified this often involved being on her feet, and that the resident children tended to be unpredictably aggressive and would act out.

While working on 7/12/13, Petitioner testified she was called to a resident's (Michael) room. He couldn't articulate what he wanted, so he pulled her down the hallway by her arm to the living room, wanting to move the living room TV to his room. When she indicated he could not do so, the resident became aggressive and began to hit and claw at her, scratching at her face and biting both the back of her left elbow and right forearm. Petitioner sought treatment at Provena St. Joseph's and was diagnosed with human bite wounds and facial lacerations. She received a Tetanus shot and pain medication. The MedWorks (the company occupational health facility) records indicate bites to the right forearm and lateral left elbow, which were healing. Petitioner was treated with antibiotics and a Hepatitis B vaccination. She subsequently had a negative HIV test on 1/12/14 at MedWorks, and she followed up about a year later and underwent further blood work in January 2015. She had no further treatment related to this incident. (Px2).

The Petitioner identified photographs of her face, left elbow, right forearm submitted into evidence as Px13, Px14 and Px15. However, these photos were all taken in 2013. A fourth photo was taken of her chest, where she indicated the resident slapped her with a closed hand. The Arbitrator notes that he determined that these photos are relevant for purposes of pinpointing the locations of the bite and scratch marks, they otherwise are not relevant to the issues in this case, in particular the issue of permanency, given that they are from almost eight years prior to the hearing date. Petitioner testified the only remaining marking/scarring on her skin from the 7/12/13 incident is on her right forearm. She indicated she has no pain at this location, but that the bite mark area appears brighter when she has warm or cold skin. The Arbitrator had an opportunity to view the

Petitioner's right forearm at the hearing and saw minimal evidence of any ongoing visible scarring. Petitioner also testified she lost no time from work as a result of injuries related to this incident.

Petitioner suffered a subsequent injury at work on 4/30/14. While making her evening rounds of the residents' rooms following her lunch break, around 7 p.m., two residents, Robbie and Michael, were fighting over a blanket. She tried to separate them as they were tugging on and fighting for the blanket and was knocked to the ground. She testified that Michael and Robbie fell on top of her as they continued to fight, and her right foot became twisted underneath her body. Her left leg was extended, causing her left foot to be jammed hard into the corner of a computer desk with a twisting motion. She testified that while she went to St. Joseph's Hospital with the residents that night, she did not seek treatment there for herself. She indicated she didn't initially have much pain in the left ankle until she was getting out of bed the next morning. While she acknowledged that she'd undergone prior treatment for plantar fasciitis, she testified that this pain was a different type of pain, in a different area on the outside of the ankle going up into the calves, and she denied any prior treatment to her left or right ankles. She testified she also had right ankle pain with swelling and a feeling of tightness.

A Staff Accident/Injury Event Form, which is undated, indicated that on 4/30/14 the Petitioner was pushed down while trying to separate two residents involved in a physical altercation, and one of them fell on top of her while one of her feet were underneath her body. The report notes the injury was to the right foot, and the report notes co-worker witness Jessica Adams indicated Petitioner's ankle was "swollen and red." The report further noted the Petitioner iced it that night, called her supervisor the next day and went to MedWorks for treatment. The report also notes Petitioner was off work for 6 days and then returned to work. (Px1). Petitioner testified that Respondent's HR representative, Amanda Progress, referred her for treatment at MedWorks.

The history stated in the 5/1/14 report from MedWorks was of Petitioner trying to separate two clients in an altercation and being pushed down to the floor, with her right foot turned underneath her body while the clients fell on top of her, injuring her right ankle. She reported significant pain and swelling along both ankles. She denied any prior injuries to these body parts. Swelling and erythema was noted at the right ankle on exam. She had limited dorsiflexion and difficulty with weightbearing. Right ankle x-ray was normal other than medial and lateral soft tissue swelling. Petitioner was diagnosed with right bimalleolar right ankle sprain, given an air cast and was limited to sedentary work duties. (Px2).

Petitioner testified that her preexisting left-sided plantar fasciitis was worse after the 4/30/14 injury, but the right-sided plantar fasciitis was basically unchanged. Petitioner also testified that she had left ankle pain at this time but not as bad as the right ankle, and that she remained off work because the Respondent could not accommodate the sedentary duty restriction.

At her 5/6/14, follow up, Petitioner reported being much improved, but had some ongoing pain with standing and ambulation. The report corroborates she was off work due to no light duty availability. It was noted: "She has not been using the Ace wrap or applying ice or heat to the affected region since she states she does not have problems all the time." Petitioner was advised to start weight bearing and to use the Ace wrap. Light duty restrictions were continued, and the plan was to release her at the next visit. (Px2). Petitioner testified Respondent continued to be unable to accommodate her restrictions.

A 5/9/14 MedWorks report notes Petitioner had been pain free until that day other than minor pain (1 out of 10) she attributed to the damp weather. She was ambulating without difficulty and was not using the Ace wrap or anti-inflammatories. Examination was normal and Petitioner was released from care and advised to return to work without restrictions. (Px2). As to her indication of only 1/10 level pain at this visit, the Petitioner testified she was on crutches and non-weightbearing at that time, and her pain would come and go depending on weightbearing, activity and use of pain medication.

Petitioner testified she received a call from the Respondent's house manager on 5/10/14 indicating they were short staffed and needed her to come back to work, which she did. She did not recall if she had been receiving temporary total disability benefits or not at that time.

On 5/15/14, Petitioner sought treatment with Dr. Shanholtzer, who she testified was a podiatrist/orthopod specializing in the foot/ankle. The intake form notes complaints of ankle pain, cramps in the feet and legs, heel pain and, swelling and tired feet. The medical report documents complaints of pain in both legs and feet and plantar fasciitis, left greater than right: "She has about 2 years of problems with this and also with her right foot. She has seen [Dr. Caneva] and had injections and several different kinds of orthotics and still has problems. She is on her feet all the time with Cornerstone patients, taking them from place to place and standing for long periods of time." The report goes on to note Petitioner was taking cortisone, had an x-ray of her heel and wore a tall or short boot at times and an elastic wrap. Several injections had provided only temporary relief and "it has come back. Mostly this time the left one is also bothering her but she is concerned about her legs also. The swelling seems to be going up to her knee area." The assessment was bilateral plantar fasciitis, and she was advised to see a family doctor for swelling in her lower leg for a possible diuretic. Dr. Shanholtzer wanted her to see Dr. George for her ankle area, and an orthopedic surgeon at George's office for her lower leg. He stated: "Patient has plantar fasciitis, left and right foot, aggravated by a maximal amount of edema in both legs and feet." She was prescribed Cataflam for pain, noting she already used biofreeze, and she was advised to soak in epsom salts. (Px3).

Petitioner testified that at this point her left ankle felt worse than the right, which she believed was due to favoring her right ankle, and she was using two crutches. At a 5/30/14 visit to her general physician, Dr. Chourdry, the doctor's PA documented a medical history that included "various foot issues (including plantar fasciitis, pronation deformity of foot – sees podiatry)." (Px6).

On 6/17/14, Petitioner saw podiatrist Dr. George, testifying this was the first treatment she sought after her return to work. She reported bilateral foot pain, left greater than right, in the plantar fascia and over the medial calcaneal tubercle: "States pain with the first few steps out of bed." Petitioner noted she had treated with Dr. Caneva for foot issues that had been going on for two years, including heel pain with multiple treatments (injections, orthotics, night splints, etc.), but was unhappy with the lack of improvement. X-rays revealed no acute findings. Pain was palpated over the left plantar medial tubercle of the Achilles, no significant pain on the right side. Given two years without improvement, Dr. George prescribed a left ankle MRI. The 6/18/14 radiologist's impression was: 1) medial band plantar fasciitis at its origin (differential diagnoses for this included high grade partial thickness and complete nonretracted tears of the medial band of origin with aponeurotic swelling), 2) Stieda process without Stieda process syndrome, 3) short segment longitudinal fraying juxtamalleolar peroneus brevis tendon. The report indicates there was moderate to severe plantar fasciitis at its origin evident with at least a partial thickness tear, possibly a full thickness tear, without retraction. At 6/24/14 follow up, Dr. George noted the partial plantar fascia tear along with peroneal tendon longitudinal tear, and some tibiotalar capsulitis with impingement. Dr. George noted that given the ongoing problem, arthroscopic surgery would be beneficial, including debridement, possible syndesmotic repair with peroneal tendon and 10 X fasciotomy of the left plantar fascia. (Px4). Left ankle surgery was performed by Dr. George on 7/9/14, involving arthroscopic debridement, peroneal tendon repair, syndesmotic repair using stainless steel tightrope and plantar fasciotomy with a Tenex. Post-surgical diagnoses included left ankle impingement with peroneal tendinopathy, syndesmotic insufficiency and recalcitrant plantar fasciitis. (Px5). A 7/14/14 note of Dr. George kept Petitioner off work. On 7/24/14, Petitioner reported she had tripped and fallen the night before, putting full weight on her left foot, but her pain remained well controlled. On 8/12/14, Dr. George noted Petitioner had progressed with therapy but had shooting pain at night and ongoing swelling. She was advised to discontinue

the use of crutches and advance out of the boot. She was to continue therapy and remain off work for approximately a month. (Px4).

Petitioner attended physical therapy from 7/29 to 8/22/14, which she testified involved range of motion exercises, massage, and electrotherapy. The initial evaluation noted complaints of pulling sensation in the inner left ankle. On 8/6/14, Petitioner reported she was still sore and tight, but was better overall. On 8/11/14, Petitioner had better range of motion and less overall pain but had ongoing swelling. On 8/12/14, it was noted that Dr. George was happy with her progress, and on 8/18/14 he indicated Petitioner was returning to her job the next day. On 8/22/14, she indicated she was feeling good but was frustrated by ongoing swelling, which the therapist indicated remained elevated. On 8/26/14, Petitioner noted she was having problems getting physical therapy authorized, reporting pain and intense swelling in the ankle, and that she was beginning to have right sided pain "following an ankle sprain at work 5/1/14. She is having increased swelling and bruising and pain at times, though no pain currently." Petitioner testified her right sided pain had "returned", as she had been putting more weight on the right leg. On 9/2/14, Petitioner reported she would be re-starting therapy on 9/3/14. (Px4).

On 9/16/14, Petitioner reported stubbing her 5th toe, and x-rays showed a minimally displaced 5th proximal phalanx fracture, so the 4th and 5th toes were taped together. On 9/25/14, Petitioner reported improvement even after discharge from therapy. She was using her old orthotics for her plantar heel pain and wanted to discuss a release to return to work, which Dr. George medically cleared her to do. (Px4).

Petitioner testified that when she returned to work following this release, she would have intermittent left ankle pain and swelling depending on her activities. She denied receiving TTD following her left ankle surgery. She testified that her right ankle pain never resolved, was worse with activity, and that over time she developed constant swelling.

Petitioner testified that on 9/27/14, a resident pushed a chair into a table, which hit her left foot. The 9/27/14 report from Presence St. Joseph's ER noted Petitioner's prior left foot surgery and that a resident at work hit the bottom of her left foot that day and hurt it. She was able to walk without pain but indicated she was sent for evaluation by Respondent due to the recent surgery. Exam was benign and x-ray showed no fracture or change in bone structure. Petitioner indicated she felt fine and was able to return to work. (Px5). The Arbitrator notes that the x-ray states the films showed evidence of a prior operative fusion of the distal talofibular joint, as well as scattered degenerative changes throughout the midfoot and forefoot and a small plantar calcaneal spur. (Px5).

On 11/10/14, Petitioner saw Dr. Chourdry and reported complaints of bilateral knee pain, right greater than left, and bilateral foot pain, noting she hadn't improved following left foot surgery: "Twisted Rt ankle in May (fell with foot underneath)." Petitioner was requesting a referral to orthopedics, noting she had treated with podiatrist Dr. Caneva in the past with orthotics, which she reported didn't fit well and which she believed was causing her knee pain. She reported the incident in May involved twisting her right ankle when she fell with her foot rolled inward underneath her. She reported off and on swelling of the lateral ankle and muscle spasms of the right foot. She noted she had undergone prior 2012 knee x-rays. No edema was noted in the feet or ankles on exam. She was referred back to Dr. George for her foot/ankle issues and to Dr. Pizinger for her knees. (Px6).

Petitioner returned to Dr. George on 11/13/14, reporting right ankle and foot pain similar to what she had on the left: "Pain to heel plantarly and lateral ankle." Dr. George prescribed right foot and ankle MRIs. The 12/11/14 right foot MRI reflected: 1) Moderate FHL tendon tenosynovitis proximal to the master knot of Henry, 2) a focal region of nonspecific mild subchondral bone marrow edema in the plantar aspect of the first metatarsal head, and 3) mild first and second intermetatarsal bursitis. The right ankle MRI from the same date noted a history of right ankle instability and history of injury. The impression was of 1) mild to moderate subcutaneous edema about the ankle, 2) mildly attenuated appearance of the anterior talofibular ligament compatible with

sequelae of a prior partial thickness tear, and 3) small ganglion cyst along the dorsal aspect of the talar head. (Px4).

Petitioner followed up with Dr. George on 12/12/14, at which time he stated: "This is an old injury that has gotten more symptomatic. She relates that this happened at work." Noting the MRI finding, he recommended arthroscopic right ankle surgery with debridement and Tenex procedure of the plantar fascia if she did not respond to conservative treatment, including a cortisone injection, which was performed at this visit. Petitioner testified this was performed for plantar fasciitis. Dr. George was not optimistic given the failure of the same injection previously on the left. (Px4).

On 1/4/15, Petitioner returned to the Presence St. Joseph ER, this time indicating she slipped while walking down a stairway, getting her foot caught in the railing, with pain across the top of her 2nd, 3rd and 4th toes. X-rays were unremarkable and she was advised to follow up with her podiatrist. (Px5).

On 1/13/15, Dr. George noted the right ankle problem and that "Two clients got in an altercation, the patient was trying to break up the fight when she fell down and was piled on by about 4 patients." Based on the failure to improve with the injection, Dr. George recommended surgery and issued work restrictions with ambulation as tolerated with breaks as needed. (Px4).

The next visit appears to have occurred on 6/2/15, with Petitioner telling Dr. George her claim for the right ankle/foot was being denied by Respondent and that, while she hired an attorney, she wanted to undergo the surgery through her group health coverage. Dr. George stated: "Her right ankle has gotten worse in addition to her previous issues with her pain at the ATFL ligament and the plantar fascia which is essentially unchanged from her prior visit." He noted she also had a peroneal subluxation which would also need to be addressed with the surgery. (Px4). Dr. George performed surgery on 6/8/15, involving arthroscopic debridement, peroneal stabilization and ATFL ligament repair. The diagnosis was right lateral ankle instability with ATFL instability and insufficiency, peroneal subluxation and anterior ankle lateral impingement. (Px4; Px5).

Petitioner testified that the Respondent had been unable to accommodate her work restrictions and terminated her on 6/12/15, receiving a letter on that date from HR stating that her FMLA time had expired.

At a 6/12/15 follow up, Petitioner complained of right ankle pain and tightness from swelling. She was prescribed a CAM boot and crutches and advised to stay non-weightbearing for 10 days. On 6/22/15, Petitioner reported minimal (1/10) pain and swelling was noted to be within normal limits. (Px4).

Petitioner had an initial physical therapy evaluation at ATI on 7/2/15 On 7/13/15, Petitioner reported great improvement in her symptoms. She had persistent swelling, but stiffness was improving with therapy. An 8/10/15 report from notes improvements in strength and range of motion but ongoing difficulty with SLS activities and that she remained at the sedentary level. (Px7). On 8/11/15, Petitioner told Dr. George she was doing very well with very intermittent episodes of soreness. (Px4). The Arbitrator notes that these records of Dr. George do not reflect statements regarding work status.

On 8/24/15, Dr. George indicated Petitioner was there for her *left* foot with forefoot pain to the 3rd interspace of the ball of the foot, noted to be a neuroma. An injection was performed with relief. She last saw Dr. George on 9/10/15, and she reported no complaints as to the right ankle, while the injection provided only 4 days of relief for the neuroma. It was noted that a return to work note was issued, but the Arbitrator could not locate such note in the evidentiary record. (Px4). Petitioner indicated she was returned to full work duties at this time.

On 9/16/15, Petitioner told her therapist she was doing great without any significant pain. The last therapy note from ATI, dated 9/17/15, indicated Petitioner had difficulty with prolonged standing, but otherwise had met all goals and was capable of medium duty work, which is what her regular job was rated at, and she was discharged. (Px4; Px7).

Records which predate the Petitioners alleged 4/30/14 accident from podiatrist Dr. Caneva were presented into evidence by the Respondent. An initial visit, based on an 8/7/12 referral from Dr. Chaurdry for bilateral foot pain, occurred on 8/20/12. Petitioner presented with worsening sharp bilateral heel pain she rated as 3 out of 10 (3/10) that was impacting ambulation and prolonged standing. Gel soles and athletic shoes had provided no relief. Petitioner was noted to be morbidly obese. Diagnoses included foot pain, plantar fasciitis and, based on x-ray, subtalar joint pronation. Stretching, ice, rest, elevation, over-the-counter analgesics and orthotics were prescribed. Petitioner followed up on 8/31/12 to pick up her custom orthotics. On 9/17/12, Petitioner reported moderate relief with the recommended treatment and orthotics. While steroid injections were discussed if Petitioner's pain persisted, she called in on 9/28/12 to report her orthotics were working fine and that she needed no further follow up. Petitioner next returned to Dr. Caneva on 11/22/13, again reporting 3/10 level bilateral heel pain that had been present for a year. She requested replacement orthotics, with Dr. Caneva reporting: "Pointing toes causing shin splints. Heel pain bilateral with cramping." X-rays showed subtalar joint pronation and pes valgoplanus bilaterally. Diagnoses remained the same but now included posterior tibial tendonitis and shin splints. The same treatment recommendations were made, this time along with elastic ankle wraps. While it was not specified in his report, Dr. Caneva ordered bilateral ultrasound testing as well, which was performed on 12/5/13. The radiologist's impression bilaterally was: 1) plantar fasciitis medial band origin, 2) mild peroneus brevis tendinopathy posterior to the lateral malleolus, and 3) mild posterior tibialis insertional tendinitis. At the 12/10/13 follow up with Dr. Caneva, Petitioner reported the same pain in her left foot with improvement on the right, noting she had discontinued use of the ankle wraps and was alternating use of her old orthotics and arch supports. She was again advised to use the ankle wraps and to continue the other treatments, and the left heel was injected with Depo-Medrol. (Rx3).

The next and last noted visit with Dr. Caneva was on 4/10/14. Petitioner reported increasing left heel pain and requested another injection. She noted she had a CAM walker at home, which apparently had been provided to her previously, and Dr. Caneva advised her to continue to use this device. He also performed another left heel steroid injection. (Rx3).

The Petitioner was examined by orthopedic surgeon Dr. Holmes of Midwest Orthopaedics at Rush at the request of the Respondent (see Section 12 of the Act) on 2/27/19. Petitioner related a 4/30/14 history of falling to the ground and bracing herself during a fight between two residents. She reported a previous history of bilateral heel pain "for which she was treated until the exact same month as her injury", April 2014. The doctor reviewed Petitioner's prior medical records, including those of Dr. Caneva and the operative reports. He noted Petitioner presented to him with some complains of stiffness and occasional swelling in both ankles, that she used no assistive devices for ambulation, took no medications and had returned to work. Examination appeared to be benign. Dr. Holmes diagnosed left-sided plantar fasciitis "and other conditions of the foot or ankle", and right sided plantar fasciitis, which were not causally related to the 4/30/14 accident. Dr. Holmes did not believe the conditions were caused or aggravated by the work incident given she had a long history of plantar fasciitis treatment up to and including 4/12/14, just weeks prior to the incident. He further opined that the surgical procedures performed by Dr. George were not related to the 4/30/14 incident. He believed Petitioner required no further treatment or work restrictions and had an excellent prognosis. (Rx1).

Dr. George testified via deposition on 6/5/19. A podiatric surgeon, he testified the bulk of his practice was sports medicine with surgery of the foot and ankle. Petitioner initially treated with him on 6/17/14 for the left foot and ankle, after which she was released and then later returned regarding her right foot and ankle. He had

no knowledge of the mechanism of Petitioner's 4/30/14 injury other than what was in his 10/12/14 report. Dr. George's left extremity diagnosis was recalcitrant plantar fasciitis, syndesmotic insufficiency and left ankle impingement with peroneal tendinopathy. On the right, he diagnosed lateral ankle instability with ATFL tear, ligament instability and insufficiency, peroneal tenson subluxation and anterolateral impingement. Asked about his causation opinions, Dr. George testified: "In my opinion, based on the type of injury that the patient stated that she sustained, these type of injuries to the ankle that causes a disruption of the ligament and a band of tissue called the retinaculum which also holds the peroneal tendons in place, and when that retinaculum is disrupted, it can cause instability of the ankle, but it can also cause, over time, fraying of the tendon due to the fact that the retinaculum was also damaged or injured." Dr. George also opined that the ankle injuries bilaterally could be related to "the mechanical fall" she had. He testified that plantar fasciitis is typically not a result of an acute injury but rather from a chronic issue or injury, though there was a possibility it could have been exacerbated. He testified that if Petitioner had undergone immobilization treatment prior to seeing him, it could have caused Achilles tightening, which can increase plantar fasciitis symptoms. Despite this testimony, he indicated that he was unable to opine one way or the other as to whether the 4/30/14 incident aggravated the plantar fasciitis condition. (Px9).

Dr. George opined that the surgical procedures involving left ankle debridement, peroneal tendon repair and syndesmotic insufficiency were all causally related to the 4/30/14 incident. He further opined that the right ankle arthroscopy, peroneal stabilization and ATFL ligament repair were also related to this incident. As to the causal connection bilaterally, he testified these pathologies were usually seen with a twisting injury to the ankle. Dr George's understanding was that Petitioner had undergone conservative measures, including immobilization, injections, orthotics and splinting, with no improvement prior to her seeing him. As to the left sided treatment, he discharged Petitioner on 9/9/14, and believed the treatment had been successful. She returned on 11/13/14 with right-sided complaints, approximately 7 months post-accident, and Dr. George stated his understanding is that she had undergone right sided treatment subsequent to the accident date. As to the right sided MRI findings, Dr. George opined that the ATFL ligament and the 1st metatarsal head edema conditions could have been attributed to the 4/30/14 mechanism of injury. The metatarsal head edema basically involves a deep bone bruise. On the right, post-surgery, Petitioner underwent therapy and continued to improve. On 8/24/15, she had pain in the 3rd interspace of the left foot, which he diagnosed as a neuroma and injected, and which he opined is unrelated to the work accident: "This is something that is normally related to irritation of the nerve between the two metatarsal bones." Dr. George testified that that any left foot treatment after September 2014 was unrelated to the 4/30/14 incident. He released Petitioner back to work as to the right ankle on 9/10/15. While therapy continued after that, he testified the Petitioner never followed up with him again, so he had no knowledge or opinions regarding her post-September 2015 condition or need for work restrictions, or future treatment. (Px9).

Asked what dates he had Petitioner off work due to the 4/30/14 injury, Dr. George testified: "I don't have the exact dates, especially since there were two surgical interventions, but I believe I had her return to work after her left ankle surgery on 9/25/14, and I had her off work once again from her second surgical intervention, which was 6/8/15, until 9/10/15." Dr. George acknowledged Petitioner "may have mentioned" prior treatment for bilateral plantar fasciitis when he first saw her but he never reviewed any of her prior medical records, testifying it would not have any effect on his causal connection opinions anyway. In support of this, he indicated that while plantar fasciitis was more of a chronic issue, the ankle injuries were more typically seen with mechanical falls and twisting type injuries. He had not reviewed any records indicating Petitioner had any ankle ligament injuries bilaterally prior to 4/30/14. The pathologies he diagnosed in the ankles are typically acute or subacute but can be chronic. (Px9).

On cross examination, Dr. George testified that the intake form his patients generally complete, including a description of an injury, was not part of Petitioner's medical records from his facility. He agreed that his initial 6/17/14 report mention nothing about a work accident, and that Petitioner reported to him that she stopped

treating with Dr. Caneva because she was unhappy with his treatment. He did not have knowledge of the bilateral ultrasound testing in 2013 that resulted in findings of bilateral plantar fasciitis over the medial band, mild peroneus brevis tendinopathy posteriorly to the lateral malleolus or mild posterior tibial insertional tendinitis. He agreed the Petitioner is obese and that obesity can aggravate plantar fasciitis, "and that's the reason why it would be more symptomatic or not improving." He agreed that the first time Petitioner mentioned right foot pain was 8/26/14, which she then related to a right ankle sprain on or approximately 5/1/14. He could not recall any further details regarding that injury: "I don't recall her mentioning exactly how it occurred." On 12/12/14, Petitioner did state that her right ankle injury was related to falling at work, but she did not provide any details on how exactly she fell or how she landed. When he initially saw the Petitioner, "she stated that the left caused more discomfort than the right, but she did not have any specific complaints on the right side initially." Initially, he did not treat her right ankle/foot. He testified that a bone bruise can take up to eight months to heal. On redirect, Dr. George agreed that the initial diagnosis of a bimalleolar right ankle sprain is consistent with his later diagnosis of a ligament tear, and that this could not be confirmed until an MRI was reviewed. None of the questions he was asked on cross changed any of his stated opinions. (Px9).

Dr. Holmes also testified via deposition (on 10/21/19). An orthopedic surgeon who specializes in the foot and ankle. Dr. Holmes indicated Petitioner reported her injury was falling to the ground and bracing herself. Examination on 2/27/19 was essentially normal with stable ankles and symmetrical measurements. Dr. Holmes diagnosed Petitioner as status left foot plantar fasciitis, based on her longstanding history of treatment for this condition from 2012 to 2014, supported by her medical records, and the 6/18/14 MRI. He testified this evidence also supported his opinion that the condition was unrelated to her work injury, noting there had not been any resolution of this condition prior to the injury. He further opined that she needed no additional treatment to the left foot or work restrictions, noting he saw no evidence of treatment since 2015. As to the right foot, Dr. Holmes diagnosed plantar fasciitis, again unrelated to the 4/30/14 work injury for the same reasons he opined as to the left side. He did not believe she needed any further treatment or any work restrictions related to the right extremity. Dr. Holmes testified he did not find any specific ongoing ankle pathology on exam bilaterally. As to the MRI findings and surgeries performed by Dr. George, Dr. Holmes opined that Petitioner's ankle conditions predated 4/30/14: "Specifically, she was diagnosed early on with issues of peroneus brevis tendinopathy, mild posterior tibial tendonitis bilaterally in 2013, and ultimately underwent some – something that addressed that from podiatrist, Joe George, but those were not related to the injury and did not appear to be active problems when I saw her on 2/27/19." (Rx2).

On cross, Dr. Holmes was questioned as to whether Petitioner's pre-4/30/14 complaints included ankle symptoms, and he testified "I'm not sure that's completely correct" that there were no ankle complaints. He referenced a 12/5/13 report where Dr. Caneva diagnosed bilateral peroneal brevis tendinopathy and posterior tibial insertional tendinitis and testified that these two structures are adjacent to and around the ankle. He could not reference any other reports which would support his determination that Petitioner's bilateral ankle conditions were unrelated to the 4/30/14 accident. As to there being no pre-accident evidence of a right ankle tendon tear, Dr. Holmes testified this was not correct, as the term peroneus brevis tendinopathy is sometimes used interchangeably with a tendon tear issue. He agreed there was no pre-accident MRI showing such a tear, there was no pre-accident documentation of an ATFL injury, and no pre-accident surgical recommendations. (Rx2).

As to his testimony that Petitioner's plantar fasciitis was unrelated to the accident, Dr. Holmes agreed that "theoretically" this condition can be aggravated by trauma and made more symptomatic. He agreed, again theoretically, an injury involving falling on the right foot and ankle and twisting it could be the type of trauma to aggravate plantar fasciitis. He agreed plantar fasciitis manifests as foot and heel pain while peroneal tendinitis manifests as ankle pain. He agreed, again theoretically, that an injury as described could make a pre-existing tendon injury symptomatic or more symptomatic, but still opined that this was not what occurred in this

case. Dr. Holmes disagreed that the lack of a pre-accident diagnosis or treatment for an ATFL tear, and right ankle injury complaints immediately after the injury, supported a causal connection, testifying that Dr. George initially diagnosed plantar fasciitis and did not mention ankle pain or an ATFL tear. He testified that Dr. George's 6/17/14 report did not mention any ankle injury, his exam demonstrated pain to the plantar fascia, and his MRI prescription had nothing to do with ankle symptoms. It was only after that scan that Dr. George mentioned ankle surgery, along with plantar fasciitis surgery. Dr. Holmes testified: "So it is my opinion, given the patient's height and weight and morbid obesity, and my research and knowledge of patients with tendinopathy and tendon tears, that that was the finding of the MRI that was unrelated to the injury." He referenced studies in which people with no traumatic ankle injuries or problems underwent MRIs and 35-40% of these seemingly normal people had pathologies such as ATFL tear, peroneus brevis tear/tendinopathy, loose bodies, OCDs. He further testified: "That research is directed for physicians to examine the patient, and not simply operating, go after findings that are abnormal on MRI scan." Dr. Holmes agreed he had not reviewed any MedWorks records - when asked about an initial post-accident MedWorks report diagnosing a right bimalleolar sprain and on 5/6/14 a right ankle sprain, he testified this information would not change his opinions. He disagreed with both surgeries performed by Dr. George as well as the timing – he testified: "From my standpoint and training, the patient sustained an injury on 4/30/14; and I did not see a sufficient course of conservative treatment prior to her surgery that was performed on 7/9/14, and surgery had been recommended as early as 6/24/14, which was only, approximately, two months after the date of injury. So for someone who theoretically had the issues that were being ascribed to the injury of 4/30/14, from my training/experience, to do the amount of surgery that was done, that quickly thereafter, was not appropriate from my standpoint, from that of an orthopedic foot and ankle surgeon." (Rx2).

On redirect examination, Dr. Holmes testified he had no knowledge of any pre-accident MRI testing. He testified that, "first and foremost, almost everyone who has an ankle sprain has an ATFL ligament tear." Thus, such a tear, per MRI, must be weighed with its clinical significance, including there being some instability, prior to considering surgery, and he did not see any documentation of such findings in Dr. George's records. Dr. Holmes testified that the 6/18/14 MRI also showed no evidence of the acute collateral damage that would be anticipated if the problem was the result of an injury, including effusion, hematoma or soft tissue edema. Given no such acute MRI findings, Dr. Holmes testified that even if Petitioner had sustained an ankle sprain in the accident with resulting findings in the peroneal tendons, the treatment performed was inappropriate given such patients generally undergo 3 to 6 months of conservative treatment, after which 50% of them do not require surgery. An ankle sprain, in and of itself, does not indicate instability in the ankle. It was Dr. Holmes' opinion that Petitioner did not have an acute peroneal tendon tear, but rather a chronic tear, and if she had previously undergone 3 to 6 months of physical therapy, surgery would have been reasonable. If it had been acute, as indicated by Dr. George, she should have then undergone that 3 to 6 months of therapy. (Rx2).

At the time of the hearing, the Petitioner complained of ongoing bilateral pain and swelling, but agreed she was improved following the surgeries and that any ongoing pain did not prevent her from working. Stiffness, swelling and discomfort, more so than pain, comes and goes with activity. Petitioner testified that she continues to have daily swelling in the right ankle with scarring at the surgical site and within the ankle. If she tries to stand on her toes to reach up, her feet want to collapse back down. Stairs, prolonged standing and walking are problematic for her. She testified that if she tries to kneel, the bending of the foot causes cramping behind the ankle and in the calf. She can get cramping at night. She testified she has basically the same symptoms on the left side, with more intense swelling. Petitioner reiterated that she did not have any of these problems prior to the alleged accident date and that she had never had a similar surgery previously recommended, including by Dr. Caneva. Following her 6/12/15 termination, Petitioner has worked as a receptionist for Heartland, and has performed programming and calibrating breathalyzers for Lifesafer Interlock. She testified that both were sedentary jobs. At the time of trial, Petitioner had been working for Amita Health as a front desk receptionist since 12/1/20. She has no future treatment scheduled for ankle/foot treatment. Petitioner testified she was off

work from 4/30/14 to 5/10/14, again from 7/9/14 to 9/25/14 following her first surgery, and from 6/8/15 to 9/10/15 following the second surgery. Petitioner did not recall Dr. Caneva diagnosing peroneal brevis tendinopathy and posterior tibial tendinitis on 9/5/13 and did not know why such diagnoses would be indicated in his records. She testified she believed the medical bills contained in Px8, totaling $122,616.43 total, are true and accurate.

On cross examination, Petitioner agreed she was never diagnosed with any diseases following the human bites she sustained on 7/12/13. As to the 4/30/14 incident, she agreed she was released without restrictions by MedWorks on 5/9/14. As to her 6/17/14 report of two years of foot pain, Petitioner testified this was a different type of pain than what she had following the alleged work injury. She initially started treating with Dr. Caneva for plantar fasciitis in August 2012 and had been provided with orthotics, which she wasn't wearing on 4/30/14. Petitioner agreed a pronation deformity had been diagnosed, but she denied being prescribed ankle wraps: "I had a sock." She was not wearing this on 4/30/14. She acknowledged seeing Dr. Caneva on 4/24/14 just prior to the 4/30/14 incident. She did complain of increased right ankle pain on 11/14/14, the same type of pain she had on the left side. Petitioner does not currently take any pain medications. To her recall, she was hired by Heartland shortly after Dr. George released her, and she had filed for unemployment following her termination by the Respondent. Petitioner agreed she was not working at the time she reported increased right ankle pain on 8/26/14.

The Arbitrator notes that the Petitioner also submitted photographs of her ankle that were taken no later than 2015, and as such are not of any relevance in this case. (Px12).

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 sustained accidental injury which arose out of and in the course of her employment with Respondent on 4/30/14.

Petitioner's job involved supervision of developmentally disabled children. While doing so on 4/30/14, she had to separate two residents who were physically quarreling over a blanket, and ended up being knocked down, where they fell on top of her. Her testimony in this regard was unrebutted and is supported by the contemporaneous medical records. The incident clearly occurred in the course of her employment, as she was performing her regular work duties. In doing so, it is also clear that her injuries arose out of the employment, as the risk of such injury and her exposure to same was a work-related risk, given that her duties specifically involved supervision of the resident children. Petitioner also testified that outbursts such as what occurred on 4/30/14 were not unusual in her job.

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 issue of causation in this case is of key importance and is a very difficult question. Prior to the 4/30/14 accident, the Petitioner clearly was having problems with the bilateral feet. She was diagnosed in 2012 and 2013 with bilateral plantar fasciitis. In fact, she visited Dr. Caneva with ongoing bilateral foot problems, left greater than right, on 4/10/14, just 20 days prior to the 4/30/14 accident date. She had treated from August 2012 through September 2012, indicating bilateral foot pain that she indicated resolved with new orthotics. However, when she returned in November 2013, Petitioner reported bilateral heel pain that had been present for a year.

The left heel was injected on 12/10/13. She didn't return to Dr. Caneva again until 4/10/14, but at that time reported increasing left heel pain and requested another injection, which was performed, and Dr. Caneva advised to her to wear a CAM walker. Additionally, an ultrasound was obtained of both distal lower extremities in December 2013 and reflected findings of plantar fasciitis, mild peroneus brevis tendinopathy and mild posterior tibialis insertional tendinitis.

In terms of the 4/30/14 accident itself, the Petitioner testified that her right foot became twisted underneath her when she fell, and the residents fell on top of her. She also testified that her left foot was jammed into a desk area. The Respondent's accident report (Px1) notes only an injury to the right foot. The history contained in the initial 5/1/14 MedWorks report was of her right foot turned underneath her body while the clients fell on top of her, injuring her right ankle. She also apparently reported significant pain and swelling along both ankles and denied any prior injuries to these body parts. Swelling and erythema was noted at the right ankle on exam, a right ankle x-ray was obtained, and Petitioner was diagnosed with right bimalleolar right ankle sprain. There was no indication of left ankle exam, testing or diagnosis that the Arbitrator noted. By 5/9/14, MedWorks reported Petitioner was essentially pain free and released her from care, while Petitioner testified she was on crutches and non-weightbearing at that time, and her pain would come and go depending on weightbearing, activity and use of pain medication. She then returned to work. The Arbitrator notes it is difficult to believe that the Petitioner remained on crutches and non-weightbearing at the same time she was being released to full duty work, and that she returned to full duty work on 5/10/14 if she remained on crutches and non-weightbearing. This does not impact the Petitioner's credibility in the Arbitrator's view as much as it impacts her memory, given that this occurred 7 years prior to her testimony.

Petitioner did seek further treatment after 5/9/14, seeing podiatrist Dr. Shanholtzer on 5/15/14. His report references ankle pain, cramps in the feet and legs, heel pain, swelling and tired feet, along with complaints of bilateral leg and foot pain and plantar fasciitis, left greater than right. However, interestingly, the report references two years of problems "with this and also with her right foot", noting she had treated with Dr. Caneva with injections and orthotics with no relief beyond temporary. While Petitioner noted she was on her feet all the time at work, whether ambulating or standing, nothing whatsoever was indicated with regard to the 4/30/14 accident or injuring the feet or ankles on that date. One concern about swelling in the legs appeared to be water retention, as she was referred to her family doctor to consider a diuretic. Dr. Shanholtzer did refer Petitioner to Dr. George after diagnosing Petitioner with plantar fasciitis aggravated by swelling in the lower legs and feet.

Dr. George's initial report indicates complaints of bilateral foot pain, left greater than right, in the plantar fascia and over the medial calcaneal tubercle, and that she had been treating with Dr. Caneva for foot problems for two years, including injections, orthotics and night splints, and was unhappy with a lack of improvement with Caneva. X-rays were noted to show no acute findings, and pain was palpated over the left plantar medial tubercle of the Achilles, which was not present on the right, which appears to have been the foot that was twisted beneath Petitioner when the residents fell on her on 4/30/14. As Dr. Holmes indicated in his testimony, it did not appear that there was any specific reference to Petitioner's ankle until after the 6/18/14 left ankle MRI, which indicated, in addition to plantar fasciitis, "Steida process without Stieda process syndrome", which was never explained to the Arbitrator by Dr. George, and short segment longitudinal fraying juxtamalleolar peroneus brevis tendon. Dr. George's review of the MRI also noted some tibiotalar capsulitis with impingement.

Dr. George acknowledged in his testimony that his original treatment of the Petitioner did not involve the right foot or ankle, and his records do not even reference the work accident until 12/12/14. On 11/10/14, she had seen her primary care provider, Dr. Chourdry, reporting complaints of bilateral knee pain, right greater than left, and bilateral foot pain, with no improvement following the left-sided surgery. At this time the doctor noted a statement from Petitioner: "Twisted Rt ankle in May (fell with foot underneath)." Petitioner wanted a referral to

orthopedics, as the orthotics she had received previously from Dr. Caneva didn't fit well, and she felt they were causing the knee pain. No edema was noted in the feet or ankles on exam, and she was referred back to Dr. George for her foot/ankle issues. The doctor's testimony acknowledged that he was not addressing the right lower extremity until November 2014, which is approximately 7 months post-accident.

While Dr. Holmes' testimony also left something to be desired in terms of completeness, given that he agreed he had not reviewed the initial MedWorks records referencing a right ankle sprain, his explanation of Petitioner's condition was more persuasive to the Arbitrator than that of Dr. George. First, Dr. Holmes references the fact that the training of a podiatrist is not the same as that of a medical doctor of orthopedic surgery. Secondly, Dr. Holmes explained that the findings in the ultrasound included findings related to the ankles, and that tendonitis/tendinopathy are terms that often are used interchangeably with partial tears in the ankle ligaments.

Often in circumstances like this where there is a preexisting condition that is alleged to be aggravated, the Arbitrator will look to whether the accident date in question represented a change in the claimant's condition in some fashion, which would reflect a chain of events-type finding of compensability. Here, the Arbitrator finds it difficult to find a true line of demarcation between the preexisting condition and Petitioner's ongoing condition after 4/30/14. This is particularly the case when she had last treated for her feet just a few weeks prior to the alleged accident date. The subsequent medical records paint a picture of a temporary aggravation that had essentially resolved as of the 5/9/14 visit with MedWorks, as the initial reports of Petitioner's subsequent treatment with Dr. Shanholtzer and Dr. George do not even reference the work accident, but rather reference the problems Petitioner had been having on an ongoing basis prior to 4/30/14. Additionally, Dr. George's testimony did not sufficiently explain how the ultrasound findings in December 2012 regarding how preexisting peroneus brevis tendinopathy and mild posterior tibialis insertional tendinitis may have impacted any causal relationship of the ankle conditions to the 4/30/14 accident. The December 2013 ultrasound testing identified tendinitis problems with both the peroneus brevis posterior to the lateral malleolus and posterior tibialis insertion. Further, the records of Dr. Caneva also reference subtalar joint pronation and pes valgoplanus bilaterally, the latter of which the Arbitrator understands from experience to reference "flat" feet. This certainly appears to reference problems for the Petitioner beyond just plantar fasciitis. Dr. George opined that the surgical procedures involving left ankle debridement, peroneal tendon repair and syndesmotic insufficiency were all causally related to the 4/30/14 incident. He further opined that the right ankle arthroscopy, peroneal stabilization and ATFL ligament repair were also related to this incident. However, the preexisting ultrasound findings were just not sufficiently explained by Dr. George, in the Arbitrator's view, in terms of how they interrelate with his causation opinions.

The Arbitrator also cannot ignore that the Petitioner was morbidly obese during this time period, which both Dr. George and Dr. Holmes indicate impacts the conditions of her feet. While the Respondent takes the Petitioner as it finds her, there clearly was a preexisting condition here in the Petitioner's feet before the accident occurred, and it appears that there also were ankle findings in 2013 as well. Dr. Holmes testified that even if the post-4/30/14 conditions were related to that accident, the proper treatment would have been three to six months of conservative treatment before consideration of surgery. Thus, it would appear that if this timeline is correct, Dr. George was considering Petitioner's pre-4/30/14 treatment as part of the treatment for the allegedly work-related condition, which makes no sense unless the condition was preexisting.

While Petitioner's counsel references the fact that Dr. Holmes did not review the initial MedWorks records referencing a right ankle sprain diagnosis, it is accurate to state that Dr. George also did not review the pre-accident records of Dr. Caneva. While these are deficiencies in the testimony of both doctors, the burden of proof in this case is on the Petitioner to prove her case by the preponderance of the evidence. The burden is not on the Respondent to disprove a causal connection.

Overall, it is certainly possible that the accident of 4/30/14 caused or aggravated some of the conditions in the Petitioner's distal lower extremities. However, it is difficult for the Arbitrator to say that the Petitioner was able to prove this by the preponderance of the evidence, as required, based on the evidence referenced by the Arbitrator above, and thus the Arbitrator cannot find that such a finding is probable based on the preponderance of the evidence. The Arbitrator also notes that while the more significant injury would appear to have been to the right foot/ankle, given that is the extremity the Petitioner fell onto along with the residents, the initial treatment was all directed to the left side following the release from MedWorks. As such, the Arbitrator finds that the treatment to the left lower extremity, as well as the treatment of the right lower extremity after 5/9/14, was unrelated to the 4/30/14 accident. The treatment to the right foot and ankle from 4/30/14 through 5/9/14 was causally related to the accident.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator awards all medical expenses contained in Px8 that are related to the 4/30/14 injury which were incurred through the 5/9/14 release from MedWorks. Respondent is entitled to credit for any awarded medical expenses that were paid prior to the hearing date, so long as Respondent holds Petitioner harmless with regard to same.

All other medical expenses contained in Px8, other than those awarded in the 15 WC 06858 claim and awarded in this case, are denied.

Respondent is not entitled to take any medical expense credit under Section 8(j) against any other workers' compensation benefits that may be owed, including any TTD and/or permanency.

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:

Petitioner was held off work from 5/1/14 through 5/9/14, and she testified she returned to work on 5/10/14. According to Section 8(b) of the Act, a claimant can only recover the initial three days of lost time benefits if they are off work for at least 14 days. Here, the Petitioner was off work for less than 14 days, and thus she is not entitled to the initial three days of lost time on a statutory basis. The Petitioner is entitled to TTD from 5/4/14 through 5/9/14, a total of 6/7 weeks.

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 has presented an AMA permanent partial impairment rating or report into evidence. Therefore, this factor carries 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 Direct Service Professional at a children's group home in Minooka, Illinois for the developmentally disabled at the time of the accident. She returned to that same job on 5/10/14. This factor carries some medium weight in the permanency determination.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 33 years old at the time of the accident. Neither party has submitted evidence in support of the impact of the Petitioner's age on any permanent disability condition that may exist related to the 4/30/14 accident. This factor carries no significant weight in the permanency determination.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that the Petitioner returned to her regular job following her 5/9/14 release. While she did undergo further treatment, including bilateral distal lower extremity surgeries, the Arbitrator has determined that these surgeries were unrelated to the 4/30/14 accident. The Arbitrator also notes that the Petitioner ultimately was released to return to full duty work. This factor carries moderate weight in the permanency determination.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner appears to have sustained bilateral strains of the right foot/ankle and left foot/ankle. The greater weight of the evidence supports the further finding that these conditions resolved as of 5/9/14. The greater weight of the subsequent treatment records state that the Petitioner's ongoing problems relate back to preexisting conditions bilaterally. This factor carries the most significant 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 the loss of use of 5% of the right foot pursuant to §8(e) of the Act.

WITH RESPECT TO ISSUE (N), IS THE RESPONDENT DUE ANY CREDIT, THE ARBITRATOR FINDS AS FOLLOWS:

As noted above, the parties have stipulated to the Respondent's entitlement to a $280.00 credit for TTD previously paid prior to the hearing.

As to the medical expenses, the Arbitrator notes that the Respondent's stipulated 8(j) credit may not be applied to anything other than specifically awarded medical expenses in this case, i.e. it may not be applied in any way against TTD and/or permanency.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	06WC041743
Case Name	BEAN, ALLEN J v. SUNKEL PLUMBING
Consolidated Cases	
Proceeding Type	8(a)/19(h) Petition
Decision Type	Commission Decision
Commission Decision Number	22IWCC0217
Number of Pages of Decision	22
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	William Trimble
Respondent Attorney	John Kamin

DATE FILED: 6/13/2022

/s/ Deborah Baker, Commissioner

Signature

22IWCC0217

STATE OF ILLINOIS)
) SS.
COUNTY OF McLEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ALLEN J. BEAN,

Petitioner,

vs. NO: 06 WC 41743

SUNKEL PLUMBING,

Respondent.

DECISION AND OPINION ON REVIEW PURSUANT TO §19(h) Or §8(a) OF THE ACT

This matter comes before the Commission pursuant to Petitioner's Petition for Review Under §19(h) or §8(a) of the Act ("Petition")[1], alleging a causal connection between his June 27, 2006 accidental work injury and the medical care and prospective medical care recommendations he received after the February 17, 2010 Decision of the Arbitrator. A hearing on the Petition was held before Commissioner Stephen Mathis on September 8, 2021 and a record was made. After reviewing the record in its entirety and being advised of the applicable law, the Commission grants Petitioner's Petition and finds that Petitioner established a causal relationship between his June 27, 2006 work accident and his incurred medical expenses under Section 8(a) of the Act, and further finds causation between said accident and the prospective medical care recommended by Dr. Lawrence Li for the reasons set forth below.

[1] Petitioner is only proceeding under §8(a). The parties previously entered into a settlement agreement, the terms of which indicate that Petitioner waived the provisions of §19(h) of the Act, but expressly left his rights under §8(a) of the Act open. *Transcript of Proceedings on Review, p. 5*.

I. FINDINGS OF FACT

A. Procedural History and Background

On June 27, 2006, Petitioner was 51 years old and was working as an Apprentice Plumber for Respondent when he suffered a work-related injury to both shoulders and hands. Respondent's Section 12 examiner, Dr. Stephen Treacy, diagnosed bilateral carpal tunnel syndrome, impingement syndrome of the left shoulder, and a labral tear of the right shoulder with secondary impingement, all related to Petitioner's employment as a Plumber. On April 17, 2007, treating physician Dr. Lawrence Nord performed a left shoulder surgical decompression. On September 12, 2007, he performed a right shoulder surgical decompression. He also performed bilateral open carpal tunnel releases on October 30, 2007 and November 20 2007. On January 29, 2008, Dr. Nord released Petitioner from care, although Petitioner still complained of bilateral shoulder pain at the time.

On April 1, 2008, Petitioner sought additional treatment at Fort Jesse Family Medicine Clinic for his bilateral shoulder pain which worsened when he put his arms out or raised them. Petitioner was referred to a different orthopedist and chose board-certified orthopedic surgeon Dr. Lawrence Li at Orthopedic and Sports Medicine Center.

On April 7, 2008, Dr. Li examined Petitioner's shoulders and found reduced range of motion and positive Hawkin's and Neer's signs bilaterally. Bilateral shoulder MRIs were ordered and revealed high grade partial thickness tears of the supraspinatus and infraspinatus tendons in the left shoulder and significant tendinosis and high-grade partial thickness tears of the supraspinatus and infraspinatus tendons in the right shoulder.

On May 14, 2008, Dr. Li performed a left shoulder arthroscopy to repair Petitioner's rotator cuff, a subacromial decompression and excision of distal clavicle, and debridement of a type 1 labral tear. On August 22, 2008, Dr. Li performed the same on Petitioner's right shoulder.

Subsequently, Petitioner continued suffering from limited range of motion and discomfort in his shoulders bilaterally. Dr. Li referred him to pain management at Applied Pain Institute. He underwent acupuncture therapy, which only provided temporary pain relief.

Petitioner underwent occupational therapy until May 11, 2009. On that date, the therapist noted Petitioner had undergone 62 therapy sessions since May 16, 2008, and that his pain was improved but was still 5/10 with decreased range of motion.

Petitioner also treated with Dr. Li on May 11, 2009, who discharged him from care, despite noting Petitioner had made no significant progress with his pain levels. He discharged Petitioner to a home exercise program and scheduled a functional capacity examination ("FCE").

On July 13, 2009, Petitioner underwent an FCE at the Orthopedic and Sports Medicine Center. It was found that Petitioner worked hard, but did not use safe lifting techniques consistently. The therapist opined that due to Petitioner's deficits in strength and range of motion

in both shoulders, limited cardiovascular endurance and balance deficits limited his ability to return to work. Petitioner's functional limitations were as follows:

20 pounds from waist to floor and waist to crown
10 pounds frequently from waist to floor and waist to crown
35 pounds maximum front carry
No frequent front carry
Significantly limited elevated work
No climbing ladders
Some limits on forward bending
Some limits on crouching
Some limits on walking

Due to his limitations, the therapist opined Petitioner could not return to work as a plumber.

Respondent did not provide any vocational rehabilitation, and Petitioner eventually procured his own counselor, Mr. Bob Hammond. Mr. Hammond interviewed Petitioner, noted he had an 11th grade education but had taken special education classes throughout his entire school career. Mr. Hammond determined Petitioner read at a 4th grade level. Mr. Hammond concluded that, based on the FCE, Petitioner was incapable of returning to work as a plumber, which was classified as heavy work. He opined that no amount of training could assist Petitioner in gaining employment in the general labor market due to his physical limitations and low intellectual function.

Respondent hired vocational consultant Jim Ragains to perform a labor market survey. Mr. Ragains concluded Petitioner could not return to work as a plumber and had no transferable job skills.

At the time of arbitration, Petitioner was still taking pain medication. He still had constant aching in each shoulder, and pain worsened with normal movements.

On February 17, 2010, the Arbitrator issued a Decision (hereinafter "Decision of the Arbitrator"). The parties stipulated to the June 27, 2006 work accident, and the Arbitrator found that Petitioner's current bilateral carpal tunnel syndrome, bilateral impingement syndrome, bilateral rotator cuff tear and bilateral labral tear conditions of ill-being were causally related to said accident. The Arbitrator found that Petitioner was entitled to 148 & 5/7ths weeks of temporary total disability ("TTD") benefits, and also found that as of July 14, 2009, Petitioner was permanently and totally disabled as a result of his accidental work injury. The Arbitrator also found Respondent was entitled to TTD credit in the amount of $25,876.42.

Subsequently, Respondent filed a review of the Decision of the Arbitrator and while pending, the parties entered into a settlement agreement, which was approved by the Commission on August 31, 2011 (hereinafter "Settlement Agreement"). In the Settlement Agreement, the parties represented that Petitioner sustained bilateral compressive neuropathies and rotator cuff tears as a result of the June 27, 2006 work accident.

On August 16, 2016, Petitioner initially filed the instant Petition, and a hearing was held before Commissioner Stephen Mathis on September 8, 2021.

B. Section 8(a) Hearing

At the September 8, 2021 Commission hearing, Petitioner testified that he signed the aforementioned Settlement Agreement on June 29, 2011 with the condition that his medical rights remain open. Petitioner testified that since that time, he has not suffered an intervening accident, but his bilateral shoulder conditions kept getting worse and he experienced throbbing in his shoulders. He initially treated with Dr. Nord, followed by Dr. Lawrence Li, who performed physical examinations and various diagnostic tests. He testified that at one point, Dr. Li sewed clips into Petitioner's shoulders. Petitioner testified that Dr. Li characterized his shoulder tears as "bad" and told him to take it easy. Petitioner's pain management progressed from as few as one pill to as many as five with no success. He then tried a different medication at Dr. Li's recommendation which was "way too much" for him to handle. Eventually, Dr. Li recommended bilateral surgeries. Petitioner would like to undergo surgery for both shoulders as recommended by Dr. Li.

C. Medical History after the December 17, 2009 Arbitration Hearing

On June 26, 2012, Petitioner underwent a left shoulder MR which revealed low-grade tendinosis within the repaired supraspinatus insertion distally with no high-grade partial or full thickness cuff tear.

On July 2, 2012, Dr. Lawrence Li reviewed the MR and found supraspinatus tendinopathy but no tear.

On September 2, 2014, Petitioner treated with Dr. Lawrence Li, complaining of constant bilateral shoulder pain, left worse than right. Examination revealed bilateral flexion of 170. Dr. Li diagnosed bilateral rotator cuff tendinopathy or possible tear. Dr. Li recommended updated MRIs of both shoulders in order to determine treatment.

The MRIs were performed on September 3, 2014. The radiologist found that the right shoulder revealed moderate tendinosis of the supraspinatus and infraspinatus tendons with a low-grade partial thickness tear and severe atrophy of the teres minor muscle, raising the possibility of denervation. The left shoulder MRI revealed the same with the exception of the teres muscle atrophy.

On September 5, 2014, after reviewing the MRIs, Dr. Lawrence Li echoed the radiologist's findings for both MRIs and added that the left shoulder MRI also revealed a possible superior labral tear. He recommended physical therapy. Dr. Li testified via deposition that these were significant residual partial thickness tears with significant inflammation. Dr. Li also testified that these findings were consistent with a patient who has previously undergone a rotator cuff repair.

On September 17, 2014, the occupational therapist noted that Petitioner's pain was 7/10 even with medication. It was also noted that Petitioner continued to be limited functionally secondary to decreased strength, decreased range of motion and increased pain. Continued occupational therapy was recommended.

On October 3, 2014, Dr. Lawrence Li noted ongoing decreased strength and limited range of motion (flexion was 170 bilaterally) in Petitioner's shoulders. He diagnosed bilateral supraspinatus and infraspinatus tendinosis with partial tearing, and continued occupational therapy and medication.

During therapy, Petitioner routinely described his pain as 7/10.

On October 31, 2014, Dr. Lawrence Li noted Petitioner still had significant pain, which was aggravated by activities of daily living and interfered with his sleep. Examination results and diagnosis were the same. Dr. Li discussed a left shoulder arthroscopic surgery.

On January 6, 2015, Dr. Lawrence Li noted Petitioner's pain continued and now required Vicodin to obtain relief. Pain was aggravated by activities of daily living, which limited his desired lifestyle. Pain also awakened Petitioner from sleep. His bilateral shoulder range of motion had decreased, and he now had flexion of 160 on the right and 150 on the left. Dr. Li's diagnosis remained the same and Dr. Li planned to perform a left arthroscopic surgery once it was approved. Dr. Li opined that this was a continuation of a work injury suffered in 2006.

On March 26, 2015, Petitioner underwent a Section 12 examination at Respondent's request with Dr. Michael J. Cohen, a board-certified orthopedic surgeon who limits his practice to upper extremities. Dr. Cohen reviewed Petitioner's bilateral shoulder medical history. Upon examination Dr. Cohen noted Petitioner had external rotation of 40 degrees bilaterally, internal rotation to S1, 135 degrees of abduction bilaterally, and was tender across the AC regions with positive crossover signs bilaterally with positive secondary impingement signs on the left. Petitioner had full supraspinatus strength bilaterally without pain. Dr. Cohen opined that Petitioner's most recent MRIs were consistent with his prior surgeries, finding tendonitis and post-operative changes, that Petitioner's subjective complaints far outweighed his objective findings and that he saw no evidence or support for surgical indications. Dr. Cohen noted that Petitioner had already undergone two surgeries for each shoulder, and his conditions were just as bad as before the initial surgeries. He opined that another surgery was more likely to make it worse than better. Dr. Cohen opined that an FCE would be more appropriate in order to determine Petitioner's work restrictions, if any, and then place him at maximum medical improvement. He did not believe any further treatment was likely to improve Petitioner's situation, but would consider an EMG of the right parascapular muscles to evaluate atrophy.

On April 20, 2015, Dr. Li noted that Petitioner's range of motion was getting worse, as he had flexion of 150 on the right and 140 on the left. Petitioner continued taking Vicodin.

On May 22, 2015, Dr. Lawrence Li continued recommending surgery. Dr. Li reviewed Dr. Cohen's Section 12 report and opined that the FCE recommended by Dr. Cohen would be of no use to help Petitioner's pain.

On June 24, 2015, Petitioner's complaints continued, but now included popping in the left shoulder and he was more tender in the left biceps tendon. Dr. Lawrence Li performed a steroid injection in Petitioner's biceps tendon.

On July 22, 2015, Dr. Lawrence Li noted Petitioner's Hydrocodone prescription had been increased due to his pain. The injection provided relief of discomfort for a few weeks. Petitioner had significant pain with shoulder usage, left worse than right. The steroid injection provided relief for a few weeks. Dr. Li's diagnosis was the same, but now included left biceps tendonitis. Dr. Li continued noting that Petitioner's diagnosis was a continuation of a work injury suffered in 2006.

On September 16, 2015, Dr. Li notes that Petitioner's complaints continued and now included tenderness over the left distal clavicle. He indicated Petitioner now required Hydrocodone to sleep. Dr. Li's diagnosis was the same.

On November 13, 2015, Dr. Lawrence Li noted that Petitioner's left shoulder pain was getting worse. Further, Dr. Li noted Petitioner began taking Hydrocodone on a regular basis and was frustrated with this prolonged process. Petitioner had decreased range of motion bilaterally, with 150 on the right and 145 on the left. Dr. Li opined Petitioner had failed conservative treatment and required arthroscopic surgery due to pain.

On June 7, 2016, Petitioner returned to Dr. Li who noted that Petitioner's complaints continued, with his left shoulder being worse. Petitioner was out of medications. Dr. Li's examination revealed progressively decreasing range of motion (flexion 140 on the right and 130 on the left), and decreased strength and tenderness over the biceps tendon. Dr. Li's diagnosis was the same and he continued recommending surgery. Dr. Li continued noting that Petitioner's diagnosis was a continuation of a work injury suffered in 2006.

From February 27, 2019 through August 9, 2021, Petitioner treated with pain management physician, Dr. Ji Li at Applied Pain Institute, LLC. Petitioner routinely treated for his chronic bilateral shoulder pain during this time, and his pain medications were either continued or refilled. Petitioner frequently complained of pain rated 7 out of 10; but complained of pain rated 4 out of 10 on one occasion and increased pain rated 8 out of 10 on one occasion. Dr. Li routinely indicated that Petitioner's treatment was related to a work-related injury.

On April 13, 2021, Dr. Lawrence Li noted Petitioner still had significant bilateral shoulder pain, worse on the left. Petitioner indicated he could not tolerate the pain anymore. A physical examination revealed further decreased range of motion (flexion 125 on the left) and he was in pain all the time. Dr. Li recommended a left shoulder corticosteroid injection and noted that Petitioner was still awaiting surgical authorization. On April 16, 2021, Dr. Lawrence Li performed the left shoulder injection.

On May 13, 2021, Petitioner presented at St. Joseph Medical Center due to his chronic and ongoing bilateral shoulder pain. Although these records also mentioned various other unrelated medical issues, the record indicated that he primarily sought treatment for his bilateral shoulders.

Petitioner was hospitalized for six days and received treatment including a lidocaine patch on his shoulder.

On August 9, 2021, Pain management physician Dr. Ji Li noted Petitioner's shoulder pain level was rated 7 out of 10 and was worsened by movement. It was noted that Petitioner still needed pain medication to function. Dr. Li opined that Petitioner may need another left shoulder surgery. He continued Petitioner's medications.

Petitioner testified that since he settled his claim, he has been performing home therapies and his lifting restrictions remain the same. Although surgery was recommended in 2015, Petitioner testified that he has yet to undergo it because "My lawyer didn't do anything." He testified that he occasionally phoned his attorney, who routinely told him he "was working on it." Subsequently, Petitioner retained new Counsel.

Petitioner also testified that he has unrelated health conditions. Petitioner recently had a pacemaker implanted and he had three stents put in his heart. He does not know if his cardiologist will clear him for surgery. He testified that his heart is at about 30 percent right now. Additionally, he has stomach cancer and kidney problems.

Deposition Testimony

i. Dr. Lawrence Li

On March 13, 2017, Dr. Lawrence Li was deposed. He testified that he was currently recommending left shoulder surgery since it was more symptomatic. If surgery improved Petitioner's left shoulder and he had significant right shoulder pain, Dr. Li would then look to perform surgery on the right shoulder as well.

Dr. Li diagnosed status post bilateral rotator cuff repair with residual dysfunction and pain from residual partial thickness tears of the bilateral rotator cuff tendons. Petitioner also had biceps tendinopathy and tendonitis in the left shoulder. He opined that Petitioner's current condition was residual from his multiple bilateral surgeries. He testified that surgery is reasonable because Petitioner's symptoms after his bilateral 2008 shoulder surgeries were never completely better, and his persistent symptoms since that time have progressed to the point of now being intolerable. Conservative treatment has not provided adequate relief. Dr. Li noted Petitioner is now taking Hydrocodone at a relatively young age (58 years old at the time), which he cannot do for the rest of his life.

Dr. Li testified he would not operate on Petitioner if he believed Petitioner was exaggerating his symptoms. He acknowledged that Petitioner has never approached him asking about submitting surgical bills through any other available source of payment.

ii. Dr. Michael J. Cohen

On May 4, 2017, Dr. Cohen was deposed. His testimony corroborated his Section 12 examination report. He testified that after reviewing the medical history and examining Petitioner,

he did not see anything that pointed to the need for surgery. He was a little concerned about atrophy in the teres muscle, which is why he recommended the EMG. He testified that such atrophy can sometimes be indicative of a nerve issue. He testified there were no surgical indications on Petitioner's September 3, 2014 bilateral shoulder MRIs, including the tendonitis shown on the MRIs, which he opined was residual from the initial surgery. Dr. Cohen further opined that if Petitioner had a symptomatic partial thickness rotator cuff tear or symptomatic rotator cuff tendonitis, he would have pain and weakness with rotator cuff strength testing, which Petitioner did not have when Dr. Cohen tested him. Thus, Dr. Cohen opined Petitioner's subjective complaints did not match the objective findings.

On cross examination, Dr. Cohen acknowledged that none of Petitioner's findings of external rotation of 40 degrees, internal rotation to S1, positive crossover signs nor abduction to 135 degrees were normal. He declined to answer whether decreased range of motion or positive crossover signs were indicators of surgical necessity, but did acknowledge that impingement can be a sign of surgical necessity in conjunction with other tests. Dr. Cohen did not believe that the 2014 MRIs revealed partial thickness tears, only tendonitis and post-operative changes.

On re-direct, Dr. Cohen stated that considering Petitioner's surgical history and his diabetic condition as evidenced in the medical records, he would anticipate Petitioner having decreased range of motion with external rotation, internal rotation and abduction.

II. CONCLUSIONS OF LAW

Per the aforementioned Settlement Agreement, the provisions of Section 19(h) of the Act have been waived, thus the Commission will only analyze the merits of Petitioner's claim under Section 8(a) of the Act.

In relevant part, Section 8(a) of the Act reads:

> The employer shall provide and pay the negotiated rate, if applicable, or the lesser of the health care provider's actual charges or according to a fee schedule, subject to Section 8.2, in effect at the time the service was rendered 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) (West 2004).

An employer's liability under this section of the Act is continuous so long as the medical services are required to relieve the injured employee from the effects of the injury. *Second Judicial District Elmhurst Memorial Hospital v. Industrial Comm'n*, 323 Ill. App. 3d 758, 764 (2d Dist. 2001). However, the employee is only entitled to recover for those medical expenses which are reasonable and causally related to his industrial accident. *I*d. at 764. The claimant has the burden of proving that the medical services were necessary, and that the expenses incurred were reasonable. *City of Chicago v. Illinois Workers' Compensation Comm'n*, 409 Ill. App. 3d 258, 267 (1st Dist. 2011).

A. Causal Connection

Based on the record as a whole, the Commission finds that Petitioner has sustained his burden of proving by a preponderance of the evidence that his medical care subsequent to the December 17, 2009 arbitration hearing is causally related to the original June 27, 2006 accident. Further, The Commission finds that Petitioner proved by a preponderance of the evidence that his medical treatment subsequent to the December 17, 2009 arbitration hearing was reasonably required to cure or relieve the effects of his work-related bilateral shoulder injuries, and further finds that Petitioner has proven the same for the prospective surgery recommended by Dr. Li. Accordingly, the Commission grants Petitioner's Petition For Review under Section §8(a) of the Act.

i. Prospective Medical Care

In its brief, Respondent argues that Petitioner's request for the prospective left shoulder surgery recommended by Dr. Li should be denied because the most recent MRIs do not indicate a surgical necessity, and in fact, are simply consistent with post-operative changes. Respondent notes that even though Petitioner's Section 8(a) rights remained open, he still bears the burden of proving that the proposed surgery is reasonable and necessary to cure and relieve the effects of his injury. Respondent relies on the opinions of Section 12 examiner Dr. Cohen, who noted that Petitioner had already undergone two surgeries for each shoulder, and opined that a third procedure without any defined cause is not reasonable or necessary, especially since Petitioner has effectively been functioning in the same capacity since 2011. Considering Petitioner's prior poor response to surgical intervention, Respondent argues, in reliance on Dr. Cohen's opinion, that a third surgery will not cure Petitioner's shoulder condition and is unlikely to reduce Petitioner's pain.

Petitioner argues that he has met his burden of proving that the recommended left shoulder surgery is causally related to the instant work accident. Petitioner argues that the medical records detail treatment for severe and ongoing shoulder pain. Petitioner also points out that Dr. Lawrence Li's records consistently relate Petitioner's current pain back to his 2006 accident. Petitioner further argues that Dr. Cohen's opinions are refuted by Petitioner's testimony of increased pain. Thus, Petitioner requests that the Commission grant his Petition with respect to prospective medical care recommended by Dr. Lawrence Li.

The Commission agrees with Petitioner and finds that Petitioner's current bilateral shoulder condition is causally related to the June 27, 2006 work accident, and also finds that the recommended prospective left shoulder surgery is reasonably required to cure or relieve the effects of said accident. Prior to reaching a settlement in 2011, and due to bilateral shoulder pain and decreased range of motion, Petitioner underwent two bilateral shoulder surgeries on each shoulder, neither of which were successful in curing or relieving his symptoms. Between the first and second set of shoulder surgeries, Petitioner underwent bilateral shoulder MRIs in April of 2008 which revealed high-grade partial thickness tears of the supraspinatus and infraspinatus tendons in the left shoulder and significant tendinosis and high-grade partial thickness tears of the supraspinatus and infraspinatus tendons in the right shoulder. After the second set of surgeries Petitioner's symptoms persisted. In May of 2009, Petitioner's bilateral shoulder pain was rated 5 out of 10. At arbitration, Petitioner was found to be permanently and totally disabled as a result of his accidental

work injury. Petitioner continued complaining of ongoing shoulder issues after entering into a settlement agreement wherein his 8(a) rights were left open.

On September 3, 2014, Petitioner underwent bilateral shoulder MRIs. Dr. Li concurred with the radiologist's finding of right shoulder moderate tendinosis of the supraspinatus and infraspinatus tendons with a low-grade partial thickness tear and severe atrophy of the teres minor muscle, raising the possibility of denervation. Dr. Li also concurred with the radiologist's finding of the same in the left shoulder, with the exception of the teres muscle atrophy. Dr. Lawrence Li opined that these were residual partial thickness tears, which were consistent with a patient who had previously undergone a rotator cuff repair. Dr. Li opined further that Petitioner's condition was a continuation of the work injury suffered in 2006. After more than a year of additional treatment, Dr. Li opined that conservative care had failed, and that Petitioner required arthroscopic surgery. Dr. Li was clear in his disagreement with Dr. Cohen's FCE recommendation, asserting that it would do nothing to cure Petitioner's ongoing pain. Additionally, on August 9, 2021, pain management physician Dr. Ji Li noted that Petitioner still required pain medication to function, and indicated that another left shoulder surgery may be necessary.

Based on the above, the Commission finds the opinions of treating physician Dr. Li to be more persuasive than the opinions of Section 12 examiner Dr. Cohen as the diagnostic evidence, the corroborating opinion of Dr. Ji Li, and Petitioner's own quantification of his pain support a reasonable belief that a third shoulder surgery is reasonably necessary to improve Petitioner's condition. Dr. Li's opinion that conservative treatment had failed, and that surgery was reasonably necessary to cure or relieve Petitioner's symptoms is persuasive. Petitioner's September 3, 2014 MRI results, increased symptomatology, increased reliance on pain medication, failed conservative treatment, and additional diagnosis of left biceps tendonitis belie Dr. Cohen's opinion that there was no evidence of surgical indications. Further, the Commission agrees that Dr. Cohen's recommendation for an FCE is unreasonable. Petitioner has already undergone an FCE, received permanent restrictions and has been designated as permanently and totally disabled. Another FCE will not eliminate or relieve his current symptoms. Indeed, as noted in Dr. Li's medical records, the partial thickness tears found in the 2014 MRIs are causally related to the 2006 work accident. The Commission agrees with Dr. Li that the recommended left shoulder surgery is reasonably necessary to cure or relieve Petitioner's ongoing symptoms.

Further, the Commission finds Petitioner's testimony was credible. The Commission finds the medical records corroborate Petitioner's credible testimony regarding the increase in his shoulder symptomatology since 2011. Petitioner's post settlement pain complaints remained constant over the years, as he routinely described his pain as rated 7 out of 10, with occasional slight fluctuation. This supports Petitioner's claim of increased pain subsequent to arbitration, as he rated his pain 5 out of 10 prior to the December 17, 2009 arbitration hearing. Further supporting this claim are the post-hearing records of Dr. Lawrence Li, which note decreased strength, range of motion, and flexion on examination; increased pain; and an increased reliance on Vicodin and other pain medications to cope with pain. Further, there is nothing in the record to cast doubt on Petitioner's testimony. For these reasons, the Commission grants Petitioner's request for the prospective left shoulder surgery recommended by Dr. Li.

ii. Incurred Medical Expenses

Regarding incurred medical expenses, the parties agree that treatment rendered by Dr. Lawrence Li, Applied Pain Institute, LLC, and Prescription Partners identified in Petitioner's Exhibit Number 8 in relation to Petitioner's bilateral shoulder treatment were contemplated in connection with the August 2011 settlement agreement, and should thus be awarded to Petitioner. However, with respect to the outstanding balance for treatment at OSF St. Joseph Medical Center, the Commission finds that these bills must be parsed in order to accurately deduce which expenses are related to treatment of Petitioner's shoulders. Although these records indicate Petitioner primarily sought treatment for his bilateral shoulders, it is clear that Petitioner was also treating for unrelated issues during his time there as well. The Commission finds that there is insufficient detail in the medical records and bills for the Commission to properly parse the bills. However, the Commission finds that all medical treatment at OSF St. Joseph Medical Center related to Petitioner's bilateral shoulder conditions was reasonable and necessary and is awarded to Petitioner.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition For Review under §8(a) is hereby granted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is liable for all past reasonable, necessary and causally related medical expenses incurred in the care and treatment of Petitioner's bilateral shoulder injuries, pursuant to §8(a) and subject to §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for left shoulder surgery, including post-surgical rehabilitative treatment, as recommended by Dr. Lawrence Li as provided in §8(a) of the Act.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $15,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

June 13, 2022
O: 4/13/21
DJB/wde
043

/s/ *Deborah J. Baker*
Deborah J. Baker

/s/ *Stephen Mathis*
Stephen Mathis

/s/ *Deborah L. Simpson*
Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BEAN, ALLEN J
Employee/Petitioner

Case# **06WC041743**

SUNKEL PLUMBING
Employer/Respondent

On 2/17/2010, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.18% 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:

0293 KATZ FRIEDMAN EAGLE EISENSTEIN
CHRISTOPHER MOSE
77 W WASHINGTON 20TH FL
CHICAGO, IL 60602-2983

0358 QUINN JOHNSTON HENDERSON ETAL
JOHN J KAMIN
227 NE JEFFERSON ST
PEORIA, IL 61602

RX#2

STATE OF ILLINOIS)
)SS.
COUNTY OF McLean)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Allen J. Bean
Employee/Petitioner
v.
Sunkel Plumbing
Employer/Respondent

Case # **06** WC **41743**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Ruth White**, Arbitrator of the Commission, in the city of **Bloomington**, on **December 17, 2009**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **June 27, 206**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$13,962.00**; the average weekly wage was **$268.50**.

On the date of accident, Petitioner was **51** years of age, ***single*** with **1** child under 18.

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

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

Respondent shall be given a credit of **$25,876.42** for TTD.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$199.32**/week for **148 5/7** weeks, commencing **September 7, 2006** through **July 13, 2009**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent and total disability benefits of **$411.10**/week for life, commencing **July 14, 2009**, as provided in Section 8(f) of the Act.

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

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

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

Signature of Arbitrator

February 15, 2010
Date

FEB 17 2010

IN REGARD TO ISSUE (F), IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS THE FOLLOW:

Petitioner worked as an apprentice plumber for Respondent and did frequent overhead work. On June 27, 2006, he was pulling a heavy pipe through a long-distance in a row boat type of position when he experienced pain in both shoulders.

He sought treatment with Dr. Lawrence Nord and received cortisone injections into both shoulders. Petitioner also complained of numbness in both hands which developed gradually. EMG studies were positive for bilateral carpal tunnel syndrome.

Respondent had Petitioner examined by Dr. Stephen Treacy on January 18, 2007. Dr. Treacy diagnosed Petitioner as having bilateral carpal tunnel syndrome, impingement syndrome in his left shoulder and a labral tear in the right shoulder with secondary impingement. He also concluded that these conditions were related to Petitioner's employment as a plumber. (Px#1).

Dr. Nord performed a surgical decompression on Petitioner's left shoulder on April 17, 2007 and a surgical decompression on the right shoulder on September 12, 2007. He later performed open carpal tunnel releases on October 30, 2007 and November 20, 2007. Dr. Nord released Petitioner from his care on January 29, 2008 despite the fact that Petitioner still complained of pain in both shoulders. (Px#2)

On April 1, 2008, the Petitioner sought treatment with Dr. Jani at the Fort Jesse Family Medicine Clinic for evaluation of pain in both of his shoulders which was made worse by putting his arms out or raising them. Dr. Jani referred to a different orthopedic doctor for an opinion, and Petitioner chose to see Dr. Lawrence Li of the Orthopedic and Sports Medicine Center. Petitioner saw Dr. Li on April 7, 2008 and the doctor's examination showed that Petitioner had reduced range of motion, strength that was 4.5/5, and positive Hawkin's and Neer's signs in both shoulders. He ordered MRIs for both shoulders and these revealed that Petitioner had a high grade partial thickness tears of both the supraspinatus and infraspinatus tendons in the left shoulder and significant tendonosis with high grade partial thickness tear of the supraspinatus and infraspinatus tendons in the right shoulder. (Px#3).

Respondent had Petitioner examined by Dr. David Fletcher on May 19, 2008. Based upon his exam, Dr. Fletcher concluded that Petitioner had bilateral shoulder impingement and persistent median neuropathy due to incomplete carpal tunnel releases. He recommended that Petitioner "receive any necessary medical treatment," and if he did not require surgery he could be released to return to return to work within the Light-Medium physical-demand level. (Rx#2).

Dr. Li performed an arthroscopy on Petitioner's left shoulder to repair a rotator cuff tear, subacromial decompression and excision of distal clavicle, and debridement of a type 1 labral tear on May 14, 2008. He later performed an arthroscopy on the right shoulder to debride a type 1 labral tear, subacromial decompression and excision of distal clavicle, and rotator cuff repair on August 22, 2008.

Following surgery, Petitioner continued to have limited range of motion and significant discomfort in his shoulders. Dr. Li referred him to pain management with Dr. Ji Li and Dr. Gu at the Applied Pain Institute. He underwent acupuncture therapy which provided only short term pain relief. (Px#3 and #6). Dr. Li continues to prescribe Vicodin and Relafen for the Petitioner. (Px#6).

Petitioner testified that he takes Vicodin three times per day and Relafen once per day. Both of his shoulders and his right arm constantly ache and then pain is made worse by normal movements.

Respondent had Petitioner examined by Dr. Fletcher again on April 21, 2009. Dr. Fletcher felt the Petitioner had reached maximum medical improvement. He took it upon himself to perform his own functional capacity evaluation in which he concluded that the Petitioner did not give his maximum effort. He also concluded that the Petitioner exhibited excessive pain behaviors. He opined that the Petitioner was capable of occasional lifting of 40 pounds from floor to waist, occasional lifting of 20 pounds from waist to overhead, and only occasional short-term overhead work. (Rx#1).

Petitioner continued to undergo physical therapy until his final appointment on May 11, 2009. The therapist noted that Petitioner had gone through 62 occupational therapy sessions since May 16, 2008 and that pain was improved but still at a 5/10 level at all times with decreased range of motion and due to pain. The Petitioner also saw Dr. Li on May 11, 2009 and discharged him from care, although he noted Petitioner had made no significant progress with his pain level and rated his pain at 5/10 bilaterally and found his strength diminished to 4.5/5 in external rotation. He discharged him to a home exercise program and scheduled a functional capacity evaluation. (Px#3).

Petitioner underwent a full functional capacity evaluation at the Orthopedic and Sports Medicine Center on July 13, 2009. Testing was done for the full day and Petitioner was found to be working hard as evidenced by heart rate changes and sweating. He was believed to be self-limiting in pushing, pulling, and lifting tests due to his stated fear of re-injury. He did not use safe lifting techniques on a consistent basis. (Px#7).

Regarding Petitioner's ability to return to work, the therapist concluded that Petitioner's deficits in strength and range of motion in both of his shoulders, his limited cardiovascular endurance, and balance deficits all limited his ability to return to work. She also noted that Petitioner is very anxious and fearful of re-injury which prevents him from giving his maximal effort. As a result, she concluded that Mr. Beans Functional ability was limited to the following:

20 pounds maximum from waist to floor and waist to crown
10 pounds frequently from waist to floor and waist to crown
35 pounds maximum front carry
No frequent front carry
Significantly limited elevated work
No climbing of ladders
Some limits on forward bending
Some limits on crouching
Some limits on walking

She further concluded that he could not return to work as a plumber due to these limits. (Px#7).

Respondent did not provide any vocational rehabilitation for Petitioner. Petitioner eventually retained his own vocational counselor, Mr. Bob Hammond. Mr. Hammond interviewed the Petitioner and determined that the Petitioner had completed the 11th grade but had taken special education classes throughout his entire school career. Mr. Hammond gave the Petitioner the Minnesota Reading & Writing Quick Inventory test and this demonstrated that the Petitioner reads at the 4th grade level. (Px#4).

In his report, found that Petitioner's work experience consisted of working as an apprentice plumber for the past 20 years, including the last eleven for Respondent. He has never taken a license test and did not have a plumber's license. His work restrictions as set forth in the functional capacity evaluation precluded him from returning to work as a plumber, which is classified as heavy work. Mr. Hammond concluded that the Petitioner had no transferable skills to perform less physically demanding positions. Although plumbing is a skilled position, he had been taught by family and friends, and his low intellectual function and very low reading ability indicated a lack of transferable skills. (Px#8).

Mr. Hammond concluded that no amount of training could assist Petitioner to obtain employment in the general labor market because of the physical limitations set forth in the functional capacity evaluation and his low level of intellectual function. He felt that an employer would have to be willing to work extensively with Petitioner to overcome his difficulties, and this was unlikely given the labor market and Petitioner's difficulties. (Px#8).

Petitioner also testified that he did attempt to find work on his own. He submitted his notes regarding the employers that he contacted, the dates on which he did so, the manner of the contact and the result of the contacts as an exhibit. These records indicate that he applied for or inquired about employment 171 times from July 16, 2009 through December 3, 2009, either by calling a company on the phone or going there in person. (Px#10). He testified that the only opportunity came from Goodwill, where he was told that he would be hired on the spot to load trucks if he could lift more than 50 pounds. When he explained that he was restricted in lifting and from performing overhead work, he was told that they had nothing else for him.

Respondent presented Morris Sunkel, the owner of Sunkel Plumbing, as a witness. Mr. Sunkel stated that Petitioner worked for him as a laborer first and then as an apprentice plumber. According to him, the State of Illinois allows individuals to work as an apprentice plumber for up to six years and then they must obtain a plumbing license. Because Petitioner did not obtain a plumbing license, he is ineligible to work as a plumber. He did confirm that Petitioner had asked him for lighter work, but that he had no lighter work available for him to do.

Respondent hired vocational consultant Jim Ragains to perform a labor market survey regarding this case. Mr. Ragains did not meet with Petitioner nor obtain any information from him about his educational or vocational background or any information about his physical and mental abilities. He assumed Petitioner was capable of performing at a physical level as stated by Dr. Fletcher and did not review or consider the functional capacity evaluation performed at the Orthopedic and Sports Medicine Center. It does not appear that Mr. Ragains took into account that Petitioner reads at the fourth-grade level. (Rx#5).

Based upon this information provided, Mr. Ragains did conclude that Petitioner could not return to work as a plumber and had no transferable job skills. (Rx#5).

Based upon a survey conducted by his assistant, Mr. Ragains stated that there were 15 employers in the Bloomington area who had current job openings and for which Mr. Bean would qualify. Of these 15 jobs, two were part-time. Of the remaining 13, three were listed as Assembler, five as cashier, five as Janitor or Cleaner, one as a dry cleaning presser, and one as a part-time assembler. Fourteen other employers were identified who did not have openings but for whom it was felt that Mr. Bean would qualify. These positions were also listed as cashiers, janitors, or assemblers. (Rx#5).

Mr. Ragains did not determine whether the assembler, janitor or cleaner jobs were within Mr. Bean's physical limitations, nor did he determine whether the cashier jobs were the kind that Mr. Bean could perform given his limited intellectual function and poor reading skills. (Rx#5).

At arbitration, Mr. Ragains acknowledged that he provided no vocational assistance whatsoever to the Petitioner, not even helping him prepare a resume or helping him obtain a GED.

After Mr. Ragains issued his report, Petitioner attempted to contact the 29 employers listed to look for a job. Petitioner testified that he was told that some of the people listed as providing the information to Mr. Ragains either did not work there or had not worked there in several months or that the alleged job openings did not exist. Petitioner did not obtain any job leads from these contacts.

Bob Hammond also contacted the employers listed in Mr. Ragains report. According to Mr. Hammond, nine of the 15 employers alleged to have present job openings suitable for the Petitioner did not have any such suitable positions because they required either high school diplomas, GEDs, or an ability to lift more than Petitioner demonstrated he could lift on his functional capacity evaluation. Of the 14 employers alleged to have suitable employment in the future, five required either diploma, GED, or lifting in excess of Petitioner's restrictions, one did not exist, one was unable to furnish any hiring information, and was only part-time employment.

In regard to issue (O) whether the Petitioner had any children under 18 at the time of his injury, the Arbitrator finds the following:

The Application for Adjustment of claim which was filed stated that the Petitioner did not have any children under the age of 18 at the time of his accident. During the course of Petitioner's testimony, however, Petitioner discussed his children and testified that the youngest of his four children was under the age of 18 on the date of injury. Petitioner's counsel then moved to amend the Request For Hearing form to reflect the fact that the Petitioner had one child under the age of 18 at the time of his injury.

Respondent's counsel objected to such an amendment.

Petitioner presented an Order of Parentage from the Circuit Court of Macon County which reflects that Petitioner is the father of a Christopher Hall who was born on January 21, 1990. It further reflects that Petitioner is obligated for support, maintenance, education and welfare of this child.

The Arbitrator therefore finds that Petitioner had one child under the age of 18 at the time of his accident.

In regard to issue (J) whether the medical services provided to Petitioner reasonable and necessary, the Arbitrator finds the following:

Petitioner submitted bills for the treatment rendered for this injury. The bill from Applied Pain Institute demonstrates an unpaid balance of $186.00. The bill from the Orthopedic Center for Sports Medicine reflects an unpaid balance of $793.09 for treatment and an additional charge of $1,019.68 for the functional capacity evaluation performed on July 13, 2009.

The Arbitrator finds that these services were necessary for the treatment of Petitioner's work injury and are reasonable. The functional capacity evaluation was necessary to determine Petitioner's physical capabilities and his ability to return to work. It was a necessary expense of physical and vocational rehabilitation, as described in Section 8(a) of the Act. Respondent is therefore liable for these expenses.

The Arbitrator further finds that Respondent is liable for the expense Mr. Hammond's efforts at vocational rehabilitation. Section 8(a) states that an employer shall pay for "treatment, instruction, and training necessary for ... vocational rehabilitation of the employee."

Commission Rule 7110.10 requires an employer to prepare a written assessment of the course of medical care and rehabilitation required to return an injured worker to employment when it can be reasonably determined that the injured worker will, as a result of the injury, be unable to resume the regular duties in which engaged at the time of the injury, or when the total incapacity for work exceeds 120 days, whichever occurs first. Such an assessment must address the necessity for any plan or program which may include medical and vocational evaluation, modified or limited duty, and/or retraining.

In this case, the Respondent failed to comply with its obligations under Rule 7110.10 even though it knew Petitioner was unable to return to work. Respondent took no action except to unilaterally terminate his TTD payments and made no effort to assess whether any kind of rehabilitation could aid Petitioner in finding gainful employment. As a result of Respondent's refusal to comply with the mandate of Rule 7110.10, Petitioner was forced to retain his own vocational counselor to make such an assessment. Respondent is in fact liable for Mr. Hammond's vocational assessment as reflected in his report of July 24, 2009 (Px#8) and his bill in the amount of $1,102.75 for that date. (Px#13).

Respondent is therefore ordered, pursuant to Section 8(a), to pay to the Petitioner the sum of $3,101.52 for medical and vocational expenses.

In regard to issue (K) what amount of compensation is due for temporary total disability, the Arbitrator finds the following:

Because the Arbitrator has found that the Petitioner had one child under 18 at the time of his injury, the appropriate TTD rate would be the minimum set forth by the Commission for his date of injury, which is $225.32.

Petitioner sustained bilateral carpal tunnel syndrome, bilateral impingement syndrome, bilateral rotator cuff tears, and bilateral labral tears as a result of his work injury. Although the parties dispute the exact nature of the Petitioner's restrictions, there is no dispute that Petitioner's disabilities prevent him from returning to work as a plumber or from returning to work with Respondent.

Petitioner is entitled to temporary total disability benefits from September 7, 2006 through July 13, 2009, the latter being the date on which the FCE was performed that determined Petitioner's limitations.

In regard to issue (L), what is the nature and extent of the injury, the Arbitrator finds the following:

Petitioner is too limited in terms of physically function, education, and intellectual abilities to find employment in a stable labor market. The quality of Petitioner's self-directed job search reflects Petitioner's limitations. Petitioner has presented evidence through the opinion of a certified vocational consultant, Bob Hammond, that he is unable to obtain work in a stable labor market and he has also presented evidence of an unsuccessful job search. The Arbitrator therefore concludes that the Petitioner's physical limitations, combined with his age, education, training, and work history make him unemployable.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC039777
Case Name	HERNANDEZ, JONATHAN CAMACHO v. QFS SERVICES, INC. LOANING EMPLOYER/ CCA RESTORATION INC BORROWING EMPLOYER
Consolidated Cases	
Proceeding Type	Petition for Review Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0218
Number of Pages of Decision	31
Decision Issued By	Maria Portela, Commissioner

Petitioner Attorney	Damian Flores
Respondent Attorney	Carol Cesaretti

DATE FILED: 6/13/2022

/s/Maria Portela, Commissioner

Signature

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

JONATHAN CAMACHO HERNANDEZ,

Petitioner,

vs. NO: 15 WC 39777

QFS SERVICES, INC., LOANING EMPLOYER, AND CCA RESTORATION, INC., BORROWING EMPLOYER,

Respondents.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and Respondent, QFS Services, Inc., herein and notice given to all parties, the Commission, after considering the issues of accident, causation, medical expenses, prospective medical treatment, temporary total disability, nature and extent and penalties and attorney's fees and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof, but makes clarifications as outlined below. The Commission further remands this case to the Arbitrator for further proceedings for a determination of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Commission affirms the Arbitrator's findings of accident, causation, medical expenses, the denial of prospective medical treatment and the denial of penalties and fees.

The Respondent does not dispute that the automobile accident took place, but instead argues that it was not a *compensable* accident. The Commission affirms the Arbitrator's finding that Petitioner was in an automobile accident that arose out of and in the course of employment but strikes the second sentence of paragraph 1 of page 23 of the Arbitrator's Decision in its

entirety, finds the legal basis for doing so is that Petitioner was a traveling employee and provides the following analysis.

It is undisputed that an automobile collision occurred on November 30, 2015 while Petitioner was part of a crew leaving a work site to return to the company office. It is also undisputed that Petitioner was riding in a car owned and driven by one of his co-workers for the purposes of transporting the work crew to and from the job site.

An injury "arises out of" employment if it had its "origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Sisbro, Inc. v. Industrial Comm'n* 207 Ill.2d 193, 203 (2003). "Typically, an injury arises out of one's employment if, at the time of the occurrence, the employee was performing acts he or she was instructed to perform by the employer, acts which he or she had a common law or statutory duty to perform, or acts which the employee might reasonably be expected to perform incident to his or her assigned duties." *Brais v. Illinois Workers' Compensation Comm'n*, 2014 IL App (3d) 120820WC ¶18.

"'The general rule is that an injury incurred by an employee in going to or returning from the place of employment does not arise out of or in the course of the employment and, hence, is not compensable.'" *Venture – Newberg-Perini, Stone & Webster v. Illinois Workers' Compensation Comm'n*, 2013 IL 115728, ¶16 (quoting *Commonwealth Edison Co. v. Industrial Comm'n*, 86 Ill.2d 534, 537 (1981)). Courts have explained this rule, stating that "'the employee's trip to and from work is the product of his own decision as to where he wants to live, a matter in which his employer ordinarily has no interest.'" *Sjostom v. Sproule*, 33 Ill.2d 40, 43 (1965). An exception exists, however, "when the employer provides a means of transportation to or from work or affirmatively supplies an employee with something in connection with going to or coming from work." *Xiao Ling Peng v. Nardi*, 2017 IL App (1st) 170155, ¶10 (citing *Hall v. De Falco*, 178 Ill.App.3d 408, 413 (1988) (citing *Hindle v. Dillbeck*, 68 Ill.2d 309, 320 (1977) and *Sjostrom*, 33 Ill.2d at 40).

In *Xiao Ling Peng*, 2017 IL App (1st) 170155, ¶3, Peng was injured in a multi-vehicle accident while riding to work in a 15-seat passenger van. The van was driven by a co-employee and owned by the employer. *Id.* ¶3. Although Peng was not compensated for her commute time or mandated to use the company owned van, the court determined that she had "relinquished control over her conditions of transportation when she climbed into a vehicle owned by her employer and driven by her coemployee under the employer's direction." *Id.* ¶25 (citing *Johnson v. Farmer*, 537 N.W.2d 779, 772 (1995)). More specifically, the court considered the van to be an extension of her work site or a "'a small ambulatory portion of the [employer's] premises.'" *Id.* ¶25. The court determined that the employer exposed itself to liability for its employees' injuries during the commute because the employer controlled the conditions and the risks of transportation. *Id.* ¶26 (citing *Hall*, 178 Ill.App.3d at 413).

Moreover, the court in *Xiao Ling Peng* determined that, in order to receive compensation through the workers' compensation system, it made no difference whether an employee was not physically present at a job site, not performing any job-related tasks and not being compensated for his or her time. *Id.* ¶27. Rather, the "dispositive facts for purposes of compensation are that the vehicle was an employer-controlled conveyance for employee travel." *Id.* Thus, the employer was liable for Peng's injuries because the employer provided the van and driver, and thus, had control over the conditions of Peng's commute. *Id.*

Similar to *Xiao Ling Peng, Hindle* also involved an accident that occurred in an employer-controlled vehicle that transported employees to and/or from the job site. *Hindle*, 68 Ill.2d at 309. Specifically, in *Hindle*, the employer required the crew leader to supervise and transport team members from the cornfields to the nearest town. *Id.* at 309.

A traveling employee is one who is required to travel away from his employer's premises to perform his job. *Cox*, 406 Ill.App.3d at 545. As a general rule, a traveling employee is held to be in the course of his employment from the time he leaves home until he returns. *Id.* at 545 (citing *Urban v. Industrial Comm'n*, 34 Ill.2d 159, 162-63 (1966)). In order to qualify as a traveling employee, "the work-related travel at issue must be more than a regular commute from the employee's home to the employer's premises." *Pryor v. Illinois Workers' Compensation Comm'n*, 2015 IL App (2d) 130874WC, ¶22. Otherwise, the exception for traveling employees would swallow the rule barring recovery for injuries incurred while traveling to and from work, and every employee who commuted from his home to a fixed workplace would be deemed a traveling employee. *Pryor*, 2015 IL App (2d) 130974WC ¶22.

Employees whose duties require them to travel away from their employer's premises are treated differently from other employees when considering whether an injury arose out of and in the course of employment. *Venture – Newberg-Perini, Stone & Webster v. Illinois Workers' Compensation Comm'n*, 2013 IL 115728, ¶17; *Cox*, 406 Ill.App.3d at 545. An injury sustained by a traveling employee arises out of and in the course of employment if claimant was injured while engaging in conduct that was reasonable and foreseeable, *i.e.*, conduct that "'might normally be anticipated or foreseen by the employer.'" *Pryor*, 2015 IL App (2d) 130874WC ¶20 (quoting *Robinson v. Industrial Comm'n*, 96 Ill.2d 87, 92 (1983); *Kertis*, 2013 IL App (2d) 120252WC, ¶16; see also *Cox*, 406 Ill.App.3d at 545-46).

The Commission therefore finds that in the instant case this was, in fact, a compensable accident under the theory that the Petitioner was a traveling employee as he was returning to the company office in a company car driven by a co-worker.

Finally, The Commission remands this matter back to the Arbitrator for the determination of a permanency award.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 28, 2020 is hereby affirmed and adopted with the clarification as outlined 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, QFS Services, Inc., pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent, QFS Services Inc., 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.

June 13, 2022

MEP/dmm
O: 041922
49

/s/ *Maria E. Portela*

/s/ *Thomas J. Tyrrell*

/s/ *Kathryn A. Doerries*

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

22IWCC0218

HERNANDEZ, JONATHAN CAMACHO Case# **15WC039777**

Employee/Petitioner

TOTAL STAFFING SOLUTIONS A/K/A QFS SERVICES & CCA RESTORATION INC

Employer/Respondent

On 4/28/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.15% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1922 STEVEN B SALK & ASSOC LTD
DAMIAN FLORES
150 N WACKER DR SUITE 2570
CHICAGO, IL 60606

4866 KNELL O'CONNOR DANIELEWICZ
THOMAS RYAN BOYD
901 W JACKSON BLVD SUITE 301
CHICAGO, IL 60607

5074 QUINTAIROS PRIETO WOOD & BOYER
KRISTIN K LINDEMANN
233 S WACKER DR 70TH FL
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jonathan Camacho Hernandez Case # **15 WC 39777**
Employee/Petitioner
v.

Total Staffing Solutions a/k/a QFS Services & CCA Restoration, 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 **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **January 25, 2019.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the 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: *Contract between Total Staffing and CCA Restoration re: Workers' Compensation liability*

FINDINGS

On **November 30, 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 52 weeks preceding the injury, Petitioner earned $17,680.00; the average weekly wage was **$340.00**.

On the date of accident, Petitioner was 28 years of age, single, 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 **$13,200** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for medical benefits under §8(j) of the Act, for a total credit of **$13,200.00.**

While the issue of liability on the part of the Co-Respondents is moot in light of the fact that Petitioner failed to prove he suffered a compensable work accident, the Arbitrator notes that, per stipulation of the parties, any and all worker's compensation liability in the case at bar lies with Respondent Total Staffing/QFS Services and not CCA Restoration.

ORDER

The Arbitrator finds that Petitioner failed to prove that his current condition of ill-being is causally related to an accidental work injury. Petitioner did prove that he sustained muscular strains to his cervical and lumbar spines, for which he attained MMI by January 13, 2016.

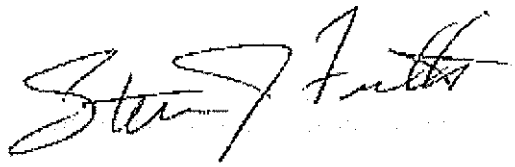
Respondents shall pay Petitioner's bills and charges for medical care and treatment provided through Jamuary13, 2016, the date on which Petitioner attained MMI, all bills to be adjusted in accord with the medical fee schedule provided in §8.2 of the Act.

Respondents shall pay Petitioner total temporary disability benefits from December 1, 2015 through January 13, 2016, 6 & 6/7 weeks, at $226.67/week, for which Respondents are entitled to a credit of $13,200 TTD benefits previously paid.

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

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

date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.



Signature of Arbitrator

April 21, 2020
Date

APR 28 2020

Jonathan Camacho Hernandez v. Total Staffing Solutions a/k/a QFS Services & CCA Restoration, Inc.
15 WC 39777

INTRODUCTION

This matter proceeded to hearing before Arbitrator Steven Fruth. The disputed issues were: ***C:*** Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?; ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***J:*** Were the 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 prospective medical care?; ***L:*** What temporary benefits are in dispute? TTD/TPD; ***M:*** Should penalties be imposed upon Respondent?

The parties agreed that Respondent Total Staffing Solutions a/k/a QFS Services, Inc. was the loaning employer and that Respondent CCA Restoration, Inc. was the borrowing employer. A contract between the Co-Respondents was stipulated to by all the parties and was admitted into evidence. The parties stipulated that, in accord with that contract, Total Staffing, Inc., a/k/a QFS Services, is liable for coverage of this claim.

FINDINGS OF FACT

Petitioner Jonathan Camacho Hernandez testified that he was in his first day of work for Respondent CCA Restoration, Inc. (CCA) on the claimed date of accident, November 30, 2015. He had been hired by Respondent Total Staffing Solutions a/k/a QFS Services (QFS) and assigned to CCA on the date of the claimed accident.

Petitioner testified that prior to November 30, 2015 he was in a "perfectly fine" health. Petitioner did acknowledge that he slipped on ice and sought treatment on January 15, 2010, at Presence St. Joseph Hospital for a low back injury. The medical records from the ER document low back pain rated at 10/10 with no radiation or weakness into the legs (PX #1). After a clinical exam and lumbar X-ray, Petitioner was diagnosed with a lumbar strain and discharged. Petitioner testified he was not referred to physical therapy, did not undergo injections, and never sought follow up care. He testified that he never missed a single day of work due to low back pain after that.

Petitioner worked a variety of warehouse jobs in the years prior to the claimed accident. He worked jobs that involved repetitive lifting of boxes weighing up to 30 pounds and bending to load and stack them. Petitioner testified that he was able to do these jobs without back pain.

At the direction of Respondent QFS Services, Inc., on November 30, 2015 Petitioner reported to work at 7:50 a.m. at CCA, at their facility in Alsip, Illinois. Upon arrival, Petitioner was driven to an apartment located in Chicago. With the help of co-workers, Petitioner loaded the contents of the apartment (i.e. a washing machine, stove, boxes & dresser drawers) into a 30 foot-long moving truck. The heaviest items Petitioner carried on his own were boxes weighing approximately 30 pounds. Petitioner testified that with a co-worker's assistance, he carried an old-fashion TV weighing more than 200 pounds from the apartment to the garbage. Petitioner worked for approximately 7 hours without issue. He completed his work duties for Respondent on November 30, 2015, without any complaints of back pain and without any symptoms traveling down either of his lower extremities.

Petitioner testified that the job of loading the truck finished around 3:50 or 4:00 p.m. The work crew got into the company Ford Escape to return to CCA's office. The Escape was driven by a co-worker and Petitioner sat in the back seat. During the commute, Petitioner and his co-workers were involved in a motor vehicle accident when the Escape was rear-ended on the highway. Petitioner testified that his driver had been driving 40 to 50 mph, swerved to avoid striking a car ahead, and made a sudden stop. The Escape was stopped one to two seconds and then was rear-ended by another car. Petitioner testified that he never saw the other vehicle prior to the accident and did not know how fast the other vehicle was traveling when it rear-ended the Escape.

Petitioner had his seat belt on during the incident. Upon impact, his body went forward and back in a fast motion. He immediately noted a "little poke" in his back that he rated at a 1 or 2. Petitioner got out of the vehicle temporarily and about 10 minutes later, they were back on the road to CCA's office. Petitioner testified that he requested an ambulance, but was told it would not come to the scene. During the commute back, Petitioner called QFS Services, the loaning agency and reported the accident. He was informed they would send him for treatment.

On cross-examination, Petitioner testified there was damage to the vehicle he was in following the car accident, which was a "bump" in the fender the size of an orange. He testified that another of the passengers, Angel, told him she was "bothered" by the accident. Petitioner testified that he didn't remember if they pulled off the highway after the accident but that he was awake during the accident. Petitioner also testified that he contacted a lawyer the evening of the date of accident.

Petitioner presented to Ingalls Family Care in Tinley Park at 6:14 p.m. that day with complaints of 7-8/10 low back, neck, bilateral thigh, and bilateral knee pain following a motor vehicle accident (PX #2). X-rays were negative for fractures. On examination Petitioner had tenderness to the posterior aspect of his knees. Range of motion of the knees is limited by pain although there was no joint laxity. There was mild tenderness to

palpation cervical and lumbar regions. Mild pain on lumbar range of motion was noted. He was diagnosed with neck/lumbar sprains, a knee contusion, was given work restrictions, and discharged without directions for follow-up. Petitioner then reported to work for Respondent for the next 2 days and was assigned to work in the office, sitting all day. Despite the lack of heavy activity, Petitioner had ongoing back pain, and also pain traveling down the back of both legs.

At Respondent QFS's direction, Petitioner sought treatment at Physicians Immediate Care (PIC) December 2, 2015, with complaints of neck, right shoulder, low back, and bilateral lower extremity pain since November 30 (PX #3). The PIC records note Petitioner was a passenger in a motor vehicle traveling at 50-55 or 55-70 miles per hour, when the driver stopped suddenly to avoid another vehicle and was then rear-ended in a "high force collision." The records document negative Waddell signs. Petitioner was diagnosed with strains of the neck, right shoulder, low back, and thigh. He was released with lifting restrictions and given a follow-up appointment for December 7.

Petitioner kept working and followed up with PIC on December 7, 2015 with ongoing complaints of neck and low back pain with symptoms of pain, weakness, and tingling traveling down his bilateral lower extremities; Petitioner also reported that the day before, he noticed tingling traveling down the right leg into the right foot. Petitioner received a prescription for prednisone and cyclobenzaprine and was again returned to work with restrictions.

On December 8, 2015, Petitioner sought a second opinion with Dr. Axel Vargas, reporting consistent complaints of low back pain traveling into his bilateral lower extremities (PX #4). Petitioner did not report the history of his prior back injury in 2010. Petitioner gave a history of being a restrained rear passenger in a motor vehicle, which was rear-ended by another vehicle traveling 40-50 miles per hour. Petitioner reported being "forcefully" thrown back and forth within the car, striking the inside of the vehicle. Petitioner reported that he experienced an "unexpected pop" in the lower back with immediate onset of lower back pain and pain shooting into the lower extremity. Dr. Vargas noted Petitioner sought treatment within the hours due to worsening symptoms.

On physical examination Dr. Vargas noted an "irritation response," "mild focalized weakness," and "subjective moderate decrease response throughout the L4-L5 and L5-S1 dermatomes," Dr. Vargas' impression of was lumbosacral discogenic radiculopathy, lumbo-sacral discogenic pain syndrome, as well as lumbar facet pain syndrome. Dr. Vargas ordered an MRI, as well as physical therapy and a course of NSAID's, Mobic, Protonix, Flexeril, Tramadol, and Gabapentin.

Petitioner underwent a lumbar MRI at Lakeshore Open MRI and CT on December 8, 2015 (PX #4). A 3-4 mm subligamentous posterior disc herniation at L5-S1 appearing

broad-based with extruded nucleus pulposus, indenting the thecal sac with generalized bilateral neuroforaminal narrowing was noted. A 3-4 mm central and slightly right-sided posterior disc herniation at L2-L3 with extruded nucleus pulposus, indenting the ventral and slightly right side of the thecal sac with central stenosis was also noted. The rest of the lumbar spine appeared unremarkable.

Petitioner returned to Dr. Vargas on December 15, 2015, at which time they discussed the results of the MRI. Dr. Vargas did not review the images himself but relied on the radiologist's report. Dr. Vargas noted that Petitioner's overall physical findings were correlated by the MRI, but noted that "on initial consultation, he did not present L2-L3 radiculopathy." Dr. Vargas noted that he did not believe Petitioner would benefit from epidural steroid injections at the L2-L3 level because "the patient did not complain of L2-L3 on initial consultation on the one hand, but also because there was not extrapolating physical findings on initial examination of L2-L3." Dr. Vargas direct diagnosed herniated discs at L2-3 and L5-S1 with bilateral neural foraminal stenosis, lumbosacral discogenic pain syndrome, and lumbosacral discogenic radiculopathy.

At his evidence deposition (PX #35) Dr. Vargas testified that his original impression was that the vehicle in which Petitioner was traveling at the time of the accident was rear-ended by another vehicle traveling at 40 to 50 mph. However, he continued that a 5 mph rear-end collision would be sufficient to cause Petitioner's injuries. Dr. Vargas emphasized that Petitioner had no history of prior radicular complaints, was able to complete work duties without issue hours before the accident, and then that Petitioner sought immediate treatment within hours of the accident. On cross-examination Dr. Vargas found no relevance in Petitioner's prior low back injury in January 2010 because there had been no follow-up and that Petitioner had not had pain within the weeks or months before the accident.

Petitioner was examined by orthopedic surgeon Dr. Kevin Tu on December 17, 2015 for an §12 IME (RX C). Dr. Tu testified at an evidence deposition August 29, 2018, at which time he confirmed his findings and opinions from the IME.

Dr. Tu noted a history of a "high-speed" car accident on November 30, 2015. Petitioner stated he was not sure if his knee struck the seat in front but reported pain in his right knee worse than his left as well as pain in his lower back and complained that pain radiated from his lower back down to his right leg. On exam Dr. Tu noted lumbar flexion to the mid tibia, tenderness to palpation over the paraspinal muscles, no evidence of gross motor or sensory deficits, and a positive straight-leg test on the right. Examination of Petitioner's knees revealed no pathology. Petitioner's lumbar MRI demonstrated disc herniations at L2-3 and L5-S1.

Dr. Tu testified at his deposition that Petitioner's low back pain with radiation into the right leg was consistent with a right L5-S1 dermatome. He noted a positive straight-leg sign, which indicated possible radiculopathy or a possible disc herniation. Dr. Tu diagnosed bilateral knee contusions and possible lumbar disc herniation. Dr. Tu found the prednisone prescription, physical therapy, and the lumbar MRI to be reasonable and necessary, however he found the compound cream medication was not necessary. Dr. Tu found that Petitioner was not at MMI and recommended continued work restrictions. Dr. Tu also opined that Petitioner could benefit from physical therapy, oral medication, possible steroid injections, and possible surgery. Dr. Tu did not express an opinion of whether a car accident on November 30, 2015 caused Petitioner's condition.

On December 24, 2015, Petitioner began a series of epidural steroid injections (ESI) with Dr. Vargas, who also referred Petitioner for physical therapy. Petitioner began physical therapy at Integrity Medical on December 29, 2015, and followed-up for the second injection on January 7, 2016. Petitioner testified that although the first two injections helped with a 50 to 60% decrease in pain. Dr. Vargas released Petitioner to light duty work, but Petitioner felt worse after his return to work. The third injection on January 28, 2016 did not help at all.

Petitioner reported back to work with Respondent QFS at the agency office and was paid to sit all day in a metal chair. On February 16, 2016, Dr. Vargas recommended a discogram and a neurosurgical consultation with Dr. Robert Erickson. On February 23, 2016, Dr. Pontinen at Integrity Medical examined Petitioner and prescribed Norco and Tramadol (PX #5). Although he noted improvement, Petitioner did not like taking the medication because he found himself addicted. Petitioner reported that Norco made him drowsy and when combined with other prescribed medication, caused him to fall asleep at work. This led to his termination by Respondent QFS March 24, 2016. He testified that he was falling asleep at work because "I was drinking, taking sleeping pills, too, at the moment with the painkillers. And the next day I would wake up tired...I would drink muscle relaxer, and I was waking up tired."

While working with restrictions from February 2, 2016, through March 24, 2016, Petitioner's gross income totaled $1,904.01 (PX #41).

Petitioner testified that around February 2016, Dr. Vargas was prescribing medications, but he did not remember which specific medications. Dr. Vargas's records note on February 16, 2016 Dr. Vargas refilled Petitioner's prescriptions for Mobic, Protonic, Flexeril, and Gabapentin, referred Petitioner to Dr. Robert Erickson for a neurosurgical consultation, and recommended a discogram (PX #4).

Petitioner saw neurosurgeon Dr. Ronald Michael of the Illinois Neurospine Institute between March 17 and May 25, 2016 (PX #6). Petitioner complained of low back pain

radiating into his leg. Dr. Michael reviewed Petitioner's MRI and diagnosed herniated nucleus pulposus at L-3 and L5-S1. Dr. Michael also recommended a discogram. There is no indication in the medical records how Petitioner was referred to Dr. Michael. On May 9, 2016, Dr. Michael prescribed Mobic, Protonix, Flexeril, Gabapentin, Topamax, and an analgesic cream. On May 25, 2016, Dr. Michael noted in his chart that Petitioner had called his office that day:

> The patient called today and said that he is allergic to all of the medications that I have prescribed for him. Specifically, he is apparently allergic to Mobic, Protonix, Flexeril, gabapentin, Topamax, and the analgesic cream. I do not believe ever in my nearly quarter century in neurosurgery has a patient been allergic to all of these medications at one time. He then went on to say that he is going to send them back because he would like narcotics. He knew specifically what he wanted. I believe this patient is a drug seeker. He then went on to threaten my staff that if we did not send the narcotics that he would find another doctor. I reiterated that I will not send him narcotics and therefore he is free to switch to another doctor. My assumption is that he is switching to another doctor. I suspect that he has discharged himself. However, should he come to his senses, I would be happy to care for him.

Petitioner testified at trial that he is addicted to narcotics.

On April 1, 2016, Dr. Vargas performed a discogram, which Dr. Vargas noted revealed unequivocal concordant discogenic pain at L2-L3 and L5-S1 levels. He noted that the discogram correlated with the MRI findings in petitioner's clinical presentation. On April 14, 2016, Dr. Vargas recommended Petitioner discuss his surgical options with the neurosurgeon in his group to follow-up with the neurosurgery service. Dr. Vargas also noted on April 14 that Petitioner continued to take all medications as prescribed without any side effects.

On May 17, 2016, Petitioner was seen by Dr. Mark Levin for another §12 IME (RX D). Petitioner gave a history that on the date of the alleged accident, he manually loaded furniture for eight hours into a moving truck. Petitioner stated that he was in a company SUV returning to the moving company to clock out when they were rear-ended by another car. Petitioner told Dr. Levin that the police were called to the scene and made a report. Approximately 15 minutes later, Petitioner reported that he started having low back pain. Petitioner then described a medical history consisting of treatment with Ingalls Hospital, Dr. Vargas, and Dr. Michael.

At the time of the examination, Petitioner told Dr. Levin that his low back pain was constantly 8/10, with numbness and tingling going down his right leg when he walked. Petitioner also described urinary urgency that did not appear in prior medical records. Petitioner informed Dr. Levin that he was taking hydrocodone twice a day and denied any prior low back pain or leg pain as well as any prior treatment for low back pain or leg pain.

Dr. Levin's physical examination of Petitioner's lumbar spine showed "complaints of tenderness beginning over the upper lumbar spine going down the entire lumbar spine to the lumbosacral junction diffusely." There was tenderness in the buttocks and greater trochanters. Petitioner could flex forward and touch his thighs and had no pain with hyperextension. He complained of low back pain with side-to-side movement. Petitioner had a negative Trendelenburg. He was able to sit with his hips flexed 90° and knees fully extended and stated that his right leg hurt. Petitioner was able to remove his socks from a sitting position. Dr. Levin noted, "[W]hen placed in a supine position, on straight leg raise he becomes rigid at 20 degrees of straight leg raising bilaterally and resists any additional motion. When distracted and actively asked to raise his leg, he could do over 80 degrees of straight leg raising bilaterally." Additionally, Dr. Levin noted with passive range of motion of the hips and knees was tested, "he will only flex his hips to 10 degrees and knees to 10 degrees in the supine position and becomes rigid and gives facial grimacing."

Dr. Levin reviewed the images from the December 8, 2015 MRI. Dr. Levin noted the study showed L2-3 degenerative disc signal changes with central bulging of the disc, no evidence of nerve impingement, and decreased signal with bulging of the disc posteriorly at L5-S1 with generalized neural foraminal narrowing. Dr. Levin also reviewed the post discogram CT. He noted that the study showed evidence of a right-sided disc herniation with dye extending on the right side, generalized bulging of the L3-4 and L4-5 discs, and bulging of the disc at L5-S1 with no dye noted.

Dr. Levin asked to see the records of Dr. Michael and recommended further work-up including an EMG study of the lower extremities by a blinded evaluator.

In his evidence deposition on September 5, 2018, Dr. Levin explained that the disc bulge at L2-3 was degenerative based on the fact that the MRI was only taken 9 days after the accident, which was not enough time for an acute disc herniation to be seen on MRI. Dr. Levin continued that the MRI images did not show nerve impingement at the L2-L3 level, which was correlated with the CT study from April 5, 2016. At the L5-S1 level, Dr. Levin noted that the MRI findings did not show any acute disc herniation because there was no extrusion out the back of the disc, and therefore the signal changes at L5-S1 were chronic.

Dr. Levin had initially opined that the accident had caused Petitioner's complaints. However, upon learning that there was minimal damage to the vehicle he noted "[I]f you aggravate the lumbar disc, the method of injury would be a compressive injury, which in a minor for damage doesn't make sense. But again, my opinions have been totally related to his subjective report this is when it started."

Dr. Levin also opined that the three ESIs were appropriate based on Petitioner's subjective complaints. Dr. Levin recommended an EMG but did not offer an opinion regarding future treatment, such as surgery, until he could review additional medical records.

Petitioner was seen on May 27, 2016 by Dr. Leonard Kranzler (PX #7). Petitioner gave a history of his prior low back injury but reported that he was fine after the initial treatment. Based on the history, physical examination, review of the discogram, and review of the MRI, Dr. Kranzler opined that Petitioner's symptoms were compatible with lumbar radiculopathy. He recommended a dermatomal somatosensory evoked potential study (SSEP), which was performed June 7, 2016. The report by Dr. Shakuntala Chhabria noted conduction latencies at L3, L4, L5, and S1 on the right. No data included with Dr. Chhabria's report and there is no reference to a control level.

On June 29, 2016, Petitioner was seen by Dr. Robert Erickson at American Center for Spine and Neurosurgery with ongoing complaints of low back pain radiating down the posterior right thigh and with paresthesias/tingling affecting the bilateral thighs. Dr. Erickson took a history from Petitioner with particular note of lack of pain immediately before the accident and documented low back pain within hours of the accident, performed a physical examination, and reviewed the SSEP, MRI, and the post-discogram CT scan, as well as Dr. Levin's IME report. Dr. Erickson noted that Petitioner's diagnostic testing correlated with his complaints rather exactly, and diagnosed mechanical pain with radicular complaints. He opined that the diagnosis was causally related to the "mechanism of injury."

At his evidence deposition (PX #36) Dr. Erickson stated that a 5 mph collision is sufficient to cause a discal injury. He acknowledged that there might be some element of pre-existing stenosis but opined that the motor vehicle accident likely caused the stenosis to become clinically significant. He added that petitioner's 2010 incident was too remote in time to be a factor in Petitioner's condition or his causation opinion. He particularly noted Petitioner's ability to work full duty without issue on the date of the accident because it demonstrated Petitioner's good health at that time.

He stated that surgery was reasonable and that an instrumented lumbar fusion at both L2-3 and L5-S1 was the better option to relieve Petitioner's mechanical low back pain than a simple decompression. He added that Petitioner was an excellent surgical candidate.

Petitioner was next seen on July 13, 2016 by Dr. Erickson, at which time Petitioner decided to proceed with the surgery recommended by Dr. Erickson. On July 22, 2106, Dr. Erickson performed a hemilaminectomy, medial facetectomy and foraminotomy at L2-3

with a transforaminal interbody fusion, and hemilaminectomy, medial facetectomy and foraminotomy at L5-S1 with transforaminal interbody fusion at L5-S1.

Dr. Erickson saw Petitioner on August 2, 2016 and prescribed physical therapy and Norco. Petitioner began therapy at Integrity Medical and remained off work. On September 9, 2016, Petitioner saw Dr. Erickson again for follow-up and was noted to be doing well.

Petitioner testified that he saw Dr. Vargas on November 5, 2016 with continued complaints of incapacitating low back and radicular pain (PX #4). Dr. Vargas then recommended a spinal cord stimulator. However, Dr. Vargas' medical records indicate that Petitioner was seen on November 1, 2016, and that at that time Dr. Vargas' recommendations included that Petitioner continue to treat with Dr. Erickson, who was also to continue prescribing Petitioner's medications. Petitioner was also to remain off work. Dr. Vargas noted in this record that it could take 8–12 months for a solid fusion to develop and that in the interim pain management should be limited to opiate and non-opiate analgesic medications, but that if symptoms persisted beyond 8–12 months then Petitioner might be a candidate for a revision surgery. If Petitioner was not a candidate for a revision surgery, "then most clinicians would recommend at that juncture to proceed with a dorsal column spinal cord neural stimulation."

Dr. Vargas also testified at his evidence deposition that the last time he saw Petitioner was November 5, 2016, and that at that time, his recommendation was for Petitioner to continue to treat with Dr. Erickson (PX #35). Dr. Vargas testified that he also advised that if Petitioner was not going to be a candidate for a revision surgery that he would offer the potential treatment option of a spinal cord stimulator.

Petitioner returned to Dr. Erickson on January 18, 2017, at which time Dr. Erickson noted that Petitioner must stop his narcotic medication, that he was being prescribed Norco instead of Percocet, and that he would be referred to a pain specialist to successfully taper from the narcotics.

On March 21, 2017, Petitioner was again seen by Dr. Mark Levin for a second §12 IME. Petitioner reported that he felt that the surgery performed by Dr. Erickson actually made him worse. He stated that his pain was constant and ranged from 8/10 with medication and 10/10 without medication. He described numbness, tingling, and weakness in his legs greater left than right. His medications included Norco, Tramadol, and Gabapentin, and that he had no allergies.

Dr. Levin's physical examination noted straightening of the normal lumbar lordosis with diffuse pain over the entire midline of the lumbar spine. Petitioner complained of pain over the greater trochanters bilaterally but not the buttocks, and there was no lumbar

spasm. Petitioner could flex forward and touch his fingers to his upper thigh and extend back to neutral. He was able to sit with his hips flexed 90° and knees with fully extended but complained of tightness in his hamstrings. Petitioner stated that he could not remove his socks from a sitting position. From a supine position, Petitioner's straight-leg raise bilaterally was 70°. Hip range of motion in the supine position was full, but right side flexed to 90°and left side flexed to 70°. Petitioner flexed his right knee to 130°and his left knee to 90°. He had 5/5 motor strength over the lower extremities. Dr. Levin noted, "[H]is pinprick sensation is inconsistent on multiple testing and does not isolate to any dermatomal level." The quadriceps and mid-calf measurements were symmetric.

Dr. Levin also reviewed Petitioner's treatment notes from Dr. Erickson and diagnostic reports and studies. Based on Petitioner's history, his physical examination, and Dr. Levin's review of the records and studies, Dr. Levin that Petitioner was at MMI. He recommended an FCE and a course of work conditioning in order to determine Petitioner's functional work abilities. Dr. Levin's diagnosis was subjective low back pain with failure to improve with multi-level discectomy and fusion. He noted, "[I]n regard to relationship to work injury of November 30, 2015, the only association with a work injury is his subjective report of discomfort beginning at that time."

In his September 5, 2018 evidence deposition, Dr. Levin testified that his opinion of causal relationship between Petitioner's symptoms and the car accident were based on Petitioner's subjective reporting. He also testified that there were inconsistencies between Petitioner's subjective reports and the objective tests and reports. He emphasized that he never offered an opinion as to whether or not the surgery performed by Dr. Erickson on July 22, 2016 was or was not appropriate, but he added that "...if it was a true pathology should have been cured. With lack of improvement from epidurals, from lack of improvement of fusion, it doesn't make sense." He noted that Petitioner's spine was chronic with conditions which pre-existed the accident. Dr. Levin testified that he found Petitioner at MMI at his March 21, 2017 IME.

Dr. Levin's IME reports were offered in evidence but were refused on hearsay grounds.

Petitioner followed up for pain management with Dr. Farag at Midwest Anesthesia & Pain Specialists on April 20, 2017, with ongoing 8/10 pain. He also reported ongoing weakness, numbness and tingling traveling down both legs (PX #10). In light of the ongoing debilitating pain affecting Petitioner's quality of life, Dr. Farag found Petitioner to be an excellent candidate for a spinal cord stimulator; he, thus, recommended a psychological evaluation and a trial spinal cord simulator.

Petitioner testified that after his surgery he felt "horrible." He saw Dr. Erickson on April 26, 2017. Dr. Erickson noted Petitioner has some low back pain and some numbness. Petitioner reported that he felt that he was getting worse. Dr. Erickson also noted that Petitioner had successfully tapered his narcotic medications approximately 4 months before and was taking Gabapentin. Dr. Erickson ordered a CT scan to check the status of the hardware and fusion. The CT scan demonstrated a soft tissue structure indenting the thecal sac with mild stenosis noted at L2-3 and another soft tissue structure indenting the ventral and thecal sac with mild lateral recess narrowing, "presumably postsurgical epidural scarring with granulation tissue changes." There was no noted nerve impingement.

On May 10, 2017 Dr. Erickson noted "mild paraspinal tenderness present," but reassured Petitioner about his good neurologic examination and ordered work conditioning. Petitioner saw Dr. Erickson for his final visit on July 10, 2017. Dr. Erickson noted Petitioner had constant pain that was constant. However, he noted the April 26, 2017 CT scan had a "satisfactory appearance. " He released Petitioner to pain management with permanent sedentary work restrictions per an FCE performed at Elite Physical Therapy June 21, 2017.

The evidence deposition of Dr. Erickson was taken on May 29, 2018 (PX #36). Dr. Erickson is a board-certified neurosurgeon. He testified that Petitioner told him he was injured when the vehicle he was riding in was rear-ended. Dr. Erickson testified that he performed a physical examination of Petitioner on his initial visit and that Petitioner had a positive straight-leg test and was uncomfortable in a seated position but had an otherwise normal neurological examination. Dr. Erickson did not note Petitioner's treatment prior to this initial evaluation. His diagnosis was mechanical low back pain with radicular components, and his opinion that Petitioner's condition was acute as opposed to degenerative, based on Petitioner's history of the car accident without a significant past history. Dr. Erickson also testified that he did not know the speed of the vehicle at the time of the accident.

Dr. Erickson testified that he saw Petitioner for follow-up visits on May 10, 2017 and July 10, 2017. Although Petitioner complained of ongoing low back pain both dates, Dr. Erickson did not note a diagnosis for those complaints. He further testified that Petitioner was being seen by Dr. Vargas at this time for pain management, which was actually not the case. Dr. Erickson also testified that Dr. Vargas had recommended a spinal cord stimulator for Petitioner and that he agreed with that recommendation.

Dr. Erickson testified that his causation opinion was based on Petitioner's report of the car accident on November 30, 2015 and Petitioner's history of his status before and

after the accident. Dr. Erickson noted that Petitioner's history, description of how his problems evolved after the accident made sense and correlated with his testing.

Petitioner testified that after his release by Dr. Erickson, he continued to see doctors with Integrity Medical Group (Integrity) for pain medication, including Norco and Percocet. Petitioner was first prescribed medication on February 23, 2016, by Dr. Thomas Pontinen of Integrity (PX #5). On that date, Petitioner was prescribed Meloxicam, Tramadol, and Norco. Petitioner saw Dr. Mark Farag at Integrity on April 4, 2016, who noted that Petitioner continued to take his medication including Tramadol, Terocin lotion, and patches. Petitioner returned to Dr. Farag May 2, 2016, for follow up. It was noted Petitioner was taking Tramadol, Terocin patches, Terocin lotion, and Norco. Dr. Farag noted, "He states the Norco is not helping his pain. He would like something stronger." Dr. Farag refilled Petitioner's Terocin patches, Terocin lotion, Flexeril, and Tramadol that day, and also prescribed Norco 7.5/325 mg. Dr. Farag also noted, "The patient states that 5/325 mg is not providing relief, so the dosage increased. He can take this up to four times in a day." Dr. Farag's notes from that day, and from all subsequent visits, noted that Petitioner had no signs of impairment, no apparent distress, and that his gait was normal.

On June 13, 2016, Dr. Farag again noted that Petitioner was asking for Norco to help with his pain and refilled his prescription. On July 11, 2016, Dr. Farag refilled Petitioner's Tramadol and increased his prescription for Norco from 7.5 mg to 10 mg. Dr. Farag's records note that Petitioner was prescribed Percocet by Dr. Erickson following his surgery on July 22, 2016, and Dr. Farag provided him with refills of Tramadol on September 9 and October 3, 2016.

On November 28, 2016, Dr. Farag noted Petitioner might be a good candidate for a spinal cord stimulator in the future. Additionally, "He was getting Percocet from Dr. Erickson; however, he said Dr. Erickson was unable to prescribe this for him anymore, so I will refill the Percocet for him today, 10/325 mg, up to four times a day only as needed, 120 tabs."

Dr. Farag recommended a spinal cord stimulator for Petitioner on December 28, 2016, five months after his surgery with Dr. Erickson, and after Petitioner inquired about it. At that time, Petitioner was regularly taking Meloxicam, Tramadol, and Percocet and was being directed to restart Gabapentin so his dose could be titrated. There were no notes of record of any objective or diagnostic tests being ordered to further diagnose the cause of Petitioner's pain.

Petitioner saw Dr. Farag again on January 25, 2017, when it was noted that Petitioner was having withdrawal symptoms from trying to wean himself from Percocet. Petitioner reported that he would take it to just to manage his withdrawal. Dr. Farag noted

that Petitioner was an excellent candidate for a spinal cord stimulator. On February 22, 2017, Dr. Farag refilled Petitioner's Norco 10/325 for 90 tabs, but on March 15, 2017, refilled Petitioner's Norco 10/325 for 120 tabs, and directed Petitioner to continue to take Gabapentin three times a day, Tramadol up to four times a day, amitriptyline at night, and Terocin patches and creams as directed. March 15, 2017 was the last documented visit with Dr. Farag.

Petitioner testified that he returned to work for QFS Services on August 2, 2017, at which time he was still being prescribed Norco and Percocet by Integrity Medical Group. Petitioner also testified that he wanted a second opinion following his release by Dr. Erickson, so he returned to Dr. Vargas who recommended a spinal cord stimulator. Dr. Vargas' medical records and testimony indicate the last time Petitioner was seen by Dr. Vargas was in November 2016. (PX #4).

Petitioner completed the work conditioning at Grandview Health Partners from May 15, 2017 through June 14, 2017 (PX #8). An FCE took place at Elite Physical Therapy on June 21, 2017, and found Petitioner capable of functioning at a sedentary physical demand level (PX #9). Dr. Erickson noted the FCE results were valid and discharged Petitioner with permanent sedentary restrictions which were causally related to the work accident (PX #36). Dr. Erickson did recommend, however, that Petitioner continue following up with a pain management specialist. In light of Petitioner's ongoing complaints of pain, Dr. Erickson agreed with Dr. Vargas that a spinal cord stimulator was a reasonable treatment option for Petitioner.

Petitioner testified that Dr. Vargas referred him to Dr. Sean Salehi, who he saw only once, on October 30, 2017. Dr. Salehi's records from October 20, 2017 do not note a referral source, nor do they reference a referral to Dr. Chunduri. (PX #11). Dr. Salehi's record does note that he was provided a history by Petitioner, performed a physical examination, and was provided the December 8, 2015 MRI and the April 26, 2017 CT scan. Based on that information, Dr. Salehi recommended a trial of a spinal cord stimulator and referred Petitioner to a psychologist for his complaints of depression and anxiety.

Petitioner first consulted Dr. Chunduri on October 30, 2017 on referral from Dr. Salehi (PX #12). Dr. Chunduri noted a denial of past medical history, alcohol use, tobacco use, or drug use. Dr. Chunduri notes did reference a review of any other medical records or diagnostic imaging or reports, excepting for Dr. Salehi's recommendation of a spinal cord stimulator and referral to a psychiatrist. Dr. Chunduri agreed with Dr. Salehi's recommendations of a spinal cord stimulator and a psychiatric evaluation, and refilled Petitioner's prescription for Norco 10/325 mg and Tramadol 50 mg.

Petitioner saw Dr. Chunduri every four to six weeks from November 27, 2017 through January 14, 2019 to have his prescriptions of Norco 10/325 and Tramadol 50 mg refilled. Gabapentin 300 mg was added on December 17, 2018.

Petitioner was seen by orthopedic surgeon Dr. Kern Singh at Midwest Orthopaedics at RUSH on December 18, 2017 for a §12 IME. Dr. Singh wrote a report following his examination and review of Petitioner's medical records, diagnostic studies, and reports (RX E). In his report, he noted that Petitioner gave a history of a motor vehicle accident on November 30, 2015, in which he was a restrained passenger in the rear seat of a vehicle that was rear-ended at a high speed. Petitioner stated he did not recall the speed of the accident but complained of injuries to his neck, shoulder, back, and legs. Petitioner advised Dr. Singh that he was allergic to hydrocodone and Tramadol and that he drank an unspecified amount of alcohol.

Petitioner's subjective symptoms at the time of his examination by Dr. Singh included "entire spine pain," including 3/10 pain in his neck, 6/10 for his upper back, and 10/10 for his low back. Petitioner told Dr. Singh his pain prevented him from overhead reaching, working on a computer, coughing and sneezing, and putting on his socks. His pain increased with every activity listed on the pain diagram. All the treatment he had received had provided him with "zero relief" of his symptoms.

Dr. Singh's examination of Petitioner included range of motion including flexion, extension, and axial rotation, all of which Petitioner self-limited to 5°. Monofilament testing was performed on both lower extremities and was symmetric and equal and revealed no sensory loss. Petitioner's upper and lower extremity strength tests were all 5/5, and his reflexes were all 2+ on examination. There were negative Hoffman's, Inverted Brachioradialis, and Spurling's sign tests. All five Waddell's signs were positive. Dr. Singh personally reviewed Petitioner's lumbar MRI from December 8, 2015, and noted a slight loss of disk signal intensity at L2-3 and L5-S1, with no evidence of stenosis. "There was a slight central disk protrusion without thecal sac compression." Dr. Singh also personally reviewed the lumbar discogram and post-therapy CT scan from April 1, 2016, "which reveals dye contained within the L2-L3, L3-L4, and L4-L5 space with diffuse spondylosis."

Dr. Singh diagnosed lumbar muscular strain, status post L2-3 and L5-S1 spinal fusion, and cervical muscular strain. Regarding causality and apportionment, Dr. Singh wrote, "I believe the patient sustained a soft tissue muscular strain during his work-related event, which has resolved." Dr. Singh noted Petitioner was capable of full duty work without restriction. Dr. Singh also noted the need for surgical intervention was not causally related to Petitioner's work accident because his MRI was essentially normal and that the motor vehicle accident could not have generated enough force to cause Petitioner's complaints. Dr. Singh stated that he did not believe Petitioner's lumbar fusion surgery was

medically necessary, reasonable, or causally related to the November 30, 2015 work accident. He noted that Petitioner's medical treatment had been excessive and that no further treatment was necessary as Petitioner had reached MMI approximately four weeks from the date of injury. Dr. Singh also stated that all of his opinions were based upon a reasonable degree of medical and surgical certainty.

The evidence deposition of Dr. Singh was taken August 31, 2018 (RX E). Dr. Singh testified consistently with his report. He testified that Petitioner reported significant pain in his history but did not report any radiating pain down the right or left leg, and that he did not appreciate any radiating pain either. Dr. Singh did note symptom magnification during the IME. When asked about whether pathology was likely to appear on Petitioner's MRI in light of the fact that it was done nine days after the motor vehicle accident, Dr. Singh testified that the findings on the MRI were not acute and predated the injury in question. Dr. Singh further testified that his diagnosis of Petitioner's injury was a nonstructural or grade zero strain. He reiterated that there was no indication for surgical intervention at L2-3 and L5-S1 as a result of the work injury in question. Dr. Singh further testified that his diagnosis was also based on "additional data points," including the absence of structural alterations of the muscle belly, edema, and swelling in addition to minimal radiographic findings and the absence of neural compression as well as a normal neurological examination.

On cross-examination, Dr. Singh testified that there was no nerve compression present in Petitioner's spine, that the only pathology present was a loss of disc signal intensity at L2-3 and L5-S1, and that the loss of disc signal intensity at L2-3 and L5-S1 was a degenerative finding. Dr. Singh testified his finding of five of five positive Waddell findings was "one additional component to assess the patient's overall perceived or self-perceived level of discomfort or disability" and that "in the context of the overall examination, imaging studies in question, they can provide some insight into what the patient self-perceives their level of discomfort to be."

Dr. Singh testified extensively on cross-examination regarding his interpretation of the December 8, 2015 MRI and the April 1, 2016 discogram and post-discogram CT scan. He repeated that he personally reviewed the MRI images and his opinion was that there was slight loss of disc signal intensity at L2-3 and L5-S1 with no evidence of stenosis and a central disc protrusion without thecal sac compression. Dr. Singh did not identify disc herniations at any level nor any neural impingement. When asked about Dr. Kuritza's interpretation of the MRI, Dr. Singh further explained that Dr. Kuritza's interpretation was contradictory in that he noted it was "subligamentous" and "herniated." Dr. Singh explained that subligamentous means it is contained, and a herniation involves a violation of the ligament. Dr. Singh disagreed with the MRI interpretations of Drs. Kuritza, Vargas, Tu, and Kranzler.

Dr. Singh also testified that the discogram was invalid because the results were positive at every level, meaning there was no control level and that there was no dye extravasation. The CT scan following the discogram was the objective component in this case, and "the CT scan demonstrates no dye extravasation, which you highlighted in the report given to me by Dr. Kuritza, which is not mentioned. That further confirms my suspicions that there was no disk herniation present" on the CT scan. Dr. Singh further stated:

> So, if you have a disk herniation, it means it violates the ligament and the dye should leak out. He [Dr. Kuritza] at no point mentions dye leaking out. So that would be inconsistent with his own interpretation of the MRI because we should see dye leaking on the discogram, and that would correlate with the disk herniation on the MRI which I theoretically missed. But I will stand by my opinion. There is no disk herniation, and the dye is contained and not extravasated, consistent with that finding.

Dr. Singh further testified that he disagreed with Dr. Levin's opinion that the epidural steroid injections performed were reasonable, stating, "Epidural injections are not performed or based upon subjective pain complaints. Epidural injections are based upon neural compression and identifiable radiculopathy." Dr. Singh opined was that "medically speaking there is no medical basis for surgical intervention for this individual."

Petitioner testified that he returned to work on August 2, 2017 for QFS Services and worked there until he was let go on January 22, 2018, but found work in October of 2018 and continues to work as a forklift driver making $400/week.

Subsequent to the exam by Dr. Singh, on January 22, 2018, Petitioner was notified by Respondent QFS that light duty work would no longer be provided. While working for Respondent with restrictions from August 2, 2016, through January 22, 2018, Petitioner's gross income totaled $6,735.55 (PX #41). Petitioner continued seeing Dr. Chunduri on a monthly basis; the last appointment was on January 14, 2019 (PX #12). During this last visit, Dr. Chunduri continued recommending the spinal cord stimulator and he further instructed Petitioner to remain off work. Despite Dr. Chunduri's instructions to remain off work from October 30, 2017 through the present time, Petitioner testified that he was willing to continue working with restrictions.

Petitioner testified that he did not work and did not receive benefits from Respondent after January 22, 2018. The lack of income caused financial strain and his family struggled (T. at 78). While off work, Petitioner stayed active by exercising because he wanted to find a way to get better. Petitioner testified he has increased pain after exercising. Eventually, on October 25, 2018, Petitioner found work as a forklift driver (T. at 80). Petitioner's work duties required that he lift boxes weighing twenty to fifty pounds.

He testified that it feels as though his back is about to break when he lifts the boxes. As he has worked, Petitioner has continued taking pain medication. After working a full day, he has back pain and leg pain. Petitioner testified that he returned to work, despite his pain and against the recommendations of Dr. Chunduri, because he needed to support his family. He added that if he did not work, his wife would kick him out of the house.

Even with medication, Petitioner testified that he is in constant pain. With medication, his pain is 4-5/10; if he does not take the medication, his pain is 7-8/10. Petitioner testified that he wants the spinal cord stimulator, despite being scared because the ongoing use of medication has affected his personal life. If he does not take the medication, he finds himself getting sick with a runny nose, nausea, and diarrhea. Petitioner acknowledges he is addicted and wants to get off the medication.

Cheryl Williams testified on behalf of Respondent CCA Restoration (CCA). She has been employed by CCA for almost 20 years and is a supervisor. Ms. Williams testified that she was supervising a job site on November 30, 2015. She testified that CCA is a fire and flood restoration company, and that, on the date of the claimed accident, their assignment was a "floor" job. She testified that Petitioner was a member of her crew that day, and that she was saw every item that Petitioner lifted that day because she was responsible for inventory to assure no damage occurred to any item. Ms. Williams testified that Petitioner did not carry a large TV, beds, refrigerators, washing machines, or stoves.

Ms. Williams testified that she and two other employees of CCA were in the vehicle with Petitioner at the time of the accident. Her daughter Ranisha was driving. Ms. Williams testified that they were driving back to the office when traffic ahead began to slow down on the highway. The driver of their car swerved a little to avoid hitting the car in front of them when a car behind them hit them in the back. Ms. Williams described the incident as a "tap." She testified that there was no damage to their vehicle. She further stated that right after the accident they pulled off the highway and she and the driver got out of the car. The driver of the other car also pulled over and got out of their vehicle. No one was hurt and there was no damage to the car, so information was exchanged between the drivers, and, at that point, they left the scene.

Ms. Williams testified that Petitioner was asleep until the car stopped moving after the car accident, when the drivers pulled off the highway. She further testified that she knew Petitioner was sleeping when the car accident happened because she could hear him snoring. Ms. Williams also testified that she looked at everyone in the car when the accident happened. She further testified that Petitioner did not wake up until after the vehicles pulled off the highway. Upon waking up, Petitioner asked, "what happened" and then reported neck pain upon learning of the accident.

On cross-examination, Ms. Williams acknowledged the assigned task for Petitioner on November 30, 2015 was to get furniture from an apartment into storage and that Petitioner performed some heavy lifting of objects such as a beds and couches. Ms. Williams agreed that if the police report filed by her daughter, noted minor rear-end damage, then she would agree with the report.

Angela Vasteralla also testified on behalf of Respondent CCA Restoration. Her job title is Cleaning Technician, and she has been employed with CCA for almost 14 years. Ms. Vasteralla testified that she was in the car with Ms. Williams and Petitioner on November 30, 2015. She was seated in the back seat with Petitioner.

Ms. Vasteralla testified that after they left the job site that day, there was an accident ahead of them on the highway and everyone was stopping. She stated that the driver of their vehicle veered to the left a bit to avoid hitting the car in front of them, but that the vehicle behind them did not stop on time and "kind of tapped us in the back." She stated that at that point they got off the highway to exchange insurance information with the diver behind them. Ms. Vasteralla stayed in the car while information was being exchanged but noted that she saw no damage to their car when she got out of the car at the shop.

Ms. Vasteralla testified that Petitioner was asleep next to her at the time of the accident. She testified, "He woke up after we had pulled off. It was a minute, within a minute. And he asked me, you know, what happened, and I said we got hit by a car. And then he said, you know, my neck hurts or I'm hurt or something down those lines." Ms. Vasteralla testified that Petitioner encouraged the other occupants of the car to file a claim. She also testified that they were not hurt, that no one else from the car that day filed any kind of claim, saw a doctor for an injury, or missed work for any injuries. Ms. Vasteralla testified that Petitioner did ask for an ambulance to come to the accident site.

Ms. Vasteralla further testified that CCA does not usually move televisions out of customers' homes but has a company that comes in to remove them.

CONCLUSIONS OF LAW

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

The Arbitrator finds that Petitioner proved that an accident occurred that arose out of and in the course of Petitioner's employment.

Petitioner was a passenger in a motor vehicle that was involved in a highway accident. Petitioner had worked during the day for Respondent CCA with a crew of CCA employees. The work crew, including Petitioner, were traveling in a Ford Escape back to

CCA headquarters. The Escape was being driven by a CCA employee. The driver of the Escape swerved and made a sudden stop to avoid collision with the stopped vehicle ahead. After one or two seconds the Escape struck in the rear by another vehicle.

The CCA work-crew had finished its assigned duties but were returning to CCA headquarters at the end of the workday. It is reasonable to infer that one last work duty of the day confirm that work had completed and to confirm hours worked by the work-crew. The final wrap-up and completion of this required paperwork was incidental and necessary to the work performed by Petitioner for Respondent CCA.

Whether Petitioner was injured in this motor vehicle collision to the extent he claims is addressed below

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

The Arbitrator finds the Petitioner proved that he sustained short-term and limited muscle strains to his cervical and lumbar spines that were causally related to the accident. However, the Arbitrator also finds that Petitioner failed to prove that his current condition of ill being is causally related to the accident.

Petitioner's claim is complicated by the medical evidence clearly showing radiological evidence of abnormalities in Petitioner's lumbar spine and the finding of the Arbitrator that Petitioner is not a credible witness. Petitioner was treated by an extensive array of physicians who had diagnosed lumbar disc herniations which ultimately required instrumented fusion at L2-3 and L5-S1. Petitioner's physicians, as well as Respondents' §12 examining physicians Drs. Tu and Levin, found Petitioner's condition to be causally related to the reported accident. These causation opinions were also based on the physicians' reliance on the accuracy and reliability of Petitioner's subjective complaints, as well as his reports of a high-speed/high force collision.

The Arbitrator does not find the aforesaid causation opinions persuasive or credible in light of their reliance on the credibility of Petitioner. Petitioner consistently reported to treating and examining physicians that the motor vehicle accident involved high speeds and significant impact. The Arbitrator finds these reports by Petitioner to border on the untruthful. Respondents' witnesses Angela Vasteralla and Cheryl Williams testified to an entirely different scenario than that described by Petitioner.

Ms. Vasteralla and Ms. Williams were clear and consistent in their testimony that the motor vehicle collision involved no more than a tap. More compelling, was their testimony that Petitioner slept through the accident and was not aware of any sort of incident until after the vehicles off the highway. It was compelling that Petitioner's first response was, "what happened, my neck hurts." The Arbitrator also takes note of the

testimony that Petitioner attempted to convince other passengers in the vehicle to make injury claims.

As noted above, Petitioner sought and received care from a wide array of physicians almost all of whom provided him with narcotic medications. There was no evidence in the records of those physicians that they monitored Petitioner for abuse of narcotics by ordering or conducting periodic toxicology testing. In addition, Petitioner received an impressive string of prescriptions for Norco and Tramadol over several years and yet reported to Dr. Singh that he was allergic to those medications.

In addition, Petitioner's drug-seeking behavior was blatant, as noted by Dr. Michael. In fact, Petitioner acknowledged that he was addicted to his narcotic medications. The Arbitrator notes that persons addicted to narcotics may be less credible as witnesses than those who were not addicted (*Handbook of Illinois Evidence,* 10th Edition; §607.5). The Arbitrator also notes that despite stipulating that he was single without any dependent children (ArbX #1) he testified at trial that he had a wife and son.

Petitioner misrepresented the facts of the underlying accident to his treating physicians. Causation opinions based on unreliable reports are inherently unreliable themselves. Petitioner's treating physicians, as well as Drs. Tu and Levin, also relied on Petitioner's subjective complaints. Given Petitioner's lack of credibility, opinions regarding causation, and perhaps even diagnosis, based on Petitioner's subjective complaints are not persuasive and do not meet the necessary burden of proof.

Petitioner's course was one of exaggeration and, as noted by Dr. Singh, symptom magnification. There is a reasonable inference that Petitioner exaggerated and magnified his subjective complaints to seek out continued prescriptions of narcotic medication.

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

The Arbitrator finds that Petitioner failed to prove that he required reasonable and necessary medical to cure or relieve the effects of his claimed accident injuries beyond six weeks after the November 30, 2015 accident.

The number of witnesses testifying to a particular fact or issue may not be convincing if a lesser number of witnesses is more convincing when testifying to that fact or issue. Here, Dr. Kern Singh opined that Petitioner sustained only muscular strains to his cervical and lumbar spines. Dr. Singh persuasively opined that Petitioner had not sustained any herniated lumbar discs. Dr. Singh persuasively noted that Petitioner's December 18, 2015 MRI in fact had no acute findings. He also persuasively explained the

inconsistencies between the interpretations of the MRI and the post-discogram CT by Dr. Kuritza. Dr. Singh persuasively explained why he found no disc herniations on either the MRI or the post discogram CT, particularly noting the lack of dye extrusion on the CT scan. Dr. Singh also persuasively explained his disagreement with Dr. Levin's opinion that epidural steroid injections were not appropriate because there was no evidence of neural compression and identifiable radiculopathy. Also, significantly, Dr. Singh observed symptom magnification in the five positive Waddell signs, further undermining the opposing opinions of the other physicians' opinions. Dr. Levin also noted that his exam revealed inconsistencies between Petitioner's subjective complaints and objective clinical findings.

Despite Dr. Singh being in the minority with his opinions, the Arbitrator finds his diagnoses and opinions regarding causation, reasonableness of medical care, and prospective medical care credible and persuasive, and therefore adopts the same. The Arbitrator notes that Dr. Singh opined that the lumbar fusion performed by Dr. Erickson was not medically necessary to treat any condition that was causally related to the work accident on November 30, 2015. It is noteworthy that Dr. Singh distinguished between the medical necessity of the fusion surgery versus the medical necessity of medical care to treat injuries causally related by the accident.

Dr. Singh opined that it was reasonable for Petitioner to receive conservative physical therapy for a period of 4 to 6 weeks following the November 30, 2015 accident, at which time Dr. Singh opined that petitioner would be at MMI. The Arbitrator finds this opinion reasonable and persuasive, and adopts the same. It is reasonable for Petitioner's treating physician to monitor the course of that physical therapy through periodic visits. Therefore, the Arbitrator awards Petitioner reasonable and necessary medical care for the six weeks following the November 30, 2015 accident, through January 13, 2016, to be adjusted in accord with the medical fee schedule provided in §8.2 of the Act.

K: Is Petitioner entitled to prospective medical care?

The Arbitrator finds that Petitioner failed to prove that he is entitled to the prospective medical care recommended by Drs. Chunduri and Salehi, namely a spinal cord stimulator.

As noted above, the Arbitrator did not find the opinions of Petitioner's treating physicians credible or reliable. As noted above, those opinions were based on the representations of an unreliable patient of dubious credibility. Dr. Singh aptly identified Petitioner's symptom magnification and his true objective condition. Dr. Singh's opinions that Petitioner was at MMI and not in need of further medical intervention for the muscle strains he sustained in the accident are both credible and persuasive. It is noteworthy that Dr. Levin found Petitioner at MMI in March 2017.

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

Petitioner was initially treated for his claimed injuries on the day of the accident, November 30, 2015. Staff at Ingalls Family Care discharged Petitioner with work restrictions that were not accommodated. As noted above, the Arbitrator found Dr. Singh's opinions that Petitioner was likely to be at MMI and able to return to work without restrictions within six weeks of the accident, January 13, 2016, were reasonable and credible.

The Arbitrator awards Petitioner total temporary disability benefits from December 1, 2015 through January 13, 2016, 6 & 2/7 weeks.

M: Should penalties be imposed upon Respondent?

Petitioner filed a petition for fees and penalties based on a claim that Respondents' refusal to authorize and pay for a spinal cord stimulator and related medical care was unreasonable and vexatious. Inasmuch as the Arbitrator found Dr. Singh's opinion that Petitioner does not required further medical care to cure or relive the effects of the accident injuries was credible and reasonable, the Arbitrator denies Petitioner's petitioner for fees and penalties.

April 20, 2020

Steven J. Fruth, Arbitrator

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	11WC022921
Case Name	HIGLEY, ANGELA v. WALMART 1955
Consolidated Cases	
Proceeding Type	REMAND Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0219
Number of Pages of Decision	4
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Stephen Martay
Respondent Attorney	Julie Schum

DATE FILED: 6/16/2022

/s/Stephen Mathis, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF WINNEBAGO)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Angela Higley,

Petitioner,

vs. NO. 11WC 22921

,

Walmart #1955

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the Circuit Court of Cook County. Respondent filed a Petition for Review before the Commission on March 14, 2019, seeking review of the issues of medical expenses, prospective medical care, and temporary total disability. The Commission affirmed the Arbitrator's Decision with corrections and ordered (in pertinent part) that "Respondent shall authorize and pay for reasonable and necessary prospective medical care per the direction of Dr. Michael Rock." Respondent Walmart filed for review of the Commission's Decision in the Circuit Court of Cook County.

Per the remand order, dated December 16, 2021, Honorable Daniel P. Duffy confirmed the Commission's Decision of October 2, 2020, relative to causation, medical expenses, and temporary total disability. The Court set aside the Commission's Decision relative to the award of prospective medical care pursuant to Section 8(a) of the Act. The Court remanded the matter to the Commission for further proceedings and fact finding on the issue of prospective medical care, namely "identifying whatever specific medical procedures or treatments are reasonable and necessary (including, but not limited to the neuropsychological examination and trial spinal cord

stimulator recommended by Dr. Rock and/or the spinal cord stimulator recommended by Dr. Mark Cirella)- and entry of an award for any such care."

Procedurally, this matter was tried on a 19(b) petition before Arbitrator Hegarty on October 16, 2018. Petitioner sustained a work-related accident on March 27, 2011, when a wood pallet fell on her left foot causing a contusion and non-specific bone marrow edema of the posterior talus. Petitioner was 27 years of age at the time of her injury. She developed the clinical indicia of complex regional pain syndrome in her left foot and ankle. Petitioner was referred to Dr. Mark Cirella, an anesthesiologist, and underwent a course of treatment for pain management issues. She also consulted Dr. Sean MacKenzie, a physiatrist with specialization in interventional pain management. Both Dr. Cirella and Dr. MacKenzie have opined that Ms. Higley may benefit from placement of a spinal cord stimulator to manage her chronic pain. Dr. MacKenzie commented in his charting that Petitioner's young age made the use of a spinal cord stimulator preferable to long-term management with narcotic pain medications.

In 2017 Petitioner presented to Dr. Michael Rock, an anesthesiologist at the Chicago Institute for Neuropathic Pain. Dr. Rock agreed with the diagnosis of complex regional pain syndrome. Both Dr. Cirella and Dr. Rock testified that Petitioner's current condition of ill-being i.e., CRPS is causally related to her work accident of March 27, 2011.

Dr. Cirella and Dr. Rock each testified to the opinion that Petitioner might benefit from placement of a spinal cord stimulator. The medical decision to place a permanent SCS requires that the patient first undergo a neuropsychological examination to determine if major depression, secondary gain, or psychosis are issues with the patient. Following the psychological assessment, a trial stimulator is placed to evaluate patient response and determine whether she is a candidate for placement of a permanent spinal cord stimulator.

The Commission, having reviewed the facts and evidence finds that a neuropsychological assessment and trial placement of a spinal cord stimulator are reasonable and necessary to treat Petitioner's condition of complex regional pain syndrome. The Commission further finds that if the assessment and trial placement indicate that Petitioner is a candidate for placement of a permanent spinal cord stimulator that said procedure is reasonable and necessary based upon the recommendations of Dr. Cirella and Dr. Rock, and that Petitioner is entitled to this prospective medical care.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $255.91 per week for a period of 387 4/7 weeks, commencing April 8, 2011 through April 15, 2011, and commencing May 22, 2011 through October 16, 2018; that being the period of temporary total incapacity to work under Section 8(b), and that as provided in Section 19(b) of the Act. This award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for

permanent disability, if any. Respondent is due a credit for some TTD already paid in the amount of $24,894.72
.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $2,941.11 billed by IWP, for medical expenses under Sections 8(a) and 8.2 of the Act. These bills shall be paid to Petitioner per the statutory medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for a neuropsychological examination and trial spinal cord stimulator placement followed by permanent spinal cord stimulator implantation, if medically indicated based upon the recommendations of Dr. Michael Rock and/or Dr. Mark Cirella., as well as the reasonable and necessary cost of medical services associated with the foregoing procedures.

IT IS FURTHER ORDRED 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 written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

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

The 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.

June 16, 2022
SJM/msb
o-5/25/2022
44

/s/ *Stephen J. Mathis*
Stephen J. Mathis

/s/ *Deborah J. Baker*
Deborah J. Baker

/s/ *Deborah L. Simpson*
Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC015489
Case Name	NGUYEN, ANH v. PRESENCE SAINT MARY'S HOSPITAL
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0220
Number of Pages of Decision	9
Decision Issued By	Thomas Tyrrell, Commissioner

Petitioner Attorney	Haris Huskic
Respondent Attorney	Mark Vizza

DATE FILED: 6/17/2022

/s/ Thomas Tyrrell, Commissioner

Signature

22IWCC0220

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)
Medical Expenses	☐ PTD/Fatal denied
☒ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Anh Nguyen,

Petitioner,

vs. NO: 17 WC 015489

Presence Saint Mary's Hospital,

Respondent.

DECISION AND OPINION ON REVIEW

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

As it pertains to the issue of causal connection, the Commission affirms that Petitioner's condition of ill-being is causally related to the violent assault she suffered on May 14, 2017. However, the Commission clarifies that the condition of ill-being is specifically a facial contusion and cervical strain with a temporary exacerbation of pre-existing cervical degenerative disc disease. This is supported by Dr. Kornblatt's opinion on September 11, 2017.

The Commission reverses the Arbitrator's award of medical expenses as it pertains to Midwest Specialty Pharmacy. Respondent introduced a retrospective Utilization Review certifying that the medications dispensed to Petitioner were not reasonable or necessary. RX2, RX3. The prescribing provider was given the opportunity to engage in peer-to-peer review, and failed to do so. There was no evidence in the record that a variance from the standards of care used by the Utilization Review were reasonably required to cure or relieve the effects of the injury. Thus, the provider is not entitled to reimbursement for same.

The Commission modifies the Arbitrator's award as to the nature and extent of the injury from 10% to 5% loss of use of the person as a whole pursuant to Section 8(d)2 of the Act. In so finding, the Commission modifies the Arbitrator's analysis of factor (ii) to strike the last sentence of the paragraph in its entirety and replaces it with the following: "There is no evidence in the record to support that this was anything other than a personal choice." The Commission modifies the weight

given to this factor from substantial weight to no weight.

The Commission modifies the Arbitrator's analysis of factor (iv) to state, "Petitioner testified that she did not incur a loss of earnings." The Commission strikes the remainder of the paragraph. The Commission modifies the weight give to this factor from substantial weight to no weight.

The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on May 11, 2021, is modified as stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED that Respondent shall pay reasonable and necessary medical expenses of $11,092.09, subject to §8(a)/§8.2 of the Act.

IT IS FURTHER ORDERED that Respondent pay to Petitioner the sum of $651.60 per week for a period of 25 weeks, as provided in §8(d)2 of the Act, for the reason that the injury sustained caused the loss of use of 5% of the person.

IT IS FURTHER ORDERED that Respondent shall receive credit of $10,315.81 for temporary total disability benefits paid to Petitioner on account of this injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $27,500.00. 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.

June 17, 2022

o: 4/19/2022
TJT/ahs
51

/s/ *Thomas J. Tyrrell*
Thomas J. Tyrrell

/s/ *Maria E. Portela*
Maria E. Portela

/s/ *Kathryn A. Doerries*
Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC015489
Case Name	NGUYEN, ANH v. PRESENCE SAINT MARY HOSPITAL
Consolidated Cases	
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	6
Decision Issued By	Raychel Wesley, Arbitrator

Petitioner Attorney	Haris Huskic
Respondent Attorney	Mark Vizza

DATE FILED: 5/17/2021

INTEREST RATE FOR THE WEEK OF MAY 11, 2021 0.03%

/s/ Raychel Wesley, Arbitrator

Signature

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

Anh Nguyen
Employee/Petitioner
v.
Presence Saint Mary's Hospital
Employer/Respondent

Case #**17** WC **15489**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Raychel Wesley** Arbitrator of the Commission, in the City of Chicago on March 30, 2021. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On May 14, 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 $**56,472.00**; the average weekly wage was $**1,086.00**.

On the date of accident, Petitioner was **33** years of age, ***single*** with no dependent children.

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

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

Respondent shall be given a credit of $**10,315.81** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $**10,315.81**.

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

ORDER

Respondent shall pay reasonable, related, and necessary medical services of **$19,088.52** as provided in Sections 8(a) and 8.2 of the Act, and as is set forth below. Payment shall be in accordance with the medical fee schedule or a negotiated rate with the provider, whichever is less, and shall be tendered directly to the respective provider(s).

Respondent shall pay Petitioner permanent partial disability benefits of $651.60 per week for 50 weeks, because the injuries sustained on May 14, 2017, caused 10% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

/s/ Raychel Wesley
Signature of Arbitrator

MAY 17, 2021

Facts

Petitioner was the only witness to testify and credibly testified as follows: She was employed by Respondent on May 14, 2017. She started for Respondent in 2016 as a staff or floor nurse. T11 Petitioner testified that she was a registered nurse licensed in the State of Illinois and holds a CPR certificate. T12 Her duties were to keep the floor safe, give patients medications, do assessments and intervention to keep the patients stable and safe. T12 She also admits the patient to the floor, discharges the patient, and educates the patient and family about the illness and medication. T12 She works approximately 40 hours per week. T12 Petitioner testified that she was 33 years old at the time of the accident and approximately five feet tall. On May 14, 2017, she was working and sitting in the hallway to monitor the hallway. T13 On her floor, they are required to monitor the patients 24/7. T13 She was sitting there and there were no warning signs that a patient was agitated, he just came up and punched her in the face and eye without any warning. T13 After the assault, she could not see and was very shocked. T14 She was seeing black dots and stars for a second. T14 She testified that the patient was average weight and a lot taller than she is. She was tearing from the eye that got punched, which was her left eye. T14 She reported the assault to her charge nurse, her manager and the house manager. T14 She had no prior problems with her left eye or neck before this patient assault. T15

She received treatment at Presence St. Mary's Hospital shortly after the assault on May 14, 2017. T16 A facial CAT scan was done on that visit. T17 Dr. Cynthia Moon diagnosed her with blunt trauma to the left eye and prescribed eye drops. T17 She had no acute fracture or dislocation. She was then seen by Dr. Sajjad Murtaza at Illinois Orthopedic Network on May 17, 2017. T17 She gave Dr. Murtaza a history of a patient punching her in her left eye socket which led to her neck snapping backwards, causing severe whiplash. T17,18 She was having left eye pain with neck pain radiating into her left shoulder. T18 Dr. Murtaza diagnosed her with a contusion injury, concussion syndrome and whiplash. Dr. Murtaza ordered four weeks of physical therapy and provided gel and steroids and took her off work. T18 She was seen for physical therapy at Chicagoland Orthopedics. T19 At that time, she was complaining of neck, upper back and right shoulder pain and headaches. T19 She returned to Dr. Murtaza on June 14, 2017 complaining of neck and right shoulder pain. T19 Dr. Murtaza ordered a cervical spine MRI. T20 He also indicated she should continue physical therapy. T20 She had the cervical MRI on June 27, 2017. T20 Dr. Murtaza recommended and administered three trigger point injections. T21 She returned to see Dr. Murtaza on August 4, 2017, and he noted that two rounds of trigger point injections had helped significantly with the pain. T22 Dr. Murtaza recommended two more weeks of physical therapy and stated she should be at maximum medical improvement. T22 Petitioner's cervical spine MRI revealed the following: Disc desiccation at C2-C3 to C6-7 levels and at C3-4 to C6-7 levels, there was 2 to 3 mm diffuse disc protrusion with effacement of the thecal sac. Petitioner testified that she took pain medications, underwent physical therapy and two rounds of trigger point injections. T21

Petitioner testified that since the accident, she gets jumpy easily. T22 She is more alert and stressed if a patient passes her. T23 She still has pain or sensation in her neck and sometimes she has headaches around the eyebrow above her left eye. T23 Petitioner testified that she uses a specific pillow to sleep on because of the effects that this injury has had on her neck. In addition, Petitioner testified that she does her own physical therapy at home to this day due to the neck pain.
She is now in nursing education, so she deals with nursing students instead of patients. T24 She testified that she earns the same amount of money but testified on that she refuses a lot of overtime because she does not like to be stressed out and scared. T23

Petitioner's unpaid medical expenses are as follows: Midwest Specialty Pharmacy - $7,996.43, Chicagoland Medical - $8,373.09 and Premium Healthcare Solutions: $2,719.00

On cross examination Petitioner testified that after the accident, she believes she blacked out for a little bit as she lay on the floor frozen. T24,25 She saw Dr. Meja for her eye problem on several occasions. T25 The records of Presence St. Mary's Hospital show that the patient was seen on May 14, 2017. At that time, she gave

a history of being hit in the left eye with a fist and denied any other trauma. The diagnosis was blunt trauma, left eye. She was discharged to home and told to follow up with employee health. PX1 There was no significant soft tissue swelling. PX2 Dr. Murtaza's records indicate that she was helping treat a patient who punched her. She actually caught the first punch and was pushing for a panic button when he punched her again, the second time, landing a punch directly over her left eye socket. PX2 Dr. Murtaza diagnosed her with a contusion injury, concussion syndrome and whiplash injury. PX2 When he last saw her on August 4, 2017, he indicated that she should complete two more weeks of physical therapy and then return to work, full duty without restrictions, and should return to see him as needed. PX2

The Petitioner testified that Dr. Kornblatt examined her on September 11, 2017 at the request of her employer. At that time, she was complaining of intermittent neck pain and stiffness which was moderate in severity. RX1 He diagnosed her with cervical mechanical axial neck pain with level three cervical degenerative disc disease. RX He opined that the incident on May 14, 2017 resulted in a cervical strain with a temporary exacerbation of preexisting cervical degenerative disc disease. RX1 He opined that there was a lack of abnormal objective findings on physical examination. He further opined that the findings on the cervical spine MRI were unrelated to the work incident. It was his opinion that the work incident did not cause, aggravate or accelerate her preexisting cervical degenerative disc disease. RX1

Conclusions of Law

Causal Connection:

In support of the Arbitrator's Decision regarding whether or not the Petitioner's current condition of ill being is causally related to the injury, the Arbitrator finds that based on the credible testimony of the Petitioner and the medical evidence, Petitioner's current condition of ill being is causally connected to the violent assault she suffered on May 14, 2017.

Medical Expenses:

Under Section 8(a) of the Act, a claimant is entitled to recover reasonable medical expenses that are causally related to the accident and that are determined to be required to diagnose, relieve, or cure the effects of a claimant's injury. The claimant has the burden of proving that the medical services were necessary, and the expenses incurred were reasonable. *City of Chicago v. Illinois Workers' Compensation Commission*, 409 Ill. App. 3d 258, 267 (1st Dist., 2011). Based upon the Arbitrator's finding with respect to casual connection, reasonable and necessary treatment for the neck and left eye through August 23, 2017 would be casually related.

The Respondent had a peer review performed. RX2, RX3 The Arbitrator finds that the treating physicians are more persuasive and thus does not adopt the findings set forth in the reviews.

Petitioner admitted PX4 with multiple medical balances. Having reviewed the bill exhibits and the medical records submitted, the Arbitrator finds the following bills to be reasonable, necessary and casually connected:

Midwest Specialty Pharmacy -	$7,996.43,
Chicagoland Medical -	$8,373.09 and
Premium Healthcare Solutions -	$2,719.00
Total bills awarded -	$19,088.52.

Based on the record as a whole and the Arbitrator's adoption of the opinions with respect to casual connection, the Arbitrator finds Respondent shall pay the reasonable and necessary charges for the services

related to the violent trauma Petitioner received of $19,088.52 as detailed herein, as provided in Sections 8(a) and 8.2 of the Act. Payment, however, shall be in accord with the medical fee schedule or a negotiated rate with the provider, whichever is less.

Nature and Extent:

In determining a PPD award the Arbitrator is required to consider the factors and criteria set forth in Section 8.1(b) of the Act. Pursuant to Section 8.1(b) of the Act, the Arbitrator must consider the level of impairment under the AMA Guides, the occupation of the injured worker, the age of the injured worker, the future earning capacity of the injured worker and evidence of disability corroborated by the treating medical records. The Act provides that no single enumerated factor shall be the sole determinant of disability. With respect to the five factors, the Arbitrator finds:

1. *Level of Impairment under the AMA Guides*

    a. In this case, neither party entered an impairment rating into evidence.

2. *Occupation of Petitioner*

    a. At the time of the work-related accident, Petitioner was employed as a floor nurse. Petitioner returned to work as a floor nurse for a short period of time until she transitioned into nursing education. Petitioner testified that she transitioned into nursing education because it was less stressful and frightful. That would be indicative that her ability to return as a floor nurse was permanently impaired and the Arbitrator accords substantial weight to this factor.

3. *Age of Petitioner*

    a. At the time of the accident, Petitioner was 33 years old. In light of the fact that she was relatively young worker, the results of the disability will be long term and the Arbitrator accords substantial weight to this factor.

4. *Future Earning Capacity*

    a. Petitioner testified that she did not incur a loss of earnings but that she turns down a great deal of overtime due to stress and fear related to the assault and the Arbitrator accords substantial weight to this factor.

5. *Evidence of Disability Corroborated by the Treating Medical records*

    a. Petitioner testified that she has completed a significant amount of medical care and treatment. With respect to Petitioner's cervical spine MRI, it revealed the following: Disc desiccation at C2-C3 to C6-7 levels and at C3-4 to C6-7 levels, there was 2 to 3 mm diffuse disc protrusion with effacement of the thecal sac. Petitioner testified that she took pain medications, underwent physical therapy and two rounds of trigger point injections. This element of the analysis is given considerable weight.

After considering the above factors and the entirety of the evidence, the Arbitrator finds that as a result of the injuries sustained in the violent assault of the Petitioner, Petitioner suffered 10% loss of use of her person as a whole.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC005526
Case Name	ENOKIAN, LEE v. STATE OF ILLINOIS – ILLINOIS STATE LOTTERY
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0221
Number of Pages of Decision	10
Decision Issued By	Kathryn Doerries, Commissioner

Petitioner Attorney	Haris Huskic
Respondent Attorney	Drew Dierkes

DATE FILED: 6/21/2022

/s/ Kathryn Doerries, Commissioner

Signature

21IWCC0221

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)
X add to address causal connection Arbitrator omitted, correct scrivener's error	☐ PTD/Fatal denied
☐ Modify Choose direction	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LEE ENOKIAN,

Petitioner,

vs. NO: 19 WC 05526

ILLINOIS STATE LOTTERY,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, 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 Commission, herein, under "Conclusions of Law", adds and thereto makes part of the Arbitrator's decision the following regarding causal connection, as the Arbitrator omitted discussion regard that issue:

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:

Based on Petitioner's testimony of (1) how the work accident (motor vehicle accident) occurred; (2) Petitioner's credible denial of any pre-existing neck and lower back pain and had not sought any prior treatment; (3) the fact that none of the records reflect any pre-accident treatment to his neck and low back; (4) Dr. Vijayaraj's records; (5) Dr. Nuthakki's records, as well as therapy and diagnostic records in evidence; and, (6) in part, the Section 12 examination report of Dr. Matthew Coleman from Midwest Orthopedics at Rush, the Arbitrator finds that Petitioner established a causal connection between the work accident of December 12, 2018 and his current

neck and low back conditions of ill-being.

The Commission, herein, corrects a scrivener's error in the Arbitrator's decision, under "Findings of Facts", page 1, sentence 2, to strike "Respondence", to replace with "Respondent".

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 4, 2021, is otherwise, hereby, affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $549.55 per week for a period of 37.5 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused the 7.5% loss of use of Petitioner's person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $10,504.11 for medical expenses under §8(a) of the Act. Payment shall be paid in accordance with the medical fee schedule or a negotiated rate with the provider, whichever is less, and shall be tendered directly to the respective providers.

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.

Pursuant to Section 19(f)(1) of the Act, this decision is not subject to judicial review. *820 ILCS 305/19(f)(1) (West 2013)*.

June 21, 2022

o- 5/24/22
KAD/jsf

/s/*Kathryn A. Doerries*
Kathryn A. Doerries

/s/*Maria E. Portela*
Maria E. Portela

/s/*Thomas J. Tyrrell*
Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC005526
Case Name	ENOKIAN, LEE v. ILLINOIS STATE LOTTERY
Consolidated Cases	No Consolidated Cases
Proceeding Type	Request for Hearing
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	7
Decision Issued By	Kurt Carlson, Arbitrator

Petitioner Attorney	Haris Huskic
Respondent Attorney	Drew Dierkes

DATE FILED: 10/4/2021

/s/Kurt Carlson, Arbitrator

Signature

Interest Rate for week of September 28, 2021 0.05%

CERTIFIED as a true and correct copy

pursuant to 820 ILCS 305/14

October 4, 2021

/s/ Brendon O'Rourke

Brendan O'Rourke, Assistant Secretary

Illinois Workers' Compensation Commission

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Lee Enokian
Employee/Petitioner
v.
Illinois State Lottery
Employer/Respondent

Case 19 WC 005526

An *Application for Adjustment 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 **August 16, 2021** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **12/11/2018** 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 $**47,627.84**; the average weekly wage was $**915.92**

On the date of accident, Petitioner was **50** years of age, ***married*** with **0** dependent children.

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

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

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of **$549.55 per week for 37.5 weeks**, because the injuries sustained on December 11, 2018, caused the 7.5% loss of the whole person as provided in Section 8(d)2 of the Act.

Respondent shall pay reasonable, related, and necessary medical services of **$10,504.11** as provided in Sections 8(a) and 8.2 of the Act, and as is set forth below. Payment shall be in accordance with the medical fee schedule or a negotiated rate with the provider, whichever is less, and shall be tendered directly to the respective provider(s).

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

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

KURT A CARLSON
Kurt A. Carlson

October 4, 2021

Hhuskic@vrdolyak.com
drew.dierkes@ilag.gov

ILLINOIS WORKERS' COMPENSATION COMMISSION

LEE ENOKIAN, Petitioner, v. ILLINOIS STATE LOTTERY, Respondent.	)	19 WC 005526

DECISION OF THE ARBITRATOR

FINDINGS OF FACT

On 12/11/2018, Petitioner was employed by Respondent as a lottery sales representative. On 12/11/2018, Petitioner was 50 years of age and had been employed by Respondence since December of 2017. It is undisputed that on 12/11/2018, Petitioner was working as a lottery sales representative and was involved in a motor vehicle accident. Petitioner reported this accident and sought initial treatment with Dr. Suganthi Vijayaraj at Franciscan Physicians Network on December 13, 2018, where he underwent x-rays. At that visit, Petitioner was diagnosed with a neck strain, back strain, and whiplash.

Petitioner returned to see Dr. Vijavaraj on 12/20/2018 complaining of upper neck and lower back pain. Dr. Vijayaraj ordered that Petitioner continue with naproxen and orphenadrine and to start physical therapy to address the neck and back complaints. On 1/3/2019, Petitioner presented to PTSIR Industrial Rehabilitation to start his physical therapy. On 1/17/2019, Petitioner returned to see Dr. Vijayaraj noting improvement with pain, however he was still experiencing neck and back discomfort and spams on the right side of his lower back.

On 5/22/2019, after several months of physical therapy, Dr. Vujayaraj ordered an MRI of the cervical and lumbar spines. On 6/19/2019, Petitioner underwent both the cervical and lumbar spine MRIs. The cervical spine MRI revealed the following: Cervical spondylosis with multilevel degenerative spinal stenosis at C3-4 and C4-5 with moderate right neuroforaminal stenosis at C4-5 and moderate left neuroforaminal stenosis at C3-4.

The lumbar spine MRI revealed the following: Moderate spinal canal stenosis at L3-4 and L4-5 caused by posterior bulging disc osteophyte complexes and posterior facet arthritic changes; and minimal left lateral and right lateral bulging disc osteophyte complex at L2-3.

On 6/20/2019, Petitioner returned to see Dr. Vijayaraj to review the MRI reports. After review of the MRI reports, Dr. Vijavaraj diagnosed Petitioner with: chronic neck pain; cervical spinal stenosis; degenerative lumbar spinal stenosis; bulging lumbar disc; and retropharyngeal neck swelling and ordered Petitioner to continue with therapy, get a CT scan of the soft tissue in

the neck and referred him to a pain specialist. The CT scan of the neck revealed a possible retropharyngeal mass.

On 7/15/2019, Petitioner was seen by Dr. Prasanth Nuthakki at Franciscan Physician Network Orthopedics for an interventional spine consultation. At that visit, Petitioner's primarily complaint was pain in the left side of his neck and on the right side of his lower back. On 12/24/2019, after months of physical therapy, rounds of prednisone, muscle relaxers and naproxen, Petitioner followed up with Dr. Nuthakki complaining of pain, specifically, neck pain being bilateral, worse on the right and back pain was bilateral, worse on the left side. At that visit, Petitioner was diagnosed with: dorsalgia; cervicalgia; cervical spondylosis; and lumbar spondylosis. Dr. Nuthakki ordered diagnostic blocks bilateral at L4-L5 and L5-S1 facet joint injections. On 7/2/2020, Petitioner underwent bilateral L4-L5 and L5-S1 facet joint injections with Dr. Nuthakki at Franciscan Health. Petitioner's post-operative diagnoses were: dorsalgia; lumbar facet joint arthropathy; lumbar degenerative disc disease; and lumbar spondylosis without myelopathy.

At trial, Petitioner testified that he underwent physical therapy and bilateral facet joint injections. Petitioner testified that the bilateral facet joint injections helped tremendously as the 20 sessions of physical therapy and pain medications did not help much with the pain. At trial, Petitioner testified that he still has pain and cannot do as many things as he did prior to the motor vehicle accident. In addition, Petitioner testified that he still uses pain medications, such as orphenadrine and naproxen to help with everyday living.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

Section1(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 his 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

In support of the Arbitrator's decision with respect to (J) Medical, the Arbitrator finds as follows:

Under Section 8(a) of the Act, a claimant is entitled to recover reasonable medical expenses that are causally related to the accident and that are determined to be required to diagnose, relieve, or cure the effects of a claimant's injury. The claimant has the burden of proving that the medical services were necessary, and the expenses incurred were reasonable. *City of Chicago v. Illinois Workers' Compensation Commission*, 409 Ill. App. 3d 258, 267 (1st Dist., 2011). Based upon the Arbitrator's finding with respect to casual connection, reasonable and necessary treatment for the neck and back through July 2, 2020 would be casually related.

Petitioner admitted PX 7 with multiple medical balances. These bills have not been reduced to fee scheduled. Having reviewed the bill exhibits and the medical records submitted, the Arbitrator finds the following bills to be reasonable, necessary and casually connected:

Franciscan Alliance:	*$9,925.90*
Franciscan Physician Network Orthopedics:	*$205.06*
Franciscan Physicians Network Dyer:	*$373.15*

The total bills awarded total $10,504.11. Based on the record as a whole and the Arbitrator's finding with respect to Casual Connection, the Arbitrator finds Respondent shall pay reasonable and necessary services of $10,504.11 as detailed herein, as provided in Sections 8(a) and 8.2 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:

In determining a PPD award. The Arbitrator is required to consider the factors and criteria set forth in Section 8.1(b) of the Act. Pursuant to Section 8.1(b) of the Act, the Arbitrator must consider the level of impairment under the AMA Guides, the occupation of the injured worker, the age of the injured worker, the future earning capacity of the injured worker and evidence of disability corroborated by the treating medical records. The Act provides that no single enumerated factor shall be the sole determinant of disability. With respect to the five factors, the Arbitrator finds:

1. *Level of Impairment under the AMA Guides*
    a. In this case, neither party entered an impairment rating into evidence; however, this factor alone does not preclude an award for permanent partial disability. Accordingly, the Arbitrator accords this factor no weight in determining PPD.
2. *Occupation of Petition*
    a. At the time of the work-related accident, Petitioner was employed as a lottery sales representative. Petitioner returned to work as a lottery sales representative, however at trial, Petitioner testified that he is working with some accommodations. For example, Petitioner's occupation requires him to walk around a lot and visit various sites and that still causes him problems. The Arbitrator accords great weight to this factor in determining PPD.
3. *Age of Petitioner*
    a. At the time of the accident, Petitioner was 50 years old. At the time of the hearing, Petitioner was 53 years old. Due to Petitioner's age, he will most likely experience

residuals of his injury. The Arbitrator accords great weight to this factor in determining PPD.

4. *Future Earning Capacity*
    a. Petitioner was able to return to his regular occupation after completing his treatment. Petitioner did not suffer a loss in earning capacity as a result of the injury. The Arbitrator accords this factor moderate weight in determining PPD.
5. *Evidence of Disability Corroborated by the Treating Medical records*
    a. Petitioner testified that he has completed a significant amount of medical care and treatment. Petitioner underwent both a cervical and lumbar MRI. The cervical spine MRI revealed the following: Cervical spondylosis with multilevel degenerative spinal stenosis at C3-4 and C4-5 with moderate right neuroforaminal stenosis at C4-5 and moderate left neuroforaminal stenosis at C3-4. The lumbar spine MRI revealed the following: Moderate spinal canal stenosis at L3-4 and L4-5 caused by posterior bulging disc osteophyte complexes and posterior facet arthritic changes; and minimal left lateral and right lateral bulging disc osteophyte complex at L2-3. Petitioner testified that he took and is still taking pain medications, underwent physical therapy and bilateral L4-L5, L5-S1 facet joint injections. Because of these facts, the Arbitrator therefore gives greater weight to this factor.

After considering the above factors and the entirety of the evidence, the Arbitrator finds that as a result of the injuries sustained, Petitioner suffered 7.5% loss of a person as a whole.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC000701
Case Name	GIBSON, JOHN v. CITY OF AURORA
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0222
Number of Pages of Decision	30
Decision Issued By	Kathryn Doerries, Commissioner

Petitioner Attorney	Adam Burnett
Respondent Attorney	Jason Payne

DATE FILED: 6/21/2022

/s/Kathryn Doerries, Commissioner

Signature

DISSENT /s/Kathryn Doerries, Commissioner

Signature

22IWCC0222

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
X Modify 8.1 (b) factor, correct scrivener's errors	☐ PTD/Fatal denied
☐ Modify Choose direction	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOHN GIBSON,

Petitioner,

vs. NO: 18 WC 00701

CITY OF AURORA,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, and permanent partial disability, 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, herein, modifies the Arbitrator's decision, under Section 8.1b(b), factor (iv), on page 17, to strike the Arbitrator's language of "some weight", and assigns "no weight" to the factor as no evidence was presented as to a decrease in earning capacity.

The Commission, herein, corrects a scrivener's error in the Arbitrator's decision on page 7, paragraph 2, last sentence, to replace "November 2, 2017" with "November 27, 2017".

The Commission, herein, corrects a scrivener's error in the Arbitrator's decision on page 8, paragraph 3, fourth sentence, beginning with "He did" to insert "not" after "did" and before "find". The sentence should read, "He did not find any acute structural injury occurred to the lumbar spine."

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $790.64 per week for a period of 175 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused 35% loss of use of Petitioner as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the sum of $36,003.28 for medical expenses under §8(a) of the Act. Respondent shall be given credit for medical bills paid and hold Petitioner harmless from any claims by any provider of services for which Respondent is receiving credit, as provided under Section 8(j) of the Act. Any remainder shall be paid directly to the providers pursuant to the stipulation entered as Arb. Ex 1A.

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.

June 21, 2022

/s/ *Thomas J. Tyrrell*
Thomas Tyrell

o- 4/19 /21
KAD/jsf
42

/s/ *Maria E. Portela*
Maria E. Portela

DISSENT

I disagree with my colleagues and the Arbitrator's Conclusions of Law for reasons outlined below and thus I respectfully dissent from the majority opinion regarding their finding of casual connection between Petitioner's work accident and his subsequent condition of ill-being.

Petitioner had a persistent and chronic back condition which caused bilateral radiating pain since 2002. He had aggravations and flare ups which he managed conservatively in order to continue to work for approximately 14 years despite two prior surgical recommendations. It is patently clear that the softball injury exacerbated Petitioner's pre-existing condition to the point where it was questionable whether he would recover with conservative treatment as he had in the past without surgery. He was not finished with treatment from the softball injury before the subject incident. The critical issue is whether the softball injury or the incident at work was the proverbial "straw that broke the camel's back." Based on the medical evidence including "before and after"

work incident diagnostics and expert opinions, the softball injury was unequivocally the "straw that broke the camel's back." Petitioner has the burden of proving that the incident was a contributing cause to his condition and he did not meet his burden of proof based upon the totality of the evidence and the record as outlined below.

The claimant has the burden of proving that his injuries are work related and not the result of a normal degenerative process. *Gilster Mary Lee Corp. v. Industrial Comm'n*, 326 Ill. App. 3d 177, 182, 759 N.E.2d 979, 983, 259 Ill. Dec. 918 (2001). He had to prove that there was some causal relationship between his employment and his conditions of ill-being. *Absolute Cleaning/SVMBL v. Illinois Workers' Compensation Comm'n*, 409 Ill. App. 3d 463, 469, 949 N.E.2d 1158, 1165, 351 Ill. Dec. 63 (2011).

Petitioner is not required to prove that the conditions of employment were the sole or principle cause of his injury. *Brady v. Louis Ruffolo & Sons Construction Co.*, 143 Ill. 2d 542, 548, 578 N.E.2d 921, 924, 161 Ill. Dec. 275 (1991). In this case, however, Petitioner failed to prove that the reported incident was a contributing cause for the reasons outlined below.

> When an employee with a preexisting condition is injured in the course of his employment, serious questions are raised about the genesis of the injury and the resulting disability. The Commission must decide whether there was an accidental injury which arose out of the employment, whether the accidental injury aggravated or accelerated the preexisting condition or whether the preexisting condition alone was the cause of the injury. Generally, these will be factual questions to be resolved by the Commission. However, the Commission's decision must be supported by the record and not based on mere speculation or conjecture. *Sisbro*, 207 Ill. 2d 193, 215 (2003).

After the June 2017 softball injury, Petitioner never reached a state of maximum medical improvement (MMI) from treatment as evidenced by the fact he was in the middle of a series of scheduled epidural steroid injections at the time of the subject incident.

Petitioner worked only eleven days between August 10, 2017, and the date of the subject incident September 5, 2017, and since undergoing the second ESI on August 24, 2017, he worked only 7 days. His time records confirm he was off work August 13 through August 19, 2017, and when asked on cross examination if he recalled taking off, Petitioner replied he did not know if "they were sick calls or if I turned in comp time to go play golf." (RX12; T. 61)

Although the Arbitrator notes that Petitioner was 50% recovered after the second ESI, based upon Dr. Augusthy's retroactive note from September 27, 2017, which stated "[w]ould argue 50% improved by Labor Day weekend" Petitioner was, therefore, 50% away from being recovered to his baseline, thus his future status could not be determined.

More importantly, Petitioner testified he was 75-80% normal, (T. 34) a contradiction of the medical records, and a manipulation of the facts. Therefore, after his second ESI, Petitioner could not be sure that the softball aggravation could be managed conservatively.

Diagnostics, Opinions and Objective Evidence

Treating Physicians

After the domestic call on September 5, 2017, nine days later, September 14, 2017, Petitioner sought medical care at Northwestern Medicine Occupational Health after Respondent's human resources department called him to inquire as to medical treatment status. (T. 37; PX4, 560) Petitioner reported injuring his back playing softball in June 2017 softball and indicated his back had improved "somewhat" after receiving injections with Dr. Augusthy. (PX4, 561) Petitioner reported he then had to restrain a subject. He complained of radiating pain and tingling into both legs with right foot numbness and reported that he had an upcoming follow-up appointment with Dr. Augusthy. (PX4, 562)

On September 20, 2017, Petitioner reported to Dr. Houlahan that the work injury, "significantly flared up his back pain." (PX3, 33)

Petitioner returned to Dr. Augusthy on September 27, 2017 for a previously scheduled follow-up evaluation after Petitioner's second ESI. (RX4, 997) Dr. Augusthy noted: "post ESI X2. 2nd ESI, was definitely improving with the c/o right sided low back pain to right leg; would argue 50% improved by Labor Day weekend. 9/5 sustained an injury at work…developing progressing pain which now included bilateral lumbar spine and bilateral leg. Is increased on the right and new to the left." (RX4, 997) On October 30, 2017, Petitioner reported to Dr. Augusthy that his pain was 9/10.

On November 15, 2017, Dr. Augusthy noted acute progression of low back pain to the bilateral legs that was severe and constant, neurologically intact, and "lumbar discogenic syndrome." A third ESI was performed on November 27, 2017. (RX4, 1008) Petitioner presented for evaluation with Dr. Ghaly at Ghaly Neurosurgical Associates on December 6, 2017, where it was documented that "He heard of our name through one of our former patient." On the intake form, Petitioner indicated his problem began on June 2, 2017, while playing softball that worsened after restraining a mentally ill person. (PX5, 632-633) He further reported developing back pain and right leg sciatica after playing softball in June 2017 and worse sciatica on right and additional sciatica on the left side after the work injury.

Regarding his then-current symptoms, however, Petitioner wrote on the intake form he had "Burn and Pain Rt. Lower Leg." He did not report ongoing left leg symptoms. (PX5, 636) Dr. Ghaly notes Petitioner's subjective complaints and version of the work accident including tackling the person, twisting, pushing and pulling when he had the back pain, back spasms went down to the bilateral legs. Dr. Ghaly's impression notes the right leg pain was in the L5 distribution and the prior left leg pain was almost in an S1 distribution. Dr. Ghaly recommended surgery at L4-L5 on the right side. He further noted there was no indication for surgery at the L5-S1 level. (PX5, 630-631) Dr. Ghaly reviewed the MRI studies and stated the November 7, 2017, MRI, taken after the work incident, shows an increase in the disc herniation, the protrusion in the right L4-5, with root compression. Dr. Ghaly further opined that the accident increased the disc herniation.

Dr. Ghaly further opined that the MRI performed at Fox Valley Imaging with and without

contrast on December 7, 2017, showed a right disc herniation at L4-L5, increased in severity as well as an L5-S1 broad based disc protrusion with an annular tear extending into the anterior aspect of the left neural foramen. An EMG performed on December 11, 2017, indicated findings for right greater than left radiculopathy. Dr. Ghaly's assessment was work-related injury caused two disc herniations on the right at L4-5 and the left at L5-S1.

Dr. Karahalios first saw Petitioner on May 31, 2018, approximately nine months after the claimed work-related injury. Dr. Karahalios' office note documents that Petitioner had developing progressing pain, which now includes his bilateral lumbar spine and bilateral legs that is increased on the right and now to the left. He opined that it appeared that the accident in question did exacerbate his condition to the extent that he required additional treatment, including surgery. (PX2, 17-18) In his office note on May 31, 2018, Dr. Karahalios noted that the symptoms on the left are somewhat less severe and frequent. (PX2, 9) Petitioner underwent surgery with Dr. Karahalios on June 20, 2018 consisting of an L4-5 decompressive laminectomy.

Dr. Karahalios testified he reviewed the November 7, 2017, MRI study and noted when he reviewed the MRI scan before the deposition he did in fact identify a problem at L5/S1 on the left side. He did not have the July 2017 MRI diagnostic, and compared the November MRI scan to the July MRI report only. (PX2, 14-15, 31-32) Dr. Karahalios testified that he did not see any treatment records prior to July 21, 2017 or opinion reports from physicians that looked at these on behalf of Respondent. (PX2, 33) In answer to whether his opinions could change if new or different information came to his attention, Dr. Karahalios testified, "It depends on what it is." (PX2, 35) Dr. Karahalios testified his understanding of the mechanism of injury was it was very superficial. (PX2, 36)

In answer to a hypothetical question on cross examination, Dr. Karahalios testified it was fair to say that the more problems a patient has with their spine, the more predisposed a patient would be to injury. (PX2, 40) He had no knowledge of Petitioner's condition between his first surgery in 2001 or 2002 and the day of the MRI he looked at from July 2017. (PX2, 40) Dr. Karahalios reviewed imaging studies, including the one dated October 3, 2003, showing evidence of previous surgery at the L4/5 level. (PX2, 42) Dr. Karahalios reviewed the MRI report related to a study on February 19, 2008, confirming a history showing low back pain, right greater than left and bilateral pain. (PX2, 43)

Further, despite his causal connection opinion, Dr. Karahalios agreed the same radiologist read both the July 21, 2017, and the November 7, 2017, MRI studies and concluded there were no significant integral changes at L4/5 and again notes the mild bilateral facet hypertrophy at L4/5 and L5/S1. (PX2, 54-55). Dr. Karahalios agreed the MRI that he ordered that was performed on June 4, 2018, indicated there was no evidence of disc herniation at L4-L5 and was negative for herniation at L5-S1. The L5-S1 disc continued to exhibit an annular fissure which Dr. Karahalios agreed was the same fissure shown in the earlier MRI studies and pre-dated the work injury. (PX2, 51-52, 57-58) Dr. Karahalios confirmed he personally reviewed the imaging from the June 2018

study and concurred with the radiologist's findings. (PX2, 60). Finally, Dr. Karahalios testified that it is impossible to say if Petitioner never had a work injury in September 2017, would he have had a relapse in his post injection course. (PX2, 94)

Examining Physicians

As the Arbitrator documented, on June 27, 2018, at the request of Respondent and pursuant to Section 12 of the Act, Dr. Hsu, a board certified orthopedic spine surgeon, reviewed radiology reports and personally reviewed imaging studies, with the oldest study having been performed on February 19, 2008. After reviewing the records and diagnostic films from 2003 through March 23, 2018, Dr. Hsu opined that Petitioner's diagnosis was lumbar strain-resolved and lumbar spondylosis, status post right-sided L4-L5 foraminotomy, laminotomy and discectomy. (RX6, 6)

Dr. Hsu examined Petitioner pursuant to Section 12 of the Act on July 27, 2020. (RX7)_At that time, Dr. Hsu's diagnosis was lumbar strain-resolved and lumbar spondylosis, status post right -sided L4-5 foraminotomy and laminotomy, status post revision L4-5 laminectomy.

Dr. Hsu testified a CT scan performed in November 2009 demonstrated disc calcification and he explained that a disc calcifies when it becomes arthritic and the medical term refers to calcium deposits which harden the disc and form an outer shell which can lead to impingement depending on its location. This calcification process is a progressive condition. The MRI taken after the June 2017 softball injury demonstrated a right-sided disc bulge at L4-L5 which had increased in size since the prior 2009 study. Dr. Hsu also testified surgery would have been appropriate after the June 2017 softball injury. (RX9, 49-50)

Further, Dr. Hsu reviewed the MRI performed in November 2017 and compared the images with the earlier July 2017 images and opined that they showed no interval changes. A repeat MRI in December 2017 also failed to show any changes. Dr. Hsu testified the MRI studies did not show signs for acute structural changes following the work injury (RX 9). Dr. Hsu reviewed a CT scan performed on January 3, 2018 and noted the images exhibited increased calcification of the L4-L5 disc which was consistent with continued growth of calcium deposits (RX 9).

Based on his medical records review, Dr. Hsu opined that Petitioner's work-related September 5, 2017, incident caused a temporary soft-tissue lumbar strain which had resolved. Petitioner suffered from pre-existing lumbar spondylosis which had previously been treated with surgical intervention at L4-L5. Spondylosis refers to genetic related wear and tear changes in motion segments of the spine. He opined that the work related incident did not lead to any structural changes and did not aggravate the pre-existing condition. The surgery recommended by Dr. Ghaly was not causally related to the work injury. The only injury Petitioner sustained on September 5, 2017 was a low back strain (RX 9). (ArbDec 15-16)

Addressing Petitioner's onset of left leg symptoms after the work injury, Dr. Hsu testified lumbar strains can produce referred pain into the lower extremities and opined that Petitioner's

left-sided leg pain was a referred pain and not a nerve-related radiculopathy. (RX9, 1140)

Dr. Hsu also opined that Petitioner's pre-existing condition was such that activities of daily living could present the possibility of an overexertion leading to symptomology. (RX9, 1141-1142) Dr. Hsu indicated minor bodily motions associated with bending, twisting and picking things up could be triggers. (RX9, 1142). Dr. Hsu further opined that the surgery performed by Dr. Karahalios was not causally related to the work incident. (RX 9, 1142)

Those opinions were bolstered by Dr. Racenstein, board certified in diagnostic radiology. (RX5) Dr. Racenstein reviewed all the films and reports for the MRI studies, CT cans and x-rays taken between 2008 and 2018 pursuant to Section 12. In his report, Dr. Racenstein opined there were no medically significant changes or disease progression from July to November and December 2017 in Petitioner's lumbar spine at the L4-5 level resulting from the alleged work injury. (RX5, 3) Dr. Racenstein further opined the studies from July 2017 and December 2017 are nearly identical. Dr. Racenstein did observe a small one-millimeter increase in the size of a bulging disc at L4-L5; however, this change was inconsequential and there was no compression on the nerve root seen in either the before or after studies. Dr. Racenstein thus concluded there were no significant structural changes at the L4-L5 level resulting from the alleged work injury.

Addressing the L5-S1 disc, Dr. Racenstein found a smaller left-sided disc bulge; however, this finding was present in both the before and after imaging studies. Dr. Racenstein examined both the November 2017 and December 2017 studies in comparison with the pre-accident July 2017 study and opined there was no new left-sided pathology shown in the post-accident imaging. Both before and after the work injury, the imaging demonstrated the same left sided 5mm disc bulge at L5-S1. Dr. Racenstein noted that Petitioner's lumbar spine exhibited the same disc bulge at L5-S1 as far back as 2008. (RX5, 4) Dr. Racenstein also opined there were no abnormal radiological findings consistent with a neurological issue on the left side as the two bulging discs at L4-L5 and L5-S1 did not produce any nerve impingement on the left side. Dr. Racenstein disagreed with the radiological reading of the November 2017 MRI taken at Fox Valley Imaging that there was "recurrent" disc herniation. Dr. Racenstein found the images were negative for any herniation. (RX 5).

> It is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony, and resolve conflicts in the evidence, particularly medical opinion evidence. *Berry v. Industrial Comm'n*, 99 Ill. 2d 401, 406-07, 459 N.E.2d 963, 76 Ill. Dec. 828 (1984); *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 675, 928 N.E.2d 474, 340 Ill. Dec. 475 (2009); *Fickas v. Industrial Comm'n*, 308 Ill. App. 3d 1037, 1041, 721 N.E.2d 1165, 242 Ill. Dec. 634 (1999). Expert testimony shall be weighed like other evidence with its weight determined by the character, capacity, skill and opportunities for observation, as well as the state of mind of the expert and the nature of the case and its facts. *Madison Mining Company v. Industrial Commission*, 309 Ill. 91, 138 N.E. 211 (1923). [*23] The

> proponent of expert testimony must lay a foundation sufficient to establish the reliability of the bases for the expert's opinion. *Gross v. Illinois Workers' Compensation Comm'n,* 2011 IL App (4th) 100615WC, 960 N.E.2d 587, 355 Dec. 705. If the basis of an expert's opinion is grounded in guess or surmise, it is too speculative to be reliable. Expert opinions must be supported by facts and are only as valid as the facts underlying them. *In re Joseph S., 339* Ill. App. 3d 599, 607, 791 N.E.2d 80, 87, 274 Ill. Dec. 284 (2003).
>
> A finder of fact is not bound by an expert opinion on an ultimate issue, but may look 'behind' the opinion to examine the underlying facts. Expert testimony shall be weighed like other evidence with its weight determined by the character, capacity, skill and opportunities for observation, as well as the state of mind of the expert and the nature of the case and its facts. *Madison Mining Company v. Industrial Commission*, 309 Ill. 91, 138 N.E. 211 (1923).

I find Dr. Hsu's opinion and Dr. Racenstein's opinion are more credible and reliable than Dr. Houlahan's, Dr. Ghaly's and Dr. Karahalios' opinions. Dr. Hsu and Dr. Racenstein had all of Petitioner's treating records and compared all the actual diagnostic images when forming and conveying their opinions.

Dr. Houlahan's opinions and office notes are based solely on Petitioner's history and he is neither an orthopedic surgeon, nor neurosurgeon, nor a radiology expert. Dr. Ghaly's opinion regarding the mechanism of injury was based on facts not in evidence, inconsistent with any incident report. Dr. Karaholios did not have either a history or medical records regarding the Petitioner's years of chronic lumbar back pain, treatment and diagnostics images to review until his deposition when he reviewed the multiple imaging reports at his cross-examination; he only had the July 2017 MRI report to compare to the November 2017 MRI diagnostic when he offered his causal connection opinion. Further, he testified that he was not aware Petitioner was treating since his June 2017 softball injury until the time of the work incident, did nor did not have a detailed history of the mechanism of injury before offering his opinions.

Both Dr. Ghaly and Dr. Karaholios based their opinions on an inaccurate understanding of Petitioner's former pain complaints and the onset of the same. (See *Gross v. Illinois Workers' Compensation Commission*, 2011 IL App (4^{th})100615WC ¶24- "Expert opinions must be supported by facts and are only as valid as the facts underlying them [intemal quotations omitted].")

Because the Petitioner was in the middle of treatment for the aggravation from the softball injury when the work incident occurred, the MRIs and Petitioner's subjective complaints from before and after the alleged work accident are the two most critical factors to determine if there was an actual change in Petitioner's condition after the alleged work incident. The MRIs taken before and after the accident were virtually the same according to the radiologist that authored both radiology reports. Dr. Hsu and Dr. Racenstein opined that there was no change in the objective diagnostics before and after the subject incident. Petitioner had bilateral leg pain intermittently in the past with flare-ups caused by everyday activities multiple times per year for

14 years.

Dr. Karahalios had not reviewed any treating records prior to the Petitioner's July 2017 MRI and when he testified, he ultimately conceded that there was no change between the 2017 MRI and November 2017 MRI according to the radiologist. Finally, Petitioner's pain complaints were virtually identical before and after the work accident and progressively worsened since his June 2017 softball incident.

Based upon the opinions of Dr. Hsu and Dr. Racenstein and the record as a whole, I would find Petitioner failed to sustain his burden of proving causal connection between the subject work incident and his need for surgery, rendering all other issues moot. Therefore, I dissent from the majority's opinion and would reverse the Arbitrator's decision regarding causal connection.

/s/*Kathryn A. Doerries*
Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC000701
Case Name	GIBSON, JOHN v. CITY OF AURORA
Consolidated Cases	
Proceeding Type	Request for Hearing
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	20
Decision Issued By	Stephen Friedman, Arbitrator

Petitioner Attorney	Adam Burnett
Respondent Attorney	Jason Payne

DATE FILED: 8/10/2021

/s/Stephen Friedman, Arbitrator

Signature

INTEREST RATE WEEK OF AUGUST 10, 2021 0.05%

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

John Gibson
Employee/Petitioner

v.

City of Aurora
Employer/Respondent

Case # **18** WC **000701**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Chicago**, on **June 30, 2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the 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, 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 $**96,720.00**; the average weekly wage was $**1,860.00**.

On the date of accident, Petitioner was **47** years of age, ***married*** with **0** dependent children.

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

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $921.76 to Northwestern Occ Health, $3,735.00 to Ghaly Neurosurgical, $2,958.27 to ATI Physical Therapy and $28,388.25 to Advocate Good Samaritan Hospital, 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. Any remainder shall be paid directly to the providers pursuant to the stipulation entered as Arb. Ex. 1A.

Respondent shall pay Petitioner permanent partial disability benefits of $790.64/week for 175 weeks, because the injuries sustained caused the 35% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner benefits that have accrued from through June 30, 2021, 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.

/s/ Stephen J. Friedman
Signature of Arbitrator

August 10, 2021

Statement of Facts

Petitioner John Gibson testified that he began working as a police officer with Respondent in June 1997. He took on added responsibilities and worked as a field training officer for five years and served as a member of the SWAT team for ten years. From 2000 to 2013, Petitioner served on the special response team or SRT. Petitioner testified that semi-annual physical assessments and shooting qualification tests were required for the SRT. Petitioner was employed as a patrol officer with Respondent's police department and assigned to the midnight shift working from 11:00 p.m. to 6:00 a.m. handling general calls. He testified to receiving four consecutive 100 performance ratings prior to the end of his employment. He retired in 2020.

Petitioner testified that on September 5, 2017, he responded to a domestic disturbance call placed by the father of an adult mentally ill male named David, who was on drugs and breaking windows. Petitioner testified he was the first to arrive on the scene and waited outside the home until a second officer arrived per department procedures. Upon entering the residence, the subject was observed standing in the kitchen with a smart phone in his hands. Petitioner later determined a window in the kitchen door had been broken. Petitioner described the mentally ill male as non-responsive to attempted communication, seeming to ignore everyone in the room, and violently stabbing at the phone screen with his fingers. He testified he spoke with the father who did not want to press charges and asked that his son be taken to the hospital. Petitioner testified they called for an ambulance. David was not under arrest and Petitioner and his fellow officer stood on each side of the subject in the "galley" type of kitchen with drawers and cabinets on each side. David suddenly lunged across to reach for one of the drawers. Petitioner stated he and the second officer each grabbed David's arms to pull him away from the kitchen drawer, with Petitioner grabbing hold of the subject's left arm and the second officer grabbing his right arm. Petitioner testified he strained his back while pulling the subject backwards, at which time Petitioner let go of the subject's left arm. The subject reached a second time for the kitchen drawer, forcing Petitioner to reach for his left arm again. Petitioner testified that David continued to struggle, and he believes that he and his fellow officer then "took him to the floor" and held him down for three to five minutes until the paramedics arrived. Petitioner testified that he was kneeling on one of the subject's shoulders at that time.

The Aurora Police Incident report was admitted at PX 1 and RX 10. The report was prepared by Officer Hill who arrived at the scene later. The subject is noted to be 5' 7" tall and 200 pounds. The report states that the subject began to run towards the back door before being restrained (PX 1). Petitioner testified that was not accurate. Petitioner provided a recorded interview on September 24, 2017 (RX 11). He described the incident similar to his testimony but stated "we never took him to the ground" (RX 11).

Petitioner testified his back muscles seized up and he developed severe low back pain and had difficulty standing and making any type of movement. Petitioner reported his injury to a supervisor, and after completing reports at the station, went home early. While at the station that night, Petitioner described being in so much pain he did not want to sit and leaned on his desk to take the pressure off his back.

Petitioner testified that he had a prior medical history regarding his back. He had an L4-5 discectomy in 2002 for a pinched nerve on the right side. From that time on he would get a lot of muscle spasms in his lower back, mostly on the right and sometimes on the left, a couple of times a year. He would take Naproxen and Diazepam which he was prescribed by his primary doctor, and would relax. The muscle spasms would typically last up to four or five days. He might miss a day or two of work.

Medical records of his prior care through 2017 were admitted as RX 1 and RX 2. On June 16, 2003, Petitioner sought treatment for back pain with Dr. Houlahan at Dreyer Medical Clinic (RX 1). Petitioner previously underwent surgery 1-½ years earlier for disc herniation at L4-L5 and was doing well until injuring his back playing softball. Petitioner indicated he was turning to tag up at base when he felt a sudden sharp pain in his right lower back, followed by an immediate onset of muscle spasms. On physical examination, Dr. Houlahan confirmed the presence of spasm and noted a positive straight leg raising finding. Petitioner returned for follow-up on September 15, 2003 where he was evaluated by Dr. Barnes (RX 1). Petitioner reported he twisted funny while playing softball and developed recurring pain deep in the right buttocks which he indicated was in the same location as his pre-operative pain (RX 1). On October 3, 2003, Petitioner underwent a lumbar MRI which demonstrated surgical changes at L4-L5 without evidence for recurrent herniation (RX 2). The report indicated a history for current right leg pain. On November 25, 2003, Petitioner presented to Dr. Thomas McNally for surgical consultation (RX 1). Dr. McNally documented a past history for a right-sided hemilaminectomy and discectomy at the L4-L5 level in 2002 with a Dr. Vraney. Petitioner reported good results with no symptoms until injuring his back playing softball. In addition to right buttock pain, Petitioner reported an aching sensation in the right posterolateral calf associated with working out. Dr. McNally reviewed the October MRI and diagnosed right lower extremity radiculopathy secondary to degenerative disc disease and possible lateral recess stenosis at L4-L5 impinging the L5 nerve root (RX 1). Dr. McNally recommended pain management and indicated surgery should be considered if pain management failed. Dr. McNally also cautioned Petitioner that a second surgery posed an increased risk of dural tear due to the presence of scarring (RX 1).

On February 4, 2008, Petitioner presented to the Dreyer Medical Clinic, complaining of low back pain after having fallen onto his buttocks while playing with his children (RX 1). Petitioner complained of difficulty picking things up at times for fear of causing exacerbating pain. He described a catching sensation in his right lower back. Petitioner reported he was taking Celebrex on a daily basis. He was diagnosed with a lumbar strain with radiculopathy. A lumbar MRI performed on February 19, 2008 demonstrated the surgical changes at L4-L5 along with mild evidence for epidural fibrosis involving the right L4-L5 region (RX 2). The report noted a history for low back pain, right greater than left x 6 years. On July 23, 2008, Petitioner sought treatment at Dreyer Medical Clinic for back pain of several days' duration after lifting some pool chemicals into the back of the car. (RX 1). Petitioner complained of radiating bilateral leg pain, left leg worse than the right leg. Dr. Oostman performed osteopathic manipulation and directed Petitioner to return if symptoms worsened. On November 12, 2008, Petitioner returned to Dr. Oostman and reported a new onset of low back pain after bending to pick up a target at sniper practice. Dr. Oostman provided osteopathic manipulation and indicated another updated MRI may be considered (RX 1). A lumbar MRI performed on November 24, 2008 showed a disc protrusion at L4-L5 and findings consistent with an annular fissure at L5-S1. The radiologist commented there was no recurrent herniation and no foraminal stenosis. The report indicated a history for low back pain and spasm, pain posterior right hip radiating down right leg with numbness in the right toes, history of back surgery in 2001 or 2003 (RX 2).

An MRI on October 6, 2009 demonstrated a bulging disc with right-sided epidural fibrosis at L4-L5 and a slight retrolisthesis at L5-S1. The report for this study noted a history for low back pain radiating to the right leg with numbness to the toes (RX 2). On October 12, 2009, Petitioner saw Dr. Oostman and reported he suffered an exacerbation while getting off the MRI table last Tuesday (RX 1). Petitioner complained of radiating pain into the right buttock and into the right calf with paresthesia in the right toes. He advised Dr. Oostman that he had seen Dr. Laich who recommended surgical intervention which was planned for the upcoming winter (RX 1). Dr. Oostman noted that osteopathic manipulation would not be provided because previously attempted manipulation failed to provide relief. A lumbar MRI performed on November 17, 2009 demonstrated disc space

narrowing at L1-L2, L4-L5 and L5-S1 with endplate spurring and bony remodeling of L1. The report indicated a history for back spasms and right leg numbness (RX 2).

Petitioner saw Dreyer Clinic on February 10, 2011. He reported that he missed several days of work due to back pain which developed while shoveling snow. He described low back pain with radicular pain in the right leg and tingling in the right calf and the 4th and 5th toes. Petitioner stated he had been experiencing three to four exacerbations of back pain annually, though he had avoided such exacerbations over the past year with strengthening exercises until this most recent snow shoveling incident. Petitioner reported taking Valium which provided some relief. He needed a medical clearance to return to work. The physician assistant noted Petitioner no longer desired osteopathic manipulation therapy as that form of therapy had exacerbated his pain. He was recommended for continuation of strengthening exercises and Medrol medication if symptoms recurred (RX 1).

On December 12, 2011, Petitioner returned to Dreyer Medical Clinic complaining of low back pain and spasming. Petitioner reported he was bending down to clean the shower and then developed sudden pain when he stood up. Petitioner reported missing time from work and was self-medicating with Diazepam and Naproxen which was providing partial relief. Petitioner was prescribed Vicodin to be taken when needed for severe pain (RX 1).

Dr. Houlahan evaluated Petitioner on May 15, 2013 for multiple health conditions. Dr. Houlahan noted a history for chronic low back pain and indicated Petitioner was continuing to take Naproxen on a regular basis and Vicodin for severe flare-ups (RX 1). Petitioner denied taking Vicodin. On August 19, 2014, Petitioner returned to Dr. Houlahan reporting continued use of Naproxen on a regular basis for his chronic low back pain (RX 1). In the summer of 2016, Petitioner attended physical therapy for upper extremity symptoms. A therapy progress report in the Dreyer Clinic records dated July 25, 2016, noted Petitioner prematurely terminated his therapy because the exercises had aggravated his lower back. Petitioner elected to self-treat at home instead (RX 1).

Petitioner testified that he suffered a muscle spasm in his back in June 2017 while playing softball. He testified he went to work that evening and did not have any problems because he did not have any type of altercation. RX 12 is an Hours History Detail report. It noted Petitioner was off work from June 18, 2017 through June 22, 2017. He had June 23 and June 25 as his scheduled off-days (RX 12).

He testified he went to his doctor and told him that he had some sciatica that developed a couple days following the softball strain. He was given a pack of steroids lasting seven days. He saw Dr. Oostman for some osteopathic manipulations and injections from Dr. Augusthy. Petitioner testified the sciatica was a burning feeling in his right buttock and on the outside of his right calf. It felt better after the second injection and he felt it was dwindling away. He testified he had 75%-80% relief. He testified he did not miss any work because he was on vacation for a week during that time. Medical records of this treatment were admitted as RX 2, RX 3, and RX 4.

On June 30, 2017, Petitioner saw Dr. Houlahan complaining of low back pain and right lower extremity sciatica of three weeks' duration (RX 3). Petitioner reported he was playing softball when his back just seized up. Dr. Houlahan diagnosed acute right-sided low back pain with right-sided sciatica and referred Petitioner to Dr. Oostman. He directed Petitioner to avoid lifting and excessive stooping (RX 3). Dr. Oostman evaluated Petitioner on July 5, 2017 (RX 3). Petitioner described the onset of pain and spasming when he pivoted to throw the ball during a softball game in early June. Petitioner complained of progressively worsening

symptoms including radiating pain down the buttock and into the calf and foot with paresthesia. Dr. Oostman noted that Dr. Laich had recommended surgery; however, a second opinion surgeon advised against it. Instead, the second opinion surgeon recommended a spinal cord stimulator. Petitioner did not have either. Dr. Oostman noted that Petitioner's periodic pain and spasms through the past years had been manageable until re-injuring his back playing softball in June 2017. Dr. Oostman performed osteopathic manipulation and recommended continued use of Valium along with a daily trial of Meloxicam.

Dr. Houlahan re-evaluated Petitioner on July 11, 2017. Petitioner complained of continuing back pain with right-sided sciatica shooting down to the ankle and foot. Dr. Houlahan ordered a new MRI and discussed referring Petitioner for epidural steroid injections to treat Petitioner's persistent severe lower back pain (RX 3). Petitioner returned to Dr. Oostman on July 17, 2017, complaining that his low back pain continued to persist and remain unchanged. Dr. Oostman provided osteopathic manipulation (RX. 3). Petitioner took off work from July 16, 2017 through July 20, 2017 and was scheduled off work on July 21 and July 22, 2017 (RX 12). A lumbar MRI performed July 21, 2017 showed a right lateral disc protrusion at L4-L5 contacting the traversing right L5 nerve roots. No significant foraminal narrowing was noted (RX 2).

Petitioner presented for pain management evaluation with Dr. Augusthy at the Spine Care Center on August 8, 2017 (RX 4). Petitioner completed an intake questionnaire on which he reported having developed weakness in the right leg since injuring his back playing softball in June 2017. Moving from "stand to sit" and rising from "sit to stand" positions made his pain worse and that laying down made the pain feel better. Dr. Augusthy noted Petitioner's back pain and spams had been intermittent following his 2001 surgery and then became persistent and progressive after the June 2017 softball injury. Dr. Augusthy noted numbness and tingling with weakness in the right leg and a pain score of 7/10 (RX 4, p 1-3). Physical examination noted positive right straight leg raising, positive heel/toe walking, tenderness to palpation in the right lumbar paraspinals. Dr. Augusthy diagnosed disc aggravation at L4-5. He performed a lumbar trigger point injection. He also indicated a follow-up epidural steroid injection may be necessary. Dr. Augusthy instructed Petitioner to be cautious with any bending, lifting, pushing, or pulling. Dr. Augusthy advised Petitioner that injections were intended to help decrease pain and increase functionality, but these treatments cannot 'fix' the problem (RX 4, p 5-6).

On August 10, 2017, Dr. Augusthy administered a right L5-S1 transforaminal epidural steroid injection. Dr. Augusthy's diagnosis was post-laminectomy syndrome (RX 4). Petitioner took a week off work from August 13, 2017 through Thursday August 17, 201 and was scheduled off work on August 18 and August 19, 2017 (RX 12). Petitioner underwent a second epidural steroid injection on August 24, 2017. Petitioner was to return for follow-up in two to three weeks (RX 4, p 18).

Petitioner testified that on September 5, 2017, he returned home and attempted to rest. He took Diazepam and Naproxen without relief. His wife was out of town. Petitioner testified he stayed in bed for six or seven days until he was able to get up and move around some. He testified that he spoke with HR and was told to go to Occupational Health.

Petitioner sought medical care at Northwestern Medicine Occupational Health where he was evaluated by Dr. Baksinsky (PX 4). Petitioner reported he had to restrain a subject after he attempted to reach into a kitchen drawer. The Clinical Assessment noted 9-10/10 pain in the lower back. Right leg pain is worse that the left. Positive for numbness in the left foot. Positive for tingling in both legs. He has continual spasming of the lower back and radiating pain into both legs. Petitioner advised of his 2001 surgery and the softball injury in June 2017 and indicated he had received two injections with Dr. Augusthy. Petitioner reported he improved

"somewhat" from the injections and a previously scheduled follow-up appointment was set for next week. Dr. Baksinsky prescribed medication and directed Petitioner to be off work. Petitioner returned for three follow-up visits at Northwestern Medicine Occupational Medicine through October 17, 2017 with no change in his reported complaints (PX 4).

Petitioner returned to Dr. Augusthy on September 27, 2017 for follow-up evaluation. He advised Dr. Augusthy of his recent work injury. Dr. Augusthy stated that Petitioner's condition had improved 50% after the second injection and now Petitioner presented with progressing back pain and bilateral leg pain, increased on the right and new on the left. The assessment is acute additional injury of the low back which has now progressed to bilateral low back pain to bilateral legs. Symptoms have clearly progressed in both distribution and severity. Dr. Augusthy notes that ESI were beginning to prove effective. There are no gross neuro deficits other than sensory deficit in the left foot. He states that the patient was responding to conservative interventional management before this most recent aggravation and injury. With the progression of symptomology, further evaluation should be considered. He then defers to work comp for further evaluation and treatment (RX 4). On October 30, 2017, Dr. Augusthy notes Petitioner's pain is incredibly severe. He diagnosed acute progression of low back pain with bilateral leg pain. Dr. Augusthy limited Petitioner to sedentary work and recommended another MRI (RX 4).

An MRI performed on November 7, 2017 showed no significant interval change when compared to the recent July 21, 2017 study (RX 2). On November 15, 2017, Dr. Augusthy assessed acute progression of low back pain to the bilateral legs, severe and constant, neurologically intact, lumbar discogenic syndrome. He states the MRI in noted as "unchanged." Dr. Augusthy recommended targeted anti-inflammatory therapy with lumbar ESI. He notes that if there is not rapid improvement, he recommends surgical considerations. Petitioner underwent right L4-5 and L5-S1 transforaminal epidural steroid injections on November 2, 2017 (RX 4).

Petitioner presented for an initial evaluation with Dr. Ghaly at Ghaly Neurosurgical Associates on December 6, 2017. The Health assessment filled out by Petitioner reports complaints of sciatica on both sides. He notes right side sciatica started in June from softball and an additional injury in September following a work injury back spasm causing worse sciatica on right and additional sciatica on the left side. He notes he had to restrain a subject for several minutes causing back spasm (PX 5, p 43). Petitioner advised that the pain on the right was similar to the distribution he had before his 2000 surgery. The left leg is a new onset. He stated he was recovering from the softball injury with 5/10 pain and had been able to work (PX 5, p 37). Physical exam noted L5 radiculopathy on the right and S1 radiculopathy on the left. Back range of motion was limited. Dr. Ghaly reviewed the MRI studies and stated the November 7, 2017 shows increase into the disc herniation, the protrusion in the right L4-5 with root compression. Dr. Ghaly assessed a physical altercation with twisting, bending, pulling, and pushing caused increasing pain in the lower back going down the right leg. The right leg distribution is in L5 and the left leg distribution is in S1. The accident increased the disc herniation. Dr. Ghaly recommended surgery at L4-L5 on the right side. He noted there was no indication for surgery at the L5-S1 level. Dr. Ghaly prescribed physical therapy to be conducted while Petitioner considered surgical options, Dr. Ghaly ordered EMG testing and another MRI.

The MRI performed at Fox Valley Imaging with and without contrast on December 7, 2017 showed a right disc herniation at L4-L5, increased in severity as well as an L5-S1 broad based disc protrusion with an annular tear extending into the anterior aspect of the left neural foramen (PX 6). An EMG performed on December 11, 2017 indicated findings for right greater than left radiculopathy. The exact level could not be correlated due to the

absence of any EMG changes in the lower extremities which would normally allow us to define what level of involvement may be present (PX 5, p 56).

On December 21, 2017, Petitioner reported no improvement with physical therapy. Dr. Ghaly reviewed the EMG showing bilateral radiculopathy. He also notes the right L4-5 disc extrusion is more when compared to the MRI prior to the 9/5/2017 accident. He discussed two surgical options with Petitioner, an "L4-5 redo laminoforaminotomy and microdiscectomy" on the right side, or a fusion at the L4-L5 . Petitioner indicated he was seriously considering the laminoforaminotomy and microdiscectomy and was planned for January 5, 2018. Petitioner was to continue off work (PX 5, p 31-36). On January 3, 2018, the surgery had not been approved (PX 5, p 24). Petitioner received therapy and continued to see Dr. Ghaly through April 6, 2018, but surgery was not approved by Workers' Compensation and Dr. Ghaly is not under Petitioner's Blue Cross HMO. Dr. Ghaly's assessment was work -related injury caused two disc herniations on the right at L4-5 and the left at L5-S1, had been disabled since injury on 09/05/2017. He notes Petitioner is getting worse and has the names of physicians within his HMO (PX 5).

Petitioner saw Dr. Dean Karahalios on May 31, 2018 (PX 3, p 141). Petitioner testified Dr. Houlihan referred him. Dr. Karahalios noted Petitioner's past surgical history for a microdiscectomy in 2002 and indicated Petitioner injured his back while working as a police officer in September 2017, resulting in bilateral leg pain and no relief following therapy. Dr. Karahalios noted physical therapy and the epidural steroid injection failed to provide relief. Dr. Karahalios noted the left-sided radiating symptoms were less severe and less frequent compared to the right leg. On examination, Dr. Karahalios found normal 5/5 strength. There was decreased sensation involving the right L5 distribution and the left S1 distribution. Dr. Karahalios reviewed the November 7, 2017 MRI study and assessed the presence of a right lateral disc protrusion at L4-L5 with a small appearing free fragment encroaching the L5 nerve root. Dr. Karahalios diagnosed lower extremity radiculopathy related to degenerative disease and recommended a decompressive laminectomy at L4-L5. Dr. Karahalios ordered an EMG for further testing along with a new MRI (PX 3, p 141). The June 4, 2018 MRI noted post-surgical changes at L4-5, a broad based disc bulge with mild right-sided neural foraminal narrowing and post-surgical granulation. At the L5-S1 level, the radiologist found a mild diffuse broad-based disc bulge and a small central annular tear without herniation (RX 2).

Dr. Wellington Hsu performed a record review on June 27, 2018 (RX 6). He reviewed records and diagnostic films from 2003 through March 23, 2018. Dr. Hsu opined that Petitioner's diagnosis was lumbar strain-resolved and lumbar spondylosis, status post right-sided L4-L5 foraminotomy, laminotomy and discectomy. He did find any acute structural injury occurred to the lumbar spine. He opined that Petitioner's need for surgery was due to his pre-existing condition (RX 6).
On June 20, 2018, Dr. Karahalios performed a L4-L5 decompressive laminectomy (PX 8). The Good Samaritan records note the surgery was pre-certified by Blue Advantage HMO (PX 8, p 3). The operative report notes that the surgeon confirmed adequate decompression of the neural elements including the exiting L4 and L5 nerve roots and the shoulder of the S1 nerve roots bilaterally (PX 8, p 48).

Petitioner advised Dr. Karahalios on August 16, 2018 that he was significantly improved. He reported minimal back pain and occasional radiating pain into the lower extremities. Petitioner denied numbness, tingling, or weakness. Dr. Karahalios noted Petitioner walked with a steady gait and was able to walk on his heels and toes. Dr. Karahalios ordered physical therapy (PX 3, p 167-169). On September 14, 2018, Petitioner was evaluated by a nurse. He denied back pain but will have occasional nerve pain to his bilateral lower extremities. He still complains of right drop foot, which has improved since his last visit. He denies gait

imbalance or fine motor dysfunction. Petitioner was told to begin light duty and begin building his endurance and strength. Petitioner refused PT (PX 3, p 193-194). Petitioner was discharged from physical therapy on September 19, 2018. He has met his therapy goals demonstrating improved strength and range of motion, decreased pain, improved posture, and tolerance for daily activities. He was to continue a home exercise program (PX 3, p 201). On December 12, 2018, Petitioner complained of right ankle weakness. Physical exam noted 5/5 strength in the lower extremities except for right anterior tibialis, eversion, inversion 4+/5. He had a steady gait but slight steppage gait on the right. Able to walk on toes and heels, slight difficulty with tandem gait. The evaluating nurse notes his weakness is improving. He is to continue home exercise. She ordered an MRI of the cervical spine to evaluate the balance difficulty and instructed Petitioner to return in 6 months (PX 3, p 209-212).

Dr. Karahalios authored a letter on September 30, 2019 stating Petitioner was seen on September 27, 2019 to evaluate his right foot drop. Petitioner testified that the weakness has not improved, nor has it worsened. Petitioner was placed at MMI (PX 3, p 213). Petitioner testified that following the surgery his sciatica was improved. He continues to have nerve pain in his left foot on the outside and a drop foot on his right foot. He continues his home exercise program but has difficulty walking and has to concentrate and consciously lift his right knee higher so he does not scrape the ground and trip. Petitioner testified he returned to work on restricted duty for 3 months. He then turned in his retirement papers on January 3, 2020. Respondent's Hours History Detail Report notes Petitioner worked light duty from September 16, 2018 through April 2, 2019 (RX 13) and received sick time through his retirement date (RX 14). Petitioner testified he intended to retire to Arizona to become a police officer. He did not apply because he did not meet the physical standards. He currently works two part time jobs as a firearms instructor making $20 per hour. He testified he currently does not have sciatica, but he has tightness all the time. He has the foot drop and nerve pain on the outside of his left foot.

Dr. Karahalios testified by evidence deposition taken May 31, 2019 (PX 2). Dr. Karahalios, a board-certified neurosurgeon, testified he evaluated Petitioner for another opinion on May 31, 2018. He testified to the history received, including the prior surgery, the work accident and injection received, and his physical examination. He testified to Dr. Augusthy's September 27, 2017 office note. His impression was that Petitioner suffered from a lower extremity radicular process related to lumbar degenerative disease and he agreed that a L4-L5 decompressive laminectomy was appropriate.

Dr. Karahalios testified he only reviewed the November 7, 2017 MRI films during his initial consultation. In preparation for his deposition, he reviewed the written reports for the MRIs performed on July 21, 2017, November 7, 2017 and December 7, 2017 and compared the written findings with the November 7 films. Dr. Karahalios testified that the November 7, 2017 MRI showed a right-sided protrusion at L4-L5 which appeared stable when compared with the July 21, 2017 report. Dr. Karahalios observed new left-sided pathology in the November 7 films which the radiologist did not document in the report at L5-S1. He agreed with the radiologist that the L4-5 findings have increased in severity. The December 2017 EMG showed bilateral radiculopathy or irritation which was more definitive on the right side but failed to identify the disc level involved. Dr. Karahalios opined, based on the timeline reviewed here, that the accident exacerbated Petitioner's condition to the extent that he required additional treatment, including surgery. The accident aggravated the condition. (PX 2).

Dr. Karahalios testified he performed the surgery on June 20, 2018. He testified to Petitioner's post-operative care including the continued weakness in the right ankle. He identified work restrictions given December 12,

2018 of no prolonged sitting, standing, or walking and a lifting restriction of 15 to 20 pounds. He stated if a police officer had foot pain or weakness, he could stumble (PX 2).

On cross-examination, Dr. Karahalios testified that his involvement in Petitioner's medical care began nine months after the work injury. He does not recall reviewing any medical records of prior treatment other than the July 2017 MRI report testified to. He had not reviewed any prior MRI studies. Dr. Karahalios testified his understanding of Petitioner prior condition was just that he had issues in the past, he had previous surgery, and he had symptoms related to that to some degree. His understanding of the mechanism of injury was that Petitioner was tussling with someone at work in his capacity as a police officer and injured his back. He stated his opinions were based on the information he was in possession of. His opinions could change if new or different information came to his attention, depending on what it was (PX 2).

Respondent's counsel then presented a group exhibit containing imaging from October 2003 and February 2008. Dr. Karahalios testified further that the MRI finding for epidural fibrosis referred to scar tissue and was located on the right side at L4-L5. Based on the 2008 MRI report, Dr. Karahalios noted the scar tissue was pretty close to the nerve root and testified that the presence of scar tissue can cause nerve-related issues or inflammation of the adjacent neural structures. Dr. Karahalios agreed the November 24, 2008 MRI demonstrated a broad-based right paramedian disc protrusion at L4-L5 and an annular fissure at L5-S1 which he believed represented a new development in 2008. The October 6, 2009 MRI, with a history for low back pain and radiating right leg pain with numbness in the toes, exhibited a slight retrolisthesis at L5-S1 (PX 2, p 49-50).

The July 21, 2017 MRI continued to show the same disc protrusion at L4-L5 on the right side.The report indicated a history of numbness and tingling in the right leg. Dr. Karahalios agreed the same radiologist read both the July 21, 2017 and the November 7, 2017 MRI studies and concluded there were no significant interval changes (PX 2). Dr. Karahalios agreed the June 2018 report indicated there was no evidence of disc herniation at L4-L5 and was negative for herniation at L5-S1. The L5-S1 disc continued to exhibit an annular fissure which Dr. Karahalios agreed was the same fissure shown in the earlier MRI studies and pre-dated the work injury. Dr. Karahalios confirmed he personally reviewed the imaging from the June 2018 study and concurred with the radiologist's findings (PX 2).

Dr. Karahalios testified "I know he had an issue in 2001 where had had his previous microdiscectomy. I was unaware of any injury between that time and the time of the accident in question." He was presented and reviewed extensive records of Petitioner's medical care, complaints and injuries commencing on June 16, 2003 through the June 2017 softball injuries. Dr. Karahalios agreed Petitioner suffered from a persistent chronic low back condition in November 2003 and activities of daily living were causing exacerbations or increased pain levels. He agreed with Dr. McNally's that a second discectomy carried an increased risk of dural tear secondary to the presence of scar tissue, thereby rendering the surgical outcome less predictable. He acknowledged that Dr. McNally had counseled Petitioner in 2003 to wait or hold off from undergoing a second surgery for as long as possible and he concurred with that advice (PX 2). Dr. Karahalios was unaware Petitioner had fallen on his buttocks while playing with his children in February 2008, or that Petitioner complained of low back pain with bilateral radiating leg pain and paresthesia after lifting pool chemicals into his car in July 2008. Dr. Karahalios also acknowledged an incident where Petitioner complained of pain while bending to pick up a target at sniper practice. This incident was a sign Petitioner's pathology had by then reached a point where bending over could exacerbate his condition. Dr. Karahalios agreed that the October 12, 2009 exacerbation while getting off an MRI table was a pretty mild stressor. Dr. Karahalios testified that if Dr.

Laich had recommended surgery in 2009, surgical intervention was appropriate in 2009. He also reviewed records that Petitioner developed back pain while shoveling snow in February 2011 and a December 2011 office visit documenting the onset of pain and spasms while bending and standing up in the shower. Dr. Karahalios agreed this episode was a minor physical exertion. Dr. Karahalios testified further that by 2011 Petitioner's condition had reached a point where even minor physical exertions could bring about symptomology and pain (PX 2).

Dr. Karahalios testified that Petitioner reported his back seized up while playing softball. He did not know Petitioner was still under active medical treatment for the softball injury when he encountered the mentally ill subject in September 2017. Dr. Karahalios testified there are patients who receive complete resolution with injections, patients with no response, and patients falling in between. Whether the effects from steroid injections can fade over time depends on the patient. Dr. Karahalios conceded it would be impossible to say whether or not the injections administer by Dr. Augusthy would have resolved Petitioner's pain complaints if he had not had the encounter on September 5, 2017. Dr. Karahalios opined that the pathology in Petitioner's spine had reached a point prior to the work injury where his back was pretty fragile, and it would not take much to re-injure his back. He further agreed that the pathology had reached a point where any ordinary activity of daily living could cause re-injury (PX 2).

Dr. Karahalios testified that in all the records reviewed, there were no referenced to left leg symptoms except in 2008 and the 2009 podiatrist records until after the September 5, 2017 injury. The left leg symptoms were a motivating factor in the type of surgery he recommended. After reviewing the medical records presented, Dr. Karahalios opined that the work accident exacerbated a symptomatic degenerative condition that was already present, made it more symptomatic, and caused left sided radicular complaints to recur (PX 2).

Respondent offered the report of Dr. Racenstein, a board certified in diagnostic radiology (RX 5). Dr. Racenstein reviewed films and reports for the MRI studies, CT scans and x-rays taken between 2008 and 2018. He also reviewed a report from an older MRI completed in 2003 for which the films were unavailable. Dr. Racenstein opined there were no medically significant changes in Petitioner's lumbar spine. Dr. Racenstein did observe a small one-millimeter increase in the size of a bulging disc at L4-L5; however, this change was inconsequential and there was no compression on the nerve root seen in either the before or after studies. Dr. Racenstein thus concluded there were no significant structural changes at the L4-L5 level resulting from the alleged work injury. Addressing the L5-S1 disc, Dr. Racenstein found a smaller left-sided disc bulge; however, this finding was present in both the before and after imaging studies. Dr. Racenstein examined both the November 2017 and December 2017 studies in comparison with the pre-accident July 2017 study and opined there was no new left-sided pathology shown in the post-accident imaging. Both before and after the work injury, the imaging demonstrated the same left sided 5mm disc bulge at L5-S1. Dr. Racenstein noted that Petitioner's lumbar spine exhibited the same disc bulge at L5-S1 as far back as 2008. Dr. Racenstein also opined there were no abnormal radiological findings consistent with a neurological issue on the left side as the two bulging discs at L4-L5 and L5-S1 did not produce any nerve impingement on the left side. Dr. Racenstein disagreed with the radiological reading of the November 2017 MRI taken at Fox Valley Imaging that there was of "recurrent" disc herniation. Dr. Racenstein found the images were negative for any herniation (RX 5).

Petitioner was examined by Dr. Hsu on July 27, 2020 at Respondent's request (RX 7). Dr. Hsu reviewed medical records through June 2019 and Dr. Racenstein's report. He noted Petitioner wears an AFO brace for the right foot drop. Physical exam noted good range of motion with negative Waddell signs and negative straight leg raise. Petitioner had a normal gait and was able to heal and toe walk and tandem walk without

difficulty. Neurological exam was negative except for 3+/5 strength of the right tibialis anterior. Dr. Hsu noted his prior diagnosis and opinions have not changed. He found Petitioner's symptoms and objective findings consistent with his complaints and a right foot drop. He restated his opinion that Petitioner's complaints or his surgery were in no way related to the accident but rather to the pre-existing condition which was already symptomatic. He opined that Petitioner could work with restrictions of no heavy over 50 pounds and bending, crouching, and stooping on an occasional basis (RX 7).

Dr. Hsu testified by evidence deposition taken November 23, 2020. Dr. Hsu testified to his June 2018 records review after Dr. Ghaly recommended surgery. Dr. Hsu testified to Petitioner's past medical history commencing with a spine surgery in 2001 or 2002 for a disc herniation at L4- Dr. Hsu testified the medical records he reviewed documented intermittent back complaints for the next 16 years following the surgery including the softball-related back injury in June 2017 and pain management care with Dr. Augusthy. He testified to the Northwestern Medicine Occupational Health records in September 2017 and Dr. Ghaly's records through March 2018 (RX 9).

Dr. Hsu also reviewed radiology reports and personally reviewed imaging studies, with the oldest study having been performed on February 19, 2008. He testified a CT scan performed November 2009 demonstrated disc calcification. A disc calcifies when it becomes arthritic and the medical term refers to calcium deposits which harden the disc and form an outer shell which can lead to impingement depending on its location. This calcification process is a progressive condition. The MRI taken after the June 2017 softball injury demonstrated a right-sided disc bulge at L4-L5 which had increased in size since the prior 2009 study. The MRI performed in November 2017 and compared the images with the earlier July 2017 images. showed no interval changes. A repeat MRI in December 2017 also failed to show any changes. Dr. Hsu testified the MRI studies did not show signs for acute structural changes following the work injury (RX 9). Dr. Hsu reviewed a CT scan performed on January 3, 2018 and noted the images exhibited increased calcification of the L4-L5 disc which was consistent with continued growth of calcium deposits (RX 9).

Based on his medical records review, Dr. Hsu opined that Petitioner's work-related September 5, 2017 incident caused a temporary soft-tissue lumbar strain which had resolved. Petitioner suffered from pre-existing lumbar spondylosis which had previously been treated with surgical intervention at L4-L5. Spondylosis refers to genetic related wear and tear changes in motion segments of the spine. He opined that the work related incident did not lead to any structural changes and did not aggravate the pre-existing condition. The surgery recommended by Dr. Ghaly was not causally related to the work injury. The only injury Petitioner sustained on September 5, 2017 was a low back strain (RX 9).

Dr. Hsu testified he examined Petitioner on July 27, 2020. He reviewed medical records from 2003 through 2016. He also reviewed updated medical records from Dr. Karahalios and computer discs containing imaging studies as well as an independent diagnostic imaging report from Dr. Racenstein. Dr. Hsu noted a surgical consultation with Dr. Thomas McNally with documented complaints for right buttock pain and aching in the right lateral aspect of the lower leg. Dr. Hsu testified these documented complaints were consistent with radiculopathy. He agreed with Dr. McNally's diagnosis for right lower extremity radiculopathy secondary to stenosis at L4-L5. Dr. Hsu also concurred with Dr. McNally's recommended treatment plan consisting of continued conservative care with surgery to be considered if pain management fails. Dr. Hsu reviewed Petitioner's complaints of numbness in the toes after he fell while playing with his children in 2008 which can correlate anatomically with the L4-L5 level; Petitioner's self-reported difficulty picking things up and fear of exacerbating his pain, that can be consistent for an individual suffering from a bad disc; Petitioner's July 2008

back injury sustained while lifting pool chemicals into the back of his car; a visit with Dr. Oostman in November 2008 regarding a new onset of pain after Petitioner bent over to pick up a target at sniper practice, which documented paresthesia consistent for radiculopathy. The MRI findings set forth in Dr. Oostman's November 2008 progress note found epidural fibrosis, which is the term for scarring around the dural sac lining the nerve root. Dr. Hsu testified to Petitioner's onset of back pain with right-sided buttock and calf pain after getting off an MRI table in October 2009. Based on the low back history between 2003 and 2009, Dr. Hsu testified Petitioner suffered from frequent back pain associated with relatively minor events. By October 2009, Petitioner's records revealed surgery had been recommended by Dr. Laich. Dr. Hsu agreed Petitioner was a surgical candidate at that time (RX 9). Dr. Hsu testified to continuing incidents producing back pain, noting Petitioner reported re-injuring his low back while shoveling in February of 2011, with another onset of spasming and right-sided radicular pain; treatment for back pain and spasms which began while cleaning the shower on December 12, 2011, when he bent down and then experienced pain when he stood up. This incident was a motion-induced pain trigger (RX 9).

Dr. Hsu testified the injections administered by Dr. Augusthy after the June 2017 softball injury were therapeutic and not curative. The benefits from injections can fade over time. Dr. Hsu agreed with Dr. Augusthy's diagnosis for post-laminectomy syndrome. Hsu reviewed the June 2018 MRI and found no significant changes compared to the prior MRI studies. His prior diagnosis remained the same with the addition that Petitioner had undergone a revision surgery. The surgery performed by Dr. Karahalios was limited to the L4-L5 level. Dr. Hsu stated his prior opinions concerning Petitioner's work injury and condition of ill-being remained unchanged. Dr. Hsu testified he found no evidence for a new left-sided protrusion at L5-S1 on the imaging and he disagreed with Dr. Karahalios's deposition testimony regarding the radiological findings at that level. There were no radiological MRI changes when comparing the before and after studies performed in 2017 and 2018. Dr. Hsu testified that a lumbar strain could produce referred pain radiating into the lower extremities. Dr. Hsu opined that Petitioner's left-sided leg pain was a referred pain and not a nerve-related radiculopathy. Dr. Hsu then reiterated it was his opinion that the work incident of September 5, 2017 did not aggravate Petitioner's pre-existing condition. Based on the medical history leading up to 2017, Dr. Hsu opined that Petitioner's condition was such that activities of daily living could present the possibility of an overexertion leading to symptomology. Minor bodily motions associated with bending, twisting, and picking things up could be triggers. Dr. Hsu opined that the surgery performed by Dr. Karahalios was not causally related to the work incident of September 5, 2017 (RX 9).

Dr. Hsu testified that calcification in the spine is a degenerative condition associated with age and genetics. Calcification can occur from trauma but usually takes years to develop. The increased calcification seen in the imaging on January 3, 2018 would have started years prior. Dr. Hsu agreed that a low energy trauma can injure a disc and that pre-existing pathologies in the spine can predispose someone to injury. Dr. Hsu testified the surgery was reasonable and necessary on June 20, 2018. The surgery previously recommended by Dr. Laich in 2009 would also be reasonable and necessary. Dr. Hsu testified that Petitioner's left-sided leg pain could be called a radicular symptom. Radicular is a generic term for radiating pain and does not necessarily mean the pain is neurological in origin (RX 9).

Conclusions of Law

In support of the Arbitrator's decision with respect to (C) Accident, the Arbitrator finds as follows:

To obtain compensation under the Act, a claimant must show, by a preponderance of the evidence, that he suffered a disabling injury that arose out of and in the course of the claimant's employment. An injury is accidental within the meaning of the Act when it is traceable to a definite time, place and cause and occurs in the course of employment unexpectedly and without affirmative act or design of the employee. *International Harvester Co. v. Industrial Comm.*, 56 Ill. 2d 84, 89 (Ill. 1973). An injury occurs "in the course of' employment when it occurs during employment and at a place where the claimant may reasonably perform employment duties, and while a claimant fulfills those duties or engages in some incidental employment duties. An injury "arises out of" one's employment if it originates from a risk connected with, or incidental to, the employment and involves a causal connection between the employment and the accidental injury. For an injury to 'arise out' of the employment its origin must be in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury. A risk is distinctly associated with an employee's employment if, at the time of the occurrence, the employee was performing (1) acts he or she was instructed to perform by the employer, (2) acts that he or she had a common-law or statutory duty to perform, or (3) acts that the employee might reasonably be expected to perform incident to his or her assigned duties. *McAllister v. Illinois Workers' Compensation Comm'n*, 2020 IL 124848, citing *Caterpillar Tractor*, 129 Ill. 2d at 58; see also *The Venture—Newberg-Perini, Stone & Webster v. Illinois Workers' Compensation Comm'n*, 2013 IL 115728; *Sisbro*, 207 Ill. 2d at 204.

Petitioner sustained the September 5, 2017 injury to his low back while restraining a mentally ill adult. The Arbitrator notes Petitioner's testimony that he took him to the floor is inconsistent with the reports and statements, but does not find that this detail renders the testimony of the event unpersuasive given the multiple histories given of this struggle. The act of restraining this individual is an act that Petitioner had a duty to perform and was one that he might reasonably be expected to perform incident to his or her assigned duties. The incident would be considered an employment risk.

Respondent argues that the matter is not compensable because the claimant's condition was so deteriorated that any normal daily activity is an overexertion, citing *Sisbro vs. Industrial Commission*, 207 Ill.2d 193, 210 (2003). 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. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 205 (2003). Furthermore, an employer takes its employees as it finds them. *St. Elizabeth's Hospital v. Illinois Workers' Compensation Comm'n*, 371 Ill. App. 3d 882, 888 (2007). A claimant with a preexisting condition may recover where employment aggravates or accelerates that condition. *Caterpillar Tractor Co. v. Industrial Comm'n*, 92 Ill. 2d 30, 36 (1982). *McCallister* addressed this issue stating: *Caterpillar Tractor* prescribes the proper test for analyzing whether an injury "arises out of" a claimant's employment, when a claimant is injured performing job duties involving common bodily movements or routine everyday activities. *Sisbro* and *Caterpillar Tractor* make it clear that common bodily movements and everyday activities are compensable and employment related if the common bodily movement resulting in an injury had its origin in some risks connected with, or incidental to, employment so as to create a causal connection between the employment and the accidental injury. *Sisbro*, 207 Ill. 2d at 203 (citing *Caterpillar Tractor*, 129 Ill. 2d at 58).

The Arbitrator finds that the injury did not occur as the result of a common bodily movement, but rather from the exertion in restraining the subject who was resisting a unique work related risk. Under *McCallister* and *Caterpillar*, this injury would be the result of the employment risk.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that he sustained accidental injuries arising out of and in the course of his employment with Respondent on September 5, 2017.

In support of the Arbitrator's decision with respect to (F) Causal Connection, the Arbitrator finds as follows:

The claimant in a workers' compensation case has the burden of proving, by a preponderance of the evidence, all of the elements of his claim. *O'Dette v. Industrial Comm'n, 79 Ill. 2d 249, 253, 403 N.E.2d 221, 38 Ill. Dec. 133 (1980)*. Included within that burden is proof that his current condition of ill-being is causally connected to a work-related injury. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 203, 797 N.E.2d 665, 278 Ill. Dec. 70 (2003). Even though an employee has a preexisting condition which may make him more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor. Id. at 205. "Accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it was a causative factor in the resulting condition of ill-being." Id. If the claimant had health problems prior to a work-related injury, he bears the burden of showing that the preexisting condition was aggravated by the employment and that the aggravation occurred as a result of an accident which arose out of and in the course of his employment. *Nunn v. Industrial Comm'n,157 Ill. App. 3d 470, 476, 510 N.E.2d 502, 505, 109 Ill. Dec. 634 (1987)*.

The evidence documents a significant pre-existing lumbar condition beginning with the L4-5 surgery in 2001 and ongoing treatment for low back and radicular pain from 2003 through 2017, including multiple injuries and flair ups of symptoms. Petitioner sustained the June 2017 softball injury and was under ongoing treatment through the September 5, 2017 date of accident. Following the September 5, 2017 injury, Petitioner advanced increased symptoms in the low back and right leg as well as additional radiating pain into the left leg. Petitioner sought additional treatment with Northwestern Occupational Health, Dr. Houlahan, Dr. Augusthy, Dr. Ghaly and Dr. Karahalios.

Cases involving aggravation of a preexisting condition concern primarily medical questions and not legal ones. That is, if a claimant is in a certain condition, an accident occurs, and following the accident, the claimant's condition has deteriorated, it is plainly inferable that the intervening accident caused the deterioration. The salient factor is not the precise previous condition; it is the resulting deterioration from whatever the previous condition had been. *Nanette Schroeder v. The Illinois Workers' Compensation Comm'n*, 2017 IL App (4th) 160192WC (4th Dist., 2017).

Petitioner presented the testimony of Dr. Karahalios opining that the accident aggravated the pre-existing condition. The Arbitrator also notes that on September 27, 2017, Dr. Augusthy stated that Petitioner's condition had improved 50% after the second injection and now Petitioner presented with progressing back pain and bilateral leg pain, increased on the right and new on the left. The assessment is acute additional injury of the low back which has now progressed to bilateral low back pain to bilateral legs. Symptoms have clearly progressed in both distribution and severity. He states that the patient was responding to conservative interventional management before this most recent aggravation and injury. With the progression of

symptomology, further evaluation should be considered. On November 15, 2017, Dr. Augusthy assessed acute progression of low back pain to the bilateral legs, severe and constant, neurologically intact, lumbar discogenic syndrome. Dr. Ghaly reviewed the MRI studies and stated the November 7, 2017 shows increase into the disc herniation, the protrusion in the right L4-5 with root compression. Dr. Ghaly assessed a physical altercation with twisting, bending, pulling, and pushing caused increasing pain in the lower back going down the right leg. The right leg distribution is in L5 and the left leg distribution is in S1.The accident increased the disc herniation. The MRI performed at Fox Valley Imaging with and without contrast on December 7, 2017 showed a right disc herniation at L4-L5, increased in severity as well as an L5-S1 broad based disc protrusion with an annular tear extending into the anterior aspect of the left neural foramen. An EMG performed on December 11, 2017 indicated findings for right greater than left radiculopathy. Dr. Ghaly's assessment was work-related injury caused two disc herniations on the right at L4-5 and the left at L5-S1.

Respondent offered the report of Dr. Racenstein, who reviewed all of the diagnostic studies and concluded there were no significant structural changes at the L4-L5 level resulting from the alleged work injury. Respondent also offered the testimony of Dr. Hsu who opined that the work incident of September 5, 2017 did not aggravate Petitioner's pre-existing condition. Dr. Hsu opined that Petitioner's work-related September 5, 2017 incident caused a temporary soft-tissue lumbar strain which had resolved. Petitioner suffered from pre-existing lumbar spondylosis which had previously been treated with surgical intervention at L4-L5. Based on the medical history leading up to 2017, Dr. Hsu opined that Petitioner's condition was such that activities of daily living could present the possibility of an overexertion leading to symptomology. Minor bodily motions associated with bending, twisting, and picking things up could be triggers. Dr. Hsu opined that the surgery performed by Dr. Karahalios was not causally related to the work incident of September 5, 2017.

It is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony, and resolve conflicts in the evidence, particularly medical opinion evidence. *Berry v. Industrial Comm'n*, 99 Ill. 2d 401, 406-07, 459 N.E.2d 963, 76 Ill. Dec. 828 (1984); *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 675, 928 N.E.2d 474, 340 Ill. Dec. 475 (2009); *Fickas v. Industrial Comm'n*, 308 Ill. App. 3d 1037, 1041, 721 N.E.2d 1165, 242 Ill. Dec. 634 (1999). Expert testimony shall be weighed like other evidence with its weight determined by the character, capacity, skill, and opportunities for observation, as well as the state of mind of the expert and the nature of the case and its facts. *Madison Mining Company v. Industrial Commission*, 309 Ill. 91, 138 N.E. 211 (1923). The proponent of expert testimony must lay a foundation sufficient to establish the reliability of the bases for the expert's opinion. *Gross v. Illinois Workers' Compensation Comm'n*, 2011 IL App (4th) 100615WC, 960 N.E.2d 587, 355 Ill. Dec. 705. If the basis of an expert's opinion is grounded in guess or surmise, it is too speculative to be reliable. Expert opinions must be supported by facts and are only as valid as the facts underlying them. *In re Joseph S.*, 339 Ill. App. 3d 599, 607, 791 N.E.2d 80, 87, 274 Ill. Dec. 284 (2003). A finder of fact is not bound by an expert opinion on an ultimate issue, but may look 'behind' the opinion to examine the underlying facts.

Having heard the testimony and reviewed the evidence, the Arbitrator finds the opinions of Dr. Karahalios, corroborated by the opinions of Dr. Augusthy and Dr. Ghaly persuasive and supported by the evidence of Petitioner's increased symptoms both in severity and in the reappearance of the left sided radicular complaints. Not only may the Commission decide which medical view is to be accepted, it may attach greater weight to the opinion of the treating physician. *International Vermiculite Co. v. Industrial Comm'n*, 77 Ill.2d 1, 31 Ill. Dec. 789, 394 N.E.2d 1166 (1979); *ARA Services, Inc. v. Industrial Comm'n*, 226 Ill. App. 3d 225, 168 Ill. Dec. 756, 590 N.E. 2d 78 (1992). The Arbitrator notes that Dr. Augusthy had the advantage of having seen Petitioner immediately prior to the accident and shortly thereafter. Dr. Ghaly was aware of the softball injury when he

entered his opinions. The Arbitrator notes that Dr. Karahalios did not have Petitioner's full history of low back injuries, diagnostics, and treatment when he rendered his initial opinions. A treating doctor's findings and opinions can be undermined, or even disregarded, through reliance on inaccurate or incomplete information." See *Ravji v. United Airlines*, 2012 WL 440353 at 13 (Ill. Indus. Comm'n) interpreting *Horath v. Industrial Commission*, 96 Ill.2d 349 (Ill. 1983). But during his deposition, he was presented with a complete documentation of the full treatment history and testified his opinion was unchanged that the work accident exacerbated a symptomatic degenerative condition that was already present, made it more symptomatic, and caused left sided radicular complaints to recur. This opinion was based on the same complete information as was provided to Dr. Hsu, but in addition was based upon his multiple visits and treatment of Petitioner and the actual operative viewing of his condition.

Based upon the record as a whole and the Arbitrator's finding with respect to Accident, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that, as a result of the accidental injury sustained on September 5, 2017, he suffered an aggravation of his pre-existing condition of the lumbar spine and that his condition of ill-being is causally connected to the accident.

In support of the Arbitrator's decision with respect to (J) Medical, the Arbitrator finds as follows:

Under §8(a) of the Act, a claimant is entitled to recover reasonable medical expenses that are causally related to the accident and that are determined to be required to diagnose, relieve, or cure the effects of a claimant's injury. The claimant has the burden of proving that the medical services were necessary, and the expenses incurred were reasonable. *City of Chicago v. Illinois Workers ' Compensation Commission,* 409 Ill. App. 3d 258,267 (1st Dist., 2011). Based upon the Arbitrator's findings with respect to Accident and Causal Connection, reasonable and necessary medical to treat the Petitioner's condition of ill-being in the lumbar spine would be compensable.

Petitioner has offered PX 9, being the bills of Northwestern Occ Health, Ghaly Neurosurgical, ATI Physical Therapy, and Advocate Good Samaritan Hospital. The Arbitrator has reviewed the medical records submitted and finds that they prove that this treatment is reasonable, necessary, and causally related.

The Arbitrator finds that Petitioner did not exceed his choice of physicians. Respondent sent Petitioner to Northwestern Medicine Occupational Health and this would not be a Petitioner's choice. Petitioner sought treatment with Dreyer Clinic which is in the same practice as Advocate Medical Group as testified to by Dr. Karahalios. Drs. Houlahan, Augusthy, and Karahalios are all within the same provider for Section 8(a) evaluation purposes. Dr. Augusthy referred Petitioner to Dr. Ghaly. Even if no referral to Dr. Ghaly were to be found, Dr. Ghaly constitutes Petitioner's second choice of physician. Treatment with Dr. Ghaly ended because of the Workers' Compensation denial of the claim after they had authorized the initial treatment. Since Dr. Ghaly was not within Petitioner's HMO, he returned to Advocate Medical group and treated with Dr. Karahalios and Advocate Good Samaritan Hospital who accepted his insurance. Petitioner testified that he was referred to Dr. Karahalios by Dr. Houlahan. The Arbitrator finds that this return to Advocate Medical Group, necessitated by Respondent's own decision to deny further treatment, does not constitute an additional choice.

Prior to trial, the parties entered a stipulation that if there is an award of medical bills, Respondent shall be entitled to an 8(j) credit for the medical bills paid by Respondent's group medical plan, Respondent's liability

shall be limited to the amounts in the medical fee schedule and that after repricing and taking the 8(j) credit, Respondent shall pay any remainder directly to the providers (Arb. Ex. 1A).

Based upon the record as a whole, the Arbitrator's findings with respect to Accident and Causal Connection, and the Stipulation of the Parties, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $921.76 to Northwestern Occ Health, $3,735.00 to Ghaly Neurosurgical, $2,958.27 to ATI Physical Therapy and $28,388.25 to Advocate Good Samaritan Hospital, 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. Any remainder shall be paid directly to the providers.

In support of the Arbitrator's decision with respect to (L) Nature & Extent, the Arbitrator finds as follows:

Petitioner's date of accident is after September 1, 2011 and therefore the provisions of Section 8.1b of the Act are applicable to the assessment of partial permanent disability in this matter.

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 police patrol officer at the time of the accident and that he is not able to return to work in his prior capacity as a result of said injury. Both Dr. Karahalios and Dr. Hsu opined that Petitioner required restrictions due in large part to his right foot drop. The Arbitrator notes that Petitioner was provided restricted duty and chose retirement in January 2020. Because of these facts, the Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 47 years old at the time of the accident. It would be anticipated that, absent his physical limitations, Petitioner would have remained in his previous employment as a police officer for a substantial number of years. However, based upon his significant prior history of back injuries, treatment, and the ongoing degenerative condition as discussed by the medical experts, it is questionable how long he would have been able to continue in this occupation even absent the accident on September 5, 2017. Because of these facts, 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 Petitioner retired from Respondent. He testified he intended to join a police force in Arizona, but could not meet the physical requirements. He is currently working as a part time shooting instructor making $20 per hour. The Arbitrator notes that Petitioner was accommodated with restricted duty by Respondent and chose to retire and take a pension. No evidence was offered as to whether the restricted duty could have continued, and no evidence was offered that he had any diminished earning while performing restricted duty. Because of these facts, 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 that Petitioner sustained injury to the lumbar spine including aggravation of his pre-existing degenerative condition at L4-5 and L5-S1 resulting in increased bilateral radiculopathy. As a result, he underwent surgery at the L4-5 level. He developed a right foot drop which necessitated work restrictions. He was also restricted as a result of the overall condition of his lumbar spine. Because of these facts, 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 35 % loss of use of person as a whole pursuant to §8(d)2 of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	20WC019887
Case Name	PRICE, FRED O v. NORTHERN PIPELINE CONSTRUCTION
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0223
Number of Pages of Decision	19
Decision Issued By	Carolyn Doherty, Commissioner

Petitioner Attorney	Peter Lekas
Respondent Attorney	Blake Lynch

DATE FILED: 6/22/2022

/s/Carolyn Doherty, Commissioner

Signature

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

FRED PRICE,

Petitioner,

vs. NO: 20 WC 19887

NORTHERN PIPELINE CONSTRUCTION,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 27, 2021, 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 $37,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

June 22, 2022
o: 6/16/22
CMD/ma
045

/s/ *Carolyn M. Doherty*
Carolyn M. Doherty

/s/ *Marc Parker*
Marc Parker

/s/ *Christopher A. Harris*
Christopher A. Harris

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	20WC019887
Case Name	PRICE, FRED O v. NORTHERN PIPELINE CONSTRUCTION
Consolidated Cases	
Proceeding Type	19(b) Petition & 8(a)
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	16
Decision Issued By	Molly Mason, Arbitrator

Petitioner Attorney	Peter Lekas
Respondent Attorney	Blake Lynch

DATE FILED: 12/27/2021

/s/Molly Mason, Arbitrator

Signature

INTEREST RATE WEEK OF DECEMBER 21, 2021 0.16%

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)

Fred O. Price
Employee/Petitioner

v.

Northern Pipeline Construction
Employer/Respondent

Case # **20** WC **19887**

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

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **11-17-21** . After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of 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. XWhat 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, **8-13-20**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

For the reasons set forth in the attached decision, the Arbitrator finds that Petitioner established causation as to his current right knee and spinal conditions of ill-being. The Arbitrator also finds that Petitioner established causation as to the need for the recommended right knee replacement and cervical facet injections. The Arbitrator further finds that Petitioner established causation as to the need for the right shoulder MRI and other treatment he underwent through October 2, 2020, the date Dr. Alland found Petitioner to be at maximum medical improvement with respect to the right shoulder.

In the year preceding the injury, Petitioner earned $**96,565.04**; the average weekly wage was $**1,857.02** .

On the date of accident, Petitioner was **56** 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 $**43,703.49** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**43,703.49**. Arb Exh 1.

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

ORDER

The Arbitrator orders Respondent to pay Petitioner the sum of $1,238.01 per week for the period from August 14, 2020 through November 17, 2021, a period of 65 6/7 weeks, that being the period of temporary total incapacity for work under 8(b) of the Act. Respondent shall receive a credit of $43,703.49 in temporary total disability benefits already paid.

The Arbitrator awards prospective care in the form of the right total knee replacement recommended by Dr. Karas and the cervical facet injections recommended by Dr. An.

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

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

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

Signature of Arbitrator

December 27, 2021

Fred O. Price v. Northern Pipeline Construction
20 WC 19887

Summary of Disputed Issues

The parties agree that Petitioner, a longtime union laborer, sustained an accident while working for Respondent on August 13, 2020. Petitioner testified he was in a trench, digging with a shovel, when he unexpectedly hit a root. The shovel "gave out" and he buckled and fell. He claims injuries to his right knee, neck, back and right shoulder.

Petitioner's right knee problems date back to at least April 2004, at which point he underwent an arthroscopic meniscal repair by Dr. Monaco. On July 1, 2004, he bumped the same knee on a torch rack at work. He resumed care with Dr. Monaco. A right knee MRI, performed on July 7, 2004, showed evidence of the previous meniscectomy, a tear of the proximal portion of the anterior cruciate ligament, a moderate-sized effusion and moderate generalized chondromalacia of the medial joint compartment. RX 5, pp. 11-12. By September 2, 2004, Petitioner was feeling "a lot better", according to Dr. Monaco. The doctor discharged Petitioner from care. RX 5, p. 19. Petitioner filed a claim against L. J. Keefe, his then employer, for the July 1, 2004 injury and eventually entered into a settlement equivalent to 5% loss of use of the right leg. RX 5, pp. 32-35.

Petitioner acknowledged undergoing a right knee aspiration and bilateral knee injections by Dr. Alland on December 6, 2019. He also acknowledged that, on that date, Dr. Alland told him he would need a knee replacement. He responded by saying he wanted to defer this surgery until after he had retired. Following a winter layoff, he performed full duty for Respondent between March 2020 and the August 13, 2020 accident.

After the accident, Petitioner initially underwent conservative right knee care with Dr. Alland. When this treatment failed, Dr. Alland referred Petitioner to his associate, Dr. Karas, who recommended a right total knee replacement. Respondent's knee examiner, Dr. Bare, agreed that Petitioner would likely require this surgery but did not link the need for the replacement to the work accident. He opined that the accident merely temporarily aggravated Petitioner's underlying osteoarthritic condition.

Petitioner also saw Dr. An for his spinal complaints, with the doctor recommending cervical facet injections and a pain management assessment. Respondent's spinal examiner, Dr. Bernstein, endorsed the facet injections but found no link between the work accident and the need for this care.

The disputed issues include causal connection, temporary total disability and prospective care.

Arbitrator's Findings of Fact

Petitioner testified he has worked as a union laborer for various contractors for over twenty years. He began working for Respondent four or five years before the accident of August 13, 2020. Respondent is a utility construction company that installs gas lines for Nicor. Petitioner testified his job for Respondent is physically strenuous. He digs ditches, lays concrete and loads trucks with equipment and tools weighing between fifteen and fifty pounds. He is required to crouch and climb in and out of trenches.

Petitioner acknowledged having knee problems prior to August 13, 2020. He recalled undergoing left knee surgery in the remote past but his records show he underwent a right knee meniscectomy by Dr. Monaco in April 2004 and then bumped the same knee at work on July 1, 2004. Dr. Monaco diagnosed a contusion and discharged Petitioner from care on September 2, 2004. RX 5, p. 19. Petitioner filed a claim in connection with the July 1, 2004 incident and eventually settled that claim for 5% loss of use of the right leg. RX 5, pp. 32-35.

Records in RX 6 reflect that Petitioner saw Dr. Alland, an orthopedic surgeon, on December 6, 2019 for "bilateral knee pain, right worse than left." The doctor noted that Petitioner had undergone knee injections in the past and had been told he would eventually need a knee replacement. He also noted that Petitioner wanted to consider conservative measures "as he does not plan to consider surgery until after retirement." He indicated that Petitioner denied any recent formal care. On right knee examination, he noted a 1-2+ effusion, a limited range of motion, no medial or lateral joint line tenderness and 1A Lachman testing. On left knee examination, he noted a trace effusion, a limited range of motion, no medial or lateral joint line tenderness and 1A Lachman testing. He diagnosed "bilateral knee osteoarthritis, right worse than left." He interpreted outside X-rays as demonstrating Grade 4 changes in the right knee and Grade 3-4 changes in the left knee. He aspirated the right knee and injected both knees. He discussed various conservative measures, including weight loss, injections, over the counter medication and bracing, with Petitioner. He indicated that, if these measures failed, Petitioner "may benefit from surgical consultation with one of [his] colleagues for knee replacement." He directed Petitioner to return in six weeks or sooner. There is no indication that he prescribed any medication or imposed work restrictions. RX 6, pp. 4-8.

Petitioner testified his knee condition improved after his December 6, 2019 visit to Dr. Alland. He did not return to Dr. Alland between that visit and the August 13, 2020 work accident. After the winter, he resumed working for Respondent in March 2020. He testified he initially worked as a flagman for two weeks and then resumed his regular laborer duties.

Petitioner testified he began working at approximately 7:30 or 8:00 AM on August 13, 2020. He was in a ditch, using a shovel to try to locate a streetlight wire. He testified that the ground was hard and full of debris. He unexpectedly struck a root. The shovel "gave out" and he "buckled" and fell. He initially thought he had "tweaked" his knee and back but those body parts stiffened up as he cooled off. He reported the accident to his foreman and received first aid care from "Hank", an individual who performed drug testing at the jobsite. His brother drove him home and he called his wife, who came home and then drove him to the Emergency

Room at Advocate South Suburban Hospital. By then his knee was worse and he was having trouble moving.

The Emergency Room records (PX 1) reflect that Petitioner reported slipping while digging that morning, injuring his low back and right knee. Petitioner also complained of stiffness in the right side of his neck. PX 1, p. 23 of 66. The examining nurse noted tenderness of the right lower paraspinal muscles and the right knee. Lumbar spine X-rays showed mild degenerative changes. Right knee X-rays showed moderate to severe degenerative joint disease. PX 1, pp. 24 and 37 of 66. Petitioner was diagnosed with strains. He was given medication and told to follow up with Dr. Mohammed, his primary care physician.

Petitioner testified he saw Dr. Sreerama at Advocate the following day. Dr. Sreerama is not his regular primary care physician. She recorded a history of the accident and noted complaints of low back, knee and right shoulder pain. She administered Toradol for pain and ordered cervical spine and right shoulder X-rays. She took Petitioner off work and directed him to return in one week. PX 2, pp. 15-19.

Petitioner saw Dr. Mohammed at Advocate on August 21, 2020. The doctor recorded a history of the work accident. He noted complaints of pain in the low back, neck, right shoulder and knee. He also noted that Petitioner was using a cane. He indicated that Petitioner had seen an orthopedic surgeon, Dr. Alland, for his knees and that this doctor had "recommended knee replacement." PX 2, p. 21. On examination, he noted a moderately restricted range of motion in the right shoulder and a mildly restricted range of motion in both knees. He prescribed physical therapy and various MRIs. He kept Petitioner off work and directed him to return in six weeks. PX 2, p. 25. He referred Petitioner to Midwest Orthopaedics.

Petitioner testified he saw Dr. An at Midwest Orthopaedics on September 25, 2020. Dr. An noted that Petitioner injured his neck and low back on August 13, 2020 when his shovel hit a hard object. He indicated that Petitioner acknowledged having experienced arthritic pain in the past but described this pain as having gotten much worse since the accident. On cervical spine and lumbar spine examination, he noted tenderness to palpation and a limited range of motion. He obtained cervical and lumbar spine X-rays. He interpreted the films as showing significant spondylosis affecting multiple levels. He opined that the work accident aggravated a pre-existing condition of cervical and lumbar spondylosis. He prescribed a Medrol Dosepak followed by Naprosyn and Tramadol. He imposed restrictions of no lifting over ten pounds and no frequent bending or twisting. He indicated Petitioner might need MRIs if he did not improve. PX 4.

The right knee MRI, performed without contrast on October 1, 2020, showed a complete anterior cruciate ligament tear "with both-end retraction and reabsorption related to chronic lesion", an acute Grade 2 lateral meniscal injury, severe patellofemoral osteoarthritis and a mild effusion. The right shoulder MRI, performed without contrast the same day, showed mild acromioclavicular joint osteoarthritis and tendinosis of the supraspinatus, subscapularis and biceps tendon. PX 3.

Petitioner saw Dr. Alland on October 2, 2020. The doctor described Petitioner as having a "known history of severe osteoarthritis in bilateral knees" and "presenting with a new injury that occurred at work on 8/13/20." He indicated Petitioner was digging when he hit a root and was knocked off balance, injuring his knee. He noted that Petitioner also fell and braced himself with his right shoulder but was no longer experiencing right shoulder symptoms. He indicated Petitioner was using a cane and continuing to experience right knee pain and swelling. He also noted that, following the December 6, 2019 aspiration and injection, Petitioner "was doing well and had minimal symptoms prior to this injury." On right knee examination, he noted medial tenderness and a limited range of motion. On right shoulder examination, he noted no abnormalities. He injected Petitioner's right knee with Depo-Medrol. He found Petitioner to be at maximum medical improvement with respect to the right shoulder. He recommended six weeks of physical therapy for the knee and restricted Petitioner to desk work only. He indicated he discussed this treatment plan with a nurse case manager. He obtained new right knee X-rays which showed tricompartmental osteophytic changes, right worse than left, and a moderate varus deformity bilaterally. Dr. Alland indicated the films showed "minimal change since prior X-ray and no sign of acute injury." PX 3.

Petitioner underwent an initial physical therapy evaluation at Athletico on October 6, 2020. The evaluating therapist recorded a history of the August 13, 2020 work accident and noted that Petitioner was complaining of pain in his neck, right shoulder, right knee and low back. PX 4.

A cervical spine MRI, performed without contrast on October 9, 2020, showed straightening of the cervical lordosis and bulging indenting the thecal sac at C3-C4, C4-C5, C5-C6 and C6-C7. A lumbar spine MRI, performed without contrast the same day, showed mild levoscoliosis, small and medium osteophytes throughout, modic changes at the opposing endplates of L5 and S1 and mild disc dehydration and bulging at L2-L3 and L3-L4. PX 4.

Petitioner returned to Dr. An on November 6, 2020 and reported minimal improvement secondary to the Medrol Dosepak and therapy. Petitioner indicated he was still experiencing midline neck pain with occasional radiation on the left side. He also indicated he was undergoing right knee treatment. On cervical spine re-examination, Dr. An noted tenderness in the mid cervical region, worse on the left, and a limited range of motion. On lumbar spine examination, he noted a range of motion limited by pain but full strength and sensation. He reviewed the cervical spine MRI and other imaging. He recommended left-sided facet injections at C4-C5 and C5-C6, followed by physical therapy. He also recommended a pain management assessment to determine whether Petitioner would also be a candidate for lumbar facet injections. He released Petitioner to light duty with alternating sitting and standing as needed and no lifting over ten pounds. He did not view Petitioner as a candidate for spinal surgery. PX 4,

Petitioner returned to Dr. Alland on November 11, 2020 and reported no relief from the injection and therapy. The doctor noted that Petitioner's pain and ability to walk had

"worsened since previous office visit without new injury." He recommended that Petitioner see his colleague, Dr. Karas, for consideration of a right total knee replacement. He directed Petitioner to remain off work if desk or sedentary duty was not available. He again discussed Petitioner's treatment with a nurse case manager. PX 3.

Petitioner testified that Respondent did not provide him with desk duty. He never underwent the pain management that Dr. An recommended because the insurance company did not authorize this. He has not returned to Dr. An. He called Rush after Dr. Alland referred him to Dr. Karas but had to wait for approval. He eventually saw Dr. Karas in May 2021.

At Respondent's request, Dr. Bare, an orthopedic surgeon, conducted a Section 12 examination of Petitioner on January 8, 2021. In his report of February 10, 2021, Dr. Bare indicated he reviewed various post-accident records, including the right knee and right shoulder MRIs, in connection with his examination. He recorded a history of the work accident and noted that Petitioner had experienced occasional right knee pain "over the course of the last ten years without traumatic event which he managed himself without medical care." He indicated that Petitioner did not recall previously injuring his right knee.

On right knee examination, Dr. Bare noted a 1+ effusion and a limited range of motion. He also noted tenderness to palpation over the medial and lateral joint lines and equivocal McMurray testing. He interpreted the right knee MRI as showing an anterior cruciate ligament tear as well as severe degenerative arthritis of the anteromedial aspect of the knee.

Dr. Bare diagnosed "right knee degenerative osteoarthritis." He opined that the work accident caused a temporary aggravation of this pre-existing condition. He indicated that Petitioner might eventually need a total knee replacement but attributed this to the pre-existing osteoarthritis, not the accident. He stated that Petitioner's current complaints were "likely partially causally related to" the work accident. He did not detect any signs of symptom magnification or malingering. He characterized the treatment to date as reasonable and necessary for the work-related right knee injury. He indicated that, regardless of causation, Petitioner could undergo gel injections to postpone a knee replacement. He found Petitioner to be at maximum medical improvement with respect to the work injury. He found Petitioner capable of light duty with no squatting or kneeling and no lifting over 20 pounds. He attributed the need for these restrictions to the pre-existing osteoarthritic condition, not the work accident. RX 1.

At Respondent's request, Dr. Bernstein, an orthopedic surgeon, conducted a Section 12 examination of Petitioner on January 14, 2021. Dr. Bernstein recorded a consistent history of the August 13, 2020 work accident and subsequent care. He noted that Petitioner denied having neck or low back problems prior to the accident. He indicated that Petitioner described his neck pain as worse than his low back pain. He described Petitioner as using a cane and "clearly in great discomfort related to his knee." On cervical spine examination, he noted a good range of motion and no tenderness. He interpreted the October 9, 2020 cervical spine MRI as showing multi-level cervical spondylosis from C2 to C7. He described the October 9,

2020 lumbar spine MRI as showing age-appropriate degenerative changes but no evidence of disc herniation or nerve root compression. His impression was that Petitioner was primarily suffering from right knee osteoarthritis. He indicated that "low back complaints are not unexpected given the degree of limping this patient is forced to perform due to the knee complaints." He indicated the limping might have caused a minor lumbar strain. He did not believe that Petitioner had suffered any severe structural injury to either his cervical or lumbar spine as a result of the accident. He was "not opposed to [Petitioner] having some facet injections to the left side of his neck as recommended by Dr. An" but saw no need for any further treatment. He indicated the injections "would not be causally related" to the work accident. He described the physical therapy as reasonable and necessary for the lumbar strain and causally related to the work accident. He anticipated that Petitioner would be at maximum medical improvement by mid-February with respect to his spine but indicated that Petitioner's knee was "clearly the impediment." He noted that knee problems were outside his specialty. RX 3.

Dr. Bernstein issued an addendum on January 20, 2021, after reviewing cervical spine X-rays from September 25, 2020 and the lumbar spine MRI from October 9, 2020. He indicated that this additional information did not prompt him to change any of the opinions he previously expressed. He viewed Petitioner as having "multi-level chronic degenerative changes of both the cervical and lumbar spine." RX 4.

Petitioner saw Dr. Karas on May 26, 2021. The doctor recorded a consistent history of the work accident and subsequent care. He indicated that Petitioner denied having knee symptoms prior to the accident. He described Petitioner's gait as antalgic. He also noted tenderness to palpation at the medial joint line. He obtained right knee X-rays and interpreted the films as showing varus type end-stage osteoarthritis. He opined that the work accident caused an acute exacerbation of Petitioner's right knee osteoarthritis. He recommended a right total knee replacement "once this is approved by WC." PX 5.

Petitioner testified that he agreed with Dr. Karas's surgical recommendation. Dr. Karas scheduled the knee replacement surgery for July 26, 2021 but the surgery was cancelled due to lack of authorization.

Dr. Bare issued an addendum on June 2, 2021, after reviewing additional records and comparing right knee X-rays taken on December 6, 2019 and October 2, 2020. He indicated that both X-rays showed advanced arthritis/degenerative joint disease, worse on the right, with no interval progression. He also indicated that the additional information did not prompt him to alter the opinions he expressed in his original report. RX 2.

The parties agree that Respondent paid temporary total disability benefits from August 14, 2020 through June 2, 2021. Arb Exh 1.

Petitioner testified he has not returned to Dr. Karas since May 26, 2021. His right knee swells when he walks. It is difficult to sleep. He has to sleep with a pillow between his legs. He

uses a cane that he purchased at Walgreen's per his primary care physician. He did not use a cane before the work accident. His back is stiff in the mornings. He does not currently take anything for his symptoms because he ran out of the prescribed medication and has no insurance or money to buy more.

Under cross-examination, Petitioner testified he cannot recall when a medical provider first recommended he undergo a knee replacement. When he saw Dr. Alland in December 2019, the doctor told him "you probably need a knee replacement." Petitioner testified he responded by saying: "I don't need a replacement because I feel fine. I will probably have the knee replaced when I retire, depending on how I feel." Petitioner testified he does not recall any other physician recommending a knee replacement prior to December 2019. When Dr. Alland mentioned the replacement, he (Petitioner) said, "I don't think I need it but, if I do, I will come back and see you." Petitioner did not recall injuring his right knee in 2003 and 2004. Nor did he recall undergoing right knee surgery. He believes he underwent left knee surgery. In his mind, his right knee was his "good" knee. However, if his records say he underwent right knee surgery, he would not dispute this. His practice was to see a doctor for a check-up in the winter, while he was on layoff, in anticipation of returning to work. He typically works from March to November. He recalls Dr. Alland X-raying and injecting both of his knees in December 2019. He also recalls Dr. Alland checking his shoulders and telling him nothing was wrong with them. He denied having knee symptoms before his December 6, 2019 visit to Dr. Alland. He sees his primary care physician every six months. He has anemia. In 2018, he saw Dr. Mohammed and he ordered an MRI. He saw Dr. Alland because Dr. Mohammed recommended he see an orthopedic surgeon. He cannot recall anyone recommending a knee replacement when he injured his knee in 2004. He does not recall injuring his right knee between 2004 and December 2019. He did not injure his right knee between December 2019 and the August 13, 2020 work accident. He recalls working for L. J. Keefe in 2004 but cannot recall injuring his right knee at that time. He did not undergo any knee aspirations or injections before December 6, 2019. He underwent knee injections after the August 13, 2020 accident but "they didn't work." Before August 13, 2020, Dr. Mohammed did not tell him he would need a knee replacement. He cannot recall if he underwent knee treatment before 2004. He cannot recall being told he had right knee arthritis or degenerative joint disease. During the time he worked for Respondent, he worked in a crew. As of the August 13, 2020 accident, there were five men in his crew. Three of these men were laborers. Each of them did different tasks. They could obtain lifting assistance from the operator.

On redirect, Petitioner testified that, on December 6, 2019, Dr. Alland talked about various conservative measures, including weight loss, home exercises and physical therapy. Dr. Alland said that he might need a knee replacement if these measures did not work. Dr. Alland aspirated and injected his right knee. This provided good relief of his symptoms. Dr. Alland does not perform replacement surgery. He typically sees his primary care physician annually. He has Type 1 anemia and kidney disease. After a winter layoff, he resumed working for Respondent in March 2020. Initially, he held a flag for a couple of weeks. He then resumed his regular digging and loading laborer duties. He was able to perform these duties before his accident of August 13, 2020.

No witnesses testified on behalf of Respondent.

Arbitrator's Credibility Assessment

Petitioner came across as a hard-working individual. None of the physicians who treated or examined him noted any symptom magnification.

Petitioner testified he went to Dr. Alland on December 6, 2019 not because he had severe problems relative to his right knee but rather for a general check-up in anticipation of resuming work after the winter. The Arbitrator finds this testimony credible. The doctor's note reflects that Petitioner denied any recent formal treatment but was experiencing some symptoms in both knees. While the doctor indicated Petitioner would benefit from seeing a replacement specialist, if conservative measures failed, he did not refer Petitioner to such a specialist or impose any work restrictions. He aspirated the right knee and injected both knees. Petitioner testified these measures helped. Dr. Alland's note of October 2, 2020 corroborates this testimony. There is no evidence indicating Petitioner underwent any form of knee treatment between December 6, 2019 and the undisputed work accident of August 13, 2020.

Under cross-examination, Petitioner denied undergoing right knee surgery prior to the August 13, 2020 accident. He recalled having surgery on his left knee. He also recalled settling a claim for a left knee injury. On redirect, he testified he would not dispute the records if they showed that the surgery and settlement actually involved the right knee. The Arbitrator views Petitioner as legitimately confused rather than prevaricating. The right knee meniscectomy took place in 2004, seventeen years before the hearing. Moreover, Dr. Alland's note of December 6, 2019 documents left as well as right knee complaints.

The causation opinions expressed by Respondent's examiners were not particularly persuasive. Dr. Bare, the knee examiner, viewed the accident as merely temporarily aggravating an underlying condition but conceded that Petitioner's current complaints were at least partially related to the accident. Dr. Bernstein, the spine examiner, conceded that Petitioner's back condition could be gait-related. He also agreed with Dr. An's recommendation of cervical spine injections, although he did not link the need for these injections to the work accident.

Arbitrator's Conclusions of Law

Did Petitioner establish a causal connection between the undisputed work accident of August 13, 2020 and his claimed current conditions of ill-being?

The Arbitrator initially finds that Petitioner established causation, via an aggravation theory, with respect to his current right knee condition of ill-being. In so finding, the Arbitrator relies on the following: 1) the fact that Dr. Alland did not document any recent knee treatment or impose any work restrictions on December 6, 2019; 2) the fact that Petitioner successfully

performed strenuous laborer duties for Respondent between March 2020, when he resumed working after the winter layoff, and the undisputed accident of August 13, 2020; 3) the lack of evidence of any additional right knee treatment between December 6, 2019 and August 13, 2020; 4) Petitioner's credible description of the accident, i.e., that the unexpected "giving way" of the shovel was sufficient to throw him off balance; 5) the fact that Petitioner's post-accident right knee symptoms were sufficiently severe to prompt him to seek Emergency Room care on the night of the accident; and 6) Dr. Bare's concession that the work accident contributed to Petitioner's current right knee complaints.

The Arbitrator acknowledges that Petitioner had significant right knee osteoarthritis prior to the work accident and that Dr. Bare noted no interval progression of the arthritic changes when he compared the right knee X-rays of December 2019 with those taken after the accident, in October 2020. RX 2. The Arbitrator also acknowledges that, on December 6, 2019, Dr. Alland described Petitioner as wanting to defer a knee replacement until after he retired. In Schroeder v. IWCC, 2017 IL App (4th) 160192WC, the Appellate Court clarified that the "chain of events" principle does not apply solely where a claimant is in a condition of absolute good health. Rather, a claimant need only establish that an accident was a cause of his condition. Sisbro, Inc. v. Industrial Commission, 207 Ill.2d 193, 205 (2003). A claimant such as Petitioner, with a pre-existing condition, may recover where employment aggravates or accelerates that condition. Caterpillar Tractor Co. v. Industrial Commission, 92 Ill.2d 30, 36 (1982). In the instant case, Petitioner went from being a laborer who could climb in and out of trenches, dig ditches and unload trucks, despite his knee arthritis, to an individual whose debilitating right knee pain required him to use a cane to simply get around. It was the undisputed accident that brought about this change.

The facts of the instant case are similar to, but perhaps more compelling, than those of Schroeder. In Schroeder, the claimant was a truck driver who briefly worked for Swift Transportation in 2005 and did not return to the company until May 2013. In the interim, she underwent two back surgeries, a fusion and a discectomy, and started receiving Social Security disability benefits. In January or February 2013, she consulted Dr. Yazbak, a neurosurgeon, due to "a lot of" back pain and numbness in her feet. As of March 2013, Dr. Yazbak was contemplating performing another fusion but the claimant decided not to proceed. Dr. Yazbak did not impose any work restrictions. The claimant then took a refresher course in truck driving. She resumed working for Swift on May 30, 2013, after passing two physical examinations. At that point she was subject to restrictions relative to her fibromyalgia but had no restrictions relative to her back condition. She worked full-time until December 19, 2013, when she fell on ice after making a delivery at a Wal-Mart and landed on her back. She sought care at an Emergency Room and then resumed seeing Dr. Yazbak. Dr. Yazbak noted that she was still having foot symptoms, although the pattern of numbness in her toes had changed subtly. He took the claimant off work and, after a course of conservative care, performed a third back surgery on April 10, 2014. He performed the same surgery, i.e., a fusion, he had previously recommended although he used a somewhat different technique due to the subtle change in Petitioner's symptoms. At his deposition, he conceded under cross-examination that the claimant's pre- and post-accident X-rays were essentially the same. The Commission

acknowledged the claimant's significant pre-existing condition but relied on her inability to work after the accident in finding causation. The Appellate Court affirmed this result, finding that "the salient factor is not the precise previous condition" but rather "the resulting deterioration from whatever the previous condition had been."

As of December 2019, Petitioner, like the claimant in Schroeder, decided he wanted to put off the notion of surgery and instead return to work. Dr. Alland, like Dr. Yazbak, went along with this plan and did not impose any restrictions. Petitioner, like the claimant in Schroeder, worked successfully for a number of months before sustaining an accident at work. During this this period, he performed significantly more strenuous duties than the claimant in Schroeder. It was the accident, and not his pre-existing knee condition, that prevented him from resuming those duties, since he could no longer walk easily, let alone climb down into a trench and dig in hard ground. Schroeder clearly supports a finding of causation in the instant case.

Respondent improperly cites a Rule 23 order, Zoie, LLC v. IWCC, 2020 IL App (5th) 200161 (Ill.App.Ct. 2020), in support of its argument that Petitioner failed to establish causation as to the need for the recommended right knee replacement. Rule 23(e)(1) was amended on November 20, 2020 to allow litigants to cite Rule 23 orders for persuasive purposes but only with respect to orders issued on or after January 1, 2021. The Fifth District issued Zoie on December 18, 2020.

The Arbitrator also finds that Petitioner established causation as to the need for the knee replacement surgery recommended by Dr. Karas. While Dr. Alland anticipated the need for this surgery in December 2019, months before the work accident, he did not actually prescribe the surgery or impose any restrictions. Instead, he took a conservative approach, in the form of aspiration and injections, with those measures allowing Petitioner to resume working the following March. But for the accident, Petitioner presumably would have been able to continue working and stick to his plan of having his knee replaced once he retired. As previously noted, there is no evidence suggesting that Petitioner returned to Dr. Alland or otherwise sought additional right knee treatment between the office visit of December 6, 2019 and the accident of August 13, 2020.

The Arbitrator further finds that Petitioner established causation as to his claimed current spinal conditions of ill-being. Petitioner had multi-level cervical and lumbar spondylosis prior to the work accident, as demonstrated on X-ray and MRI, but there is no evidence indicating he underwent neck or back care in the period preceding the accident. Dr. An opined that the work accident aggravated the pre-existing spondylosis. PX 4. Respondent's spine examiner, Dr. Bernstein, opined that the accident-related limping might have caused a lumbar strain. While he did not view Petitioner's cervical spine condition as accident-related, he agreed with Dr. An's recommendation of facet injections. With respect to the cervical spine, the Arbitrator finds Dr. An more persuasive than Dr. Bernstein. The Arbitrator again relies on Sisbro and Schroeder in finding causation as to the cervical and lumbar spine conditions.

With respect to the right shoulder, the Arbitrator finds that Petitioner established causation as to the need for the MRI and other treatment he underwent but that Petitioner reached maximum medical improvement as of his October 2, 2020 visit to Dr. Alland. At that visit, Dr. Alland noted that Petitioner denied any current right shoulder symptoms. He found Petitioner to be at maximum medical improvement with respect to the shoulder. RX 6, pp. 9-10. The Arbitrator also notes that Petitioner did not testify to any ongoing right shoulder problems at the hearing.

Is Petitioner entitled to temporary total disability benefits?

Petitioner claims he was temporarily totally disabled from August 14, 2020, the day after the undisputed accident, through the hearing of November 17, 2021. Respondent disputes this claim based on its causation defense. The parties agree that Respondent paid $43,703.49 in temporary total disability benefits from August 14, 2020 through June 2, 2021 (the date of Dr. Bare's addendum, RX 2).

The Arbitrator has previously found that Petitioner established a causal connection between his undisputed work accident of August 13, 2020 and his current right knee and spinal conditions of ill-being. The Arbitrator has also found that Petitioner established causation as to the need for the right total knee replacement recommended by Dr. Karas and the cervical facet injections and pain management assessment recommended by Dr. An. The Arbitrator views Petitioner's right knee and spinal conditions as unstable. Interstate Scaffolding v. IWCC, 236 Ill.2d 132 (2010). Dr. Alland found Petitioner capable of sedentary/desk duty but Petitioner credibly testified Respondent did not offer him such duty. Respondent did not call any witness to rebut this testimony.

The Arbitrator finds that Petitioner was temporarily totally disabled from August 14, 2020 through the hearing of November 17, 2021, a period of 65 6/7 weeks. Respondent is entitled to credit for its payment of $43,703.49 in temporary total disability benefits in accordance with the parties' stipulation. Arb Exh 1.

Is Petitioner entitled to prospective care?

Petitioner seeks prospective care in the form of the right total knee replacement recommended by Dr. Karas and the cervical facet injections and pain management assessment recommended by Dr. An. Respondent maintains that Petitioner failed to establish causation as to the need for these measures. The Arbitrator has previously found in Petitioner's favor on the issue of causation.

With respect to the right knee, the Arbitrator awards prospective care in the form of the replacement surgery recommended by Dr. Karas. The Arbitrator notes that Respondent's knee examiner, Dr. Bare, agreed Petitioner is a potential candidate for such surgery, regardless of causation. RX 1.

With respect to the cervical and lumbar spine, the Arbitrator awards prospective care in the form of the cervical facet injections and pain management assessment recommended by Dr. An. The Arbitrator notes that Respondent's spinal examiner, Dr. Bernstein, viewed the injections as appropriate, regardless of causation. RX 3-4.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC019747
Case Name	TORREZ, RUBEN v. NAYLOR PIPE COMPANY
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0224
Number of Pages of Decision	59
Decision Issued By	Carolyn Doherty, Commissioner

Petitioner Attorney	Michael Casey
Respondent Attorney	Kisa Sthankiya

DATE FILED: 6/22/2022

/s/Carolyn Doherty, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ruben Torrez,

Petitioner,

vs. NO: 15 WC 019747

Naylor Pipe,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, temporary total disability, permanent partial disability, and the admissibility of a Form 45 at hearing, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof, with the changes made below.

While affirming and adopting the Decision of the Arbitrator, the Commission writes additionally on the issue of the admissibility of the Form 45 as raised by the Arbitrator at hearing. In this case, the Arbitrator excluded any use or introduction of the Form 45 during the examination of Petitioner's supervisor, Robin Olson, ruling that admission or use of the form conflicted with section 6(b) of the Act[1]. The Commission takes a different view and concludes that section 6(b) does not support the blanket exclusion of a Form 45 in an arbitration proceeding. Notwithstanding, the omission of the Form 45 at trial constituted harmless error.

In all other respects, the Commission affirms and adopts the Decision of the Arbitrator.

[1] "Except as provided in this paragraph, all reports filed hereunder shall be confidential and any person having access to such records filed with the Illinois Workers' Compensation Commission as herein required, who shall release any information therein contained including the names or otherwise identify any persons sustaining injuries or disabilities, or give access to such information to any unauthorized person, shall be subject to discipline or discharge, and in addition shall be guilty of a Class B misdemeanor." 820 ILCS 305/6(b) (West 2020).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on December 3, 2021 is hereby affirmed and adopted with the changes stated herein.

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 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.

June 22, 2022
o: 6/16/22
CMD/kcb
045

/s/ *Carolyn M. Doherty*
Carolyn M. Doherty

/s/ *Marc Parker*
Marc Parker

/s/ *Christopher A. Harris*
Christopher A. Harris

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC019747
Case Name	TORREZ, RUBEN v. NAYLOR PIPE
Consolidated Cases	
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	56
Decision Issued By	Joseph Amarilio, Arbitrator

Petitioner Attorney	Michael Casey
Respondent Attorney	Kisa Sthankiya

DATE FILED: 12/3/2021

THE INTEREST RATE FOR THE WEEK OF NOVEMBER 30, 2021 0.09%

/s/ Joseph Amarilio; Arbitrator

Signature

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

Ruben Torrez
Employee/Petitioner

v.

Naylor Pipe
Employer/Respondent

Case # **15** WC **019747**

Consolidated cases: **None**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Joseph Amarilio**, Arbitrator of the Commission, in the city of **Chicago**, on **9/16/2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On April **23, 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 **$43,056.00;** the average weekly wage was **$828.00.**

On the date of accident, Petitioner was **60** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$3,639.96** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**3,639.96**.

Respondent is entitled to a credit in the amount of $**90,172.01** under Section 8(j) of the Act.

ORDER

Medical benefits: Respondent shall pay reasonable and necessary medical services as identified and directed in the attached Findings of Fact and Conclusions of Law and Order and as provided in Sections 8(a) and 8.2 of the Act.

Temporary Total Disability: Respondent shall pay Petitioner temporary total disability benefits of $552.00/week for 59-4/7th weeks, commencing 4/28/2015 through 6/17/2016, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $3,639.96 for temporary total disability benefits that have been paid.

Permanent Partial Disability: Respondent shall pay Petitioner permanent partial disability benefits of $496.80 per week for 237.5 weeks, because the injuries sustained caused the 47.5 % loss of the person as a whole, as provided in Section 8(d)2 of the Act for the lumbar spine injury resulting in L4-5 transforaminal lumbar interbody fusion and right L4-5 hemilaminectomy. Further, Respondent shall pay Petitioner permanent partial disability benefits of $486.80 per week for 17.5 weeks, because the injuries sustained caused the 3.5 % loss of the person as a whole, as provided in Section 8(d)2 of the Act for the inguinal hernia.

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

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

/s/ *Joseph D. Amarilio*

Signature of Arbitrator Joseph D. Amarilio

DECEMBER 3, 2021

THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ATTACHMENT TO ARBITRATION DECISION

RUBEN TORREZ v. NAYLOR PIPE CO. 15 WC 0019747

FINDINGS OF FACT AND CONCLUSIONS OF LAW

I. PROCEDURAL HISTORY

Mr. Ruben Torres (Petitioner) caused to be filed on June 23, 2015 an Application for Adjustment of Benefits under the Illinois Workers' Compensation Act. Petitioner alleged that on April 23, 2015 he sustained an injury to his low back and groin area while working in his capacity as a steel worker machine operator for Naylor Pipe Co. (Respondent). (IWCC File)

This matter was heard on September 16, 2021 before the Arbitrator in the City of Chicago and County of Cook. Petitioner testified in support of his claim. Mr. Robin Olson testified on behalf of the Respondent. Additionally, Petitioner's treating neurosurgeon, Dr. Sean Salehi, and Respondent's Section 12 orthopedic examiner, Dr. J.S. Player, testified by evidence deposition. The submitted exhibits and the trial transcript of the hearing were examined by the Arbitrator.

The parties proceeded to hearing on five disputed issues: (1) whether Petitioner sustained an accident which arose out of and in the course of his employment by Respondent; (2) whether Petitioner's current two claimed conditions of ill-being (hernia and low back) are causally connected to the work accident; (2) whether Respondent is liable for medical bills incurred; (3) whether Petitioner is entitled to temporary total disability benefits, and if so for what time period; and, (4) the nature and extent of Petitioner's injury. (Arb. Ex. 1).

II. FINDINGS OF FACT

Petitioner testified through a Spanish language interpreter in open hearing before the Arbitrator who had opportunity to view his demeanor under direct examination and under cross-examination.

On the day of trial, Petitioner was two days shy of his 67th year and was 60 years old at the time of the claimed April 23, 2015 work injury. Petitioner testified that on April 23, 2015, he had been employed with Naylor Pipe for 22 years and approximately 15 to 17 years as a machine operator. (Tr. 16) His job duties included unwrapping metal rolls and putting them into the machine. (Tr. 17) He testified that his job required lifting 50-pound metal pieces for scrap, and the amount of times he had to lift this amount varied day to day. (Tr. 18) Petitioner stated he worked five day, 10-hour shifts, and he often worked 5 hour Saturday shifts for many years. (Tr. 19)

Prior Medical Treatment at Concentra Occupational Health

Before the accident of April 23, 2015, Petitioner had injured his back on September28, 2004. (Px 5) He was treated with therapy at Concentra Occupational Health and returned to work. T 20. In July 2009 he had another accident at work lifting a bar of heavy metal with an onset of pain in his back. He was treated at Concentra Occupational Health. T 20. He was diagnosed with a lumbar strain and returned to work. From July 22, 2009, when he had injured his back at work and received conservative treatment until April 23, 2015, he had not injured his back in any other accidents. He had not sought medical treatment from any other doctors during that time up until April 23, 2015. T 21. On April 23, 2015, while at work he had an accident

which injured his back and groin by his stomach. He had no problems with a hernia before April 23, 2015. The accident occurred while he was pulling and lifting metal sheet as scrap from the machine which weighed approximately 50 pounds. T 22. As he was lifting, he felt pain in his back, and he felt pain in his groin by his stomach. T 22-23. He reported the pain to his supervisor. The supervisor directed him to go to a doctor. T 23.

The Medical records of Concentra Occupational Health Occupational Health were admitted in evidence as Petitioner Exhibit 1 and as Respondent Exhibit 5.

Petitioner admitted that he had back problems prior to April of 2015. (Tr. 20) He admitted that in September of 2004 he had a back injury at work. (Tr. 20) Petitioner testified that he treated with physical therapy for this injury, and then returned to full duty work. (Tr. 20) On cross-examination, Petitioner admitted that for his October 2014 injury he was off of work until January of 2015. (Tr. 63) He stated that he did not remember if he worked or not, and that some of his memory might be unclear because it has been so long. (Tr. 67)

In July of 2009 he had recurrent pain in his back after lifting a bar of heavy metal and again sought immediate medical treatment at Concentra Occupational Health Occupational Health. (Tr. 16) After this injury, Petitioner testified that he was diagnosed with a lumbar strain and received some physical therapy before returning back to full duty work. (Tr. 21) Petitioner denied injuring his back in any other accidents between July of 2009 and April of 2015. (Tr. 21)

Prior medical records reflect that Petitioner treated on September 28, 2004 at Concentra Occupational Health. He reported that he was lifting some metal piece which became stuck on a cord causing him to pull hard injuring his back his left lower back. He reported lower back pain that was left-sided. Pain was described as tight and aching. He was released to return to work

light duty. He had one follow up visit for his back on September 30, 2004 and completed physical therapy on October 7, 2004. (RX5)

Petitioner returned to Concentra Occupational Health Occupational Health on September 20, 2007 for a cervical strain injury. He reported that he was injured that date and had pain in his neck, arm and shoulder. Petitioner alleged that he did repeated pushing and pulling with his right arm when operating a machine with force and that he had soreness and discomfort over his right lower cervical trapezius and elbow area for the past three days. Petitioner was diagnosed with a cervical and trapezius strain, as well as sprains and strains of the right elbow and forearm. Petitioner underwent therapy and on October 8, 2007, Petitioner returned for a recheck and was diagnosed with a cervical strain and degeneration of a cervical intervertebral disc. Petitioner was stable with functional limitations or residual complication. He was released from care and returned back to work full duty. (RX5)

Petitioner treated again at Concentra Occupational Health Occupational Health on July 22, 2009 for a lumbar stain injury. At that time, he reported that he was bending forward pulling and lifting on a bar to move a heavy steel piece when he noted pain and discomfort over his right lumbar area. The pain was located on the right lumbosacral region at a level of 7/10. The pain radiated to the right thigh and hip. Upon physical examination, Petitioner had tenderness of the right lumbar spine as well as a spasm in right lumbar spine. His right straight leg raise test pulled at 60 degrees. There was tenderness over the lateral right hip. Petitioner walked with a slight limp. Petitioner was diagnosed with lumbar sprains and strains of the right hip and thigh. Petitioner was scheduled for physical therapy three times a week for two weeks. Petitioner was released to return to work light duty with a 20-pound lifting restriction. (RX5)

On October 21, 2014, Petitioner sustained a left lateral epicondylitis injury Petitioner received conservative treatment at Concentra Occupational Health through December 4, 2014. The Arbitrator notes that no complaints of low back pain noted or recorded nor any complaints of groin pain. (RX 5)

On December 18, 2014, Dr. Alexander noted tenderness in the cervical spine and left upper extremity. He diagnosed Petitioner with a left-sided cervical radiculopathy. He referred Petitioner for a cervical EMG. (PX13) Petitioner saw Dr. Alexander on January 8, 2015. At that time, he reported that he had a cervical EMG two weeks prior. (PX13) On January 15, 2015, Petitioner returned to Dr. Alexander and requested a return to work letter. He still reported pain in his left elbow and shoulder. (PX13)

Non-Claimed Conditions of Ill-being

Petitioner testified at the hearing and Petitioner told Dr. J.S. Player, Respondent's Section 12 examiner, on November 11, 2015 that he is not claiming treatment rendered to his neck, shoulders, arms and lower extremities is related to the work accident of 4/23/15. RX 2, p 30; T 43-44. The Arbitrator will confine his evaluation of the evidence in the record to the claimed body parts, the low back and inguinal hernia.

Claimed Conditions of Ill-being – Hernia and Low Back

On April 23,2015, Concentra Occupational Health Occupational Health records document the following. History of present illness: Ruben Torrez 60-year-old male who presents today with a right inguinal pain complaint; injury date 4/23/15 at 11:00 AM; this is a result of lifting; occurred while at work; he was bent over the steel press machine to lift a 50-pound steel

sheet out of the machine; the machine is about 4 feet high; as he was pulling the sheet out he felt a sharp pain in his left inguinal region; sitting makes the pain better; reports feeling fine as he stands and walks is painful when he runs, running makes it worse; report of worsening with running suggests that today's reported event may be an exacerbation of chronic previous condition. Physical examination of the abdomen demonstrated reducible right inguinal hernia was palpated. PX 1, p 34. After examination assessment was inguinal hernia; encounter for preventive health examination. Petitioner was provided medication and referred to a general surgeon. PX 1, p 32. Petitioner complained of right pelvic pain. (Px 5)

Petitioner testified the Concentra Occupational Health physician sent him back to work. However, Petitioner did not return to work that day. T 27. Petitioner returned to work on April 27, 2015. He worked until about 11 o'clock. He told his union representative his back was hurting. The union representative told him to return to the doctor because the doctor had reported it was just a hernia. T 28. Petitioner returned to Concentra Occupational Health on April 27, 2015 He reported to the doctor his back was hurting a lot. The doctor told him it was not a back problem; it was a problem from a hernia. The doctor provided him no instructions regarding his back. T 29.

On 4/27/15, Concentra Occupational Health records document the following. History of present illness: 60-year-old male who presents today with right inguinal pain complaint; occurred while at work. At last visit he was standing and walking comfortably. He only had mild pain upon palpation which also supports that his inguinal hernia is chronic and not an acute disruption of the inguinal fascia. Today he is reporting that area hurts when he walks; he now has back pain which was not previously reported. He was advised to discuss the new complaint with human resources to have it approved to see the patient for back pain. I advised that he see a general

surgeon to evaluate his hernia, especially since reports worsening pain today at 9/10 (he is smiling during his examination). When I told the patient that his hernia was not a work-related injury, he stated that he did not understand, and he needed an interpreter. He had not requested an interpreter beforehand. PX 1, p 36. The assessment was: 1. Inguinal hernia; 2. Strain of right inguinal muscle; 3. Encounter for preventive health examination. The plan was: heat area of pain for 20 minutes for relief; naproxen as needed; consultation with general surgeon; follow-up in one week for inguinal muscle strain, then further care and limitation should be continued with general surgery; your inguinal hernia is not a work-related injury; whereas the inguinal muscle strain was and should resolve by next week. Respondent Exhibit 5. (The Arbitrator notes that Petitioner Exhibit 1 which are the subpoenaed employer medical provider Concentra Occupational Health medical records, contains only 3 of the 4 pages of records generated by Concentra Occupational Health on the 4/27/15 examination. The missing page is included in Respondent Exhibit 5 which is also the medical records of Concentra Occupational Health.)

On 4/28/15, Petitioner consulted with his family doctor, Dr. PK Alexander. T 30. The medical records of Hegewisch Medical Center/PK Alexander MD were admitted in evidence as Petitioner Exhibit 11.

On 4/28/15, Hegewisch Medical Center/PK Alexander MD records document the following. Patient complaining of severe abdominal pain and severe groin pain on right side. Tender lumbar, tender right inguinal. Diagnosis was sciatica, lumbar radiculopathy. Ultram, Naprosyn and X-ray of the lumbar spine were ordered. PX 11, p 28-29.

The Arbitrator notes that the medical records of Petitioner's primary care physician, Dr. PK Alexander, document medical examinations of Petitioner by Dr. Alexander on 4/18/14, 4/21/14, 5/8/14, 9/27/14, 12/8/14, 12/10/14, 12/16/14, 1/8/15, 1/15/15, and 4/10/15. These

records reflect that in none of those office visits to Dr. Alexander did Petitioner make any complaint of low back pain or of groin pain and no diagnosis is contained in those records suggesting Petitioner had any problem with his low back or inguinal hernia. PX 11, p 30-49.

On 4/28/15, an x-ray of the lumbar spine was performed. The x-ray was interpreted to show normal lumbar lordosis with no acute fracture or dislocation; marked disc space narrowing L4-L5 with vacuum degenerated disc and posterior and anterior spurring seen and moderate to marked disc space narrowing L5-S1 level is also seen; some mild posterior disc space narrowing with posterior spurring at the remaining lumbar disc levels are seen**;** moderate posterior facet arthritic changes bilaterally L5-S1 lumbar pentacles appear intact; if patient has persistent symptoms of back pain consider CT or MRI lumbar spine for further diagnostic evaluation. PX 11, p 54.

On 5/5/15, Hegewisch Medical Center/PK Alexander MD records document follow-up on x-ray results; continues to complain of severe low back pain with numbness down left thigh and difficulty ambulating. The document reflects that the last exam was on 4/28/15. PX 11, p 26.

On 5/15/15, Petitioner underwent an MRI of the lumbar spine at Preferred Open MRI. Radiologist, Dr. Amar Shah noted prominent diffused lower thoracic and lumbar spondylosis and diffuse degenerative disc disease. The findings were severely marked at L5-S1 where there was also marked disc narrowing and disc degeneration. There was mild diffuse congenital narrowing of the lumbar spinal canal. Dr. Shah noted posterior disc bulges at all levels from L2-L3 through L5-S1. Dr. Shah noted that the findings with the marked facet and posterior element arthropathy produced varying degrees of significant central canal and neural foraminal stenosis. The findings were most severe at L5-S1. (PX3, p. 22-23)

On 5/22/15, the Hegewisch Medical Center/PK Alexander MD records document Petitioner was seen in follow-up. The office visit record of 5/22/15 notes that the patient reports having MRI last Friday; continues to have back pain. Patient was referred to pain management Dr. Hassan, for persistent back pain. Diagnosis was LDD and inguinal hernia. Flexeril and Motrin were ordered. PX 11, p 24-25. The Arbitrator notes that at the top of page 24 of Dr. Alexander records, the date is indicated as "5/22/14." The Arbitrator further notes that on this same page of Dr. Alexander records, the date of last exam is documented as "5/5/15." Since the date of the last exam cannot be after 5/22/14, the Arbitrator interprets the date of 5/22/14 to be an error and interprets the date of the document to be 5/22/15. The document also references patient is here for follow-up today, reports having MRI last Friday and also notes that patient continues to have back pain, all of which is consistent with the MRI that was performed on 5/15/15, PX 2, p 8-10, and consistent with Dr. Alexander's prior and subsequent notes. Additionally, the document indicates that Petitioner was referred to Dr. Hassan for persistent back pain. PX 11, p 25.

Petitioner testified he was referred to Dr. Osama Abdellatif who is also known as Dr. Hassan. T 31. The medical records of ProClinics/Dr. Osama Abdellatif were admitted in evidence as Petitioner Exhibit 3.

On 6/8/15, the medical records of ProClinics/Dr. Osama Abdellatif document the following. Ruben Torrez is a patient that comes in today due to lumbar, cervical, left shoulder, left elbow pain, left knee pain due to work-related injury on 4/23/15. As he was lifting metal sheets weighing approximately 30-50 pounds felt sharp pain across his entire lower back and upper body also on the left side the body as he used left side for support when lifting. He reported injury. He went to company clinic; recommended rest and light duty work; has since

stopped working due to increasing pain and minimal response to physical therapy rest and medications up to date as pain continues primarily across low back, cervical left shoulder, left elbow, left knee pain ; now comes to us today with cervical pain radiating to bilateral upper extremities causing constant tingling and numbness focused on left shoulder; left elbow region tenderness down to bilateral hands and wrists; unable to be in one position for short periods due to increasing discomfort and pain; unable to sleep at night occasionally due to pain and bothersome when laying down; also continuing headaches, limited range of motion; current level pain 8/10 ; also presents with low back pain radiating to bilateral lower limbs; focused on left knee tenderness, limited range of motion causing tingling and numbness; current pain level 8/10; unable to fully extend bilateral lower extremities due to pain and discomfort, more so on left side; tenderness on left knee. Treatment was explained; understood. Patient would like to start to help alleviate pain and relieve also increase range of motion. No history of cervical spine pain prior to date of injury; no other complaints or complications; no motor or sensory loss. Lumbar pain was described as 8/10. After examination and review of MRI the diagnosis was: cervical radiculopathy cervical facet syndrome; lumbar radiculopathy lumbar facet SI syndrome; myofascial pain left shoulder pain left knee pain left elbow pain. Assessment /Plan was lumbar radiculopathy LES; lumbar facet SI syndrome L FSI; cervical radiculopathy left shoulder left elbow left knee pain; myofascial pain trigger point injections; continue physical therapy and medication. PX 3, p 103-106. Petitioner was ordered off work. PX 3, p 14.

Petitioner testified that he gave history to Dr. Hassan of pain in parts of his body other than the low back. He testified he injured his elbow years before the accident. T 33-34. Petitioner testified he is not making any claim that the cervical, left shoulder, left elbow, left knee

complaints documented in Dr. Hassan's records (PX 3, p 103-106) are causally related to the work accident of 4/23/15. T 43-44.

On 6/8/15, an EMG/NCV ordered by Dr. Hassan/Dr. Osama Abdellatif, performed by Midwest Neurodiagnostic Specialists, was interpreted to reveal radiculitis affecting the L4-S1 bilaterally. PX 3, p 27-28.

On 6/24/15, Dr. Osama Abdellatif performed lumbar facet injection L3-L4, L4-L5, L5-S1 and lumbar epidural steroid injection. PX 3, p 95-102. The procedure was performed at the Hammond Community Ambulatory Care Center.

The records and bills of Hammond Community Ambulatory Care Center were admitted in evidence as Petitioner Exhibit 4. Petitioner testified he was referred by Dr. Alexander to Dr. James Egan for physical therapy. T 31.

The records of Hegewisch Medical Center/Dr. James Egan DC were admitted in evidence as Petitioner Exhibit 6. These records document that Petitioner underwent physical therapy addressed to his lumbar spine from 7/3/15 through 3/8/16. PX 6, p 12-78.

On 7/3/15, the Hegewisch Medical Center/Dr. James Egan DC records document Petitioner initial evaluation. History was that he injured himself on 4/24/15. He was lifting a heavy metal sheet at work and felt sharp pains in multiple regions. He was seen a few times by the company doctor complaining of abdominal and low back pain. Patient then saw his primary care physician where a lumbar spine MRI was ordered. Patient was then seen by Dr. Hassan complaining of pains in multiple regions. Therapy was ordered. Mr. Torrez states that he has experienced constant pain in the low back and numbness down both legs. He rated his pain 8/10. After examination and review of MRI, the diagnosis was: disc displacement lumbar; disc

degeneration lumbar; radiculitis lumbar myalgia. Dr. Egan noted: Mr. Torrez symptoms appear to have come on as result of work-related accident consistent with one described in this report. His history, subjective and objective findings show evidence from a medical viewpoint, that his condition is due to the current injury only and no contribute factors are present from pre-existing conditions. Likelihood of some symptomatic relief within 4 weeks is moderate. Prognosis is guarded. Treatment plan indicated: physical therapy 3 times a week for a period of 4 weeks; therapy will include manual therapy and therapeutic exercises on the lumbar region to increase mobility and to restore normal spinal biometrics; additional therapy will include neuromuscular reeducation on the lumbar region to decrease muscle contracture and muscle spasms; further therapy will include EMS and hot moist packs on the lumbar region to reduce pain. PX 6, p 77-78.

On 7/6/15, Dr. Hassan noted in follow-up post completion of the first lumbar procedure: patient had positive response in pain and range of motion by 50% but continued to experience tingling and numbness on bilateral lower extremities. He ordered 2nd lumbar epidural steroid injection, continued physical therapy, medication and ordered off work. PX 3, p 91-94. Off work order PX 3, p 15.

On 7/ 8/15, Dr. Hassan performed a second epidural steroid injection at L5-S1 by an epidurogram. He also performed a trigger point injection in the lumbar spine. He performed a lumbar and sacral facet neurolysis or radiofrequency ablation at L4-5, L5-S1 in the bilateral SI joints. PX 3, p 84-90; PX 3, p 8-9.

On 7/13/15, Dr. Hassan noted follow-up post completion of second lumbar procedure stating initial positive response in pain and range of motion by 60% but currently experiencing continuing tingling and numbness on bilateral lower and upper extremities more so toward the

left side. After examination Assessment/plan was ordered 3rd lumbar epidural steroid injection; ordered radiofrequency bilateral lumbar SI; other orders relating to cervical left shoulder left elbow left knee; trigger point injection medication. He was ordered off work. PX 3, p 80-83. Work status order. PX 3, p 16.

On 7/22/15, Dr. Hassan performed 3rd epidural steroid injection, radiofrequency ablation, trigger point injection to the lumbar spine. PX 3, p 73-79.

On 8/3/15, the Dr. Hassan records document follow-up post 3rd lumbar procedure. Ongoing complaints of lumbar numbness tingling and pain were documented. After examination the Assessment/Plan was discogram and CT scan and surgical consult for the lumbar radiculopathy lumbar facet SI syndrome. Petitioner was ordered off work. Work conditioning program followed by a functional capacity evaluation was also ordered. PX 3, p 69-72. Off work order. PX 3, p 16.

On 8/12/15, Petitioner was examined by Dr. Steven Bines of University Surgeons at Respondent's request pursuant to Section 12 of the Act to evaluate his hernia. (Tr. 40) Dr. Bines indicated that Petitioner at 60 years presented for a second opinion for his right groin pain. Petitioner reported sharp pain at his right groin that started on approximately April 23rd while lifting a heavy object at work. He denied any associated sensation of bulges and mass. He saw the company doctor who diagnosed hernia and recommended surgery. Petitioner did not wish to pursue surgery at that time because he felt unease at the lack of imaging work up. He continued to deny sensation of bulge or mass and his symptoms had not worsened. His symptoms only occurred during walking or heavy lifting. Dr. Bines performed a physical examination. Dr. Bines noted that Petitioner did have palpable bilateral inguinal hernias without tenderness. Notably, Petitioner's neck exam and back exams were normal. Petitioner's musculoskeletal

exam was normal. Dr. Bines diagnosed Petitioner with bilateral inguinal hernias. He indicated that the right inguinal hernia was symptomatic with pain and the left inguinal hernia was asymptomatic. He believed that the right and left inguinal hernias were associated with heavy lifting at work. He recommended a bilateral inguinal hernia repair although Petitioner may elect not to have a repair of the left inguinal hernia as it was currently asymptomatic. (PX9, pp. 1-4)

In direct contradiction to the opinions of the company physical at Concentra Occupational Health who opined that Petitioner's hernia was not work related and preexisted the accident, Dr. Bines in a letter to Respondent's agent stated the he "believed that the preferred therapy for his injury is to repair the hernia…. His treatment has been appropriate. I believe his injury is a direct result of the working injury. The appropriate diagnosis is imaginal hernia and the prognosis is excellent. The history is consistent with an injury suffered at work on April 23, 2015. I do not believe a preexisting condition was present. The patient should be able to return to work without restrictions after repair of the hernia. At this point, I don't think he is a maximum medical improvement. I believe the hernia should be fixed." (Px 9, p. 1)

On 8/12/15, Dr. Hassan performed lumbar discogram which was interpreted to demonstrate pain concordant with L4-L5 and L5-S1 levels discogenic pain. PX 3, p 60-68. Recommendation was for percutaneous disc decompression procedure at the above levels. Physical therapy order was continued with medications. PX 3, p 62-63.

On 8/12/15, a Post discogram CT lumbar spine without contrast was performed by Advantage MRI. Referral was by Dr. Osama Abdellatif. Impression was post discogram findings as described above with spinal stenosis of L2-L3, L3-L4 and L4-L5. PX 3, p 29-30.

Petitioner testified that Dr. Hassan had referred him to Dr. Sean Salehi for consult. T 40-41. The medical records of Neurological Surgery/Dr. Sean Salehi were admitted in evidence as Petitioner Exhibit 7.

On 8/14/15, the Neurological Surgery/Dr. Sean Salehi records document Petitioner was examined by Dr. Salehi. In report of examination addressed to Dr. Osama Hassan, Dr. Salehi noted the following. In office today for initial consultation. 60-year-old man who reports injury at work on 4/23/15. States he was lifting a heavy piece of metal and felt pain in his low back. States that he saw a work physician and was diagnosed with 2 inguinal hernias so treatment for his back did not begin until June. He has done one month of physical therapy and has had 3 injections without relief. He complains of pain across the low back radiates down both legs left greater than right. He rates his pain as 5-6/10. His pain is worse with walking long distances. He also has tingling down the left leg. He, to a lesser extent, complains of pain in the neck. He denies arm pain or paresthesia. He denies frank weakness, falls, bowel or bladder incontinence. He is taking naproxen and another pain medication. He had prior back pain many years ago that he underwent physical therapy for and had resolution. He denies any ongoing or spontaneous back pain. He denies any other work-related injuries or MVA resulting in medical attention. After examination and review of MRI of the lumbar spine 5/15/15 Dr. Salehi's Impression and Recommendations were: 1. Lumbar degenerative disc disease; 2. Lumbar stenosis; 3. Cervical degenerative disc disease. Dr. Salehi noted Mr. Torrez has mechanical low back pain with radiculopathy as result of the described work injury. This is secondary to disc disease at L4-5 and central and lateral recesses stenosis at the same level. Dr. Salehi recommended that Petitioner undergo an additional course of physical therapy for core strengthening given his injury is only a few months old and he had a delay in treatment due to earlier hernia repairs. He

will return to see me in 6 weeks at which time if he continues to be symptomatic then I will recommend surgical intervention in the form of a left L4-5 transforaminal lumbar interbody fusion (T LIF) and right L4-5 hemilaminectomy. For now, he can work with desk work restrictions (no lifting, pushing, pulling more than 10 pounds, no bend/twist greater than 3 times per hour). PX 7, p 11-14.

On 8/24/15, the Dr. Hassan records document Petitioner was seen post completion of lumbar discogram and CT scan and surgical consult, recommending surgical intervention, pending approval. Lumbar pain was described as 5/10. Medications were Norco PRN. Physical therapy was continuing. After examination, Assessment/Plan were lumbar radiculopathy/lumbar facet SI syndrome, surgical consult, myofascial pain, trigger point injection PRN. Start work conditioning and Aqua therapy followed by FCE. Petitioner was ordered off work. PX 3, p 56-59.

Petitioner testified he was referred by Dr. Osama Abdellatif-Dr. Hassan to Dr. Vijay Patel. The records of Hammond Community Ambulatory Care Center/Dr. Vijay Patel were admitted in evidence as Petitioner Exhibit 4.

On 9/1/15, Petitioner was examined by Dr. Vijay Patel. Referral is documented from Dr. Hassan for bilateral inguinal hernia. After examination Dr. Patel diagnosed bilateral inguinal hernia and scheduled Petitioner for laparoscopic bilateral inguinal hernia repair, possible open. PX 4, p 197-198.

On 9/11/15, Dr. Vijay Patel performed surgery consisting of repair of bilateral inguinal hernia at the Hammond Community Ambulatory Care Center. PX 4, p 200-201.

On 9/18/15, the Dr. PK Alexander records documents: patient presents for follow-up on blood pressure; patient's states no longer feeling dizziness nausea; patient states had surgery to remove hernias on bilateral side of abdomen. PX 11, p 20-21.

On 9/25/15, the Dr. Sean Salehi records document: Ruben Torrez in the office today for follow-up consultation. His wife was present who helped to translate Spanish as needed. Since his last evaluation he underwent herniorrhaphy 2 weeks ago and is still recovering from that surgery area; he also continues with constant pain in his low back with radiation down both legs, left much more so than right. He rates the pain as ranging between a 5-9/10 for which he is taking Norco. He feels weak in the legs, but denies any falls, bowel or bladder incontinence. He was injured at work on 4/23/15. He is currently off work. After examination Impression and Recommendations were: 1. Lumbar degenerative disc disease; 2. Mechanical back pain and bilateral radicular pain due to disc disease at L4-5 and central and lateral recess stenosis at the same level; once he has been cleared by general surgery, Dr. Salehi recommended he undergo a dedicated course of physical therapy for lumbar core strengthening as he was unable to complete such therapy in the past due to hernia issues; he will return to see me for reevaluation after the therapy at which time if he continued to remain symptomatic I will discuss surgical intervention in the form of a left L4-5 transforaminal lumbar interbody fusion (T LIF) and right L4-5 hemilaminectomy; for now, as it relates to his lumbar spine, he can work with desk work restrictions (no lifting, pushing, pulling more than 10 pounds, no bend/twist more than 3 times per hour). PX 7, p 15-17.

On 11/2/15, the Dr. Hassan records document: he is here for follow-up due to constant pain on low back and cervical spine and left knee and left shoulder and awaits lumbar surgery

approval; has pain on cervical spine continues currently; off work recommended as he continues treating; waiting orthopedic and surgical approval. PX 3, p 53-55.

On 11/4/15, Dr. Hassan performed a series of injections directed toward Petitioner's neck. PX 3, p 45, p 52.

Petitioner testified that he was examined by Dr. John Scott Player at the request of Respondent pursuant to Section 12 of the Act.

The first report of two reports of Dr. John Scott Player was admitted in evidence as Respondent Exhibit 2. Dr. Player's report states that he examined Petitioner on November 11, 2015. An interpreter was provided. He took history that Petitioner had never had problems with his cervical spine for lumbar spine prior to 4/23/15 work exposure. Medical records were reviewed documenting he injured his low back on 9/28/04 and was diagnosed with cervical strain as result of repetitive pulling and pushing with his right arm while operating machine required medical treatment from 9/ 20/07 through 10/ 08/07. The examinee sustained a second lumbar spine injury was noted on 7/22/09 after picking up a bar and injuring his lower hip and back. After examination and review of records Dr. Player opined the following. Physical examination documents no positive objective neurological findings: there is no documentation of cervical spine, left elbow, left shoulder or left knee complaints until 6/8/15, six weeks following the 4/23/15 alleged work exposure. Diagnosis was non-radicular cervical spine subjective complaints not supported with positive objective neurological findings; lumbar spine subjective complaints not supported with positive objective neurological findings. RX 2, p 29. During the interview today the examinee stated the 4/23/15 work exposure caused no injury to his left shoulder, left elbow or left knee. RX 2, p 30. There is no causal relationship between the 4/23/15 alleged work exposure with examinee's current cervical and lumbar spine subjective complaints.

RX 2, p 30. Petitioner's treatment to date may have been reasonable and necessary but has not been causally related to the alleged 4/23/15 work exposure. RX 2, p 30. Regardless of whether the medical treatment was excessive, the necessity for the treatment to date is unrelated to the 4/23/15 work exposure. RX 2, p 30. The examinee requires no additional treatment including surgery for his cervical spine or lumbar spine which could be causally related to the 4/23/15 work exposure. RX 2, p 30. The examinee's subjective complaints are not supported with positive objective physical findings. The objective medical testing results for cervical spine and lumbar spine document nontraumatic pre-existing degenerative disc disease which could be responsible for his current pain complaints. The examinee is capable of returning to full and regular duty without restrictions relative to the alleged 4/23/15 work exposure and relative to the current non-work-related cervical and lumbar spine subjective complaints. RX 2, p 31.

Petitioner testified he is not claiming a cervical injury as part of the work accident. T 43-44. On 11/16/15 Dr. Hassan noted follow-up post first cervical procedure. He recommended a 2nd series of cervical injections. PX 3, p 34-36 On 11/18/15 Dr. Hassan performed a series of cervical injections. PX 3, p 37-44.

On 11/20/15, the Dr. Salehi records document: follow-up consultation. Family was present who helped to translate Spanish as needed. Continues with pain in the low back then occasionally radiates down both legs to the feet. He rates his pain as 7/10 today. He is taking Norco and naproxen. Feels weak in the legs, but denies any falls, bowel or bladder incontinence. Injured at work 4/23/15. He is currently off work. Dr. Salehi recommended L4-5 transforaminal lumbar interbody fusion and right L4-5 hemi laminectomy. Work restrictions were ordered. PX 7, p 18-20.

On 11/30/15, the Dr. Hassan records noted: follow-up examination post cervical injections. He noted Petitioner was waiting for approval of lumbar surgical. He noted that Petitioner had been referred by Dr. Alexander. PX 3, p 31-33.

On 12/12/15, Dr. Salehi performed surgery consisting of left L4-L5 transforaminal lumbar interbody fusion and right L4-L5 hemilaminectomy. PX 7, p 24-26. That surgery was paid by Petitioner's group insurance, Blue Cross Blue Shield. PX 7, p 32-34.

On 12/28/15, the Dr. Salehi records document Petitioner was seen for follow-up status post left L4-5 TLIF and right L4-5 hemilaminectomy. Patient was doing well and pleased with the results of the surgery; complains of mostly low back, some numbness in the left leg. Medications were ordered. Physical therapy was ordered to begin 3 weeks postoperatively. He was ordered off work. PX 7, p 21-23.

On 12/31/15, Dr. Alexander notes document patient states he had surgery on lower back and spine Dr. Salehi MD. PX 11, p 16-17.

On 1/8/16, through 3/8/16 Petitioner received physical therapy through Hegewisch Medical Center/Dr. Egan DC, on the order of Dr. Salehi. PX 6, p 12-36.

On 2/12/16, Dr. Salehi noted: 2 months status post left L4-5 TLIF and right L4-5 hemilaminectomy. Continues to do well. He is pleased with the results of the surgery. Does complain of some mild pain in the low back for which he takes Tylenol. Denies any radiation down into the legs or any associated paresthesia. Has undergone physical therapy. He was injured at work on 4/23/15. He is currently off work. After examination Dr. Salehi ordered continued physical therapy for an additional four weeks; take Tylenol as needed. PX 8, p 70-72.

On 3/11/16, Dr. Salehi noted: three months now status post left L4-5T LIF and right L4-5 hemilaminectomy. Has undergone an additional four weeks of physical therapy and continues to do well. Occasionally gets some right-sided low back pain for which he takes Tylenol. Denies any radiation down into the legs. Injured at work on 4/23/15. Currently off work. After examination Dr. Salehi noted: continues to do well status post lumbar fusion. Can return to work at light duty capacity no lifting more than 20 pounds, no pushing/pulling more than 35 pounds, no repetitive bending/twisting and alternate sitting/standing every 30-45 minutes as needed. Return in 3 months. Take Tylenol as needed. PX 8, p 73-75.

On 6/17/16, Dr. Salehi noted: 6 months status post left L4-5 TLIF and right L4-5 hemilaminectomy. Doing very well and only sometimes has pain in the low back or with bending. Occasionally feels a hot sensation on the left anterior thigh. Denies any radiating leg pains or paresthesia. He is overall very happy. He takes Tylenol but not every day. He was injured at work on 4/23/15. He is currently off work. He is not planning on returning to work. Dr. Salehi reviewed x-ray of the lumbar spine 6/2/16 and found no instrumentation failure. After examination Dr. Salehi noted: doing well status post lumbar fusion. X-rays show no instrumentation failure. Should undergo FCE to determine permanent work restrictions. Continue to perform home exercises on a daily basis. PX 8, p 76-78.

Evidence Deposition of Dr. Sean Salehi

On June 16, 2016, Arbitrator Bocanegra, the arbitrator previously assigned to this claim, issued a Dedimus Potestatem to take the deposition of Dr. Sean Salehi on July 21, 206 due to the refusal of the attorney for Respondent to agree to take to evidence deposition of Dr. Salehi. The objection by the attorney for Respondent was overruled by Arbitrator Bocanegra. (IWCC file)

The evidence deposition of Dr. Sean Salehi taken on July 21, 2016 was admitted in evidence as Petitioner Exhibit 8. Dr. Salehi is a board-certified neurosurgeon, licensed in the State of Illinois practicing in Westchester Illinois. He had faculty position at Northwestern University School of Medicine.

Dr. Salehi opined that based upon the mechanism of injury described by the patient and his examination and the MRI findings that the work accident described by the patient aggravated an otherwise asymptomatic pre-existing condition rendering it symptomatic. PX 8, p 12-13. The basis of that opinion was that he had no ongoing back pain except for that episode years ago and was asymptomatic and the mechanism of lifting a heavy object would be consistent with aggravation of the disc disease. A disk which is abnormal is more likely to take on a new injury than a normal disc. PX 8, p 13.

Dr. Salehi opined that the mechanism of injury as described by the patient in his records is an effective and consistent cause of the aggravation of the condition which he found in this patient. Dr. Salehi opined after he performed the surgery on the patient there was no change in his opinion as to the causation of the work accident aggravating the pre-existing condition. PX 8, p 19.

Dr. Salehi testified that the mechanical back pain was rendered symptomatic by the accident. Degeneration of the disc was there prior to the accident. The MRI clearly suggests that, but a disk which is degenerated is more likely to take on a new injury, you break something at its weakest point, and the weakest point in his back is that L4-5 disc which is degenerated, so that's where when he lifted something heavy, he resulted in that symptom, and that level to become symptomatic. PX 8, p 20-21.

Dr. Salehi explained how the work accident brought about the radicular pains. He testified that degeneration and pinching of the nerves was asymptomatic before the accident and then symptomatic after the accident. PX 8, p 21-22. Dr. Salehi testified that if someone were to aggravate a pre-existing condition it would not necessarily result in back pain on the day of the accident. You could have pain right at the time or the pain could be delayed because of the delayed inflammatory response. He noted that everybody has sprained your ankle at some point when they were younger, and we know that you may not feel the sprained ankle right at the time, but the next morning you could hardly get out of bed. So that's because of the delayed inflammation, and the same thing applies to the low back. PX 8, p 30.

Dr. Salehi testified it would not surprise him that Mr. Torrez did not report back pain to his supervisor or to the initial treating physician on April 23, 2015. PX 8, p 30. Dr. Salehi testified he would not be surprised that Mr. Torrez would not report back pain to Dr. Bines, the physician he was seeing for a hernia evaluation. He explained that in his experience if you have back pain and you go to a doctor for inguinal pain diagnosis, you may just focus on the inguinal pain. PX 8, p 32.

On 2/23/17, Petitioner underwent a second examination performed by Respondent Section 12 examiner, Dr. JS Player. Report of that examination was admitted in evidence as Respondent Exhibit 3. After review of records and examination of Petitioner, Dr. Player opined the following. The examinee's cervical spine subjective complaints are not supported with positive objective neurological findings nor positive objective physical findings. The examinee's lumbar spine objective complaints are consistent with his objective neurological findings, and correlate with the good postoperative result. RX 3, p 18. There is no causal relationship between the 4/23/15 alleged work exposure with the examinee's cervical or lumbar spine conditions. RX

3, p 18. Dr. JS Player stated one of bases of his opinions is that the 5/15/15 lumbar spine MRI and the 6/29/15 documents pre-existing, congenital, and degenerative conditions, but no acute traumatic pathology. RX 3, p 18. Dr. Player opined Petitioner is at MMI. RX 3, p 19. Dr. Player opined that all treatment rendered to Petitioner after his IME of November 10, 2015 may have been reasonable and necessary but was not causally related to the alleged accident of 4/23/15. RX 3, p 19. Dr. Player opined all treatment received from the chiropractor, Dr. Egan, may have been reasonable and necessary but it was not causally related to the alleged accident of 4/23/15. RX 3, p 19. Dr. Player opined that any work restrictions would be not related to the alleged work accident of 4/23/15. RX 3, p 19. Dr. Player opined regardless of cause Petitioner's AMA impairment rating was 7% whole person. RX 3, p 21.

Evidence Deposition of Dr. JS Player

Dr. Player testified by evidence deposition admitted in evidence as Respondent Exhibit 1. Dr. Player is a board-certified general orthopedic surgeon since 1982 and is licensed in the State of Illinois. He has not performed surgeries since 2006. He sees very few patients, on a given week he averages 5 patients, form none to 10 patients a week so with an average of 5 patients. (Rx 1, Dx7)

Dx 6) His primary source of income is performing Section 12 examinations. Dr. Player reiterated his opinions expressed in his two reports. He testified that he did not find any symptom magnification which he thought was significant in the Petitioner when he examined him on two occasions. RX 1, p 46-47. (Rx. 1, Dx 6)

Dr. Player examined the Petitioner, Ruben Torrez, twice. (Rx. 1, Dx. 11) The first examination was completed on November 10, 2015. (Rx. 1, Dx. 11) Petitioner told him that he

denied experiencing problems with his cervical spine or lumbar spine prior to the date of the work accident in questions. (Rx. 1, Dx. 11) When Dr. Player asked about the work accident, Petitioner reported he injured his lower back and neck. (Rx. 1, Dx. 16) He reported that he did not injure his left elbow, left shoulder, or left knee on April 23, 2015. (Rx. 1, Dx. 16) When asked what pain he felt after lifting the scrap metal, Petitioner stated he felt pain in his lower back and belly. (Rx. 1, Dx. 17) Petitioner said he experienced severe low back pain just moments after, and he was not able to walk and had to sit down. (Rx. 1, Dx. 17) Petitioner stated that after that event, he had severe low back pain from that point forward. (Rx. 1, Dx. 17)

During the examination, Dr. Player viewed Petitioner's MRI of the lumber spine, and concluded that the MRI documented generalized degenerative disc disease throughout the lumber spine, with a congenitally narrow trefoil. (Rx. 1, Dx. 15) Dr. Player's testified that with respect to Petitioner's cervical spine, Petitioner's complaints were not supported with positive objective neurologic findings. In regard to the lumber spine those complaints were not supported with positive objective neurologic findings, other than the right-side knee-deep tendon reflex. (Rx. 1, Dx. 26) Dr. Player testified that there was no causal relationship between that injury event on April 23, 2015 and Petitioner's alleged back pain. He noted this was supported by the 4-day delay in symptoms, the prior history of back pain, and the negative lumbar spine MRI. (Rx. 1, Dx. 27)

Dr. Player examined Petitioner a second time on February 23, 2017. (Rx. 1, Dx. 32) He stated he examined the new medical records from June 8, 2015 through March 8, 2016. (Rx. 1, Dx. 33) At this exam, he stated that Petitioner had submitted for lumbar fusion surgery. (Rx. 1, Dx. 34) He said that Petitioner had been discharged by his surgeon to light duty work but had not returned to light duty work. (Rx. 1, Dx. 34) After reviewing the new medical records and

examining Petitioner, Dr. Player concluded that there was no causal relationship between the need for the lumbar surgery and the April 23, 2015 work accident. (Rx. 1, Dx. 41)

Petitioner testified that other than working a few hours on Monday, 27 April, after the accident date, he never returned to work for respondent. He has worked since April 27, 2015. T 47.

As of the date of hearing, his daily activities are different now than they were before the April 23, 2015 accident at work. When he walks, he gets more tired than before his work injury. Standing for long time causes increased pain. If he has to lift, he limits himself to lifting lighter objects because his back hurts. He takes pain pills. When he said he gets tired that means his back starts hurting. T 49. If he lifts more than 20 pounds his back hurts. T 50. If he sits down in one position for too long his back starts hurting. He takes ibuprofen 2-3 times a week to obtain pain relief. T 50. He was awarded Social Security disability. T 51.

With regard to his groin, he does not lift anything heavy because he is afraid of injury. T 51. He was not seeing any doctors currently. He believes his primary care physician, Dr. PK Alexander, passed away. T 52.

Petitioner testified he felt immediate pain only to his lower back and groin. T 57. He did not remember claiming any injuries for his left arm. T 57. He testified that everything was hurting, and he did not remember exactly everything. He did not hurt his left arm in the accident. T 58. He did not injure his left knee on April 23, 2015. His back was hurting and perhaps the pain was traveling. T 59. He did injure his low back on April 23, 2015. T 60. He felt immediate pain. The pain was going from his back up to his groin. T 60-61. He told the doctor and the supervisor at Naylor that his back was hurting. T 62.

Admitted in evidence as Petitioner Exhibit 2 are the medical records/bill of Preferred Open MRI for an MRI lumbar spine 5/15/15. PX 2

Admitted in evidence as Petitioner Exhibit 4 are the medical records/Bill Hammond Community Ambulatory Care Center covering dates of treatment 6/24/15 through 11/30/15; 9/11/15 laparoscopy inguinal hernia bilateral repair. PX 4.

Admitted in evidence as Petitioner Exhibit 5 are the medical records/bill of Archer Open MRI for MRI's of the cervical spine, upper left extremity, lower left extremity left and upper let extremity left. Petitioner has testified he is not making claim that cervical spine, left upper extremity, left lower extremity are causally related to the work accident of 4/23/15. T 43-44.

Admitted in evidence as Petitioner Exhibit 10 are a list of unpaid bills with the bills attached. PX 10.

Admitted in evidence as Petitioner Exhibit 12 is Social Security Administration disability award letter dated April 9, 2016 addressed to Petitioner finding that he was disabled as of April 24, 2015 PX 12.

Mr. Robin Olson Testimony

Respondent called Mr. Robin Olson as witness. The witness testified he is a current employee of Respondent with job title of supervisor. He has worked in that capacity for 24 years. Mr. Olson was one of the supervisors of Petitioner on the day of the accident and for 5 years prior to the date of the accident. He had no difficulty understanding Petitioner. T 82. He was called to the scene of the accident to help. Petitioner told him that there was a piece of scrap that was taken out of machine and then it was carried by Petitioner over to the scrap hopper which was approximately 25 to 30 feet from the machine when Petitioner had pain in his groin and

waist area around his stomach. Petitioner did not report anything to his low back at the time. T 84. Petitioner did not report anything to his left arm, left shoulder, left knee or neck. The witness did not recall whether Petitioner had any limitations walking after the injury. T 85. The accident report was made, and Petitioner was transported to Concentra Occupational Health Clinic. Respondent Exhibit 9 is the supervisor's incident accident report. T 89. The other supervisor, not the witness, completed the report. T 90. The witness testified Petitioner never contacted Respondent requesting to return back to employment. The witness was not aware of Petitioner presenting any return to work restrictions to Respondent from any providers. T 91. Whether Respondent would have accommodated restrictions depends upon what the restrictions were. T 92. The witness did not bring Petitioner's employment file to the hearing. T 92-93.

The witness never formed the opinion that Petitioner was dishonest, unbelievable or incredible. The witness testified Petitioner did his job and did a good job and an efficient job that kept him in his job for 17 years with respondent. T 95.

Admitted in evidence as Respondent Exhibit 4 are the Naylor Pipe Company earnings history report of Petitioner from 4/21/14 through 4/26/15. The check covering the accident date of 4/23/15 is identified as check number 129216 covering dates from 4/20/15 through 4/26/15. During that period Petitioner is reported to have worked 32 hours with no overtime. The Arbitrator notes that for most of the pay periods prior to the date of the accident, Petitioner worked 40 hours plus overtime, The time periods wherein the Petitioner worked less were consistent with is left elbow injury in 2014. The Arbitrator further notes that the company clinic physician at Concentra Occupational Health released Petitioner to return to work with restrictions on the date of accident.

The Arbitrator takes judicial notice that April 23, 2015 is a Thursday and, thus, April 27, 2015 fell on a Monday.

Admitted in evidence as Respondent Exhibit 5 are the records of Concentra Occupational Health Medical Center. RX 5. These records corroborate Petitioner's testimony that his job duties were physically demanding.

Admitted in evidence as Respondent Exhibit 6 is the Consolidated Statement Benefits from Petitioner's Group Carrier Blue Cross Blue Shield. For the accident date of 4/23/15 the document indicates that for those bills identified with providers and dates, the total of bill charges was $176,111.63. The benefits paid by Blue Cross Blue Shield against those charges is represented to be $90,172.01. RX 6.

Admitted in evidence as Respondent Exhibit 7 is Respondent TTD and bill payment log.

Admitted in evidence as Respondent Exhibit 9 is the Supervisors Incident/Accident Report for date of incident April 23, 2015. The document, signed by supervisor, indicates machine operator, Ruben Torrez, bent over to pick something up and felt something pull in his groin area-per Ruben Torrez. Time of accident is indicated to be 9:30 AM. Date/time reported is indicated to be 9:45 AM. Attached to that document is another document with a claim number dated 4/23/15 indicating: "Ruben Torrez picked up a piece of scrap and felt pain in groin per Rob Olson." Time of accident is indicated to be 11:00 AM. The Arbitrator notes the documents were not signed by Petitioner. The Arbitrator further notes that there is an inconsistency between the two documents. The first reports an accident occurred at 9:30 AM and was reported 9:45 AM and the second indicates an accident occurring at approximately 11:00 AM. RX 9.

Admitted in evidence as Respondent Exhibit 10 is a letter dated November 30, 2016 from Naylor Pipe Company addressed to Ruben Torrez indicating his employment is separated effective 12/3/2016 because he has not provided a doctor's note to let them know status and because the collective bargaining agreement provides that absence for more than 18 months is a basis for termination. RX 10.

Admitted in evidence as Respondent Exhibit 11 is a letter from Dr. Sean Salehi dated 6/18/19 indicating that the patient has not been prescribed any medication from this office in the last 2 years. RX 11.

Admitted in evidence as Respondent Exhibit 13 is Respondent fee schedule analysis of bills.

III. 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 Petitioner 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 or her claim *O'Dette v. Industrial Commission,* 79 Ill. 2d 249, 253 (1980) including that there is some causal relationship between the employment and the injury. *Caterpillar Tractor Co. v. Industrial Commission*, 129 Ill. 2d 52, 63 (1989). And, yet it also is well established that the Act is a humane law of remedial nature and is to be liberally construed to effect the purpose of the Act - that the burdens of caring for the

casualties of industry should be borne by industry and not by the individuals whose misfortunes arise out of the industry, nor by the public.. *Shell Oil v. Industrial Comm'n,* 2 Ill.2nd 590, 603 (1954). Decisions of an arbitrator shall be based exclusively on stipulation of the parties, the evidence in the record of proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e)

The Arbitrator, as the trier of fact in this case, has the responsibility to observe the witnesses testify, judge their credibility, and determine how much weight to afford their testimony and the other evidence presented. *Walker v. Chicago Housing Authority*, 2015 IL App (1st) 133788, ¶ 47 The Arbitrator viewed his demeanor under direct examination and under cross-examination. The Arbitrator considered the testimony of Petitioner with the other evidence in the record. Petitioner's testimony is found to be credible. He does appear to be an unsophisticated individual and any inconsistencies in his testimony are not attributed to an attempt to deceive the finder of fact.

Petitioner testified in open hearing before the Arbitrator who viewed the demeanor of Mr. Robin Olson under direct examination and under cross-examination. The Arbitrator considered the testimony of Mr. Olson with all other evidence in the record. The Arbitrator finds Mr. Olson was a sincere whose recollection was hampered as he did not bring Petitioners' employment file.

Evidentiary Issue

Respondent requested to admit into evidence, Respondent's Exhibit Number 8, the Employer's First Report of injury (commonly known as a Form 45). A form completed by the Respondent as required by 6(b) of the Act. A form that is to remain confidential pursuant to §6(b) of the Act the release of which to unauthorized persons. The Arbitrator *sue sponte* rejected

the exhibit as being in violation of the confidentiality mandate of §6(b) of the Act. The exhibit was made part of the record as rejected Respondent's rejected exhibit number 8.

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 ARBITRATORFINDS AS FOLLOWS:

The Act is a remedial statute, which should be liberally construed to effectuate its main purpose of providing financial protection for injured workers. *Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Comm'n*, 236 Ill. 2d 132, 149 (2010). According to the Act, in order for a claimant to be entitled to workers' compensation benefits, the injury must "aris[e] out of" and occur "in the course of" the claimant's employment. 820 ILCS 305/1(d) (West 2014). Case law interpreting the Act makes it clear that both elements must be present at the time of the accidental injury in order to justify compensation. *Illinois Bell Telephone Co. v. Industrial Comm'n,* 131 Ill. 2d 478, 483 (1989) Therefore, in order to obtain compensation under the Act, a claimant bears the burden of proving by a preponderance of the evidence two elements: (1) that the injury occurred in the course of claimant's employment and (2) that the injury arose out of claimant's employment. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 203 (2003); *McAllister v. Illinois Workers' Compensation Comm'n*, 2020 IL 12484

The phrase "in the course of employment" refers to the time, place, and circumstances of the injury. Scheffler Greenhouses, Inc. v. Industrial Comm'n, 66 Ill. 2d 361, 366-67 (1977). "A compensable injury occurs 'in the course of' employment when it is sustained while a claimant is at work or while he performs reasonable activities in conjunction with his employment." Wise, 54 Ill. 2d at 142. *McAllister v. Illinois Workers' Compensation Comm'n*, 2020 IL 12484

In this case, the evidence established that at the time Petitioner sustained his hernia injury and low back injury, Petitioner was at work and performing his job duties. Accordingly, he has satisfied his burden of proof that he had an injury that occurred in the course of his employment.

"The 'arising out of' component is primarily concerned with causal connection. 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, 207 Ill. 2d at 203 (citing Caterpillar Tractor, 129 Ill. 2d at 58); see also Baggett v. Industrial Comm'n, 201 Ill. 2d 187, 194 (2002) ("An injury 'arises out of' one's employment if it originates from a risk connected with, or incidental to, the employment, involving a causal connection between the employment and the accidental injury."); A risk is incidental to the employment when it belongs to or is connected with what the employee has to do in fulfilling his or her job duties. Orsini, 117 Ill. 2d at 45. *McAllister v. Illinois Workers' Compensation Comm'n*, 2020 IL 12484. In this case, the Petitioner was lifting and pulling 50 lbs. of steel when he sustained his injuries which is a risk incidental to his employment with the Respondent.

The Supreme Court in *McAllister* stated that the first step in risk analysis is to determine whether the claimant's injuries arose out of an employment-related risk—a risk distinctly associated with the claimant's employment. Mytnik, 2016 IL App (1st) 152116WC, ¶ 39; Steak 'n Shake, 2016 IL App (3d) 150500WC, ¶ 38. As noted above, a risk is distinctly associated with an employee's employment if, at the time of the occurrence, the employee was performing (1) acts he or she was instructed to perform by the employer, (2) acts that he or she had a common-law or statutory duty to perform, or (3) acts that the employee might reasonably be expected to perform incident to his or her assigned duties. Caterpillar Tractor, 129 Ill. 2d at 58; see also The

Venture—Newberg-Perini, Stone & Webster v. Illinois Workers' Compensation Comm'n, 2013 IL 115728, ¶ 18; Sisbro, 207 Ill. 2d at 204. ¶ 47; *McAllister v. Illinois Workers' Compensation Comm'n*, 2020 IL 12484

In this case Petitioner's hernia injury and back injury arose out of an employment-related risk because the evidence establishes that at the time of the occurrence his injury was caused by one of the risks distinctly associated with his employment as a steel worker machine operator. The evidence established that the acts that caused hernia injury and lumbar injury (lifting and pulling 50 lbs. of steel) were risks incident to his employment because these were acts his employer might reasonably expect him to perform in fulfilling his assigned job duties as a machine operator . See, e.g., Orsini, 117 Ill. App. 2d at 45; Ace Pest Control, Inc. v. Industrial Comm'n, 32 Ill. 2d 386, 388 (1965); *McAllister v. Illinois Workers' Compensation Comm'n*, 2020 IL 12484

The credible testimony of Petitioner indicates that on April 23, 2015, Petitioner worked for Respondent as a steel worker machine operator. He was required to unwrap and feed metal into the machine and pick up metal and scrap from the machine. As he was pulling and lifting metal scrap from the machine which weighed approximately 50 pounds, he felt pain in his right back and his right groin by his stomach. T 22-23. He reported the pain to his supervisor who directed him to a doctor at employer's medical clinic, Concentra Occupational Health. T 23. History to the medical providers of the onset of symptoms in the accident was consistent with Petitioner's testimony at hearing. A Supervisor's Incident/Accident Report, RX 9, prepared by Respondent, described the accident consistent with Petitioner's testimony at hearing. The Arbitrator finds the weight of credible evidence in this record demonstrates that Petitioner

suffered injury on April 23, 2015 in an accident that arose out of and in the course of Petitioner's employment by respondent.

The Arbitrator finds that the mechanism of injury regarding the hernia and low back is consistent with Petitioner's physically demanding job duties as evidenced by Petitioner's testimony and corroborated by the records of Concentra Occupational Health wherein Petitioner sustained low back, neck and arm injuries while performing his duties as a machine operator.

The Arbitrator notes the Respondent Supervisor's Incident/Accident Report dated 4/23/15 and medical records of the employer's doctors at Concentra Occupational Health dated 4/23/15 document only groin/hernia pain and do not document the back pain which are first documented on Monday, April 27, 2015, the next date of treatment at Concentra Occupational Health . The Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that he sustained an accident that arose out of and in the course of his employment by the Respondent on April 23, 2015. The Arbitrator will address this in the disputed issue of Causal Connection.

WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATORFINDS AS FOLLOWS:

The Arbitrator incorporates the findings of fact and conclusions of law noted above. The Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that his current condition of ill-being to his lumbar spine and his hernia are causally related to the injury sustained on April 23, 2015.

The Arbitrator is mindful that the Petitioner's job duties as a machine operator are physically demanding and have taken a toll on his body over the years of hard labor. This is well demonstrated and corroborated in the records of Concentra Occupational Health wherein Petitioner was treated for multiple work injuries due to the nature of the work. It is clear and undisputed that the mechanism of Petitioner's injuries and the nature of the injuries are consistent with his job duties and his description of the accident. Petitioner recalled that he immediately felt pelvic , low back pain, groin pain. The accident reports and the initial medical record only record hernia like pain. And, yet by the very next medical visit, back pain is recorded. The Arbitrator is persuaded by the opinion of Dr. Salehi that lifting and pulling accident sufficient to cause a hernia is also sufficient to aggravate a preexisting asymptomatic condition in the low back and that the inflammatory process clearly explains the delayed intense back pain. The Arbitrator finds both the hernia and low back pain to be related to the accident after considering the record as a whole.

Petitioner credibly testified that prior to the work accident of April 23, 2015, he had worked for Respondent 22 years and in the capacity as a steel worker machine operator for 15 to 17 years before the accident date. In that job, he would unwrap roles of metal and put them into the machine which unrolled the metal sheets and turned the metal sheets into pipes. T 16-17. He usually lifted up to 50 pounds as a machine operator. The pieces of scrap metal weighed 50 pounds. At the time of the accident he had worked up to 10 hours a day and an additional 5 hours on Saturday. He worked those hours for many years before the accident date. T 18-19. Petitioner's testimony is corroborated by the payroll records. (Rx 4).

Petitioner had injured his back in September 2004. He was treated conservatively with therapy at Concentra Occupational Health and went back to work. T 20. In July 2009 he had

another accident at work lifting a bar of heavy metal with an onset of pain in his back. He was treated conservatively at Concentra Occupational Health. T 20. He was diagnosed with lumbar strain and went back to work.

From July 22, 2009 when he injured his back at work and had therapy, he had not injured his back in any other accidents until his April 23, 2015 accident He had not sought medical treatment from any doctor during that time up until April 23, 2015. T 21. The medical records of Concentra Occupational Health for the period of through December 4, 2014, document multiple visits during this time period without mention of any low back pain nor groin pain. The treatment was limited to the October 21, 2014 left elbow injury. (RX 5)

The medical records of Petitioner's primary care physician, Dr. PK Alexander, document medical examinations of Petitioner by Dr. Alexander on 4/18/14, 4/21/14, 5/8/14, 9/27/14, 12/8/14, 12/10/14, 12/16/14, 1/8/15, 1/15/15, and 4/10/15. In none of those office visit notes is there any documentation of any complaint of either groin pain or low back pain. PX 11, p 30-49. Four days after the accident when Petitioner returned to the doctors to which Respondent had referred him, Concentra Occupational Health, he was told by Concentra Occupational Health that his back pain and hernia pain were not caused by the work accident.

Petitioner sought treatment the next day with his primary care physician, Dr. PK Alexander, whose records document both lumbar pain and right inguinal pain and who made diagnosis of sciatica and lumbar radiculopathy with order for x-ray of the lumbar spine. PX 11, p 28-29. Petitioner testified he felt immediate pain in his groin and back and he had made complaints of both groin pain and back pain on the first visit to Concentra Occupational Health. T 57, T 62.

Petitioner's treating neurosurgeon, Dr. Sean Salehi, persuasively explained in his deposition that Petitioner had mechanical back pain that was rendered symptomatic by the accident. Dr. Salehi testified that degeneration of the disc was there prior to the accident. The MRI should a degenerated disc at L4-5 . A disc which is degenerated it is more likely to take on new injury; something breaks at its weakest point, and the weakest point in his back is that L4-5 disc which is degenerated. Dr. Salehi explained when he lifted something heavy, it resulted in a pressure on the disc at that level to become symptomatic. PX 8, p 20-21. Dr. Salehi explained how the work accident brought about the radicular pains. He testified that degeneration was asymptomatic before the accident and then symptomatic after the accident. PX 8, p 21-22.

Dr. Salehi testified that if someone were to aggravate a pre-existing condition it would not necessarily result in back pain on the day of the accident. You can have pain right at that time, or the pain could be delayed because of the delayed inflammatory response. He explained that everybody has sprained his ankle at some point when they were younger, and we know that you may not feel the sprained ankle right at that time, but the next morning you could hardly get out of bed. That is because of the delayed inflammation, and the same thing applies to the low back. PX 8, p 30. Dr. Salehi explained it would not surprise him that Mr. Torrez did not report back pain to his supervisor or to the initial treating physician on April 23, 2015. PX 8, p 30. After the surgery performed by Dr. Salehi, Petitioner's condition of low back and radiating pain significantly improved.

Respondent's Section 12 examiner for Petitioner's lumbar condition, Dr. J.S. Player, opined that Petitioner's subjective complaints of lumbar pain are not supported by positive objective physical findings and with the delay in reporting lumbar pain, Petitioner's current condition of the low back is not causally related to the work accident of April 23, 2015. He

opined that the examinee is capable of returning to full and regular duty without restrictions relative to the alleged April 23, 2015 work exposure. He opined that with regard to Petitioner's current condition of ill-being of his back, the treatment was reasonable and necessary, but the treatment was not causally related to the work accident. RX 2, p 31.

Dr. Player opined objective medical testing results for lumbar spine document nontraumatic pre-existing degenerative disc disease which could be responsible for his current pain complaints. RX 2, p 31. Dr. Player reiterated these opinions in his second Section 12 report of February 23, 2017. RX 3, p 18. Dr. Salehi also noted Petitioner had pre-existing degenerative condition of the lumbar spine and explained how the work accident caused that previously asymptomatic condition to become symptomatic.

The Arbitrator notes that there is no evidence in this record that Petitioner's pre-existing degenerative condition of his lumbar spine was advanced to the point that any activity of daily living could have caused the condition to become symptomatic. It is well established that an accident need not be the sole or primary cause of a claimant's condition. *Sisbro, Inc. v Industrial Commission*, 207 Ill. 2d 193, 205 (2003). An employer takes its employees as it finds them. *St. Elizabeth Hospital v Worker's Compensation Commission*, 371 App 3rd 882, 888 (2007). A claimant with a pre-existing condition may recover where employment aggravates or accelerates that condition. *Caterpillar Tractor Co. v Industrial Commission*, 92 Ill 2nd 30, 36 (1982).

The Arbitrator gives more weight to the opinions treating physicians and that of Dr. Salehi which are supported by more persuasive explanations than to the opinions of Dr. Player. The Arbitrator finds, based upon the weight of credible evidence in this record, that Petitioner's current condition of ill-being with regard to his lumbar spine is causally related to the work accident of 4/23/15. Additionally, the Arbitrator finds under a chain of events analysis,

Petitioner's current condition of ill-being with regard to the lumbar spine is causally related to the work accident of April 23, 2015.

Respondent's Section 12 examiner for the inguinal hernia, Dr. Bines, opined that the hernia was caused by the work accident and recommended surgery. PX 9, p1-4. The medical records of Petitioner's primary care physician, Dr. PK Alexander, indicate no complaints of hernia pain or symptoms prior to the work accident. The onset of symptoms was immediate with the work accident. The Arbitrator is not persuaded by the opinion of the Concentra Occupational Health Clinic physician that the hernia is not work related. The Arbitrator finds that the weight of credible evidence demonstrates that Petitioner's current condition of being regarding the inguinal hernia was caused by the work accident of April 23, 2015. Additionally, the Arbitrator finds under a chain of events analysis that Petitioner's current condition of ill-being of the inguinal hernia was caused by the work accident of April 23, 2015.

Causation in this matter is also supported by chain of events analysis. In *Walquist Farm P'ship v. Ill. Workers' Comp. Comm'n*, 2021 IL App (5th) 190163 (Ill. App. Ct. 2021) a Rule 23 issued after January 1, 2021, a decision which may be cited for its persuasiveness, the court held that the 'chain of events' analysis to demonstrate the existence of an injury also supports its use to demonstrate an aggravation of a preexisting injury. In the original *Walquist Farm P'ship* decision the Commission affirmed and adopted the decision of the Arbitrator. The Commission found that Petitioner's preexisting back problems and three-month history of foot numbness prior to the accident precluded a chain of events analysis to prove a causal connection. The Appellate Court disagreed. In *Price v. Industrial Comm'n*, 278 Ill. App. 3d 848, 853-54 (1996), the Appellate Court considered the applicability of this principle to a case involving a preexisting condition and reasoned as follows: "The employer also contends that the facts of the present case do not

support the Commission's 'chain of events' analysis because [the claimant] had a preexisting condition. The employer cites no authority for the proposition that a 'chain of events' analysis cannot be used to demonstrate the aggravation of a preexisting injury, nor do we see any logical reason why it should not. The rationale justifying the use of the 'chain of events' analysis to demonstrate the existence of an injury would also support its use to demonstrate an aggravation of a preexisting injury."

Considering the medical records submitted, the Arbitrator finds that the work accident incurred on April 23, 2015 aggravated Petitioner's pre-existing automatic back degenerative changes causing his condition to become significantly symptomatic. The Petitioner was able to perform his physically demanding job duties before his accident of April 23, 2015. After the accident, he was initially given restricted duty work by Concentra Occupational Health and he was authorized off work shortly thereafter by his family physician. He was not able to work and did not work. The Arbitrator disagrees with the conclusions of Dr. Player. It is plainly evident that the accident of April 17, 2020 caused Petitioner to experience significant lumbar back pain, pain that has remained and persistent and required further medical treatment and surgery The Arbitrator finds the findings and opinions of the treating neurosurgeon, Dr. Salehi, to be more persuasive than the findings and opinions of Dr. Player.

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 ARBITRATORFINDS AS FOLLOWS:

The Arbitrator incorporates the findings of fact and conclusions of law noted above. The Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that the

medical treatment for the injuries he sustained was necessary. The Arbitrator, therefore, finds that the medical services that were provided to the Petitioner regarding his hernia and low back to be reasonable and necessary.

Petitioner testified that he is not claiming bills for medical treatment other than for the lumbar spine condition and for the inguinal hernia are related to the work accident of 4/23/15.

Dr. Salehi testified that the surgery he performed was necessary to address the lumbar injury caused by the work accident. Respondent's Section 12 examiner for the lumbar condition, Dr. Player, testified that although the treatment up to the date of his Section 12 examinations may have been reasonable and necessary, it was not causally related to the work accident of April 23, 2015 accident. The Arbitrator has found that the condition of ill-being of Petitioner's lumbar spine is causally related to the work accident. The Arbitrator finds the medical bills, as listed below, for treatment of the lumbar spine from Petitioner Exhibit 10 are reasonable, necessary and causally related medical and Respondent is ordered to pay at the fee schedule or negotiated rate, whichever is less, pursuant to Section 8.2 of the Act.

Dr. Bines, Respondent's Section 12 examiner, opined that the work injury directly caused the inguinal hernia and recommended surgery to address the inguinal hernia. That surgery was performed by Dr. Vijay Patel. The Arbitrator finds medical bills, as listed below, from Petitioner Exhibit 10 for treatment of the inguinal hernia are reasonable, necessary, and causally related medical bills and Respondent is ordered to pay those bills at the fee schedule or negotiated rate whichever is less.

The following is a list of the bills from PX 10 that have been paid by Petitioner's group insurance, Blue Cross Blue Shield, showing the amount paid by the group insurance as the

negotiated rate and additionally a list of bills that remain unpaid. Respondent shall pay to Petitioner all unpaid bills in the following as listed below as reasonable and necessary medical services, pursuant to the medical fee schedule or the negotiated rate, as provided in Sections 8(a) and 8.2 of the Act. Pursuant to the Appellate Court decisions in *Mentzer v Van Scyoc,* 233 Ill. App 3rd 438, 422 (4th District 1992) and *McMahon v. Industrial Commission*, 183 Ill. 2nd 499, 512 and the Commission Decision in Janet *Spencer v State of Illinois,* 20 IWCC 0609, which hold that an award of medical expenses is an award of compensation and must be paid to Petitioner, Respondent is ordered to make payment of the bills that have been awarded herein directly to Petitioner.

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.

Specifically, Respondent shall hold the Petitioner harmless for medical bills paid by Blue Cross/Blue Shield and noted below. And, pursuant to the stipulation of the parties, Respondent is entitled to a credit of $90, 172.01 under Section 8(j) of the Act. (Arb. Ex. 1)

**PAID BY PETITIONER'S GROUP BLUE CROSS/BLUE SHIELD*

BC/BS BENEFITS PROVIDED

MEDICAL PROVIDER	DATE OF SERVICE	BILLED AMOUNT	AMOUNT PAID *	PX RECORD LOCATION
PK ALEXANDER MD LLC	4/28/2015	$175.00	$134.65	Px 11, p 28-29
FRANCISCAN ST MARGARET	4/28/2015	$547.00	$465.06	Px 11, p 54
IMAGING ASSOCIATES	4/28/2015	$95.00	$11.68	Px 11, p 54

PK ALEXANDER MD LLC	5/5/2015	$345.00	$154.36	Px 11, p 26
PK ALEXANDER MD LLC	5/22/2015	$160.00	$58.29	Px 11, p 24-25
CHGO ADVANCED PAIN AND HE	6/8/2015	$267.00	$78.12	Px 3, p 14
CHGO ADVANCED PAIN AND HE	6/8/2015	$6,700.00	$798.93	Px 3, p 14
CHGO ADVANCED PAIN AND HE	6/24/2015	$6,929.44	$597.25	Px 3, p 95-102
CHGO ADVANCED PAIN AND HE	7/6/2015	$117.00	$38.62	Px 3, p 91-94
CHGO ADVANCED PAIN AND HE	7/8/2015	$11,276.52	$1,002.40	Px 3, p 84-90; Px 3 p 8-9
CHGO ADVANCED PAIN AND HE	7/22/2015	$11,276.52	$1,002.40	Px 22, p 73-79
CHGO ADVANCED PAIN AND HE	8/3/2015	$117.00	$38.62	Px 3, p 16
NEUROLOGICAL SURGERY AND	8/14/2015	$471.00	$185.14	Px 7, p 11-14
VISHAR MEDICAL CENTER S C	9/1/2015	$655.00	$0.00	Px 4, p 197-198
VISHAR MEDICAL CENTER S C	9/1/2015	$655.00	$272.19	Px 4, p 197-198
VISHAR MEDICAL CENTER S C	9/11/2015	$5,000.00	$1,270.93	Px 4, p 200-201
PK ALEXANDER MD LLC	9/18/2015	$160.00	$58.62	Px 11, p 20-21
NEUROLOGICAL SURGERY AND	9/25/2015	$224.00	$75.55	Px 7, p 15-17
NEUROLOGICAL SURGERY AND	11/20/2015	$224.00	$75.55	Px 7, p 18-20
NEUROLOGICAL SURGERY AND	12/12/2015	$8,708.00	$1,020.61	Px 7, p 32-34
NEUROLOGICAL SURGERY AND	12/12/2015	$35,906.00	$5,256.94	Px 7, p 32-34

NEUROLOGICAL SURGERY AND	12/12/2015	$3,150.00	$627.35	Px 7, p 32-34
MD2X SC	12/12/2015	$2,700.00	$1,326.00	Px 7, p 32-34
ST JAMES HOSPITAL AND HLT	12/12/2015	$77,969.15	$74,194.15	Px 7, p 32-33
NEUROLOGICAL SURGERY AND	6/17/2016	$224.00	$75.55	Px 8, p 76-78
TOTAL BILLED CHARGES - $176,111.63		*TOTAL BENEFITS PROVIDED - $88,818.96*		

The following is a list of unpaid medical bills which Respondent is ordered to pay to Petitioner as provided in Sections 8(a) and 8.2 of the Act.

MEDICAL PROVIDER	DATES OF SERVICE	AMOUNT OUTSTANDING	PX RECORD LOCATION
DR J EGAN SC	7/3/2015 – 3/8/2016	$15,205.00	Px 6, p 1-131
NEUROLOGICAL SURGERY	12/12/2015	$1,796.74	Px 7, p 32-34
HAMMOND COMMUNITY AMBULATORY CARE	7/8/2015	$16,570.72	Px 3, p 84-90; Px 3, p 8-9
HAMMOND COMMUNITY AMBULATORY CARE	7/22/2015	$16,570.72	Px 3, p 73-79
HAMMOND COMMUNITY AMBULATORY CARE	6/24/2015	$17,662.32	Px 3, p 95-102
HAMMOND SPINE PAIN & ORTHO	8/12/2015	$19,838.85	Px 3, p 62-63
PROCLINICS	8/12/2015	$5,778.38	Px 3, p 60-68
TOTAL BILLED CHARGES - $93,422.73		*TOTAL UNPAID - $93,422.73*	

WITH RESPECT TO ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATORFINDS AS FOLLOWS:

An employee is temporarily totally disabled from the time an injury incapacitates him until such time as he is as far recovered as the permanent character of the injury will permit. *Archer Daniels Midland Company v. Industrial Commission,* 138 Ill 2nd 107, 118 (1990); *Westin Hotel,* 372 Ill. App. 3rd, at 542. To be entitled to TTD benefits, the employee must establish not only that he did not work, but also that he is unable to work and the duration of that inability to work. *Pietrzak v. Industrial Commission,* 329 Ill. App. 3rd 828, 832 (2002); *Interstate Scaffolding, Inc. v. Illinois Worker's Compensation Commission,* 236 Ill 2nd 132, 146 (2010) ("when determining whether an employee is entitled to TTD benefits, the test is whether the employee remains temporarily totally disabled as result of a work-related injury and whether the employee is capable of returning to the workforce."). Once an injured employee has reached maximum medical improvement, the disabling condition has become permanent and he or she is no longer eligible for temporary total disability benefits. *Nascote Industries v Industrial Commission,* 353 Ill. App 3rd 1067, 1072 (2004). The factors to be considered in determining whether an employee has reached maximum medical improvement include a release to work, medical testimony or evidence concerning the employee's injury, and the extent of the injury. *Land & Lake Co. v Industrial Commission*, 359 Ill. App. 3rd 582, 594 (2005). Petitioner last worked for a few hours on April 27, 2015 and was under medical care thereafter for the hernia and back both of these conditions required surgery. Petitioner here was ordered off work for the lumbar condition by Dr. Osama Abdellatif on 6/8/15 and thereafter. PX 3, p 14, 15, 16, 56-59. Dr. Salehi ordered work restrictions beginning 9/25/15. PX 7, p 15-17. There is no indication Respondent accommodated those work restrictions although his supervisor testified that they

may have been able to do so. And, there is no evidence that Respondent would do so on a denied claim.

On 12/12/15 Dr. Salehi performed surgery consisting of left L4-L5 transforaminal lumbar interbody fusion and right L4-L5 hemilaminectomy. PX 7, p 24-26. On 12/28/15 Dr. Salehi continued off-work order. PX 7, p 21-23. On 3/11/16 Dr. Salehi ordered light duty work, no lifting more than 20 pounds, no pushing/pulling more than 35 pounds, no repetitive bending/twisting and alternate sitting/standing every 30-45 minutes as needed. PX 8, p 73-75. On 6/17/16 Dr. Salehi ordered a functional capacity evaluation (FCE) to determine permanent work restrictions. There is no evidence the FCE was authorized or paid by Respondent. The FCE was never performed.

The Arbitrator finds that on 6/17/16 Petitioner reached maximum medical improvement. Petitioner never returned to work for respondent. Petitioner was terminated by Respondent on 12/3/16 in letter from Respondent dated November 30, 2016. Respondent alleged Petitioner had not provided Respondent with a doctor's note and additionally stated Petitioner had been off for more than 18 months which under the collective bargaining agreement allowed Respondent to terminate Petitioner. RX 10. There is no evidence that Respondent accommodated the work restrictions last imposed by Dr. Salehi. Although respondent's witness, Mr. Olson, testified he thought Respondent could accommodate restrictions, he further testified that whether Respondent could accommodate would depend upon restrictions. There is no evidence that Respondent offered an accommodated job to Petitioner within the restrictions ordered by Petitioner's treating physicians. There is no evidence that Respondent offered or would have offered Petitioner a light duty job in a denied claim. Petitioner testified that Respondent medical provider, Concentra Occupational Health, ordered him back to work and told him that his hernia

and back injury were not related to a work accident. He testified he attempted to work on Monday when he returned to work but was unable to work because of the back pain. Petitioner was on Social Security disability at the time of hearing.

Petitioner testified that when he lifts now, he has to be careful because of pain and he does not lift more than 20 pounds

Admitted in evidence as Petitioner Exhibit 12 is Social Security Administration disability award letter dated April 9, 2016 addressed to Petitioner finding that he was disabled as of April 24, 2015 PX 12. Although not conclusive evidence nor binding evidence on the Commission, the Social Security Administration finding that Petitioner was disabled is some evidence consistent with the record as a whole and is evidence consistent with Petitioner's entitlement to temporary total disability benefits.

The Arbitrator finds that Petitioner has proven by a preponderance of the evidence that he entitled to TTD from April 28, 2015 through the date of release by Dr. Salehi on June 17, 2016 representing 59-4/7 weeks at the rate of $552.00 per week. Respondent is ordered to pay Petitioner TTD from 4/28/15 through 6/17/16. Respondent Exhibit 7 documents Respondent paid TTD to Petitioner from 5/1/15 through 6/18/15 stipulated in the amount of $3,639.96. RX 7. Respondent is given credit in the amount of $3,639.96 against the TTD payment to Petitioner ordered herein.

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

Pursuant to the provisions of Section 8.1b of the Act, permanent partial disability is determined by evaluation of the factors provided therein.

For the inguinal injury the Arbitrator finds as follows:

(i) Neither party submitted an AMA impairment rating. Accordingly, The Arbitrator finds no evidence of any impairment rating in the record, and, therefore, assigns no weight to this factor.

(ii) Petitioner's occupation was as a machine operator which required standing on his feet and lifting up to 50 pounds. Petitioner had restrictions ordered by Dr. Sean Salehi which precluded him from returning to that job. Petitioner did not return to that job. The Arbitrator gives this factor some weight.

(iii) Petitioner's age at the time of the injury was 60 years. The Arbitrator finds the effects of the hernia and the lumbar spine surgery would have more significant impact on Petitioner because of his age. The Arbitrator gives this factor some weight.

(iv) There is no evidence in the record that Petitioner's ability to earn income was impacted by the inguinal hernia and surgery performed to repair that. The Arbitrator gives this factor some weight.

(v) Petitioner underwent surgery for the hernia documented in the medical records. There is no evidence that any permanent restrictions were imposed on him as result of that hernia surgery. The Arbitrator gives this factor some weight.

Considering all the factors and the record as a whole, the Arbitrator finds Petitioner suffered permanent partial disability to the extent of 3.5 % of his person as a whole representing 17.5 weeks of permanent partial disability benefits pursuant to Section 8(d) 2 of the Act as result of the inguinal hernia.

For the lumbar spine injury, the Arbitrator finds as follows.

(i) Respondent submitted an AMA impairment rating performed by Dr. JS Player dated February 23, 2017. RX 3. The impairment rating as determined by Respondent 's Section 12 examining physician was 7% whole person. The Arbitrator gives this factor some weight.

(ii) Petitioner's occupation was as a steel worker machine operator which required standing on his feet and lifting up to 50 pounds. Petitioner had restrictions ordered by Dr. Sean Salehi which precluded him from returning to that job. Petitioner did not return to that job. Petitioner lost his trade. The Arbitrator gives this factor significant weight.

(iii) Petitioner's age at the time of the injury was 60 years. The Arbitrator finds that the effects of the lumbar spine injury and the surgery to treat that would have more significant impact on Petitioner because of his age. The Arbitrator gives this factor some weight.

(iv) Petitioner was released with permanent restrictions which would preclude him from returning to the job that he had at the time of the accident. His age and education and limited language skills would impact on his ability to obtain a job and earn income. The Arbitrator gives this factor great weight.

(v) Petitioner sustained a work-related aggravation of an underlying asymptomatic degenerative condition of his spine. That condition was treated with medication, physical therapy, injections and lumbar fusion surgery performed by Dr. Sean Salehi. The medical records

document that Petitioner continues to have pain in the back which affect his daily activities. He testified credibly that when he stands too long, sits too long or lifts more than 20 pounds, he has pain in the back. His complaints are corroborated by the medical records. He takes over the counter medication for that pain. The work restrictions last imposed by Dr. Sean Salehi would not permit him to return to the job with duties as described by Petitioner's testimony at the hearing. The Arbitrator notes that Respondent retained Section 12 examiner, Dr. Player opined that Petitioner could return to work with a lifting and carrying limit of 50 pounds. RX 3, p 19. It appears that Dr. Player was unaware or overlooked the long workdays and long work week which Petitioner frequently worked. The Arbitrator notes that the restrictions imposed by Dr. Sean Salehi were more restrictive than this and addressed bending twisting, standing and sitting which are consistent with a post-fusion lumbar surgery and a 60-year-old steel worker. The Arbitrator finds the work restrictions and opinion of Dr. Sean Salehi more detailed in addressing the various activities of Petitioner's job. The Arbitrator finds that the opinions of Dr. Salehi are more persuasive regarding postinjury work restrictions on 60-year-old steel worker. Therefore, the Arbitrator gives the opinions of Dr. Sean Salehi more weight. There is no indication that the job is any different from the demands and duties as described by Petitioner and were not rebutted by Respondent's witness. The Arbitrator finds that the work injury to Petitioner's lumbar spine, the treatment thereof and the restrictions imposed by his treating physician preclude him from returning to his trade with Respondent.

The Concentra Occupational Health Clinic records establish that Petitioner's job duties as steel worker machine operator combined with up to 10-hour workdays and 5-hour Saturdays took their toll over the 22 years of work with Respondent. It is clear that hernia surgery and lumbar fusion were the final straw that caused the Petitioner to prematurely leave the work force.

He lost about 7 years of work. The Arbitrator finds Petitioner's testimony regarding his current condition is corroborated by the treating medical records. The Arbitrator gives greater consideration to this factor.

Section 8(d)2 of the Act addresses Person-as-a-Whole Awards when employees are unable to return to their prior employment and opt out of a wage differential award under Section 8(d)1. 820ILCS 305/8.1b. states:

> If such injuries partially incapacitate him from pursuing the duties of his usual and customary line of employment but do not result in impairment of earning capacity, or having resulted in an impairment of earning capacity, the employee elects to waive his right to recover under the foregoing subparagraph 1 of paragraph (d) of this Section then in any of the foregoing events, he shall receive in addition to compensation for temporary total disability under paragraph (b) of this Section, compensation at the rate provided in subparagraph 2.1 of paragraph (b) of this Section for that percentage of 500 week that the partial disability resulting from the injuries covered by this paragraph bears to total disability. 820 ILCS 305/8(d)2

As a result of his injuries, Petitioner was incapacitated from returning to work as a steel worker machine operator. As no labor market survey or vocational rehabilitation report was entered into evidence, the Arbitrator finds Petitioner waived his right to recover a wage differential award. The Arbitrator finds Petitioner has suffered a loss of trade.

The Arbitrator is mindful of Commission precedent wherein the Commission affirmed the arbitrator's finding of 60% loss use of a person as whole under Section 8(d) 2 for a disputed lumbar injury resulting in multiple surgeries with significant restrictions. See, e.g., *Donald Schmidt v. Menards, Inc.* 2019 Ill. Wrk. Comp. Lexis 1343, 12 WC 11730

The Arbitrator notes that after Respondent denied the lumbar back claim, Petitioner applied for and promptly received Social Security Disability benefits to obtain income. It is clear, however, that after the injury of April 23, 2015, Petitioner simply threw in the towel. He

had enough. He feared reinjury. He could not do his work as a steel worker anymore. Dr. Player noted Petitioner was diagnosed with depression. The Arbitrator finds that evidence of disability is corroborated by the medical records and that as result of the work injury on April 23, 2015 injuring Petitioner's lumbar spine, Petitioner sustained disability to the extent of 47.5 % person in regard to his lumbar injury.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	11WC048125
Case Name	DIVENERE, AGATA v. RESURRECTION HEALTH CARE
Consolidated Cases	11WC048126; 11WC048127;
Proceeding Type	Petition for Review Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0225
Number of Pages of Decision	4
Decision Issued By	Carolyn Doherty, Commissioner

Petitioner Attorney	Anita DeCarlo
Respondent Attorney	Peter Stavropoulos

DATE FILED: 6/22/2022

/s/Carolyn Doherty, Commissioner

Signature

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

AGATA DIVENERE,

Petitioner,

vs. NO: 11 WC 48125 consol. w/
11 WC 48126 and 11 WC 48127

RESURRECTION HEALTH CARE

Respondent.

DECISION AND OPINION ON REVIEW

Petitioner has timely filed a Petition for Review, wherein she requests review of the Arbitrator's order denying reinstatement of her case. The Commission, after considering the filings of the parties and the record, and being advised of the facts and law, reverses the Arbitrator's denial of reinstatement, reinstates the case and remands the matter to the Arbitrator for further proceedings. The Commission's findings of fact and conclusions of law are as follows.

I. STATEMENT OF FACTS

A. Procedural History

On December 21, 2011, Petitioner filed three Applications for Adjustment of Claim alleging she sustained injuries while working on March 1, 2009, April 1, 2010 and December 4, 2011. On December 4, 2014, Petitioner's Counsel substituted in and on January 28, 2019, a Substitution of Attorney for Respondent's Counsel was filed reflecting new counsel for Respondent.

The consolidated cases appeared on the November 17, 2020 status call and were set for pre-trial on December 1, 2020 pursuant to a Request for Hearing and the fact that they were above the red line. Petitioner's Counsel did not appear on December 1, 2020 and the Arbitrator specially set the matters for December 18, 2020. When Petitioner's Counsel did not appear again, the Arbitrator dismissed the three cases on December 18, 2020. On January 12, 2021, the Commission issued a Notice of Dismissal. On January 19, 2021 Petitioner's Counsel filed a timely Motion to Reinstate all three cases. Subsequent to the filing of the Motion to Reinstate, the IWCC implemented a new electronic filing system and Petitioner's Counsel re-noticed the Motion to Reinstate in the filing system on

July 12, 2021. The Motion to Reinstate received an in person hearing date of October 1, 2021. The October 1, 2021 transcript indicated that after arguments by both parties were presented, the Arbitrator denied the Motion to Reinstate.

B. The Record of Proceedings on the Motion to Reinstate

The Motion for Reinstatement of all three cases was eventually heard on October 1, 2021 and Counsel for both Petitioner and Respondent were present.

During the hearing, Petitioner's Counsel admitted she failed to appear for the December pre-trial dates due to docketing errors. However, upon receipt of the Notice of Dismissal, she filed a timely Motion to Reinstate on January 19, 2021 and received a hearing date of February 23, 2021. Petitioner's Counsel further stated that in the midst of the pandemic limitations and the pending electronic change-over she inadvertently missed the hearing date of February 23, 2021. Counsel thereafter expended efforts to get the Motion to Reinstate again set for hearing via the new system. In July 2021, the Motion to Reinstate was successfully filed electronically, per the new filing system requirements of the Commission. The Motion was set for the in-person hearing date of October 1, 2021.

At the hearing, Respondent's Counsel agreed that the Motion to Reinstate was timely filed within the requirements of Rule 9020.90. However, Respondent asserted the holding of *Banks v. Indus. Comm'n (Mariah Boats*) to argue that the time from filing to hearing was unreasonable and further prejudiced his client. In *Banks*, there was a two-year delay between filing and hearing. *See Banks v. Indus. Comm'n (Mariah Boats*), 345 Ill. App. 3d 1138, 804 N.E.2d 629, 2004 Ill. App. LEXIS 67, 281 Ill. Dec. 664 (2004). Respondent further asserted that the motion should be denied based on the overall prejudice to his client. Specifically, Respondent argued that the general delays surrounding efforts to effectuate an agreed upon settlement of the case (preceding the dismissal) resulted in financial prejudice to his client who was required to re-work the Medicare Set-Aside agreement accompanying the settlement. Petitioner's Counsel conceded that the settlement was prepared but not effectuated before the dismissal and that there was a nine-month delay in presenting the timely filed motion for hearing. Petitioner's counsel cited the pandemic related complications in concert with the nuances of the Commission's new filing system as a basis for the delays.

In denying the Motion to Reinstate, the Arbitrator focused on the "obligation on any party to follow their case" and Petitioner's Counsel's "inattention to the matter." The Arbitrator denied the motion stating that he weighed the equities and determined that Respondent suffered substantial financial prejudice as a result of Petitioner's Counsel's inattention and delays.

II. CONCLUSIONS OF LAW

Petitioner's timely filed Petition for Review requests the Commission reverse the Arbitrator's denial of reinstatement. "On a petition to reinstate before the Commission, the burden is on the claimant to allege and prove facts justifying the relief sought." *Banks v. Indus. Comm'n,* 345 Ill. App. 3d 1138, 804 N.E.2d 629, 631 (2004). "Whether to grant or

deny a petition to reinstate rests within the sound discretion of the Commission." *Banks*, 345 Ill. App. 3d at 1140, 804 N.E.2d at 631; *see also Conley v. Industrial Comm'n*, 229 Ill. App. 3d 925, 930, 594 N.E.2d 730, 171 Ill. Dec. 586 (1992). On review, the Commission's determination will not be disturbed absent an abuse of that discretion. *TTC Illinois, Inc./Tom Via Trucking v. Illinois Workers' Compensation Comm'n*, 396 Ill. App. 3d 344, 355, 918 N.E.2d 570, 579, 335 Ill. Dec. 225 (2009).

Based on our review of the Motion to Reinstate and the on the record as a whole as it pertains to the dismissal and the request for reinstatement, the Commissions finds that the Petitioner's Motion for Reinstatement was timely and substantially compliant with Sections 9020.90(a)-(c). In addition, it should be noted that the timeliness of the Motion was acknowledged by both parties during the hearing.

The Commission further notes that nine months passed from the date of first filing in January 2021 until the October 2021 hearing with 3 months passing between the July 2021 date of re-filing in the Commission's new filing system to the October 2021 hearing date. In *Banks*, two years passed between filing and the hearing date without any extenuating circumstances to justify that period of delay. In exercising its discretion and applying standards of fairness and equity to the arguments of delay in both the presentation of the motion and the effectuation of a settlement in this case, the Commission reaches a different conclusion than the Arbitrator. The Commission gives greater weight to the timely filing of the Motion to Reinstate, the fact that at the time of dismissal the cases were settled in principle, and that the time lapse between filing and hearing on the motion was not unreasonable given the proffered circumstances.

Therefore, having considered the totality of evidence and having balanced the equities, the Commission reverses the denial of the reinstatement and remands this matter to the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's denial of Petitioner's Motion to Reinstate is reversed, that this matter is reinstated, and that this matter is remanded to the Arbitrator for a full hearing and disposition on the merits.

June 22, 2022
o: 6/16/22
CMD/jjm
045

/s/ *Carolyn M. Doherty*
Carolyn M. Doherty

/s/ *Marc Parker*
Marc Parker

/s/ *Christopher A. Harris*
Christopher A. Harris

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	11WC048126
Case Name	DIVENERE, AGATA v. RESURRECTION HEALTH CARE
Consolidated Cases	11WC048125; 11WC048127;
Proceeding Type	Petition for Review Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0226
Number of Pages of Decision	4
Decision Issued By	Carolyn Doherty, Commissioner

Petitioner Attorney	Anita DeCarlo
Respondent Attorney	Peter Stavropoulos

DATE FILED: 6/22/2022

/s/Carolyn Doherty, Commissioner

Signature

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

AGATA DIVENERE,

Petitioner,

vs. NO: 11 WC 48125 consol. w/
11 WC 48126 and 11 WC 48127

RESURRECTION HEALTH CARE

Respondent.

DECISION AND OPINION ON REVIEW

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I. STATEMENT OF FACTS

A. Procedural History

On December 21, 2011, Petitioner filed three Applications for Adjustment of Claim alleging she sustained injuries while working on March 1, 2009, April 1, 2010 and December 4, 2011. On December 4, 2014, Petitioner's Counsel substituted in and on January 28, 2019, a Substitution of Attorney for Respondent's Counsel was filed reflecting new counsel for Respondent.

The consolidated cases appeared on the November 17, 2020 status call and were set for pre-trial on December 1, 2020 pursuant to a Request for Hearing and the fact that they were above the red line. Petitioner's Counsel did not appear on December 1, 2020 and the Arbitrator specially set the matters for December 18, 2020. When Petitioner's Counsel did not appear again, the Arbitrator dismissed the three cases on December 18, 2020. On January 12, 2021, the Commission issued a Notice of Dismissal. On January 19, 2021 Petitioner's Counsel filed a timely Motion to Reinstate all three cases. Subsequent to the filing of the Motion to Reinstate, the IWCC implemented a new electronic filing system and Petitioner's Counsel re-noticed the Motion to Reinstate in the filing system on

July 12, 2021. The Motion to Reinstate received an in person hearing date of October 1, 2021. The October 1, 2021 transcript indicated that after arguments by both parties were presented, the Arbitrator denied the Motion to Reinstate.

B. The Record of Proceedings on the Motion to Reinstate

The Motion for Reinstatement of all three cases was eventually heard on October 1, 2021 and Counsel for both Petitioner and Respondent were present.

During the hearing, Petitioner's Counsel admitted she failed to appear for the December pre-trial dates due to docketing errors. However, upon receipt of the Notice of Dismissal, she filed a timely Motion to Reinstate on January 19, 2021 and received a hearing date of February 23, 2021. Petitioner's Counsel further stated that in the midst of the pandemic limitations and the pending electronic change-over she inadvertently missed the hearing date of February 23, 2021. Counsel thereafter expended efforts to get the Motion to Reinstate again set for hearing via the new system. In July 2021, the Motion to Reinstate was successfully filed electronically, per the new filing system requirements of the Commission. The Motion was set for the in-person hearing date of October 1, 2021.

At the hearing, Respondent's Counsel agreed that the Motion to Reinstate was timely filed within the requirements of Rule 9020.90. However, Respondent asserted the holding of *Banks v. Indus. Comm'n (Mariah Boats*) to argue that the time from filing to hearing was unreasonable and further prejudiced his client. In *Banks*, there was a two-year delay between filing and hearing. *See Banks v. Indus. Comm'n (Mariah Boats*), 345 Ill. App. 3d 1138, 804 N.E.2d 629, 2004 Ill. App. LEXIS 67, 281 Ill. Dec. 664 (2004). Respondent further asserted that the motion should be denied based on the overall prejudice to his client. Specifically, Respondent argued that the general delays surrounding efforts to effectuate an agreed upon settlement of the case (preceding the dismissal) resulted in financial prejudice to his client who was required to re-work the Medicare Set-Aside agreement accompanying the settlement. Petitioner's Counsel conceded that the settlement was prepared but not effectuated before the dismissal and that there was a nine-month delay in presenting the timely filed motion for hearing. Petitioner's counsel cited the pandemic related complications in concert with the nuances of the Commission's new filing system as a basis for the delays.

In denying the Motion to Reinstate, the Arbitrator focused on the "obligation on any party to follow their case" and Petitioner's Counsel's "inattention to the matter." The Arbitrator denied the motion stating that he weighed the equities and determined that Respondent suffered substantial financial prejudice as a result of Petitioner's Counsel's inattention and delays.

II. CONCLUSIONS OF LAW

Petitioner's timely filed Petition for Review requests the Commission reverse the Arbitrator's denial of reinstatement. "On a petition to reinstate before the Commission, the burden is on the claimant to allege and prove facts justifying the relief sought." *Banks v. Indus. Comm'n,* 345 Ill. App. 3d 1138, 804 N.E.2d 629, 631 (2004). "Whether to grant or

deny a petition to reinstate rests within the sound discretion of the Commission." *Banks*, 345 Ill. App. 3d at 1140, 804 N.E.2d at 631; *see also Conley v. Industrial Comm'n*, 229 Ill. App. 3d 925, 930, 594 N.E.2d 730, 171 Ill. Dec. 586 (1992). On review, the Commission's determination will not be disturbed absent an abuse of that discretion. *TTC Illinois, Inc./Tom Via Trucking v. Illinois Workers' Compensation Comm'n*, 396 Ill. App. 3d 344, 355, 918 N.E.2d 570, 579, 335 Ill. Dec. 225 (2009).

Based on our review of the Motion to Reinstate and the on the record as a whole as it pertains to the dismissal and the request for reinstatement, the Commissions finds that the Petitioner's Motion for Reinstatement was timely and substantially compliant with Sections 9020.90(a)-(c). In addition, it should be noted that the timeliness of the Motion was acknowledged by both parties during the hearing.

The Commission further notes that nine months passed from the date of first filing in January 2021 until the October 2021 hearing with 3 months passing between the July 2021 date of re-filing in the Commission's new filing system to the October 2021 hearing date. In *Banks*, two years passed between filing and the hearing date without any extenuating circumstances to justify that period of delay. In exercising its discretion and applying standards of fairness and equity to the arguments of delay in both the presentation of the motion and the effectuation of a settlement in this case, the Commission reaches a different conclusion than the Arbitrator. The Commission gives greater weight to the timely filing of the Motion to Reinstate, the fact that at the time of dismissal the cases were settled in principle, and that the time lapse between filing and hearing on the motion was not unreasonable given the proffered circumstances.

Therefore, having considered the totality of evidence and having balanced the equities, the Commission reverses the denial of the reinstatement and remands this matter to the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's denial of Petitioner's Motion to Reinstate is reversed, that this matter is reinstated, and that this matter is remanded to the Arbitrator for a full hearing and disposition on the merits.

June 22, 2022
o: 6/16/22
CMD/jjm
045

/s/ *Carolyn M. Doherty*
Carolyn M. Doherty

/s/ *Marc Parker*
Marc Parker

/s/ *Christopher A. Harris*
Christopher A. Harris

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	11WC048127
Case Name	DIVENERE, AGATA v. RESURRECTION HEALTH CARE
Consolidated Cases	11WC048125; 11WC048126;
Proceeding Type	Petition for Review Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0227
Number of Pages of Decision	4
Decision Issued By	Carolyn Doherty, Commissioner

Petitioner Attorney	Anita DeCarlo
Respondent Attorney	Peter Stavropoulos

DATE FILED: 6/22/2022

/s/Carolyn Doherty, Commissioner

Signature

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

AGATA DIVENERE,

Petitioner,

vs. NO: 11 WC 48125 consol. w/
11 WC 48126 and 11 WC 48127

RESURRECTION HEALTH CARE

Respondent.

DECISION AND OPINION ON REVIEW

Petitioner has timely filed a Petition for Review, wherein she requests review of the Arbitrator's order denying reinstatement of her case. The Commission, after considering the filings of the parties and the record, and being advised of the facts and law, reverses the Arbitrator's denial of reinstatement, reinstates the case and remands the matter to the Arbitrator for further proceedings. The Commission's findings of fact and conclusions of law are as follows.

I. STATEMENT OF FACTS

A. Procedural History

On December 21, 2011, Petitioner filed three Applications for Adjustment of Claim alleging she sustained injuries while working on March 1, 2009, April 1, 2010 and December 4, 2011. On December 4, 2014, Petitioner's Counsel substituted in and on January 28, 2019, a Substitution of Attorney for Respondent's Counsel was filed reflecting new counsel for Respondent.

The consolidated cases appeared on the November 17, 2020 status call and were set for pre-trial on December 1, 2020 pursuant to a Request for Hearing and the fact that they were above the red line. Petitioner's Counsel did not appear on December 1, 2020 and the Arbitrator specially set the matters for December 18, 2020. When Petitioner's Counsel did not appear again, the Arbitrator dismissed the three cases on December 18, 2020. On January 12, 2021, the Commission issued a Notice of Dismissal. On January 19, 2021 Petitioner's Counsel filed a timely Motion to Reinstate all three cases. Subsequent to the filing of the Motion to Reinstate, the IWCC implemented a new electronic filing system and Petitioner's Counsel re-noticed the Motion to Reinstate in the filing system on

July 12, 2021. The Motion to Reinstate received an in person hearing date of October 1, 2021. The October 1, 2021 transcript indicated that after arguments by both parties were presented, the Arbitrator denied the Motion to Reinstate.

B. The Record of Proceedings on the Motion to Reinstate

The Motion for Reinstatement of all three cases was eventually heard on October 1, 2021 and Counsel for both Petitioner and Respondent were present.

During the hearing, Petitioner's Counsel admitted she failed to appear for the December pre-trial dates due to docketing errors. However, upon receipt of the Notice of Dismissal, she filed a timely Motion to Reinstate on January 19, 2021 and received a hearing date of February 23, 2021. Petitioner's Counsel further stated that in the midst of the pandemic limitations and the pending electronic change-over she inadvertently missed the hearing date of February 23, 2021. Counsel thereafter expended efforts to get the Motion to Reinstate again set for hearing via the new system. In July 2021, the Motion to Reinstate was successfully filed electronically, per the new filing system requirements of the Commission. The Motion was set for the in-person hearing date of October 1, 2021.

At the hearing, Respondent's Counsel agreed that the Motion to Reinstate was timely filed within the requirements of Rule 9020.90. However, Respondent asserted the holding of *Banks v. Indus. Comm'n (Mariah Boats*) to argue that the time from filing to hearing was unreasonable and further prejudiced his client. In *Banks*, there was a two-year delay between filing and hearing. *See Banks v. Indus. Comm'n (Mariah Boats*), 345 Ill. App. 3d 1138, 804 N.E.2d 629, 2004 Ill. App. LEXIS 67, 281 Ill. Dec. 664 (2004). Respondent further asserted that the motion should be denied based on the overall prejudice to his client. Specifically, Respondent argued that the general delays surrounding efforts to effectuate an agreed upon settlement of the case (preceding the dismissal) resulted in financial prejudice to his client who was required to re-work the Medicare Set-Aside agreement accompanying the settlement. Petitioner's Counsel conceded that the settlement was prepared but not effectuated before the dismissal and that there was a nine-month delay in presenting the timely filed motion for hearing. Petitioner's counsel cited the pandemic related complications in concert with the nuances of the Commission's new filing system as a basis for the delays.

In denying the Motion to Reinstate, the Arbitrator focused on the "obligation on any party to follow their case" and Petitioner's Counsel's "inattention to the matter." The Arbitrator denied the motion stating that he weighed the equities and determined that Respondent suffered substantial financial prejudice as a result of Petitioner's Counsel's inattention and delays.

II. CONCLUSIONS OF LAW

Petitioner's timely filed Petition for Review requests the Commission reverse the Arbitrator's denial of reinstatement. "On a petition to reinstate before the Commission, the burden is on the claimant to allege and prove facts justifying the relief sought." *Banks v. Indus. Comm'n,* 345 Ill. App. 3d 1138, 804 N.E.2d 629, 631 (2004). "Whether to grant or

deny a petition to reinstate rests within the sound discretion of the Commission." *Banks*, 345 Ill. App. 3d at 1140, 804 N.E.2d at 631; *see also Conley v. Industrial Comm'n*, 229 Ill. App. 3d 925, 930, 594 N.E.2d 730, 171 Ill. Dec. 586 (1992). On review, the Commission's determination will not be disturbed absent an abuse of that discretion. *TTC Illinois, Inc./Tom Via Trucking v. Illinois Workers' Compensation Comm'n*, 396 Ill. App. 3d 344, 355, 918 N.E.2d 570, 579, 335 Ill. Dec. 225 (2009).

Based on our review of the Motion to Reinstate and the on the record as a whole as it pertains to the dismissal and the request for reinstatement, the Commissions finds that the Petitioner's Motion for Reinstatement was timely and substantially compliant with Sections 9020.90(a)-(c). In addition, it should be noted that the timeliness of the Motion was acknowledged by both parties during the hearing.

The Commission further notes that nine months passed from the date of first filing in January 2021 until the October 2021 hearing with 3 months passing between the July 2021 date of re-filing in the Commission's new filing system to the October 2021 hearing date. In *Banks*, two years passed between filing and the hearing date without any extenuating circumstances to justify that period of delay. In exercising its discretion and applying standards of fairness and equity to the arguments of delay in both the presentation of the motion and the effectuation of a settlement in this case, the Commission reaches a different conclusion than the Arbitrator. The Commission gives greater weight to the timely filing of the Motion to Reinstate, the fact that at the time of dismissal the cases were settled in principle, and that the time lapse between filing and hearing on the motion was not unreasonable given the proffered circumstances.

Therefore, having considered the totality of evidence and having balanced the equities, the Commission reverses the denial of the reinstatement and remands this matter to the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's denial of Petitioner's Motion to Reinstate is reversed, that this matter is reinstated, and that this matter is remanded to the Arbitrator for a full hearing and disposition on the merits.

June 22, 2022
o: 6/16/22
CMD/jjm
045

/s/ *Carolyn M. Doherty*
Carolyn M. Doherty

/s/ *Marc Parker*
Marc Parker

/s/ *Christopher A. Harris*
Christopher A. Harris

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC005923
Case Name	RAMOS, ROGER v. ATLAS EMPLOYMENT
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0228
Number of Pages of Decision	22
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	David Froylan
Respondent Attorney	JASON ALLAIN

DATE FILED: 6/22/2022

/s/Marc Parker, Commissioner

Signature

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

Roger Ramos,

Petitioner,

vs. NO: 19 WC 5923

Atlas Employment,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 15, 2021, is hereby affirmed and adopted. The Commission corrects a clerical error in the Arbitrator's award of maintenance benefits, reported as ***16-3/8 weeks*** for the period November 18, 2020 through March 12, 2021, to be ***16-3/7*** weeks for that same period.

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 $12,100.00. 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.

June 22, 2022
MP:yl
o 6/15/22
68

/s/ *Marc Parker*
Marc Parker

/s/ *Carolyn M. Doherty*
Carolyn M. Doherty

/s/ *Christopher A. Harris*
Christopher A. Harris

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC005923
Case Name	RAMOS, ROGER v. ATLAS EMPLOYMENT SERVICES INC
Consolidated Cases	
Proceeding Type	8(A)
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	19
Decision Issued By	Rachael Sinnen, Arbitrator

Petitioner Attorney	David Froylan
Respondent Attorney	Jason Allian

DATE FILED: 11/15/2021

THE INTEREST RATE FOR THE WEEK OF NOVEMBER 9, 2021 0.06%

/s/ Rachael Sinnen, Arbitrator

Signature

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
8(A)

Roger Ramos
Employee/Petitioner

Case # **19** WC **5923**

v.

Consolidated cases: _____

Atlas Employment 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 **Rachael Sinnen**, Arbitrator of the Commission, in the city of **Chicago**, on **07/23/21**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **10/25/18** Respondent ***was*** operating under and subject 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 $**10,667.97**; the average weekly wage was $**666.49**.

On the date of accident, Petitioner was **50** years of age, ***married*** with **1** dependent children.

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

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

Respondent shall be given a credit of $**34,430.29** for TTD, $**0** for TPD, and **$2,005.25 (PPD Advancement)** in other benefits to be determined.

ORDER

Respondent shall pay reasonable and necessary medical services for dates of service October 25, 2018 through August 4, 2020, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $444.33/week for 92 5/7 weeks, commencing October 26, 2018 through August 4, 2020, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner maintenance benefits of $444.33/week for 16 3/8 weeks, commencing November 18, 2020 through March 12, 2021, as provided in Section 8(a) of the Act.

Petitioner's petition for penalties as provided in Sections 16, 19(k) and 19(l) of the Act is denied.

Respondent shall authorize and pay for vocational rehabilitation services.

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

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

NOVEMBER 15, 2021

Signature of Arbitrator

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Roger Ramos, Petitioner,		
vs.	No.	19 WC 5923
Atlas Employment Services, Inc., Respondent.		

FINDINGS OF FACT

This matter proceeded to hearing on July 23, 2021 in Chicago, Illinois before Arbitrator Rachael Sinnen on Petitioner's Request for Hearing. Issues in dispute include accident, causal connection, temporary total disability ("TTD"), maintenance benefits and vocational rehabilitation. The parties jointly requested that the Arbitrator address nature and extent if maintenance benefits and vocational rehabilitation are denied. (See Arbitrator's Exhibit "AX" 1).

Petitioner testified with an interpreter and stated that in 2018 he was working for Respondent, Atlas Employment, a staffing agency. (Transcript "Tr." 10). He testified that he was sent to work in production with V&V Supremo, a cheese factory, and had been working for them for approximately four (4) months (Tr. 10, 43). He testified that on October 25, 2018, he was making queso supremo. (Tr. 11). There was a hose with hot cheese spilling out from a pot into molds that are on trays. (Tr. 12). The trays were heavy and had to be carried by two people. (Tr. 13). Petitioner testified that the trays weighed roughly 100 to 150 pounds. (Tr. 13, 44). Petitioner performed this task continuously and quickly, explaining that by the time he had moved one tray, the next tray was being filled with cheese. (Tr. 13-14). While performing this task, Petitioner felt a "strong pain" in his right shoulder and reported the injury to Respondent the next day. (Tr. 14-16). Respondent referred Petitioner to Occupational Health Centers of Illinois ("Concentra") for treatment. (Tr. 17-18).

Petitioner also testified that his shoulder pain began a week before; that he had pain in his right shoulder prior to October 25, 2018. (Tr. 47). He continued to work though, thinking that it would heal. (Tr. 15). Petitioner also confirmed that he had multiple jobs with V&V Supremo, not just pouring hot cheese into molds. (Tr. 44).

Occupational Health Centers of Illinois

Petitioner first presented for medical care at Concentra on October 26, 2018. (Petitioner's Exhibit

"PX" 1, p. 7). According to the records, Petitioner advised that he works on a production line at a factory and on October 25, 2018, he was repetitively lifting and pushing/pulling heavy weight when he felt a sharp pain with pulling and a straining sensation in his right shoulder. (PX 1, p. 7). He noted prior soreness in his shoulder which had started approximately four (4) months prior and had worsened after heavy lifting. (PX 1, p. 7). He requested that we be transferred to another area in the factory that did not require him to lift heavy materials but was told to report to the clinic for an evaluation of his shoulder. (PX 1, p. 7). Petitioner was assessed with a right shoulder strain and was provided with medications and work restrictions. (PX 1, p. 10).

Petitioner testified that he received temporary disability benefits from October 28, 2018 to roughly February 12, 2020 as well as two additional checks. (Tr. 42).

On October 31, 2018, Petitioner returned to Concentra for a follow-up. (PX 1, p. 11). Petitioner advised that he was taking medications as prescribed but that his symptoms had not improved. (PX 1, p. 11). He was referred to therapy and was to continue with restricted work. (PX 1, p. 12-13).

Petitioner presented to Concentra on November 7, 2018 for a recheck of his right shoulder. (PX 1, p. 15). He stated that he had a lot of pain in the morning when first waking up. (PX 1, p. 15). He was to continue his course of care and restricted work. (PX 1, p. 17). Petitioner also began a course of therapy on November 7, 2018 with Concentra. (PX 1, p. 18; Tr. 19).

On November 21, 2018, Petitioner presented for a recheck of his right shoulder injury. (PX 1, p. 44). He reported a lot of pain after therapy. (PX 1, p. 44). An MRI of the right shoulder without contrast was recommended. (PX 1, p. 45). Petitioner was advised to otherwise continue his course of care and restricted work. (PX 1, p. 46). Petitioner returned to Concentra on November 28, 2018. (PX 1, p. 47). He was referred for an evaluation with an orthopedic specialist and advised to hold off on therapy. (PX 1, p. 49; Tr. 20).

Hand to Shoulder Associates – Dr. Balaram

On December 5, 2018, Petitioner presented to Dr. Balaram at Hand to Shoulder Associates for an initial orthopedic evaluation. (PX 2, p. 44). Petitioner advised that he had been working as a packer where he had to get liquid cheese into large, 90-pound molds. (PX 2, p. 44). He then had to move and pack them. (PX 2, p. 44). He had been doing this repetitively for quite some time and on October 25, 2018, his pain increased severely requiring him to go to the clinic to seek treatment. (PX 2, p. 44). He noted pain in both his shoulders with the right being more severe. (PX 2, p. 44). He advised that therapy did not help and only increased his pain. (PX 2, p. 44). Dr. Balaram assessed Petitioner with right shoulder joint derangement and tenosynovitis. (PX 2, p. 45). He recommended an MRI for further evaluation of the intra-articular structures. (PX 2, p. 45). He was to continue to work on home-exercises and follow-up after completion of the MRI. (PX 2, p. 45).

On January 14, 2019, Petitioner underwent an MRI of the right shoulder. (PX 2, p. 54). The radiologist impression was superior/posterosuperior labral tear (probably degenerative in etiology), mild infraspinatus tendinosis, mild increase signal and thickening in the anterior band of the inferior glenohumeral ligament, and early degenerative changes. (PX 2, p. 55).

Petitioner returned to Dr. Balaram on February 6, 2019. (PX 2, p. 42). Dr. Balaram noted evidence of a superior labral injury as well as rotator cuff tendinopathy on the MRI, which he reviewed with Petitioner. (PX 2, p. 43; Tr. 22). Given the persistent pain complaints, Dr. Balaram recommended a steroid injection to decrease inflammation and increase range of motion with the shoulder. (PX 2, p. 43). He was to remain on restricted work. (PX 2, p. 43).

On March 6, 2019, Petitioner presented to Dr. Balaram for a follow-up. (PX 2, p. 40). He reported temporary relief from the injection for 2-3 days but that the pain returned. (PX 2, p. 40). Petitioner testified that the injection provided no relief. (Tr. 22). Dr. Balaram indicated that the MRI was consistent with a SLAP lesion and his physical examination was consistent with a SLAP lesion and impingement. (PX 2, p. 41). After discussing potential surgical and non-surgical options, Petitioner agreed to proceed with operative intervention. (PX 2, p. 41). Petitioner was to remain on restricted work in the interim. (PX 2, p. 41). Petitioner returned to Dr. Balaram on April 19, 2019 for a follow-up. (PX 2, p. 39). He was awaiting authorization for surgery. (PX 2, p. 39).

On May 23, 2019, Petitioner underwent a right shoulder arthroscopic surgery with extensive debridement, subpectoral bicep tenodesis, superior labral repair and subacromial decompression with Dr. Balaram. (PX 2, p. 47). The pre- and postoperative diagnosis was right shoulder slap lesion, proximal bicep tendon tear, impingement, and partial thickness rotator cuff tear. (PX 2, p. 47).

Following surgery, Petitioner presented to Dr. Balaram on May 29, 2019 for a post-operative follow-up. (PX. 2, p. 36). Dr. Balaram noted that Petitioner had an unstable SLAP lesion and underwent arthroscopic surgery with debridement, superior labral repair, subpectoral bicep tenodesis and subacromial decompression. (PX 2, p. 37). He was to return in a week for suture removal and transition off of narcotics as he was requiring less narcotics. (PX 2, p. 37).

On June 5, 2019, Petitioner returned for a two (2) week post-surgical follow-up with Dr. Balaram. (PX 2, p. 34). He was to start therapy in the next week and continue with his sling, only removing for showers. (PX 2, p. 35). He was also expected to return to light duty work at his next follow-up. (PX 2, p. 35). At the July 3, 2019 follow-up, Petitioner was reportedly progressing well and advised to wear his sling as needed. (PX 2, p. 30-31). He was to continue therapy and follow-up in four (4) weeks. (PX 2, p. 31).

Petitioner presented for a follow-up with Dr. Balaram on July 31, 2019. (PX 2, p. 28). Dr. Balaram reviewed the therapy notes and indicated that Petitioner was making slow progress with therapy had some improvements over the past couple weeks. (PX 2, p. 29). Dr. Balaram indicated that Petitioner would most likely require another two (2) months of therapy and potential work conditioning. (PX 2, p. 29).

At the August 28, 2019 follow-up, Dr. Balaram indicated that Petitioner was making slow but steady progress. (PX 2, p. 27). Dr. Balaram discussed with the Petitioner the importance of continuing therapy in order to regain his range of motion function and strength. (PX 2, p. 27). Petitioner returned to Dr. Balaram for a recheck on September 26, 2019. (PX 2, p. 25). He indicated that Petitioner's range of motion was improving, and the therapist noted improvement, but that Petitioner's pain was still present. (PX 2, p. 25). The plan was to progress with one more month

of therapy then transition to work conditioning. (PX 2, p. 25).

On October 23, 2019, Petitioner returned to Dr. Balaram who noted that the course had been improving slightly and there had been associated pain. (PX 2, p. 22). Petitioner continued to show improved range of motion and function associated with the shoulder and was to progress to work conditioning. (PX 2, p. 23). At the November 20, 2019 follow-up, Petitioner had just started work conditioning and was to continue with the remaining three (3) weeks and return to full duty in 1-2 months. (PX 2, p. 21).

According to the December 6, 2019, Work Conditioning Functional Status Report from Athletico, Petitioner had met 7/12 reported job demands required to function as a general labor – production worker. (PX 3, p. 77). His main limiting factor was fear avoidance in regard to progression of weights, indicating that he was afraid he was going to increase his pain or cause injury to his shoulder. (PX. 3, p. 77). The work conditioning progress notes make several references to Petitioner's slow progression/inability to progress due to reported pain. (PX 3, p. 84, 86, 87, 89, 91, 100, 103).

On December 19, 2019, Petitioner presented for a follow-up with Dr. Balaram. (PX 2, p. 89). He reported that he was making progress with strengthening but did have some increased pain after overhead lifting. (PX 2, p. 90). He was to continue with a home exercise program, with gentle progression to range of motion and overhead strength. (PX 2, p. 90).

At the January 15, 2020, follow-up, Dr. Balaram indicated that Petitioner continued to increase in range of motion and function. (PX 2, p. 90). Dr. Balaram noted that it was possible he had some residual inflammation associated with the shoulder and discussed attempting a steroid injection to decrease the inflammation and increase the range of motion and strength associated with the shoulder. (PX 2, p. 88). Dr. Balaram did not see any new onset injury but noted that Petitioner was making slow progress with therapy. (PX 2, p. 88). A corticosteroid injection was administered to the right shoulder. (PX 2, p. 88).

Petitioner returned for a recheck on February 12, 2020 in the afternoon. (PX 2, p, 85-86; Tr. 57). He reported some pain with certain ranges of motion but felt as though the majority of his function had returned. (PX 2, p. 86). There was no mechanical symptoms or obvious objective factors present on the examination. (PX 2, p. 86). X-rays showed a "well-seated button with a concentric glenohumeral joint" with "no evidence of anchor lucency". (PX 2, p. 86). Petitioner also indicated that he was apprehensive about returning to work. (PX 2, p. 86). However, Petitioner testified that he was not apprehensive about returning to work, because he wanted to go back to work. (Tr. 56). Dr. Balaram indicated that a trial return to unrestricted duty was warranted with Petitioner. (PX 2, p. 86). Petitioner testified that he tendered to work status report to Atlas following the afternoon appointment. (Tr. 58).

On March 11, 2020, Petitioner returned to Dr. Balaram for a follow-up. (PX 2, p. 83). Petitioner was to return to work on a trial basis but had not attempted a return to work. (PX 2, p. 83). Petitioner and Dr. Balaram discussed options including an evaluation by another physician versus a return to work on a trial basis. (PX 2, p. 84). Petitioner was released to unrestricted work (however, noted that he was "not return to use of the shoulder") and advised to follow-up in two (2) months. (PX.

2, p. 84).

AMITA Health St. Mary of Nazareth – Dr. Pedemonte, Psychiatrist

The records reflect that Petitioner began treating with Dr. Pedemonte, a psychiatrist, at AMITA on May 30, 2019. (PX 4, p. 6). Petitioner previously treated in Puerto Rico for depression, panic attacks and insomnia. (PX 4, p. 6; Tr. 26). He indicated that the symptoms started in 2005 when he was recently married and getting behind on payment. (PX 4, p. 61; Tr. 26). Petitioner testified he had said condition under control prior to October 2018. Tr. at 26-27. However, on or about May 2019, Petitioner began to experience anxiety, depression, and panic attacks so he began to treat with Dr. Pedemonte. Tr. at 27. He was referred to Dr. Pedemonte by Dr. Moya. (PX 4, p. 6).

At the initial consultation of May 30, 2019, Dr. Pedemonte noted that Petitioner was cooperative but guarded, slightly fidgety, and anxious. (PX 4, p. 7). Petitioner was diagnosed with generalized anxiety disorder and mild, recurrent major depressive disorder. (PX 4, p. 14). Petitioner was prescribed a sedative and anti-depressant. (PX 4, p. 7). Petitioner testified that he was to continue with the same medication he was receiving while in Puerto Rico. (Tr. 27). Petitioner continued to present to Dr. Pedemonte for follow-ups every three (3) months for refills of his medications. (PX 4).

On February 13, 2020, the day after he presented for a recheck with Dr. Balaram and was released to a trial return to unrestricted duty, Petitioner attended a prescheduled appointment with his psychiatrist, Dr. Pedemonte. Tr. at 28. Dr. Pedemonte removed Petitioner from work for one month. (PX 4, p. 87). Petitioner testified he gave his restrictions to Respondent. Tr. at 31. Other than the work status note, Dr. Pedemonte's medical records for February 13, 2020 do not discuss Petitioner's work injury.

Petitioner testified that his psychological condition worsened because he was anxious about Atlas calling him to return to work. (Tr. 29-30). On direct, Petitioner testified that he was worried because he wanted to return to work, and Atlas had not called him yet. (Tr. 30). However, on cross, he testified that he was still feeling bad and was concerned if his restrictions were removed, he would not do well. (Tr. 57, 59). He testified that he was anxious because he was unsure about returning to work. (Tr. 59).

Dr. Pedemonte issued a note indicating that Petitioner was unable to function due to underlying disorders and was unable to function even while taking the medication prescribed. (PX 4, p. 87). He noted that Petitioner had intense pain on his shoulder which was exacerbated by his depression and panic attacks. (PX 4, p. 87). He noted that Petitioner was disabled, unable to work and required sick leave of one (1) month to recuperate his strength and improve his emotional problems that intensified after his surgery. (PX 4, p. 87).

There are no other notes in Dr. Pedemonte's record taking Petitioner off-work prior to or subsequent to the February 13, 2020 appointment and Petitioner testified that this was the only time Dr. Pedemonte took Petitioner off-work. (PX 4; Tr. 60).

Specialty Orthopaedics – Dr. Samuel Park

On March 19, 2020, Petitioner presented for an initial evaluation with Dr. Samuel Park at Specialty Orthopaedics. (PX 5, p. 5). Petitioner advised that he packages cheese at work and felt a sharp pain when he lifted a heavy tray of cheese. (PX 5, p. 5). Petitioner advised that he underwent a rotator cuff repair on May 23, 2019 and finished therapy on December 6, 2019. (PX 5, p. 5). Dr. Park did not have a copy of the operative report. (PX 5, p. 5). He also advised that he had a cortisone injection in January 2020 which he says helped for one (1) day. (PX 5, p. 5). He also told Dr. Park that he tried to return to work in February 2020 but was told that he was terminated. (PX 5, p. 5). He reported shoulder pain and weakness, that he could not lift his arm overhead. (PX 5, p. 5). Dr. Park noted positive impingement and diagnosed Petitioner with status post right rotator cuff repair, tendinopathy of the right rotator cuff, and tear of the right glenoid labrum. (PX 5, p. 5). A new MRI of the right shoulder was recommended as well as work restrictions of no lifting, carrying, pushing, or pulling greater than 5-pounds. (PX 5, p. 6).

Petitioner underwent the right shoulder MRI with American Diagnostic MRI on April 30, 2020. (PX 6, p. 2.) The radiologist impression was intact rotator cuff tendons, moderate to severe acromioclavicular degenerative changes, mild glenohumeral degenerative changes, and evidence of the prior surgery. (PX 6, p. 3).

Petitioner returned for a follow-up with Dr. Park on May 19, 2020. (PX 5, p. 7). Dr. Park noted increased strength and range motion. (PX 5, p. 7-8). Dr. Park indicated that the April 30, 2020 MRI showed an intact rotator cuff repair, bicep tenodesis, posterior glenoid chondromalacia and some slight posterior translation. (PX 5, p. 8). He felt that this was contributing to Petitioner's shoulder pain. (PX 5, p. 8). Dr. Park recommended continued therapy, work restrictions and provided Petitioner with a Kenalog injection to the right glenohumeral joint. (PX 5, p. 8). Petitioner testified that the injection provided no relief. (Tr. 34).

According to the June 12, 2020, therapy progress note from Athletico, the therapist stated that Petitioner consistently complained of pain with any shoulder abduction between 80-90 degrees and with shoulder flexion (PX 3, p. 25). He also reported increased pain with any lifting and terminates the test when he does feel any pain. (PX 3, p. 25). Per the therapist, based on the response from treatment in the past couple weeks, it was not clear whether he would benefit from continued therapy given his lack of significant progress and continued significant pain that is non-responsive to therapy. (PX 3, p. 25).

On June 16, 2020, Petitioner presented for a recheck. (PX 5, p. 9). Petitioner advised that the injection helped for two (2) days only. (PX 5, p. 9). Dr. Park indicated that he thought the injection would address any pain from the glenoid chondromalacia. (PX 5, p, 10). Dr. Park also noted that Petitioner's range of motion has worsened. (PX 5, p. 10). Dr. Park also recommended another subacromial injection because he felt that Petitioner had an element of subacromial capture. (PX 5, p. 10). Dr. Park recommended continued therapy, work restrictions and provided Petitioner with a Kenalog injection to the right subacromial space. (PX 5, p. 10).

The subsequent therapy records indicate that Petitioner continued to report consistent pain in the shoulder and had not made any significant progress since the last injection (PX 3, p. 9). Petitioner

also advised that he was non-compliant with the home-exercise program stating it does not help him. (PX 3, p. 9).

At the July 14, 2020 follow-up, Petitioner reported continued subjective weakness with abduction and overhead movements and that the injection only helped for two (2) days. (PX 5, p. 11). Overall, Dr. Park noted that Petitioner's range of motion was reasonably good and functional but that he still demonstrated shoulder weakness in all planes and weakness in abduction. (PX 5, p. 11). Given the Petitioner's reported pain and weakness, Dr. Park did not think that Petitioner could return to work and recommended that Petitioner undergo an FCE. (PX 5, p. 12).

Petitioner underwent a functional capacity evaluation (FCE) with New Life Medical on July 24, 2020. (PX 7, p. 1). According to the report, Petitioner did not meet the strength requirements of a heavy strength category. (PX 7, p. 6).

Petitioner returned to Dr. Park on August 4, 2020 following completion of the FCE. (PX 5, p. 14). Dr. Park noted that the FCE showed significant shoulder weakness in all planes and an inability to lift/carry/push/pull over 10-20 pounds without significant pain or increased heart rate. (PX 5, p. 14). Accordingly, Dr. Park prescribed permanent restrictions of no lifting/carrying/pushing/pulling over 10-pounds and no overhead work. (PX 5, p. 14). Dr. Park also found that Petitioner had reached maximum medical improvement. (PX 5, p. 14).

Independent Medical Examination – Dr. Bryan Neal

On December 3, 2020, Petitioner presented for an Independent Medical Examination with Dr. Bryan Neal. (Respondent's Exhibit "RX" 1, p. 1). Petitioner advised that he worked in "production" for Atlas. (RX 1, p. 13). Petitioner stated that he worked in a standup job in a factor setting and would rotate around to different jobs. (RX 1, p. 13). He described one of the jobs as pouring cheese into molds that weighed 25-pounds or more. (RX 1, p. 13). Petitioner reported some pain, but "not much" at the examination, noting it was "more discomfort than pain". (RX 1, p. 14) He advised that he had right shoulder pain before October 25, [2018]. (RX 1, p. 14; Tr. 52). Petitioner attributed his right shoulder symptoms to his job duties and activities he was doing. (RX 1, p. 14). He reported that his right shoulder surgery did not help. (RX 1, p. 14).

Physical examination revealed slightly reduced range of motion on the right as compared to the left, with strong symmetric strength. (RX 1, p. 16-17). Empty can and isolated supraspinatus testing was reported as painful. (RX 1, p. 17). X-rays revealed AC joint arthropathy of the right and left shoulder. (RX 1, p. 18). Dr. Neal diagnosed Petitioner with residual, static, intermittent, right shoulder pain and confounding biopsychosocial undercurrents including panic attacks, depression, and anxiety. (RX 1, p. 18). Dr. Neal noted that the subjective complaints probably outweigh and are disproportional to the objective findings. (RX 1, p. 19). He indicated that Petitioner's subjective complaints and biopsychosocial undercurrents are his primary limiting factors as opposed to objective observations. (RX 1, p. 19). Petitioner had reasonable shoulder motion and demonstrated clinically intact rotator cuff. (RX 1, p. 19).

Regarding causation, Dr. Neal noted that technically there is no causal relationship between his past and current shoulder condition and the October 25, 2018 incident because Petitioner indicated

he had symptoms prior to the October 25, 2018 incident and did not describe any truly precipitating or injurious event. (RX 1, p. 19). Dr. Neal opined that the pre-existing symptoms were secondary to right shoulder impingement syndrome. (RX 1, p. 19).

Dr. Neal found that Petitioner's care had been reasonable to date, but that he did not require any future care for his right shoulder, and the need for psychiatric care was unrelated to the past occupational activities or duties or any event on October 25, 2018. (RX 1, p. 20). Dr. Neal did not believe that Petitioner required activity limitations or work restrictions and could work his regular job on a full-time basis without restrictions. (RX 1, p. 20).

Ultimately, Dr. Neal found, irrespective of causation, that Petitioner had an upper extremity impairment of 12% which is equivalent to 7% whole person impairment. (RX 1, p. 24).

FCA Report Audit – Athletico

Respondent obtained a FCE Report Audit ("Audit") of the FCE Report of New Life Medical from July 24, 2020. (RX 2, p. 1). According to the Audit, the FCE evaluator indicated that Petitioner demonstrated a high level of effort but did not state whether the FCE was consistent or valid. (RX 2, p. 1). The Audit indicated that Petitioner's consistency of effort or reliability of pain are not adequately supported by the data in the FCE report and may not be representative of Petitioner's maximal abilities. (RX 2, p. 1).

Furthermore, the Audit noted that there were several testing criteria in which Petitioner demonstrated deficits which would not be reasonably impacted by the right shoulder injury including: sitting, standing, walking, stair climbing, squatting, kneeling, and bending. (RX 2, p. 1). Petitioner also demonstrated decrease range of motion of the lumbar spine and strength deficits in the bilateral lower extremities. (RX 2, p. 1).

The Audit also stated that there were several limitation recommendations in the FCE for non-material handling and postural tolerances which were without substantiation. (RX 2, p. 1-2) For example, Petitioner reported that he has a sitting tolerance of a maximum of 30 minutes to 1 hour but was observed sitting for 1.5 hours. (RX 2, p. 1). The Audit indicated that based on Petitioner's ability to sit for an hour without changing positions, then he would be able to tolerate sitting on a consistent basis. (RX 2, p. 2).

The Audit noted that the evaluator did not state that the FCE was consistent. (RX 2, p. 2). Though the evaluator reported general signs demonstrating a high level of effort, per the Audit, the evaluator didn't state during which tasks these were observed and to what extent. (RX 2, p. 3). There is also no relation of mechanical changes to the Petitioner's shoulder injury, nor was it clear why testing was stopped or by whom during material handling tasks. (RX 2, p. 3). The Audit indicates that there was no adequate documentation to support the assertion that the Petitioner demonstrated tolerances that reflect his maximal ability. (RX 2, p. 3).

The Audit also found that the FCE lacked a Reliability of Pain metric testing which is critical in determining whether the subjective complaints of the Petitioner correlated with the diagnosis and objective findings during the FCE, as well as to assess Petitioner's reliability related to pain

complaints and symptoms and their impact on function. (RX 2, p. 3).

Regarding specific testing of the right shoulder/upper extremity, the Audit notes that the FCE indicated that the active range of motion of the right shoulder was limited to 98 degrees forward flexion with strength at 3-/5, but Petitioner was able to lift 8-pounds up to 56 inches. (RX 2, p. 3). Petitioner's right hand three (3) point pinch strength was reportedly 5-pounds but the Audit notes that there was no repeated testing to confirm consistency or other grip/pinch criteria tested nor was the other hand tested. (RX 2, p. 4). There was no documentation indicating that grip or pinch strength was a limiting factor during functional testing. (RX 2, p. 4). The Audit noted that pinch strength of 5-pounds in the absence of distal upper extremity deficits or neurological issue is unusual and may not be related to the injury. (RX 2, p. 4). There was also no job specific testing and verification of maximum and frequent weights were not present in the FCE. (RX 2, p. 3).

St. Anthony – Dr. Mitchell Goldflies

Due to ongoing right shoulder pain, Petitioner opted to continue to treat his right shoulder on his own and paying for care out of pocket. Tr. at 38. Petitioner's primary care physician referred him to Dr. Goldflies of St. Anthony Hospital. Px 8 at 2. Petitioner then presented to Dr. Goldflies for an initial evaluation on April 12, 2021. (PX 8, p. 3). X-rays of the right shoulder and thoracic spine revealed no acute findings including soft tissue swelling. (PX 8, p. 4, 6). Petitioner reported limited range of motion and was diagnosed with shoulder osteoarthritis. (PX 8, p. 3).

Petitioner underwent another MRI of the right shoulder on April 14, 2021. (PX 8, p. 21). Petitioner testified that between the MRI from April 2020 and April 2021, his pain in the right shoulder was unchanged. (Tr. 64). The radiologist impression was a full-thickness tear of the cranial fibers of the subscapularis tendon, tearing of the superior labrum anterior to posterior with probable degenerative tearing of the posterior labrum, and post-surgical changes. (PX 8, p. 22).

Petitioner returned to Dr. Goldflies for a follow-up on April 21, 2021. (PX 8, p. 8). He reported that he was tolerating the chiropractic adjustments. (PX 8, p. 8). On the April 30, 2021 follow-up, Petitioner noted that his pain slightly improved with therapy and chiropractic treatment. (PX 8, p. 10). On May 14, 2021, Petitioner advised that his pain had significant improved and he had no pain. (PX 8, p. 14). A week later, on May 21, 2021, Petitioner noted pain at 7/10. (PX 8, p. 16).

On May 24, 2021, Petitioner returned to Dr. Goldflies and advised that his pain was 8/10. (PX 8, p. 20). Dr. Goldflies reviewed the MRI and diagnosed Petitioner with a nontraumatic complete rupture of the rotator cuff of the right shoulder. (PX 8, p. 20). Surgical options were discussed, and Petitioner was referred to Dr. Sompalli. (PX 8, p. 20).

Petitioner testified that he was never asked to return to work by Atlas and denied receiving the December 15, 2020, letter from Atlas addressed directly to Petitioner with a carbon copy to his attorney. (Tr. 66-67; RX 8). According to the letter, Atlas requested that Petitioner contact them following Dr. Neal's findings that he could return to full duty work to begin an assignment on December 21, 2020. (RX 8). The letter was admitted without objection. (Tr. 82).

Petitioner testified that after Dr. Park discharged him from care, he continued to look for work but

has not returned to work because of his restrictions. (Tr. 39). Petitioner presented job logs from November 2020 thru March 2021 with a total of 212 contacts he made. Petitioner's job search logs indicate that none of the employers he contacted were hiring. (See PX 10; Tr. 70). Petitioner testified that he never went to any of the employers listed on the job search in person because of the COVID-19 pandemic, nor did he drop off an application. (Tr. 71). He testified that he contacted all the employers via telephone. (Tr. 71). He later testified that he went to some of the garages. (Tr. 78). One of the jobs listed on the job search log was for a tattoo parlor. (PX 10). However, Petitioner testified that he had no experience working as a tattoo artist or apprentice. (Tr. 69).

Labor Market Survey

On June 2, 2021, Respondent obtained a blind Labor Market Survey from Ed Rascati of Managed Care Consultants, Inc. (RX 6). Petitioner was not interviewed for the Labor Market Survey, rather Mr. Rascati relied upon employment records from Atlas including Petitioner's application, medical records from Drs. Park and Balaram, and the Functional Capacity Evaluation. (RX 6, p. 1). Petitioner testified that he has a high school diploma and an associate degree in civil engineering. (Tr. 67-68).

According to the referenced materials, Petitioner is bilingual (English and Spanish) and was employed as a General Labor Class IV at V&V Supremo Foods on the date of the alleged incident. (RX 6, p. 2). Petitioner's prior work experience included working a sign maker for about 4 years, doing signs by hand and computer, running his own business, and working as a technical surveyor and painter for a year. (RX 6, p. 3-4; Tr. 68). Petitioner also had experience using PowerPoint and typing on a computer. (RX 6, p. 4; Tr. 69).

With respect to potential employment, the Labor Market Survey lists several positions that Petitioner would be able to perform including telemarketing requiring fluency in Spanish, housing cleaning with a 10-pound lifting restriction, retail sales consultant, account executive, unarmed security, and customer sales representative. (RX 6, p. 4-11). Salaries for the positions ranged from $26,000.00 annually to $52,000.00 annually with an overall average of $36,224.00 annually. (RX 6, p. 12).

Mr. Rascati also reviewed Petitioner's independent job search. (RX 6, p. 12). According to the job search reviewed by Mr. Rascati, Petitioner allegedly contacted 212 employers from November 18, 2020 to March 12, 2021. (RX 6, p. 12). A random sampling of the 19 employers were contacted and no employer was able to confirm whether Petitioner applied with them or not. (RX 6, p. 12). Additionally, there were no contact names listed and nothing stated as to the position he applied for or regarding how he contacted them (in person, by phone, online, etc.) (RX 6, p. 13). Mr. Rascati noted that a critical aspect of the job search is diligent recordkeeping including detailing: date of contact, employer name and address, contact person and phone number, type of job, hiring, application, interview, method of contact, outcome/follow up and verification. (RX 6, p. 13).

Video Surveillance

Video surveillance was obtained of Petitioner on November 9, 2020, as well as April 6, 2021. (RX 3, 4, 5). Over the course of the surveillance video from November 9, 2020, Petitioner is observed

driving to a grocery store, pushing a shopping cart (with his left hand only), and lifting and carrying groceries with his left hand exclusively. (RX 3, RX 5). On April 6, 2021, Petitioner was observed driving, loading a washing machine using both hands, loading laundry into a vehicle using the left hand predominately, carrying a three-drawer plastic storage with the left hand, and unloading laundry and other items from his vehicle using his left hand. (RX 4, RX 5).

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

Issue C, whether the accident arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds as follows:

The phrase "in the course of employment" refers to the time, place, and circumstances of the injury. McAllister v. Illinois Workers' Compensation Comm'n, 2020 IL 124848, ¶ 34. A compensable injury occurs 'in the course of' employment when it is sustained while he performs reasonable activities in conjunction with his employment. Id.

"The 'arising out of' component is primarily concerned with causal connection. 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." Id. at ¶ 36. To determine whether a claimant's injury arose out of his employment, the risks to which the claimant was exposed must be categorized. Id. The three categories of risks are "(1) risks distinctly associated with the employment; (2) risks personal to the employee; and (3) neutral risks which have no particular employment or personal characteristics." Id. at ¶ 38. "A risk is distinctly associated with an employee's employment if, at the time of the occurrence, the employee was performing (1) acts he or she was instructed to perform by the employer, (2) acts that he or she had a common-law or statutory duty to perform, or (3) acts that the employee might reasonably be expected to perform incident to his or her assigned duties." Id. at ¶ 46.

The Arbitrator compares Petitioner's testimony with the history he gave to his medical providers including Respondent's Section 12 examiner. While Petitioner described right shoulder pain prior to his date of accident, he also described feeling a sharp pain specifically on October 25, 2018 after repetitive lifting and pushing/pulling heavy weight. (See PX 1, p. 7). Petitioner testified to lifting heavy molds of cheese at the factory when he felt a sharp pain in his shoulder. It is apparent this accident was in the course of his employment as Petitioner was at the factory and working on the production line. It is also obvious that Petitioner's accident arises out of his employment as moving mold cheese trays is a risk distinctly associated with his employment.

As explained above, the Arbitrator concludes that Petitioner met his burden in proving that his accident arose out of and in the course of his employment with Respondent.

Issue F, whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds as follows:

Right Shoulder

To obtain compensation under the Act, a claimant must prove that some act or phase of his employment was a causative factor in his ensuing injuries. A work-related injury need not be the sole or principal causative factor, as long as it was *a* causative factor in the resulting condition of ill-being. Even if the claimant had a preexisting degenerative condition which made him more vulnerable to injury, recovery for an accidental injury will not be denied as long as he can show that his employment was also a causative factor. Thus, a claimant may establish a causal connection in such cases if he can show that a work-related injury played a role in aggravating his preexisting condition. Sisbro, Inc. v. Industrial Comm'n, 207 Ill. 2d 193, 205, 797 N.E.2d 665, 278 Ill. Dec. 70 (2003).

"A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury." International Harvester v. Industrial Com., 93 Ill. 2d 59, 63 442 N.E.2d 908 (1982).

Petitioner's testimony regarding his job duties and work on October 25, 2018 are not in dispute. Petitioner testified that he was working in production with a cheese factory for approximately 4 months performing various tasks, one of which included making queso supremo. This involved carrying heavy trays repetitively with another worker to allow cheese to continuously pour into molds that are on trays. Petitioner testified (and reported to his doctors and IME examiner) that shoulder pain was developing for at least four months, and on October 25, 2018, he felt a "strong pain" in his right shoulder while carrying a heavy tray of cheese. At that point, Petitioner reported his injury and sought treatment. Although Petitioner reported pain prior to October 25, 2018, there is no evidence of prior treatment to Petitioner's right shoulder or prior work restrictions.

Petitioner does not argue a repetitive trauma and Petitioner's treating physicians did not document any causation opinions in their treatment records. Respondent's Section 12 examiner, Dr. Neal, opined that there is no causal relationship between Petitioner's shoulder condition and the October 25, 2018 incident because Petitioner indicated he had symptoms prior to the October 25, 2018 incident and did not describe any truly precipitating or injurious event. (See RX 1, p. 19). However, International Harvester does not demand that Petitioner demonstrate a previous condition of *perfect* health. See International Harvester, 93 Ill. 2d at 63. As there is no evidence of Petitioner requiring medical treatment or work restrictions prior to October 25, 2018, the Arbitrator finds that Petitioner's complaints of shoulder pain prior to his work accident do not defeat his claim. In addition to demonstrating a previous condition of good health, Petitioner demonstrated an accident, testifying credibly to sudden pain on October 25, 2018 while lifting trays. Further, medical records demonstrate a subsequent injury resulting in disability. As a result, Petitioner has met his burden in proving that his current condition of ill-being as it relates to the shoulder is casually related to his work accident.

Psychological Injuries

Psychological injuries are compensable as either "physical-mental," when the injuries are related to and caused by a physical trauma or injury, or "mental-mental," when the injuries are caused by sudden severe emotional shock traceable to a definite time, place, and cause even though no physical trauma or injury was sustained. Matlock v. Industrial Comm'n, 321 Ill. App. 3d 167, 168, 746 N.E.2d 751, 753 (1st Dist. 2001) citing Pathfinder Co. v. Industrial Com., 62 Ill. 2d 556, 558, 343 N.E.2d 913, 914 (1976). Mental disorders which develop over time in the normal course of the employment relationship do not constitute compensable injuries. In dealing with the physical-mental category, even a minor physical contact or injury may be sufficient to trigger compensability. Matlock, 321 Ill. App. 3d at 168.

While it is clear that Petitioner's psychological conditions predate the October 25, 2018 work incident, however, Dr. Pedemonte opined that Petitioner's "intense pain on his shoulder has exacerbated his depression and panic attacks." (PX4, p. 87). The Arbitrator considers the opinions of Dr. Neal, who disputes causation for the psychological issues (See RX 1, p. 20), but finds the opinions of Dr. Pedemonte to be more credible on this issue, as Dr. Pedemonte is a board-certified psychiatrist while Dr. Neal is an orthopedic surgeon. Further, Petitioner testified that his February 13, 2020 visit was the only time Dr. Pedemonte took Petitioner off-work. (See Tr. 60).

The Arbitrator does consider Petitioner's testimony regarding the circumstances of a trial return to full duty work in February 2020. Dr. Balaram recommended return to work full duty on a trial basis on February 12, 2020 but Petitioner went to his prescheduled psychologist appointment the next day on February 13, 2020 and obtained an off work note for one month. The Arbitrator does acknowledge some discrepancies in Petitioner's testimony. Petitioner testified that his psychological condition worsened because Respondent had not called him yet about returning to work (See Tr. 30). However, at that time, Respondent was not given an opportunity to offer Petitioner a return to full duty work. On March 11, 2020, Petitioner told Dr. Balaram that he had not attempted a return to work but on March 19, 2020 Petitioner told Dr. Park that he tried to return to work in February 2020 but was told that he was terminated. (See PX 5, p. 5). Despite some inconsistencies with Petitioner's testimony, when comparing Petitioner's testimony with the record as whole, the Arbitrator does not find any material contradictions that would deem Petitioner not credible.

While Petitioner testified that he wanted to return to work in February 2020, it is apparent that Petitioner was anxious about returning to work full duty. Dr. Balaram's February 12, 2020 progress note states Petitioner was apprehensive about returning to work. Petitioner also testified on cross-examination that he was concerned about returning to work with his prior restrictions removed. (See Tr. 57, 59). When Petitioner presented to Dr. Pedemonte and communicated his worries, Dr. Pedemonte found an exacerbation of his psychological conditions and placed Petitioner off work temporarily. It should be noted that Dr. Pedemonte's February 13, 2020 note is the only document that mentions Petitioner's work injury. As such, the Arbitrator finds that Petitioner's temporary exacerbation of his depression and panic attacks is casually related to his work accident.

As discussed above, the Arbitrator finds that Petitioner has met his burden in providing that his current condition of ill-being is causally related to the October 25, 2018 work injury.

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 as follows:

Having found Petitioner's current condition of ill-being causally related to his work accident, the Arbitrator also finds Petitioner's treatment through August 4, 2020 to be reasonable and necessary and finds that Respondent has not paid for said treatment.

Petitioner ended his treatment with Dr. Park on August 4, 2020 following completion of the FCE. At that point Dr. Park found that Petitioner had reached maximum medical improvement. (See PX 5, p. 14). Dr. Neal opined that at the time of his December 3, 2020 IME Petitioner's care had been reasonable to date, but that he did not require any future care for his right shoulder. (See RX 1, p. 20).

As such, the Arbitrator orders Respondent to pay Petitioner directly for the following outstanding medical services for dates of service October 25, 2018 through August 4, 2020, pursuant to the medical fee schedule and Sections 8(a) and 8.2 of the Act.

Issue L, whether Petitioner is entitled to temporary total disability and maintenance benefits, the Arbitrator finds as follows:

Having found Petitioner's current condition of ill-being causally related to his work accident as well as his treatment through August 4, 2020 to be reasonable and necessary, the Arbitrator further finds Petitioner to be entitled to TTD benefits from October 26, 2018 through August 4, 2020 and maintenance benefits from November 18, 2020 thru March 12, 2021.

Section 8(a) of the Act provides for vocational rehabilitation and mandates that the employer pay all maintenance costs and expenses "incidental" to a program of "rehabilitation." 820 ILCS 305/8(a) (West 2006)*;* see also Nascote Industries v. Industrial Comm'n*,* 353 Ill. App. 3d 1067, 1075, 820 N.E.2d 570, 289 Ill. Dec. 794 (2004). The statute is flexible and does not limit "rehabilitation" to formal training. Connell v. Industrial Comm'n*,* 170 Ill. App. 3d 49, 55, 523 N.E.2d 1265, 120 Ill. Dec. 354 (1988). The appellate court has stated that the statutory term "rehabilitation" is to be construed broadly to include an injured employee's self-initiated and self-directed job. See Roper Contracting v. Industrial Comm'n, 349 Ill. App. 3d 500, 506, 812 N.E.2d 65, 71 (5th Dist. 2004). Thus, an award of maintenance benefits is appropriate to an employee who is conducting a self-directed job search. Id.*;* see also Greaney v. Industrial Comm'n*,* 358 Ill. App. 3d 1002, 1019, 832 N.E.2d 331, 295 Ill. Dec. 180 (2005).

However, by its plain terms, Section 8(a) requires the employer to pay only those maintenance costs and expenses that are incidental to rehabilitation. That means that an employer is obligated to pay maintenance benefits only "while a claimant is engaged in a prescribed vocational-rehabilitation program." W. B. Olson v. Illinois Workers' Compensation Comm'n, 2012 IL App (1st) 113129WC, 981 N.E.2d 25. Thus, if the claimant is not engaging in some type of "rehabilitation" (whether it be formal job training, or a self-directed job search), the employer's obligation to provide maintenance is not triggered. See Id.

The Arbitrator considers the opinions of Dr. Neal who opined that Petitioner's subjective complaints outweigh and are disproportional to the objective findings. (See RX 1, p. 19). Dr. Neal opined that Petitioner could work his regular job on a full-time basis without restrictions. (See RX 1, p. 20). The Arbitrator also considers Respondent's Audit of the FCE Report indicating that Petitioner's consistency of effort or reliability of pain were not adequately supported by the data in the FCE report. (See RX 2, p. 1). While the Audit states that the FCE lacked any reliable metric testing to assess Petitioner's reliability, the Audit does not go so far as to dispute Petitioner's restrictions or physical demand level. (See RX 2, p. 3). The Arbitrator notes that the FCE report does not dictate Petitioner's work restrictions. Rather, the FCE report serves as a tool for Petitioner's treater who can recommend work restrictions. Neither Dr. Balaram, Dr. Park, Dr. Goldflies, nor Dr. Pedemonte opine that Petitioner is displaying signs of symptom magnification or malingering. In fact, video surveillance footage shows Petitioner engaging in activities of daily living (i.e. pushing a cart, carrying groceries, and doing laundry) almost exclusively with his left hand. As such, the Arbitrator relies on the opinions of Dr. Park who reviewed the FCE report and opined that Petitioner had reached MMI and prescribed permanent restrictions of no lifting/carrying/pushing/pulling over 10-pounds and no overhead work. (See PX 5, p. 14).

Respondent placed into evidence a letter addressed to Petitioner and his counsel requesting that Petitioner contact them to return to work full duty on December 21, 2020 as Respondent's IME examiner opined that he could return to full duty work. (See RX 8). Petitioner testified that he was never asked to return to work and denied receiving the December 15, 2020, letter. (See Tr. 66-67; RX 8). As the Arbitrator relies on the opinions of Dr. Park prescribing permanent restrictions, whether or not Respondent offered Petitioner full duty work is immaterial to Petitioner's claim for maintenance benefits.

Petitioner testified that he continued to look for work after his release from Dr. Park in August 2020. (See Tr. 39). However, Petitioner's job logs do not begin until November 18, 2020 and continue thru March 12, 2021 with a total of 212 contacts made via telephone. (See PX 10; Tr. 70-71). Petitioner testified that he never went to any of the employers listed on the job search in person because of the COVID-19 pandemic. (Tr. 71). The Arbitrator notes that restrictions in Illinois for the COVID-19 pandemic began around March 2020 and continued through the date of trial, July 23, 2021.

The Arbitrator considers Respondent's Labor Market Survey. Mr. Rascati indicated that Petitioner failed to keep diligent recordkeeping in his job logs and, of the 19 of 212 employers that Mr. Rascati contacted, none were able to confirm whether Petitioner applied with them or not. (RX 6, p. 12-13). While the Arbitrator acknowledges that Petitioner's job logs could have been more detailed, the Arbitrator finds that Petitioner has met its burden for maintenance benefits from November 18, 2020 thru March 12, 2021.

As discussed above, the Arbitrator finds that Petitioner is entitled to TTD benefits from October 26, 2018 through August 4, 2020 and maintenance benefits from November 18, 2020 thru March 12, 2021.

Issue M, whether penalties or fees should be imposed upon Respondent, the Arbitrator finds as follows:

The Arbitrator declines to impose penalties or fees upon Respondent as the Arbitrator finds that Respondent reasonably believed there was a legitimate dispute on compensability of the claim.

Issue O, under "Other" whether Petitioner is entitled to vocational rehabilitation or the nature and extent of the injury, the Arbitrator finds as follows:

A claimant is generally entitled to vocational rehabilitation when he sustains a work-related injury which causes a reduction in his earning power and there is evidence that rehabilitation will increase his earning capacity. Euclid Bev. v. Illinois Workers' Compensation Comm'n, 2019 IL App (2d) 180090WC, ¶ 29, 124 N.E.3d 1027 citing Greaney v. Industrial Comm'n, 358 Ill. App. 3d 1002, 1019, 832 N.E.2d 331, 295 Ill. Dec. 180 (2005). Because the primary goal of rehabilitation is to return the injured employee to work (Schoon v. Industrial Comm'n, 259 Ill. App. 3d 587, 594, 630 N.E.2d 1341, 197 Ill. Dec. 217 (1994)), if the injured employee has sufficient skills to obtain employment without further training or education, that factor weighs against an award of vocational rehabilitation. National Tea Co. v. Industrial Comm'n, 97 Ill. 2d 424, 432, 454 N.E.2d 672, 73 Ill. Dec. 575 (1983). Moreover, an injured employee is generally not entitled to vocational rehabilitation if the evidence shows that he does not intend to return to work, although able to do so. Schoon, 259 Ill. App. 3d at 594.

Here, Petitioner's work-related injury has caused him a reduction in his earning power. At the hearing, Petitioner testified that he has not found work within his work restrictions. Petitioner has credibly testified that he wants to return to work. Further, Respondent's Labor Market Survey suggests that Petitioner would benefit from rehabilitation (such as a guided job search) to increase his earning capacity.

As a result, the Arbitrator finds that Petitioner has met his burden showing entitlement to vocational rehabilitation.

It is so ordered:

RACHAEL SINNEN, ARBITRATOR

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC019537
Case Name	SCOTT, LISA v. UNITED AIRLINES, INC
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0229
Number of Pages of Decision	24
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Sean Stec
Respondent Attorney	James Flannery

DATE FILED: 6/22/2022

/s/Marc Parker, Commissioner

Signature

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

Lisa Scott,

Petitioner,

vs. NO: 18 WC 19537

United Airlines, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 8, 2021, 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 $4,620.00. 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.

June 22, 2022
MP:yl
o 6/16/22
68

/s/ *Marc Parker*
Marc Parker

/s/ *Carolyn M. Doherty*
Carolyn M. Doherty

/s/ *Christopher A. Harris*
Christopher A. Harris

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC019537
Case Name	SCOTT, LISA v. UNITED AIRLINES, INC
Consolidated Cases	No Consolidated Cases
Proceeding Type	19(b) Petition
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	21
Decision Issued By	William McLaughlin, Arbitrator

Petitioner Attorney	Sean Stec
Respondent Attorney	James Flannery

DATE FILED: 11/8/2021

/s/William McLaughlin, Arbitrator
Signature

INTEREST RATE WEEK OF NOVEMBER 2, 2021 0.06%

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)

LISA SCOTT
Employee/Petitioner

v.

UNITED AIRLINES, INC.
Employer/Respondent

Case # **18** WC **19537**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **William J. McLaughlin**, Arbitrator of the Commission, in the city of **Chicago**, on **September 30, 2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **December 2, 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 $**36,356.84**; the average weekly wage was $**699.17**.

On the date of accident, Petitioner was **49** 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 $**93,088.83** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**93,088.83**.

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

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of **$320.00** to **Central Primary Care**, **$3,500.00** to **Advantage MRI Logan Square**, **$645.00** to **Specialists in Medical Imaging**, **$41,825.21** to **ATI Physical Therapy**, and **$92.40** to **Northwestern Medicine**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall provide the C5-C6 anterior discectomy and fusion surgery, and all care incidental thereto, as prescribed by Dr. Wellington K. Hsu.

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.

November 8, 2021

Signature of Arbitrator

FINDINGS OF FACT

Prior to December 2, 2017, Petitioner had never injured her right shoulder nor received medical care of any kind for right shoulder problems. In addition, Petitioner had never missed any time from work as a result of right shoulder problems. (R. pp. 10-11). Further, Petitioner had never injured her cervical spine or neck, prior to December 2, 2017. She had never received medical care of any kind, and had not missed any time from work prior to December 2, 2017, as a result of cervical spine or neck problems. (R. p. 11).

In 1998, Petitioner began to experience symptoms that were eventually diagnosed as being the result of Relapsing-Remitting Multiple Sclerosis in 2000. (R. pp. 11-12, 15). The symptoms Petitioner experienced as a result of her Multiple Sclerosis "flare-up" on occasion, especially when the weather is hot. Petitioner's occasional symptoms include problems swallowing, dropping on one side of her face, issues with her gait, vertigo, and spots in front of her eyes. Petitioner does not have any symptoms from Multiple Sclerosis in her upper extremities of her hands. (R. pp. 14-15).

On December 2, 2017, Petitioner worked for Respondent as a Storekeeper. (R. p. 9). At approximately 6:00 p.m., Petitioner was moving a heavy box of wing tape from a cart to an ASRS pan. As Petitioner was moving the box, she felt a "pop" in her right arm and her entire right arm went numb. (R. pp. 18-20). Immediately after the accident, she felt a burning, stabbing pain in the top of her right shoulder, an aching pain in her collar bone area, a "stab-like feeling" in her shoulder blade and a tearing sensation in her right biceps. (R. p. 20). She also felt numbness and tingling in her right ring finger and little finger. (R. p. 20). Petitioner had never experienced any of those symptoms prior to her work injury on December 2, 2017. (R. pp. 37-38).

Petitioner reported her work injury to her supervisor and was sent to the company clinic, United Airlines Medical at O'Hare Field. Diana Guillaume, a Nurse Practitioner, took a history from Petitioner that, "States that today while moving a package on about 32 pounds from a cart to a pan [an pan] to ship she felt a pop on shoulder." Petitioner exhibited decreased grip strength in her right hand and was unable to elevate her right arm. Petitioner was diagnosed with right shoulder pain, provided with a sling and Toradol and was sent to the emergency room via ambulance. (Petitioner's Exhibit #2, p. 2).

Petitioner was examined in the emergency room of Resurrection Medical Center that same day. Dr. Robert P. Rifenburg took a history from Petitioner that states, "Patient was working when she lifted and twisted with her right arm heavy object. She states she felt severe pain in the shoulder radiating down the arm, heard a pop, and has diminished range of motion since that time." (Petitioner's Exhibit #3, p. 6). Dr. Rifenburg reviewed x-rays of Petitioner's right shoulder that were taken and found that they demonstrated an AC shoulder separation. The doctor directed Petitioner to wear a sling and to follow up with an orthopedic specialist. (Petitioner's Exhibit #3, p. 8). Petitioner was provided with light duty work restrictions of no lifting, no over the shoulder work and no use of the right arm. (Petitioner's Exhibit #3, p. 34).

On December 6, 2017, Petitioner was examined by her primary care physician, Dr. Joanna Lo, at Central Primary Care. Dr. Lo took a history from Petitioner that states, "pt was lifting a heavy object loss range of motion in her right arm…." Dr. Lo diagnosed Petitioner with an injury of the right rotator cuff and directed her to obtain an MRI of her right shoulder. (Petitioner's Exhibit #4, pp. 105-107).

On December 11, 2017, an MRI of Petitioner's right shoulder was completed at Central Primary Care. Dr. Mark Jundanian, a radiologist, reviewed the MRI and diagnosed Petitioner with a small focal full-thickness tear of the supraspinatus tendon. (Petitioner's Exhibit #4, p.112).

On December 21, 2017, Petitioner was examined by Dr. Christopher C. Mahr, an orthopedic surgeon. Dr. Mahr took a history from Petitioner that, "She states that on 2 December while working for United Airlines was lifting a box of parts that [with proximal] 60-70 pounds when she felt a sharp strain in her right shoulder." The associated symptoms as reported by Petitioner were weakness, stiffness, numbness, tingling and popping. Dr. Mahr diagnosed Petitioner with a tear of the right supraspinatus tendon and provided her with an injection of Lidocaine and Depo-Medrol in the right subacromial space. Dr. Mahr prescribed physical therapy for Petitioner and directed her to remain off work. (Petitioner's Exhibit #5, pp. 13-14).

Petitioner received physical therapy at Dr. Mahr's office and returned to see him on January 18, 2018. At that time, Petitioner continued to complain of pain in her collar bone, stabbing pain in the top of her shoulder, a tearing feeling in her biceps, a stabbing pain along the right shoulder blade and into the right armpit, and numbness into the 4th and 5th digits of the right hand. (R. pp. 23-24). Dr. Mahr recommended that she proceed with right shoulder arthroscopy and rotator cuff repair. (Petitioner's Exhibit #5, pp. 27-28).

On January 20, 2018, Petitioner was examined by Dr. Haresh Sawlani, a partner of Dr. Lo's, at Central Primary Care. Dr. Sawlani diagnosed Petitioner with rotator cuff tear arthropathy of the right shoulder and noted that Petitioner was scheduled for surgery on February 9, 2018. (Petitioner's Exhibit #4, pp. 97-99).

On March 9, 2018, Dr. Mahr performed a right shoulder arthroscopy, subacromial decompression, and rotator cuff repair for Petitioner at Belmont/Harlem Surgery Center, L.L.C. (Petitioner's Exhibit #10, pp. 2-3). Petitioner testified that the symptoms in her collar bone, top of her right shoulder, biceps, shoulder blade, armpit and the tingling in her right 4th and 5th digits remained. (R. pp. 24-25).

Petitioner initiated her post-operative physical therapy program at Dr. Mahr's office on March 20, 2018. (Petitioner's Exhibit #5, pp. 33-34). On March 23, 2018, Petitioner returned to see Dr. Mahr. The doctor directed her to continue physical therapy. (Petitioner's Exhibit #5, pp. 35-36).

On April 26, 2018, Petitioner returned to see Dr. Mahr. The doctor directed her to continue her physical therapy program and to remain off work. (Petitioner's Exhibit #5, pp. 52-53).

Dr. Mahr examined Petitioner again on July 17, 2018. At that time, the doctor directed Petitioner to continue her physical therapy program and released her to return to light duty desk work with no overhead lifting of her right arm and no lifting more than 1 pound, if available. (Petitioner's Exhibit #5, pp. 60-61).

On August 28, 2018, Petitioner returned to see Dr. Mahr. The doctor directed Petitioner to continue with her light duty work restrictions, if available, and to continue physical therapy. (Petitioner's Exhibit #5, pp. 76-77).
On September 24, 2018, Petitioner was examined by Dr. Lo. The doctor diagnosed Petitioner with rotator cuff tear arthropathy of the right shoulder and indicated that she required 8 more weeks of physical therapy. (Petitioner's Exhibit #4, pp. 60-62).

Dr. Mahr examined Petitioner again on October 9, 2018. The doctor directed Petitioner to continue her physical therapy program and continued her work restrictions. (Petitioner's Exhibit #5, pp. 91-92).

On November 19, 2018, Petitioner was examined by Dr. Sawlani. The doctor diagnosed Petitioner with rotator cuff tear arthropathy of the right shoulder and directed her to continue use of a CPM machine and to continue physical therapy. Dr. Sawlani also directed Petitioner to remain off work until cleared by her orthopedic surgeon. (Petitioner's Exhibit #4, pp. 52-54).

On November 20, 2018, Dr. Mahr directed Petitioner to begin a work conditioning program. (Petitioner's Exhibit #5, pp. 107-108). Petitioner began the work conditioning program at ATI Physical Therapy on December 6, 2018. (Petitioner's Exhibit #11, pp. 605-612). Petitioner switched to ATI Physical Therapy because it was closer to her home. (R. p. 26).

Petitioner was examined again by Dr. Mahr on December 18, 2018. Petitioner still exhibited positive impingement sign to abduction, internal rotation, as well as forward flexion. Dr. Mahr injected Petitioner's right subacromial space with Marcaine and Depo-Medrol and instructed her to continue her work conditioning program. (Petitioner's Exhibit #4, pp. 110-111).

Petitioner completed her work conditioning program on January 4, 2019. (Petitioner's Exhibit #11, pp. 573-576). On January 8, 2019, Petitioner returned to see Dr. Mahr. Petitioner advised the doctor that the injection helped her pain for approximately 8 hours following the procedure, but then returned. Petitioner still exhibited positive impingement sign at that time. Dr. Mahr recommended that Petitioner obtain an MRI of her cervical spine and a repeat MRI of her right shoulder to further evaluate her continued pain. (Petitioner's Exhibit #4, pp. 113-114).

On January 17, 2019, Petitioner completed the MRIs of her right shoulder and cervical spine at Advantage MRI – Logan Square. Dr. Vikram Sobti, a radiologist, reviewed the MRI of Petitioner's cervical spine and found disc bulges at C4-C5 and C5-C6 with posterior herniations causing mild foraminal stenosis and central canal stenosis. (Petitioner's Exhibit #4, pp. 148-149). Dr. Sobti also reviewed the MRI of Petitioner's right shoulder and found a small full-thickness tear of the anterior distal tendon rotator cuff graft with an underlying moderate partial tear/tendinopathy involving the remaining supraspinatus tendon and infraspinatus tendon and tenosynovitis of the long head of the biceps tendon. (Petitioner's Exhibit #4, pp. 150-151).

On January 22, 2019, Petitioner returned to see Dr. Mahr. Petitioner still exhibited positive impingement sign and decreased rotator muscle strength on the right side. The doctor reviewed the MRIs of Petitioner's right shoulder and cervical spine. Although the images were of poor quality, Dr. Mahr indicated that it appeared that Petitioner had a re-tear of her supraspinatus tendon. The doctor recommended that Petitioner proceed with a revision rotator cuff repair, subacromial decompression, and possible biceps tenodesis surgery. (Petitioner's Exhibit #4, pp. 115-116).

On February 26, 2019, Petitioner was examined by Respondent's Section 12 medical examiner, Dr. Thomas F. Gleason. Petitioner provided the doctor with a history that states, "…on December 2, 2017, while at work, she was moving a box from a cart, about waist height, down to a lower tray. As she moved the box, she felt a pop in the right shoulder with pain, numbness and tingling down the arm into the first and second digits." Upon

examination, Petitioner exhibited decreased shoulder motion and strength on the right side and positive cross over impingement test, O'Brien test, and supraspinatus test on the right side. (Respondent's Exhibit #1).

Dr. Gleason reviewed the MRI of Petitioner's cervical spine and found mild to moderate cervical spondylosis at C5-C6 where there exists a posterior spur disc complex contributing to mild central canal stenosis and moderate foraminal stenosis bilaterally, along with similar findings to a lesser degree at C4-C5 and C6-C7 with bulging contributing to central foraminal narrowing. Dr. Gleason also reviewed the MRI of Petitioner's right shoulder and found a small full thickness tear of the distal supraspinatus tendon with tendinopathy involving both the supraspinatus and infraspinatus tendons. (Respondent's Exhibit #1).

Dr. Gleason found Petitioner's current condition of ill-being as it related to her right shoulder, to be causally related to her work accident on December 2, 2017. The doctor also found that the treatment Petitioner had received to date was reasonable and necessary as a result of her work-related accident and that the surgery that had been recommended was also reasonable and necessary and as a result of her work-related injury. Although Dr. Gleason was provided with the Job Description of a Flight Attendant, he indicated that Petitioner was unable to perform her job at that time. (Respondent's Exhibit #1).

On March 11, 2019, Dr. Sawlani examined Petitioner and cleared her for surgery. (Petitioner's Exhibit #4, pp. 37-39).

On March 18, 2019, Dr. Mahr performed a right shoulder arthroscopy and subacromial decompression with open biceps tenodesis procedure for Petitioner at Belmont/Harlem Surgery Center, L.L.C. (Petitioner's Exhibit #10, pp. 4-5). Petitioner testified that her symptoms did not change following her second right shoulder surgery. (R. p. 29).

On April 2, 2019, Dr. Mahr examined Petitioner and directed her to remain off work and to begin a physical therapy program. (Petitioner's Exhibit #4, pp. 122-123). Petitioner initiated her physical therapy program at ATI Physical Therapy on April 9, 2019. (Petitioner's Exhibit #11, pp. 543-549).

On April 11, 2019, Dr. Sawlani examined Petitioner and diagnosed her with rotator cuff tear arthropathy on the right shoulder. The doctor directed her continue use of her CPM machine and to continue physical therapy. Dr. Sawlani also directed Petitioner to remain off work until November 1, 2019. (Petitioner's Exhibit #4, pp. 33-35).

On April 23, 2019, Petitioner retuned to see Dr. Mahr. The doctor directed her to continue her physical therapy program and released her to light duty work with no use of the right arm. (Petitioner's Exhibit #4, pp. 125-126). On May 9, 2019, Petitioner was examined by Dr. Sawlani. The doctor diagnosed her with a rotator cuff tear arthropathy on the right shoulder and directed her to continue her physical therapy and follow up with her orthopedic surgeon. (Petitioner's Exhibit #4, pp. 29-31).

On May 23, 2019, Petitioner returned to see Dr. Mahr. Petitioner advised the doctor that she experienced increased pain in the anterior aspect of her right shoulder, radiating into her axilla and pain radiating down her right arm into her forearm following physical therapy. Upon examination, Dr. Mahr noted marked tenderness in the anterior aspect of her right shoulder and a mild Popeye deformity in Petitioner's right arm. The doctor

directed Petitioner to obtain a repeat MRI of her right shoulder and an EMG of her upper extremities. Dr. Mahr also directed Petitioner to hold off on physical therapy. (Petitioner's Exhibit #4, pp. 127-128).

On June 6, 2019, Petitioner was examined by Dr. Sawlani. The doctor directed her to obtain an MRI of her right shoulder and an EMG. (Petitioner's Exhibit #4, pp. 25-27).

On July 11, 2019, Petitioner completed an MRI of her right shoulder at Resurrection Medical Center. (Petitioner's Exhibit #3, p. 88).

On July 12, 2019, Petitioner was examined by Dr. Sawlani. The doctor reviewed the right shoulder MRI and diagnosed Petitioner with rotator cuff tear arthropathy of the right shoulder. Dr. Sawlani directed Petitioner to follow up with her orthopedic surgeon. (Petitioner's Exhibit #4, pp. 21-23).

On July 23, 2019, Dr. Elton Dixon completed an EMG/nerve conduction study of Petitioner's upper extremities. Dr. Dixon found the study to be normal. (Petitioner's Exhibit #4, pp. 157-161).

On July 30, 2019, Petitioner returned to see Dr. Mahr. Petitioner still complained of radial pain in the anterolateral aspect of her right shoulder and numbness and tingling going down her right arm. Upon examination, Petitioner exhibited positive impingement sign to abduction, internal rotation and forward flexion, decreased rotator cuff muscle strength on the right side, tenderness over the AC joint and positive cross over test. Dr. Mahr reviewed the MRI of Petitioner's right shoulder and found tendinosis in the supraspinatus tendon. The doctor injected Petitioner's right AC joint and subacromial space with Marcaine and DepoMedrol and directed her to restart her physical therapy program. (Petitioner's Exhibit #4, pp. 129-130). Petitioner testified that the injection she received did not improve her symptoms. (R. p. 31).

Petitioner restarted her physical therapy program at ATI Physical Therapy on August 7, 2019. (Petitioner's Exhibit #11, pp. 446-455).

On August 9, 2019, Dr. Sawlani examined Petitioner and diagnosed her with rotator cuff arthropathy of the right shoulder. The doctor prescribed a CPM machine and continued physical therapy. (Petitioner's Exhibit #4, pp. 17-18).

On August 20, 2019, Petitioner returned to see Dr. Mahr. She indicated that most of her pain was in the right biceps area. Once again, Petitioner advised the doctor that the injection she had received at her last visit helped her symptoms for about 8 hours following the procedure. Upon examination, Petitioner demonstrated positive impingement sign to abduction, internal rotation, as well as forward flexion. Dr. Mahr directed her to continue physical therapy and released her to return to light duty work with no overhead lifting of the right arm. (Petitioner's Exhibit #4, pp. 133-134).

On September 17, 2019, Petitioner returned to see Dr. Mahr. Petitioner continued to complain of pain along the anterior aspect of her right shoulder with movement that radiates from the anterior aspect of her arm to her axilla, down her forearm, to her fourth and fifth fingers. Once again, Petitioner demonstrated decreased rotator cuff muscle strength testing and positive impingement sign on the right along with tenderness over the long head of the biceps tendon proximally. Dr. Mahr recommended that Petitioner obtain a second opinion

"regarding her continued right shoulder pain and nerve type pain." Dr. Mahr also indicated that Petitioner could work with no lifting greater than 5 pounds and was to continue her physical therapy program. (Petitioner's Exhibit #4, pp. 135-136).

On October 14, 2019, Petitioner was examined by Dr. Michael A. Terry at Northwestern Medicine for a second opinion. Petitioner complained of significant pain in the anterior aspect of her right shoulder that radiates down all the way to her fingers through her biceps anteriorly. Petitioner also advised the doctor that she gets numbness and paresthesias in her hand approximately 2 times per week. Dr. Terry provided Petitioner with a corticosteroid injection into the bicipital groove and ordered an MRI of her cervical spine. (Petitioner's Exhibit #6(b), pp. 157-158). Petitioner testified that the injection provided by Dr. Terry did not improve her symptoms. (R. p. 32).

On October 28, 2019, Petitioner completed an MRI of her cervical spine at Resurrection Medical Center. Dr. Jeremy R. Simon, a radiologist, reviewed Petitioner's MRI and found, "Small midline protrusions at C2-3 and C3-4. The most significant level pathology C5-6 where there is moderate disc bulge and marginal osteophyte causing moderate central canal stenosis and bilateral foraminal narrowing. There is also left-sided facet arthropathy." (Petitioner's Exhibit #3, p. 100).

On November 25, 2019, Petitioner was examined again by Dr. Terry. The doctor reviewed the MRI of her cervical spine and noted a moderate sized disk bulge at C5-C6 with some associated stenosis and facet arthropathy. Upon examination, Petitioner exhibited positive Spurling, Neer, and Hawkins tests. Dr. Terry directed Petitioner to restart physical therapy. (Petitioner's Exhibit #6(b), p. 144).

Petitioner concluded her physical therapy program on December 5, 2019. (Petitioner's Exhibit #11, p. 341).

On December 18, 2019, Petitioner was again examined by Dr. Terry. The doctor noted that Petitioner exhibited tenderness of the cervical spine, positive Spurling test, positive marked AC joint tenderness, tenderness over her biceps tenodesis site, and positive Neer's and Hawkin's test. Dr. Terry reviewed the MRI of Petitioner's cervical spine, and because of the quality of the image, recommended a repeat MRI. Dr. Terry also suggested that Petitioner proceed with another cervical epidural steroid injection. (Petitioner's Exhibit #6(b), pp. 136-137).

On January 6, 2020, Petitioner completed another MRI of her cervical spine at Northwestern Medicine. (Petitioner's Exhibit #6(a), pp. 5-6). On January 22, 2020, Dr. Garg performed a fluoroscopically guided "thoracic-cervical" epidural steroid injection for Petitioner, but the record is unclear as to the specific level of the spine where the injection was administered. (Petitioner's Exhibit #6(b), pp. 130-131). Petitioner testified that she received temporary relief from the symptoms in her neck and shoulder blade following the injection from Dr. Garg. (R. pp. 33-34).

On February 5, 2020, Petitioner retuned to see Dr. Terry. The doctor reviewed the MRI of Petitioner's cervical spine and suggested that she be evaluated by a spine surgeon. Dr. Terry also recommended that Petitioner proceed with repeat right shoulder surgery. (Petitioner's Exhibit #6(b), pp. 121-122).

On March 2, 2020, Petitioner was evaluated by Dr. Wellington K. Hsu, a spine surgeon, at Northwestern Medicine. Petitioner complained of right-sided shoulder pain and neck pain radiating to the right posterior shoulder and down to the hand on the right side for the past two years. Dr. Hsu reviewed the MRI of Petitioner's cervical spine and found that it demonstrated a C5-C6 posterior osteophyte complex causing bilateral foraminal stenosis. Dr. Hsu directed Petitioner to follow-up with him 6-8 weeks following her surgery with Dr. Terry to determine is she was still experiencing her symptoms of radiating pain. (Petitioner's Exhibit #6(b), pp. 110-111).

On March 12, 2020, Dr. Terry performed a revision arthroscopy surgery of the right shoulder which involved superior labrum anterior and posterior lesion debridement, bicipital groove opening with synovectomy of the groove, acromioclavicular joint resection, and open biceps tendon release with removal of some of the suture material. (Petitioner's Exhibit #8). Following her surgery, Petitioner no longer had pain at the top of her shoulder and did not have a tearing sensation in her right biceps, however, she still experienced pain in the right shoulder blade and armpit and numbness in her right arm and into the 4th and 5th digits of her right hand. (R. p. 36).

On March 18, 2020, Petitioner was examined by Dr. Terry's Physician Assistant, Michelle Bohn. Petitioner continued to complain of intermittent numbness and tingling in the digits of her right hand. Petitioner was directed to perform range of motion exercises at home. (Petitioner's Exhibit #6(b), pp. 100-101).
On March 27, 2020, Petitioner initiated a physical therapy program at ATI Physical Therapy. (Petitioner's Exhibit #11, pp. 286-292).

Petitioner returned to see Dr. Terry on April 29, 2020. At that time, the doctor directed her to continue her post-operative physical therapy program. (Petitioner's Exhibit #6(b), pp. 90-91).

Petitioner continued her physical therapy program until June 1, 2020. (Petitioner's Exhibit #11, pp. 250-251). From June 4, 2020 through July 10, 2020, Petitioner was hospitalized for unrelated reasons at Community First Hospital. (R. p. 38, Petitioner's Exhibit #13).

Dr. Terry examined Petitioner again on August 19, 2020, and noted that she was unable to participate in her physical therapy program because she had been ill. Dr. Terry recommended that she resume her physical therapy program. (Petitioner's Exhibit #6(b), pp. 78-79).

On August 25, 2020, Petitioner resumed physical therapy at ATI Physical Therapy. (Petitioner's Exhibit #11, pp. 164-170).

On September 16, 2020, Petitioner was examined by Dr. Terry. The doctor noted that Petitioner still had some tenderness of her AC joint and radiation of pain down into her digits. Dr. Terry directed her to continue her physical therapy program and to include some physical therapy for the cervical spine. (Petitioner's Exhibit #6(b), pp. 67-68).

On October 5, 2020, Petitioner returned to see Dr. Hsu. The doctor noted that Petitioner underwent right shoulder surgery with Dr. Terry, and that following the surgery, she had improvement with her right shoulder pain, but she continued to have pain in her neck and radiating pain into the right shoulder blade, armpit and

down the anteromedial aspect of her arm into the fourth and fifth digits of her right hand. Dr. Hsu recommended that Petitioner proceed with a repeat cervical epidural steroid injection. (Petitioner's Exhibit #6(b), pp. 57-59).

On October 19, 2020, Dr. Eleasa Hulon performed a cervical epidural steroid injection under fluoroscopic guidance at the C5-C6 interspace. (Petitioner's Exhibit #7(a), pp. 18-21). Petitioner testified that she experienced short term relief of her neck and shoulder blade symptoms following the injection. (R. pp. 39-40).

On October 26, 2020, Petitioner was again examined by Dr. Hsu. The doctor noted that Petitioner reported "…that the C5-C6 epidural steroid injection provided complete relief of her right-sided neck and arm pain." The doctor noted that as the injection wore off, Petitioner had recurrent right arm pain and numbness and tingling. Dr. Hsu diagnosed Petitioner with C5-C6 radiculopathy and recommended that she proceed with C5-C6 anterior cervical diskectomy and fusion surgery. (Petitioner's Exhibit #6(b), pp. 45-46).

That same day, Petitioner was also examined by Dr. Terry. The doctor noted that Petitioner cervical spine pain was helped by the injection she received and directed Petitioner to continue her physical therapy program and to remain off work. (Petitioner's Exhibit #6(b), pp. 33-34).

On December 7, 2020, Petitioner was again examined by Dr. Terry. The doctor directed her to continue her physical therapy program. (Petitioner's Exhibit #6(b), pp. 22-23).

On January 22, 2021, Petitioner was examined by Respondent's Section 12 medical examiner, Dr. Stanford R. Tack. Dr. Tack noted that, at the time of her examination, Petitioner had right sided neck pain with radiation to the right shoulder blade and axilla. Dr. Tack diagnosed Petitioner with cervical spondylosis with spinal stenosis at C5-C6, but opined that this was a pre-existing condition and not related to Petitioner's work injury. Dr. Tack deferred to Petitioner's treating physicians on how to further care for Petitioner's cervical condition but indicated that he would not proceed with anterior cervical diskectomy and fusion as he did not believe Petitioner's symptoms were coming from her cervical spine. (Respondent's Exhibit #2).

On January 18, 2021, Petitioner returned to see Dr. Terry. The doctor noted that Petitioner was experiencing persistent clavicle pain and right upper extremity radiculopathy. Dr. Terry directed Petitioner to participate in a physical therapy program and indicated that she was able to lift 10-20 pounds. (Petitioner's Exhibit #6(b), pp. 12-13).

On February 22, 2021, Petitioner was examined by Dr. Hsu for the final time prior to hearing. The doctor indicated that he continues to believe that Petitioner's symptoms were caused by her work accident in 2017 and again recommended that she proceed with C5-C6 ACDF surgery based on the complete resolution of her symptoms following the C5-C6 epidural steroid injection. (Petitioner's Exhibit #6(b), p. 3).

On March 1, 2021, Petitioner was examined by Dr. Terry. The doctor directed Petitioner to continue her physical therapy. (Petitioner's Exhibit #7(b), pp. 65-66).

Petitioner returned to see Dr. Terry on April 7, 2021. The doctor directed her to continue her work restrictions and her physical therapy program. (Petitioner's Exhibit #7(b), pp. 47-48).

On May 17, 2021, Dr. Terry examined Petitioner again. The doctor noted that Petitioner continued to complain of pain in her neck, tingling, and numbness down the front part of her arm, around her scapula and down into her fourth and fifth digits. Dr. Terry directed Petitioner to continue her physical therapy program. (Petitioner's Exhibit #7(b), p. 36).

On June 23, 2021, Dr. Terry examined Petitioner and directed her to remain off work, complete her physical therapy and to continue taking anti-inflammatories. (Petitioner's Exhibit #7(b), p. 15). Petitioner completed her physical therapy at ATI Physical Therapy on July 22, 2021. (Petitioner's Exhibit #12, pp. 13-14).

On July 26, 2021, Dr. Terry examined Petitioner, and directed her to continue taking anti-inflammatories and performing home exercises. (Petitioner's Exhibit #7(b), pp. 6-7).

On September 13, 2021, Dr. Terry indicated that Petitioner was to remain off work. (Petitioner's Exhibit #14). Petitioner testified that she had not injured her cervical spine or right shoulder in any way since her work accident on December 2, 2017. (R. p. 44).

Petitioner further indicated that she would like to proceed with the surgery that had been recommended by Dr. Hsu. (R. p. 41).

CONCLUSIONS OF LAW

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

The Arbitrator finds that Petitioner suffered an accident that arose out of and in the course of her employment by Respondent, on December 2, 2017.

The Findings of Fact, as stated above, are adopted herein. The Arbitrator notes that Petitioner testified that she suffered an accident on December 2, 2017, at approximately 6:00 p.m. when she was moving a heavy box of wing tape from a cart to an ASRS pan. As Petitioner was moving the box, she felt a "pop" in her right arm and her entire right arm went numb. (R. pp. 18-20). Immediately after the accident, she felt a burning, stabbing pain in the top of her right shoulder, an aching pain in her collar bone area, a "stab-like feeling" in her shoulder blade and a tearing sensation in her right biceps. (R. p. 20). She also felt numbness and tingling in her right ring finger and little finger. (R. p. 20).

The Arbitrator also notes that Petitioner's testimony is corroborated by the histories that she provided to her various medical providers. Specifically, on her date of accident, Petitioner provided a history to United Airlines Medical at O'Hare Field that indicates, "States that today while moving a package of about 32 pounds from a cart to a pan [an pan] to ship she felt a pop on shoulder." (Petitioner's Exhibit #2, p. 2).

In addition, when examined in the emergency room of Resurrection Medical Center that same day, Petitioner's history states, "Patient was working when she lifted and twisted with her right arm heavy object. She states she felt severe pain in the shoulder radiating down the arm, heard a pop, and has diminished range of motion since that time." (Petitioner's Exhibit #3, p. 6).

When Petitioner was examined by Dr. Lo on December 6, 2017, her history states, "pt was lifting a heavy object loss range of motion in her right arm…." (Petitioner's Exhibit #4, pp. 105-107).

On December 21, 2017, when Petitioner was examined by Dr. Mahr for the first time, the history provided by the Petitioner states, "She states that on 2 December while working for United Airlines was lifting a box of parts that [with proximal] 60-70 pounds when she felt a sharp strain in her right shoulder." Petitioner's Exhibit #5, pp. 13-14).

In addition, when Petitioner was examined by Respondent's Section 12 medical examiner, Dr. Gleason, on February 26, 2019, her history stated, "…on December 2, 2017, while at work, she was moving a box from a cart, about waist height, down to a lower tray. As she moved the box, she felt a pop in the right shoulder with pain, numbness and tingling down the arm into the first and second digits." (Respondent's Exhibit #1).

The Arbitrator notes that while the weight of the box Petitioner picked up varies in some of the histories, as compared to Petitioner's testimony at the time of trial, the relevant fact is that Petitioner was injured while picking up a heavy box and moving it from one location to another. Clearly, this activity which is consistently described in each of the histories provided by Petitioner *and* in her testimony arises out of and in the course of her employment with Respondent.

The Arbitrator further notes that Respondent has not offered any evidence to dispute the fact that Petitioner suffered an accident on December 2, 2017.

Based on the foregoing, the Arbitrator finds that Petitioner has proved, by a preponderance of the evidence, that she suffered an accident that arose out of and in the course of her employment by Respondent on December 2, 2017.

(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, as it relates to her right shoulder and cervical spine is causally related to her work accident on December 2, 2017.

Right Shoulder

The Arbitrator finds that Petitioner's condition of ill-being, as it relates to her right shoulder, is causally related to her work accident on December 2, 2017.

The Findings of Fact and Conclusions of Law, as stated above, are adopted herein. The Arbitrator notes that prior to December 2, 2017, Petitioner had never injured her right shoulder or received medical care of any kind for right shoulder problems. In addition, Petitioner had never missed any time from work as a result of right shoulder problems. (R. pp. 10-11).

Petitioner testified that immediately following her work accident on December 2, 2017, she felt a burning, stabbing pain in the top of her right shoulder, an aching pain in her collar bone area, a "stab-like feeling" in her shoulder blade and a tearing sensation in her right biceps. (R. p. 20). She also felt numbness and tingling in her

right ring finger and little finger. (R. p. 20). Petitioner had never experienced any of those symptoms prior to her work injury on December 2, 2017. (R. pp. 37-38).

The Arbitrator also notes that Petitioner's medical records immediately following her work accident and continuing up through the date of hearing, clearly demonstrate an ongoing condition relating to Petitioner's right shoulder.

Specifically, at the company clinic on December 2, 2017, Petitioner exhibited decreased grip strength in her right hand and was unable to elevate her right arm. (Petitioner's Exhibit #2, p. 2). In addition, on December 11, 2017, the MRI of Petitioner's right shoulder demonstrated a focal full-thickness tear of the supraspinatus tendon. (Petitioner's Exhibit #4, p.112).

The Arbitrator notes that the tear of the supraspinatus tendon in Petitioner's right shoulder was evident at that time of her right shoulder surgery on March 9, 2018, and was repaired at that time. (Petitioner's Exhibit #10, pp. 2-3). In addition, Dr. Mahr's treatment through September 19, 2019 and Dr. Terry's treatment from October 14, 2019 through the date of hearing has clearly demonstrated an ongoing right shoulder condition for Petitioner. (Petitioner's Exhibits #5, #6(a), #6(b), #7(a), #7(b), and #8).

The Arbitrator recognizes that proof of the state of good health of the Petitioner prior to and down to the time of injury, and then change immediately following the injury and continuing thereafter, is competent as tending to establish that the impaired condition was due to the injury. *Spector Freight System, Inc. v. Industrial Commission*, 93 Ill. 2d 507, 513, 445 N.E.2d 280, 67 Ill. Dec. 800 (1983). Based on this analysis, the Arbitrator finds that, in the instant case, Petitioner has established a causal connection between her current condition of ill-being, as it relates to her right shoulder and her work accident on December 2, 2017. The record is clear that Petitioner's right shoulder symptoms, began immediately following her work injury, and have continued since that time. It is equally clear that Petitioner never had these symptoms prior to her work injury.

In addition, the Arbitrator also notes that Respondent's own Section 12 medical examiner, Dr. Gleason indicates that Petitioner's condition of ill-being, as it relates to her right shoulder, is directly related to Petitioner's work accident on December 2, 2017. Specifically, Dr. Gleason stated, "The current condition as it relates to her right shoulder, based upon the review of records, history and physical examination, would be causally related to the incident on December 2, 2017, in terms of an aggravation of a pre-existing condition. (Respondent's Exhibit #1).

Lastly, the Arbitrator notes that Respondent has not offered any evidence to dispute the casual relationship between Petitioner's condition of ill-being, as it relates to her right shoulder, and her work accident on December 2, 2017.

Based on the foregoing, the Arbitrator finds that Petitioner has proved, by a preponderance of the evidence, that her current condition of ill-being, as it relates to her right shoulder, is causally related to her work injury on December 2, 2017.

<u>Cervical Spine</u>

The Arbitrator finds that Petitioner's current condition of ill-being, as it relates to her cervical spine, is causally related to her work injury on December 2, 2017.

The Findings of Fact and Conclusions of Law, as stated above, are adopted herein. The Arbitrator notes that prior to December 2, 2017, Petitioner had never injured her cervical spine or neck. In addition, she had never received medical care of any kind and had not missed any time from work prior to that time, as a result of cervical spine or neck problems. (R. p. 11).

In addition, the Arbitrator notes that Petitioner testified to experiencing pain in the right side of her neck and numbness and tingling running down her right arm and into the fourth and fifth digits of her right hand immediately following her work accident. (R. p. 20).

The Arbitrator also notes that Petitioner complained of radicular symptoms traveling into her right arm to her medical providers from the date of the accident through the date of hearing. Specifically, Petitioner exhibited decreased grip strength in her right hand at United Airlines Medical at O'Hare Field on the date of her accident. (Petitioner's Exhibit #2, p. 2).

In addition, at the emergency room later that day, Petitioner complained to Dr. Rifenburg that she "…felt severe pain in the shoulder radiating down the arm." (Petitioner's Exhibit #3, p. 6).

Further, on December 21, 2017, Petitioner's right arm symptoms were weakness, numbness, and tingling. (Petitioner's Exhibit #5, pp. 13-14). The Arbitrator notes that Dr. Mahr's treatment of Petitioner for the next year focused on her right shoulder, but it is also true during that entire period, and even following Petitioner's two right shoulder surgeries, she continued to complain of radicular symptoms into her right arm.

Because of her persistent radicular symptoms, Dr. Mahr finally ordered an MRI of Petitioner's cervical spine on January 8, 2019. (Petitioner's Exhibit #4, pp. 113-114).

Following her right shoulder surgery on March 18, 2019, the Arbitrator notes that the radicular symptoms in Petitioner's right arm continued.

On May 23, 2019, Petitioner advised the doctor that she was experiencing pain radiating into her axilla and pain radiating down her right arm into her forearm following physical therapy. (Petitioner's Exhibit #4, pp. 127-128).

On July 30, 2019, Petitioner still complained of radial pain in the anterolateral aspect of her right shoulder and numbness and tingling going down her right arm. (Petitioner's Exhibit #4, pp. 129-130).

On September 17, 2019, Petitioner continued to complain of pain along the anterior aspect of her right shoulder with movement that radiates from the anterior aspect of her arm to her axilla, down her forearm, to her fourth and fifth fingers. (Petitioner's Exhibit #4, pp. 135-136).

On October 14, 2019, Petitioner complained of significant pain in the anterior aspect of her right shoulder that radiates down all the way to her fingers through her biceps anteriorly. Petitioner also advised the doctor that

she gets numbness and paresthesias in her hand approximately 2 times per week. (Petitioner's Exhibit #6(b), pp. 157-158).

On March 2, 2020, Petitioner complained of right-sided shoulder pain and neck pain radiating to the right posterior shoulder and down to the hand on the right side for the past two years. (Petitioner's Exhibit #6(b), pp. 110-111).

Following her third shoulder surgery on March 12, 2020, the radicular symptoms in Petitioner's right arm continued once again.

On March 18, 2020, six (6) days after surgery, Petitioner complained of intermittent numbness and tingling in the digits of her right hand. (Petitioner's Exhibit #6(b), pp. 100-101).

On September 16, 2020, Dr. Terry noted that Petitioner still had radiation of pain down into her digits. (Petitioner's Exhibit #6(b), pp. 67-68).

On October 5, 2020, Dr. Hsu noted that following the surgery on March 12, 2020, Petitioner had improvement with her right shoulder pain, but she continued to have pain in her neck and radiating pain into the right shoulder blade, armpit and down the anteromedial aspect of her arm into the fourth and fifth digits of her right hand. (Petitioner's Exhibit #6(b), pp. 57-59).

On January 22, 2021, Respondent's Section 12 medical examiner noted that Petitioner had right sided neck pain with radiation to the right shoulder blade and axilla. (Respondent's Exhibit #2).

On January 18, 2021, Dr. Terry noted that Petitioner was experiencing persisting clavicle pain and right upper extremity radiculopathy. (Petitioner's Exhibit #6(b), pp. 12-13).

On May 17, 2021, Dr. Terry noted that Petitioner continued to complain of pain in her neck, tingling, and numbness down the front part of her arm, around her scapula and down into her fourth and fifth digits. (Petitioner's Exhibit #7(b), p. 36).

As indicated above, the Arbitrator recognizes that proof of the state of good health of the Petitioner prior to and down to the time of injury, and then change immediately following the injury and continuing thereafter, is competent as tending to establish that the impaired condition was due to the injury. *Spector Freight System, Inc. v. Industrial Commission*, 93 Ill. 2d 507, 513, 445 N.E.2d 280, 67 Ill. Dec. 800 (1983).

Based on this analysis, the Arbitrator finds that, in the instant case, Petitioner has established a causal connection between her current condition of ill-being, as it relates to her cervical spine and her work accident on December 2, 2017. The record is clear that Petitioner's symptoms of right arm radiculopathy, which are indicative of a cervical spine injury, began immediately following her work injury, and have continued since that time. It is equally clear that Petitioner never had these symptoms prior to her work injury.

The Arbitrator also notes that Petitioner's treating spine surgeon, Dr. Hsu directly connects Petitioner's condition of ill-being, as it relates to her cervical spine, to her work accident on December 2, 2017.

Specifically, the Arbitrator notes that Dr. Hsu testified that, "…the work-related accident aggravated her preexisting condition of a C5-6 posterior osteophyte complex." (Petitioner's Exhibit #9, pp. 17-18). Dr. Hsu further explained that his opinion was "…based upon the history that she did not have any symptoms before the accident and after the accident did have symptoms and that she continued to require treatment throughout her recovery course." (Petitioner's Exhibit #9, p. 18).

In addition, the Arbitrator finds particularly persuasive, Dr. Hsu's testimony regarding how he determined that Petitioner's symptoms were caused by a problem in her cervical spine at the C5-C6 level. The doctor explained, "If there is temporary improvement of pain from an epidural injection, that is a good prognostic indicator for a success with surgery." (Petitioner's Exhibit #9, p. 13).

The Arbitrator notes that Petitioner had a cervical epidural steroid injection under fluoroscopic guidance at the C5-C6 interspace on October 19, 2020. (Petitioner's Exhibit #7(a), pp. 18-21). Following the epidural steroid injection, Petitioner returned to see Dr. Hsu. When asked about Petitioner's symptoms at her next appointment one week later on October 26, 2020, Dr. Hsu testified, "She reported complete resolution of her symptoms with an epidural injection. And so, as a result, it was my opinion that she aggravated her C5-6 disc herniation with her work related injury from 2017." (Petitioner's Exhibit #9, p. 14).

Dr. Hsu explained the reasoning behind his opinion:

> "So she complained to me of right sided arm pain and neck pain along with shoulder pain after the work-related injury. After denying any previous treatments for those symptoms, it became my conclusion that she aggravated her cervical posterior osteophyte complex or stenosis as a result of that said injury. The fact that the epidural injection improved her pain temporarily indicated to me that she would be a good candidate for further aggressive treatment such as surgery for the C5-6 posterior osteophyte complex." (Petitioner's Exhibit #9, pp. 14-15).

The Arbitrator notes that Respondent's Section 12 medical examiner, Dr. Tack, is of the opinion that Petitioner did not injure her cervical spine as a result of her work accident on December 2, 2017. (Respondent's Exhibit #2). Dr. Tack testified that it was his opinion that Petitioner did not have a problem with her cervical spine and that her problem was "…an ongoing shoulder problem that hasn't resolved with three surgeries." (Respondent's Exhibit #3, p. 22).

The Arbitrator notes that Dr. Tack further testified he believes Petitioner underwent three ineffective shoulder surgeries, and because she does not have normal shoulder function, that she complains of neck pain, and that operating on an incidental MRI finding is not going to improve her condition at all. (RX3 at 31).

The Arbitrator notes that Dr. Tack diagnosed cervical spondylosis with spinal stenosis at C5-C6. Dr. Tack opined this was a non-injury related diagnosis and represented a pre-existing condition, as there was no evidence from the history of injury or medical records that this has any reasonable relationship to the December 2, 2017 accident, and stated it was an entirely degenerative disorder

When weighing the opinions of Dr. Hsu and Dr. Tack, the Arbitrator finds the opinion of Dr. Hsu more persuasive. Both doctors agree that Petitioner suffered from a degenerative condition in her cervical spine that

pre-dates the work accident. Dr. Hsu is of the opinion that Petitioner's work accident aggravated her pre-existing cervical spine condition causing the present need for surgery. Dr. Tack believes that Petitioner did not injure her cervical spine as a result of her work accident, and that any symptoms Petitioner is experiencing are originating from her right shoulder injury.

The Arbitrator finds that it is more probably true than not that Petitioner injured her cervical spine at the time of her work injury, thus aggravating the degenerative condition and causing the need for surgery. The Arbitrator's decision is supported by the fact that Petitioner complained of diminished right sided grip strength, right arm weakness numbness and tingling immediately following her work injury. While it is true that Petitioner had many other symptoms that were eventually resolved as a result of the three shoulder surgeries that were performed, the numbness and tingling in her right arm and right hand has persisted.

In addition, the Arbitrator is persuaded by the complete, albeit temporary, resolution of Petitioner's symptoms following her cervical epidural steroid injection at the C5-6 level on October 19, 2020.

Based on the foregoing, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that her condition of ill-being, as it relates to her cervical spine, is causally related to her work accident on December 2, 2017.

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

The Arbitrator finds that the medical services provided to Petitioner were reasonable and necessary. In addition, the Arbitrator finds that Respondent has not paid all appropriate charges for all reasonable and necessary medical services.

The Findings of Fact and Conclusions of Law, as stated above, are adopted herein.

The Arbitrator notes that Petitioner submitted medical bills from Central Primary Care for services rendered on August 2, 2018, in the amount of $320.00; Advantage MRI Logan Square, for services rendered on January 17, 2019, in the amount of $3,500.00; Specialists in Medical Imaging for services rendered on July 11, 2019 and October 28, 2019, in the amount of $645.00; ATI Physical Therapy, for services rendered from August 7, 2019 through July 22, 2021, in the amount of $41,825.21; and Northwestern Medicine, for services rendered on July 26, 2021, in the amount of $92.40. (Petitioner's Exhibit #1).

In reviewing these medical bills, the Arbitrator notes that the Central Primary Care bill was for treatment with Dr. Sawlani where the doctor examined her right shoulder. (Petitioner's Exhibit #4, pp. 68-70). The Advantage MRI Logan Square bill was for MRIs of Petitioner's right shoulder and cervical spine. (Petitioner's Exhibit #4, pp. 150-151). The Specialists in Medical Imaging bill was for an MRI of Petitioner's right shoulder at Resurrection Medical Center on July 11, 2019 and an MRI of Petitioner's cervical spine at Resurrection Medical Center on October 28, 2019. (Petitioner's Exhibit #3, pp. 88, 100). The ATI Physical Therapy bill was for physical therapy to Petitioner's right shoulder and cervical spine. (Petitioner's Exhibit #12). Lastly, the Northwestern Medicine bills was for Petitioner's appointment with Dr. Terry for her right shoulder. (Petitioner's Exhibit #7(b), pp. 6-7).

The Arbitrator notes that each of the unpaid medical bills contained in Petitioner's Exhibit #1 is a result of medical treatment for Petitioner's right shoulder or cervical spine. Based on the Arbitrator's findings above, both of these conditions are causally connected to Petitioner's work injury on December 2, 2017.

The Arbitrator notes that Respondent has not provided any evidence to dispute the reasonableness or necessity of medical treatment reflected in the bills contained in Petitioner's Exhibit #1.

Based on the foregoing, the Arbitrator finds that Petitioner has proved, by a preponderance of the evidence, that the medical bills contained in Petitioner's Exhibit #1 were reasonable and necessary. Accordingly, the Arbitrator finds that the medical bills contained in Petitioner's Exhibit #1 should be paid by Respondent, pursuant to Section 8.2 of the Illinois Workers' Compensation Act.

(K) Is Petitioner entitled to any prospective medical care?

The Arbitrators find that Petitioner is entitled to the C5-C6 anterior discectomy and fusion surgery that has been recommended by Dr. Wellington K. Hsu.

The Findings of Fact and Conclusions of Law, as stated above, are adopted herein.

As referenced above, the Arbitrator notes that there is a difference of opinion between Dr. Hsu and Dr. Tack regarding the medical care required for Petitioner's cervical spine. Dr. Hsu has recommended that Petitioner undergo a C5-6 anterior cervical discectomy and fusion. (Petitioner's Exhibit #9, p. 15). Within his report, Dr. Tack did not offer an opinion regarding what treatment would be reasonable and necessary for her cervical spine. Instead, Dr. Tack stated, "To the extent that Ms. Scott and her treating physicians believe that treatment is appropriate, this would be based on a pre-existing condition." (Respondent's Exhibit #2, p. 7). However, when later asked about the reasonableness and necessity of surgery that had been recommended by Dr. Hsu, Dr. Tack testified that "I don't think the problem is the cervical spine. I mean the cervical spine is not her problem. She's got an ongoing shoulder problem that hasn't resolved with three surgeries." (Respondent's Exhibit #3, p. 22).

As determined above, the Arbitrator provides more weight to the opinion of Dr. Hsu than the opinion of Dr. Tack. Dr. Hsu explained that, "If there is temporary improvement of pain from an epidural injection, that is a good prognostic indicator for a success with surgery." (Petitioner's Exhibit #9, p. 13). The Arbitrator notes that Petitioner had a cervical epidural steroid injection under fluoroscopic guidance at the C5-C6 interspace on October 19, 2020. (Petitioner's Exhibit #7(a), pp. 18-21). Following the epidural steroid injection, Petitioner returned to see Dr. Hsu. one week later, on October 26, 2020. When asked about Petitioner's symptoms at that appointment, Dr. Hsu testified, "She reported complete resolution of her symptoms with an epidural injection. And so, as a result, it was my opinion that she aggravated her C5-6 disc herniation with her work-related injury from 2017." (Petitioner's Exhibit #9, p. 14).

Comparatively, Dr. Tack based his opinion, at least in part, on his review of the same epidural injection and testified that the injection, "…interestingly isn't at the level in question." (Respondent's Exhibit #3, p. 21). However, a close review of the record in question indicates that while the "Plan" mistakenly identifies that

injection level as "C7-T1", the actual procedure indicates that the injection was performed at the C5-C6 interspace. (Petitioner's Exhibit #7(a), pp. 18-21).

The Arbitrator is further persuaded by Petitioner's ongoing symptoms of numbness and tingling in the right arm and hand that are documented in her medical records from the date of her work accident and have continued through the date of hearing, despite three (3) shoulder surgeries.

Based on the foregoing, the Arbitrator finds that the Petitioner has proved, by a preponderance of the evidence, that the C5-C6 anterior discectomy and fusion surgery that has been recommended by Dr. Hsu is reasonable and necessary medical treatment for Petitioner's condition of ill-being. Therefore, the surgery and reasonable and necessary medical treatment incidental thereto, should be provided by Respondent.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	20WC006711
Case Name	HEMMER, LORI v. STATE OF ILLINOIS - ILLINOIS STATE UNIVERSITY
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0230
Number of Pages of Decision	9
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Dirk May
Respondent Attorney	Bradley Defreitas

DATE FILED: 6/22/2022

/s/Marc Parker, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF McLEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lisa Hemmer,

Petitioner,

vs. NO: 20 WC 6711

Illinois State University,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 12, 2022, 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.

Pursuant to §19(f)(1) of the Act, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

June 22, 2022
MP:yl
o 6/16/22
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/s/ *Marc Parker*
Marc Parker

/s/ *Carolyn M. Doherty*
Carolyn M. Doherty

/s/ *Christopher A. Harris*
Christopher A. Harris

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	20WC006711
Case Name	HEMMER, LORI v. ILLINOIS STATE UNIVERSITY
Consolidated Cases	
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	6
Decision Issued By	Bradley Gillespie, Arbitrator

Petitioner Attorney	Dirk May
Respondent Attorney	Bradley Defreitas

DATE FILED: 1/12/2022

THE INTEREST RATE FOR THE WEEK OF JANUARY 11, 2022 0.27%

/s/Bradley Gillespie, Arbitrator

Signature

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

January 12, 2022

/s/ Michele Kowalski

Michele Kowalski, Secretary

Illinois Workers' Compensation Commission

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

LORI HEMMER
Employee/Petitioner

v.

ILLINOIS STATE UNIVERSITY
Employer/Respondent

Case # **20** WC **006711**

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 **BRADLEY GILLESPIE**, Arbitrator of the Commission, in the city of **BLOOMINGTON**, on **12/22/2021**. By stipulation, the parties agree:

On the date of accident, **11/01/2019**, 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 $**44,862.00**, and the average weekly wage was $**862.73**.

At the time of injury, Petitioner was **59** years of age, ***single*** with **0** dependent children.

Necessary medical services and temporary compensation benefits have been provided by Respondent.

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury and attaches the findings to this document.

ORDER

Respondent shall pay Petitioner the sum of $**517.64**/week for a further period of **15** weeks, as provided in Section **8(d)(2)** of the Act, because the injuries sustained caused **permanent partial disability to the extent of 3% of the person**.

What is the nature and extent of the injury?

An analysis applying the five statutory factors set forth in ILCS 305/8.1b(b) is as follows:

Regarding subsection (i) of §8.1b(b), the Arbitrator notes that Dr. Bender provided permanent partial disability impairment rating of 0. The Arbitrator has considered and gives moderate weight to this factor.

Regarding subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a Catering Administrator at the time of the accident and that she was able to return to work in her prior capacity. The Arbitrator has considered and gives limited weight to this factor.

Regarding subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 59 years old at the time of the accident. The Arbitrator therefore gives limited weight to this factor.

Regarding subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner 's wage remained the same after she returned to work. Petitioner testified on cross-examination that her wages in her new position were greater than those earned for Respondent. The Arbitrator has considered and therefore gives limited weight to this factor.

Regarding subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner was diagnosed with lumbar radiculitis. Petitioner's lumbar MRI shows degenerative disc disease with small herniations at L1-2, L3-4, L4-5 and L5-S1. (PX 1). Petitioner testified that she experiences low back pain that runs into the left leg after bending and long workdays. Petitioner treats the pain with ice and over the counter Advil approximately once a week. The Arbitrator therefore gives significant 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 3% loss of use of the person pursuant to §8(d)2 of the Act.

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

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

Bradley D. Gillespie **JANUARY 12, 2022**

Signature of Arbitrator

BEFORE THE ILLINOIS WORKERS COMPENSATION COMMISSION
BLOOMINGTON, ILLINOIS

LORI HEMMER,	)	
	)	
Petitioner,	)	
	)	
v.	)	**Case NO.: 20 WC 006711**
	)	
ILLINOIS STATE UNIVERSITY,	)	
	)	
Respondent.	)	

ADDENDUM TO THE NATURE AND EXTENT DECISION OF THE ARBITRATOR

This matter proceeded to hearing on December 22, 2021 in Bloomington, Illinois (Arb. #1). The following issues were in dispute:

- Nature and Extent of Injuries

FINDINGS OF FACT

The parties stipulate and agree that the sole issue in dispute is the nature and extent of the Petitioner's injuries. (Arb. #1) On November 1, 2019, Lori Hemmer [hereinafter "Petitioner"] worked for Illinois State University [hereinafter "Respondent"]. Petitioner testified that she was employed by Respondent as a catering administrator on the November 1, 2019. (Tr. p. 10, *see also* RX #2 & RX #3) Petitioner stated that she was lifting a beverage tub with a student assisting her when she experienced a twinge in her back. *Id.* She estimated that the beverage tub weighed approximately 50 pounds. *Id.* Petitioner testified that she felt a twinge in her low back, numbness in her left leg, problems bending over and twisting following the incident. (Tr. pp. 10-11) Petitioner was evaluated and received treatment from Dr. Mary Yee-Chow at OSF Saint Joseph Medical Center in Bloomington, Illinois. (PX #1) Petitioner was diagnosed with radiculopathy in her lumbar region and prescribed Meloxicam. (PX #1, Tr. p. 11) Petitioner underwent an MRI of the Lumbar Spine on December 10, 2019 which revealed low-grade degenerative disc disease with small disc herniations at L1-L2, L3-L4, and L4-L5. (PX #1) Petitioner underwent physical therapy from November 18, 2019 thru January 15, 2020 at Advanced Rehab & Sports Medicine Services. (PX #2) Petitioner testified that she returned to work without restrictions on January 24, 2020. (Tr. p. 11)

Petitioner testified that she returned to work in her former job. (Tr. pp. 11-12) Petitioner described pain in her low back and left leg when she works ten to twelve hour days. (Tr. p. 12) She described a tingling, pulsating pain in her low back which she described as sometimes burning, sometimes aching or a shooting pain down her left leg. *Id.* She stated that she is mindful of the tasks she performs and seeks help when anything heavy has to be lifted. (Tr. p. 13) Petitioner testified that she continues to use Advil and ice for her symptoms approximately once a week. (Tr. p. 13) Petitioner testified that she currently works at Illinois Wesleyan

University as the catering manager there. (Tr. pp. 13-14) She testified that her duties are similar, but the events tend to be smaller. (Tr. p. 14) On cross examination, Petitioner admitted that she makes more money than she did at her previous position with Respondent. (Tr. p. 15)

At the request of Respondent, Petitioner was sent for an Independent Medical Evaluation with Dr. Frank J. Bender, a Board Certified Physiatrist on December 17, 2020. (PX #3). Dr. Bender felt that Petitioner had left lumbar radiculitis due to the back injury sustained at work on November 1, 2019. *Id.* Dr. Bender provided an AMA impairment rating of 0%.

CONCLUSIONS OF LAW

Regarding Issue (L); What is the nature and extent of the injury, the Arbitrator finds and concludes as follows:

An analysis applying the five statutory factors set for the in ILCS 305/8.1b(b) follows:

Regarding subsection (i) of §8.1b(b), the Arbitrator notes that Dr. Bender provided permanent partial disability impairment rating of 0. The Arbitrator has considered and gives moderate weight to this factor.

Regarding subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a Catering Administrator at the time of the accident and that she was able to return to work in her prior capacity. The Arbitrator has considered and gives limited weight to this factor.

Regarding subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 59 years old at the time of the accident. The Arbitrator therefore gives limited weight to this factor.

Regarding subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner 's wage remained the same after she returned to work. Petitioner testified on cross-examination that her wages in her new position were greater than those earned for Respondent. The Arbitrator has considered and therefore gives limited weight to this factor.

Regarding subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner was diagnosed with lumbar radiculitis. Petitioner's lumbar MRI shows degenerative disc disease with small herniations at L1-2, L3-4, L4-5 and L5-S1. (PX 1). Petitioner testified that she experiences low back pain that runs into the left leg after bending and long workdays. Petitioner treats the pain with ice and over the counter Advil approximately once a week. The Arbitrator therefore gives significant 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 3% loss of use of the person pursuant to §8(d)2 of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	20WC018985
Case Name	LUCERO, EDGAR v. FOCAL POINT, LLC
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0231
Number of Pages of Decision	45
Decision Issued By	Christopher Harris, Commissioner

Petitioner Attorney	Matthew Smart
Respondent Attorney	G. Steven Murdock

DATE FILED: 6/22/2022

/s/Christopher Harris, Commissioner

Signature

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

EDGAR LUCERO,

Petitioner,

vs. NO: 20 WC 18985

FOCAL POINT, LLC,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed under Section 19(b) of the Act by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, occupational disease, causal connection, medical expenses and temporary total disability (TTD) 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. 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. Indus. Comm'n*, 78 Ill. 2d 327 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 21, 2021 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.

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 $25,300.00. 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 the Circuit Court.

June 22, 2022

/s/ *Christopher A. Harris*
Christopher A. Harris

CAH/pm
O: 6/16/22
052

/s/ *Carolyn M. Doherty*
Carolyn M. Doherty

/s/ *Marc Parker*
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	20WC018985
Case Name	LUCERO, EDGAR v. FOCAL POINT, LLC
Consolidated Cases	No Consolidated Cases
Proceeding Type	19(b) Petition
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	42
Decision Issued By	Joseph Amarilio, Arbitrator

Petitioner Attorney	Matthew Smart
Respondent Attorney	G. Steven Murdock

DATE FILED: 10/21/2021

THE INTEREST RATE FOR THE WEEK OF OCTOBER 19, 2021 0.06%

/s/ Joseph Amarilio; Arbitrator

Signature

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)

EDGAR LUCERO
Employee/Petitioner

v.

FOCAL POINT, LLC
Employer/Respondent

Case # **20** WC **018985**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Joseph Amarilio**, Arbitrator of the Commission, in the city of **Chicago**, on **July 20, 2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☒ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the 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 **8(a)**

FINDINGS

On the date of accident, April 17, 2020, the date in which the Petitioner was medically diagnosed with COVID-19), Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, the Petitioner ***did*** sustain a disease arising out of and in the course of the employment or one which had become aggravated and rendered disabling as a result of the exposure of the employment.

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

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

In the year preceding the injury, Petitioner earned $**41,230.80**; the average weekly wage was $**792.90**.

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

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

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0**. Respondent is entitled to a credit of $ **(see below)** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits in the amount of $528.60 /week for 47-5/7 weeks, commencing April 17, 2020 through March 16, 2021, as provided in Section 8(b) of the Act.

Respondent is entitled to a credit for all medical expenses incurred by Petitioner and paid by his group health insurance plan provided by Respondent under Section 8(j) of the Act. Respondent shall hold Petitioner harmless for the medical expenses paid. The parties stipulated that the medical expenses incurred were submitted to and all paid by Respondent's group health insurance carrier. No claim has been made for unpaid medical bills

Respondent shall pay all reasonable and necessary ongoing medical services to cure and relieve the Petitioner's COVID-19 symptoms.

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.

Joseph D. Amarilio

Electronic Signature of Arbitrator Joseph D. Amarilio

OCTOBER 21, 2021

ICArbDec19(b)

THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ADDENDUM TO ARBITRATION 19(B) DECISION

EDGAR LUCERO

v. **20 WC 018985**

FOCAL POINT, LLC

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Procedural History

The parties stipulated that on April 17, 2020, Petitioner was a 51-year old employee of Respondent. The parties agreed that Petitioner was earning $792.90 per week ($41,230.80 per year) in his employment with Respondent. (T. p. 5) Notice of the alleged accidental exposure was timely provided to Respondent. The parties further agreed that Respondent is entitled to Section 8(j) credit for all of Petitioner's medical expenses which have been paid by Respondent's group health insurance plan. Respondent disputed the claim and, thus, has not paid benefits to the Petitioner. (Arb. Ex. 1)

At the outset, the Arbitrator takes judicial notice that Petitioner's claimed exposure to the COVID-19 virus was brought by an Application for Adjustment of Claim filed with the Commission under the Illinois Workers' Compensation Act and not pursuant to the Occupational Disease Act (ODA) A copy of the Application for Adjustment of Claim in this matter was not submitted as an exhibit. However, the Arbitrator finds that at all-times relevant hereto the parties treated the claim as an exposure claim and Respondent defended the claim accordingly.

The Arbitrator further notes that the Commission may consider *sua sponte* a new theory of recovery even if that theory was never presented to the arbitrator and the claimant did not amend his application for adjustment of claim to include the new theory. The Commission enjoys such discretion as long as the Commission's consideration of the new theory does not prejudice a party's substantial rights. The Commission's decision to grant benefits under a new theory of recovery does not prejudice an employer's substantial rights if the employer is aware of evidence supporting the theory before the arbitration. *Caterpillar Tractor Co. v. Industrial Comm'n,* 215 Ill.App.3d 229, 240 (1991)

The matter of *Martin Didzerekis v Madden Graphics*, 97 IIC 820 (1997) 93 WC 307440 is clearly instructive and four-corners on point. In *Didzerekis,* like the instant case, petitioner did not indicate on his application for adjustment of claim that he would prosecute his claim under the Occupational Disease Act (ODA) (820 ILCS 310/1). And, like the instant case, petitioner also did not indicate that the claimed injury was a disease or what part of the body affected nor that it involved his pulmonary function. Additionally, in *Didzerekis* like the case at bar, at trial Petitioner did not amend his application for adjustment of claim to reflect that he was claiming an injury pursuant to the ODA or that he was claiming a disease. However, at trial, as in the case at bar, it was made clear that petitioner was prosecuting an exposure claim. As noted above, like respondent in *Didzerekis*, Respondent had all the information available to research, investigate, and defend the claim filed by claimant. *See, also John Dial v. John Crane, Inc,* 92 WC 002800, 94 IWCC 692 (1994) (Commission found Petitioner's hearing loss resulting from extended exposure to noise in a work environment is properly adjudicated un the Occupational Disease Act. The Commission modified the Arbitrator's decision which adjudicated the claim under the Workers' Compensation Act and converted it to an Occupational Disease claim.)

Here, Respondent was aware that the Petitioner was pursuing a COVID-19 claim. Petitioner did so at the hearing. It is evident that Respondent had all the information available to research, investigate, and defend the claim filed by Petitioner. In fact, Respondent's defense is founded on rebutting the COVID-19 presumption and disputing and negating Petitioner's claimed exposure to the COVID-19 virus on Respondent's premises. In workers' compensation and occupational disease cases, pleadings and procedures are informal and are designed to expedite and to achieve a right result. *Caterpillar Tractor Co. v. Industrial Comm''n* at 239. "Thus, the Commission must decide a case on the evidence presented and on the merits of the case before it and must not be restricted to the information provided on a form." *Id.*

The Arbitrator concludes that deciding Petitioner's claim under the Occupational Disease Act does not prejudice Respondent's substantial due process rights. The Arbitrator, therefore, concludes that Petitioner's COVID-19 claim is properly adjudicated under the Occupational Disease Act rather than the Workers' Compensation Act.

Having addressed which theory is proper and appropriate to adjudicate the claim, the Arbitrator now addresses the following five issues presented by the parties at the hearing: (1) whether Petitioner's accidental exposure arose out of and in the course of his employment with Respondent on April 17, 2020, as alleged in the Request for Hearing Form; (2) whether Petitioner's condition of ill-being is causally related to the alleged accidental exposure; (3) whether Respondent is liable for the medical expenses incurred; (4) whether Respondent is liable for temporary total disability benefits (TTD); and, (5) whether Respondent is liable for ongoing and prospective medical care pursuant to Section 8(a) of the Act. (Arb. Ex. 1)

This matter was brought before the Arbitrator pursuant to Sections 19(b) and 8(a) of the Act, and any claim for permanent disability benefits is reserved for future hearing.

FINDINGS OF FACT

Petitioner testified, without an interpreter, that he was employed by Respondent, a lighting manufacturer, as a CNC Operator. (Tr. p. 10-11) As a CNC Operator, Petitioner operated a laser to cut aluminum and steel to make parts for lights. He had performed this job for Respondent for about ten years. (Tr. p. 12)

On March 21, 2020, Illinois Governor Pritzker issued an Executive Order that required all businesses, with the exception of "essential businesses," to shut down operations. Respondent's business continued to operate as an essential business. (Tr. p. 12) Petitioner continued to report for work after the stay-at-home Order issued on March 21, 2020, carrying with him a document provided by Respondent confirming he worked for an essential business in case he was stopped by authorities traveling to and from work. (Tr. p. 12-13) The stay-at-home order was issued for the health and welfare of the people of the State of Illinois.

As of March 21, 2020, Petitioner had no fevers, chills or shortness of breath but did admit to having a cough that he associated with seasonal allergies he has dealt with much of his adult life. (Tr. p. 13) Petitioner commuted the 2.7 miles from his home to work in his own personal vehicle. He lived in a two-flat residence with his wife occupying the first floor (or flat), and his adult children occupying the second flat with each flat having its own entrance. (Tr. at p. 13-14). On cross-examination, Petitioner admitted that his children did stop by but not often and not long. Petitioner's testimony as to his limited interactions is consistent with Petitioner working on the second shit and being an empty nester. (Tr. at p. 32-34). Petitioner's two flat was in the same area code as Respondent's factory. He further testified on cross-examination that at the time of the stay-at-home order, his son was employed by UPS loading trucks, his daughter worked for a

pet supply company, and his wife was not working. (Tr. at p. 30-31). Petitioner testified that neither his son nor his daughter had showed any symptoms or tested positive for COVID-19 prior to his illness. His testimony is corroborated by the medical records (Tr. at p. 39, Px 1, Px 2).

Petitioner testified that his wife did the primary grocery shopping and other household errands prior to the stay-at-home order, and that circumstance did not change after the order was in place. (Tr. At p. 14). Petitioner testified that other than going to work and stopping to for gasoline which he paid at the pump, he did not go anywhere else after the stay-at-home order was in place. (Tr. at p. 14-15). Petitioner stated, quite accurately, "[There] was really nowhere else to go." His life revolved around work and home. (Tr. at p. 15).

Much of the trial testimony was understandably focused on the conditions of Petitioner's employment at the facility, including the location of his workstation, his interactions with other co-workers, and what safety measures were put in place, and when. Petitioner described the workplace as a large facility encompassing several blocks with two buildings divided into four sections. The buildings were labeled as 4141 and 4142. (Tr. p. 15) Petitioner testified that his workstation was located on the east side of building 4041 about two-and-a-half to three feet from the door of the facility leading to a large employee parking lot. (Tr. at p. 16). The time clocks were located even closer to his workstation. Petitioner testified the time clocks were located a foot closer than the door to his workstation. Petitioner stated that a time clock was located next to this door that was still a manual punch clock as of March 21, 2020. (Tr. p. 16) He then described two clocks, one that used finger scans for temporary employees and one that used whole hand scans for regular employees. (Tr. p. 16-17) There were three different time clock stations in each of the two buildings. (Tr. p. 70)

When asked if Respondent moved his workstation away from the door or the time clock after the Covid-19 pandemic began, he testified that his workstation remained in the same place.

(Tr. at p. 19). Petitioner testified that during that same time, masks were not mandated by the company, but rather, they were encouraged. (Tr. at p. 17).

Petitioner testified that the operations of the Respondent's facility were broken into two shifts, with the first shift ending and the second shift beginning at 2:30 p.m. and ending 10:30 p.m. (Tr. at p. 17-18). When the COVID-19 pandemic began, Petitioner testified that there were no modifications made to the shift schedule so as to allow for decontamination or deep-cleaning of workstations between the shifts. (Tr. at p. 18). In fact, Petitioner testified it was left up to each individual person to clean their workstation if they could. (Tr. at p. 18). Furthermore, Petitioner testified that the people entering and exiting the building would be doing so around the shift change, increasing the flow of people near each other in the halls and near the time clock. (Tr. at P. 18). Petitioner did not socialize at work, and the CNC machine on which he works is run by only one person. (Tr. p. 35) Petitioner's testimony is corroborated by the medical records noting that he is not one to socialize, even with his own family. (Px 1a)

Petitioner also testified about his awareness of co-workers contracting the COVID-19 virus after the March 21st Order, but before he himself became ill. Petitioner testified that he was notified through a company-wide text-messaging system that co-workers had tested positive for the COVID-19 virus. A copy of those text messages was not introduced into evidence by either party. (Tr. at p. 20). Furthermore, he testified this information was affirmed in a meeting held at Respondent's facility on a Tuesday or Wednesday the week before Petitioner became ill. [Tuesday, April 7th or Wednesday, April 8th] (Tr. at p. 20). Petitioner testified that the general in-person meeting was held near where he worked with roughly 20 to 25 people attending the meeting. (Tr. at p. 20-21). He testified that not all of the people in that group were wearing masks. He testified that half of them were wearing masks as the company was still in the process of making and supplying employees with masks. (Tr. p. 21, 36) (Tr. at p. 21). Petitioner testified

that the purpose of the general meeting was to notify the employees of the positive tests as well as to instruct the workers that they would be spending their shift putting up plastic screens between workstations. (Tr. at p. 20). On cross-examination, Petitioner was questioned about whether the meeting took place in the parking lot of the company, to which he replied, "No, it was inside." (Tr. at p. 36). Petitioner testified on cross-examination that there were roughly 25 employees at the meeting, with people from first shift, and few from the second shift and some maintenance people. (Tr. at p. 36). When questioned where in the building the meeting occurred, he testified that the meeting took place in the section of the facility reserved "for some new product that we have." (Tr. at p. 36). He testified that there was enough space for the group in that area at the time, but that the area in question was converted in the last year as an extension was built. (Tr. at p. 36-37). He testified he was not told whether the employee who tested positive for Covid-19 was working in his building of the facility or not. (Tr. at p. 37).

Petitioner testified that he first noticed symptoms of COVID-19 on April 13, 2020. (Tr. at p. 21). His wife called his primary care physician on April 17, 2020, and Petitioner was instructed to get a COVID-19 test. (Tr. at p. 22). He testified that he got the test, and the test results came back negative for the virus. (Tr. at p. 22). Petitioner testified that his condition worsened to the point that he nearly lost consciousness, which prompted his wife to take him to the emergency room at Mount Sinai Hospital in Chicago. (Tr. at p. 22-23).

It was mentioned that before the pandemic, about 275 employees worked in the first and second shift worked in each building for a total of about 550 employees After the pandemic, the number of employees dropped from about 70 percent and at one time to a low point of about 50 percent. (Tr. p. 78). It was not brought out when this occurred nor what percentage work force were factory workers and what percent were management working remotely.

On April 13, 2020, Petitioner testified he was not feeling well and having COVID-19 symptoms. April 13, 2020 was his last day of work (Tr. p. 21-22) When he did not begin feeling better over the next few days, his wife made an appointment to see his primary care physician on April 17, 2020. The physician referred Petitioner for a COVID-19 test, which Petitioner had completed on April 18, 2020. That test returned with a negative result for COVID-19 infection. (Tr. p. 22) By April 20th, Petitioner's symptoms became so severe he nearly passed out, and his wife took him to the emergency room at Mount Sinai Hospital. (Tr. p. 22-23)

Petitioner does not recall much after he went to the hospital on April 20, 2020 (Tr. p. 38), but testified he was placed in isolation at Mount Sinai Hospital where he was intubated on April 22, 2020 and placed in the intensive care unit (ICU). His treatment is well documented with well over 5,000 pages of records. The Rush Medical Center records alone contain 2,918 pages.

In brief summary, Petitioner, due to the severity of illness, was transferred that same day to Rush University Medical Center where he remained through May 26, 2020. (Tr. p. 23) It was at Rush that he first tested positive after another false negative test for the COVID-19 virus. On May 26, 2020, he was transferred from Rush to Kindred Hospital while still intubated for inpatient rehabilitation. (Tr. p. 24) He remained at Kindred Hospital through June 23, 2020, when he was discharged with instructions to continue following up with his primary care physician at Esperanza Health Clinic. (Tr. p 25) Following his discharge from the hospital, Petitioner continued to remain medically authorized off work as he required supplemental oxygen 24 hours per day and because he had difficulty walking due to breathing difficulties following his illness. (Tr. p. 26) Over time, he was gradually able to walk farther and to wean himself off the supplemental oxygen during waking hours. (Tr. p. 27-28) On March 10, 2021, Petitioner received a release from both physicians to return to work without restrictions and has been back to work since that date. (Tr. p. 28) As of the date of the hearing, Petitioner continued

to use supplemental oxygen while sleeping only and on days when humidity is high. He also continued to take medications prescribed by his primary care physician and his pulmonologist. (Tr. p. 28) Petitioner was observed by the Arbitrator during the hearing to have some difficulty catching his breath and having to use his inhaler on at least one occasion.

Respondent's witness, Marlen Ortega, testified that she is employed as Director of Human Resources for Respondent, a position she has held since 2016. (Tr. p. 43) She received a Bachelor's of Science Degree in Communications from Aurora University which she hesitantly stated she believed was in 2005 and an SHRM certification in human resources in 2007, which she believed it was renewed in 2011 and very four years since then. (Tr. p. 41-42)

Ms. Ortega testified that Focal Point began to focus attention on the COVID-19 outbreak as early as January 2020 before it was declared a pandemic due to the alarming way it was spreading. (Tr. p. 44) In February of 2020, Respondent (with its soon-to-be parent company) began working on contingency plans in the event the Covid-19 virus took hold in the United States. (Tr. at p. 44). She explained their contingency plans were broken into phases depending on the size and scope of the spread of the virus through the community. (Tr. at p. 44-45). These conversations were held by the executive team of Respondent and the ownership (parent company) of Respondent. (Tr. at p. 45-46). Ms. Ortega mentioned that Respondent was officially acquired by the parent company, Legrand, in March of 2020. (Tr. at p. 46).

Ms. Ortega testified that Legrand gave Respondent a "tremendous amount of guidance" on COVID-19 protocols through what she called the "COVID Safety Committee." (Tr. at p. 46-47). Ms. Ortega identified Respondent's Exhibit 1, a General Policies document pertaining to Respondent's (and Legrand's) COVID-19 policies, which the document states in effect as of March 13, 2020. (Tr. at p. 47). She testified that Respondent adopted the policies contained in RX1 as their own. (Tr. at p. 47). In fact, Ms. Ortega testified that Respondent itself began

implementation of the policies two days prior, on March 11, 2020. (Tr. at p. 48). She testified that the protocols continued to evolve over time. (Tr. at P. 48).

Beginning on March 11, 2020, Ms. Ortega testified, Respondent initiated rules stating that employee travel was cancelled, there were to be no meetings over a group of 20 people, in fact "all… in-person meetings of more than 20 people are banned" regardless of being indoors or outdoors (Rx 1, p.1) and social distancing was immediately implemented. (Tr. p. 49) And, yet in the LNCA COVID-19 Phase on Policies Employees were only "… encouraged and allowed to maintain 3-foot separation between associates." (Rx 1, p. 3)

She stated that additional handwash stations and hand sanitizer stations were brought into the facilities as well. (Tr. at p. 49). When asked how these policies were introduced and published to the employees of Respondent, Ms. Ortega testified that they had to get creative with postings and virtual meetings, because they could not use their normal method of town hall-style meetings. (Tr. at p. 49-50). Ms. Ortega testified that hand washing and sanitizing of time clocks was mandated by the company. (Tr. at p. 52). She testified that employees were directed to sanitize their workstations. (Tr. at p. 52). She commented that their safety manager had been able to stock up on hand sanitizers and cleaning supplies in January of 2020. (Tr. at p. 52).

Ms. Ortega identified Respondent's Exhibit 2, which was a timeline created by Respondent in roughly September of 2020. The chart referenced purported start-dates of certain COVID-19 safety measures; with one line showing the start date for the CDC, another for Respondent, and a third for the parent company Legrand. (Tr. at p. 50-51). The stated purpose of the graph was to "put some thought related to everything that was done in preparation [for COVID response]." (Tr. at p. 51)

When asked about mask-guidelines in March of 2020, Ms. Ortega testified Respondent's policy was that they were highly encouraged, even from the very beginning, but that they would

not mandate masks until they were physically able to provide a mask to each employee. (Tr. at p. 52). Noting the mask shortage at the time, Ms. Ortega testified that Respondent teamed with stay-at-home moms in the community to sew masks for the employees. (Tr. at p. 52-53). She testified that on April 7, 2020, masks were mandated by the Respondent. (Tr. at p. 53).

Ms. Ortega also testified about the early April meeting referenced by Petitioner in his testimony. She testified that she, in fact, led the meeting in that first week of April 2020. (Tr. at p. 53). She testified the meeting was held outside, in the parking lot facilities. (Tr. at p. 53). She testified that there were about 20-23 employees in Petitioner's building. (Tr. at p. 53). On cross-examination, she testified that the parking lot had roughly 400-500 spots, and that she had to use a microphone speaker because the employees were all socially distanced. (Tr. at p. 72). When questioned about the size of the meeting, being likely over 20 people, she testified that only indoor meetings of over 20 people was prohibited. (Tr. at p. 81).

Regarding the individual who had tested positive prior to Petitioner going out ill, Ms. Ortega testified that the employee who had tested positive was on the first shift (as opposed to Petitioner who worked on second shift) and that individual worked in a separate building from Petitioner. (Tr. at p. 56). Ms. Ortega testified that the company ran contact tracing through questionnaires, and to her knowledge, there had not been any interaction between the first individual who tested positive and Petitioner. (Tr. at p. 57). On cross-examination, she testified that the specific employee referenced in the early April meeting had not been in the facility since March 27, 2020, and that contact tracing cleared all other employees. (Tr. at p. 71-72). She testified that the facility was not shut down following the positive case, but rather, a deep cleaning was done of that individual's area. (Tr. at p. 71-72).

Ms. Ortega also testified about other things Respondent was doing to help manage the Covid-19 pandemic. She stated they began working on-site COVID testing, and they were able to

secure a partnership with Roseland Hospital to test all employees on April 25, 2020. (Tr. at p. 58-59). Ms. Ortega also testified that the company conducted serology (or an antibody test) on that date as well. (Tr. at p. 59). She testified that of the 46 individuals on second shift tested for the COVID-19 virus on April 25, 2020, none had a positive COVID test, nor did they have antibodies present. (Tr. at p. 59). On cross-examination, she testified that between the two shifts, there were roughly 275 individuals in a given building on a given day (pre-pandemic), and that number dropped to approximately 150 per building after March 17, 2020. (Tr. at p. 76-77). Of the initial Covid-19 testing purported to be done on April 25, 2020, RX3 showed a positivity rate between 10-15%, which Ms. Ortega confirmed on cross-examination. (Tr. at p. 77-78). She testified that not one of those employees who tested positive was on the second shift. (Tr. at p. 78). She testified that of that 10-15% positive COVID tests, some of those employees did in fat work in the same building as Petitioner, though she did not know exactly how many. (Tr. at p. 78). She testified that people on the first shift would regularly leave the facility at 1:30 p.m. with second shift beginning at 2:30, because the parking lot was not big enough to accommodate all of the vehicles (Tr. at p. 78). On cross-examination, Ms. Ortega admitted she could not testify to the accuracy of the tests administered on April 25, particularly when confronted with the fact that Petitioner himself had three negative PCR tests prior to testing positive through a bronchial scrape. (Tr. at p. 78-81). She did not explain how the parking lot with over 450 spaces was insufficient for 300 hundred workers.

Ms. Ortega identified Respondent's Exhibit 3, which was a chart created by Respondent purported to show the COVID-19 positivity rates of Respondent, the zip code of the area for which Respondent (and Petitioner for that matter) were located, Chicago and Cook County (as one line), and the State of Illinois as a whole, for the period of April 19, 2020 through May 19, 2020. (RX3). Of note, the positivity rate of Respondent begins on April 26, 2020, and shows a

COVID-19 positivity rate between 10 and 15%, whereas the purported positivity rate for the 60632-zip code on the whole was between 40 and 45%. (RX3). It is noted this chart was also prepared as part of monitoring the COVID-19 pandemic and the policies put in place. (Tr. p. 61). Ms. Ortega also identified Respondent's Exhibits 4 and 5, which were documents prepared by Respondent purporting to show COVID-19 positivity rates in different Chicago zip codes and a zip code heat map as of May 2020. These documents, again, were created by Respondent. It was not stated in Ms. Ortega's testimony exactly when Respondent created these documents and absolutely no supporting documentation was introduced into evidence.

Ms. Ortega testified that the organization (not specifying whether it was Respondent or the parent company, Legrand, a worldwide corporation) poured over $3,000,000.00 in COVID-19 response. (Tr. p. 63). She testified that Petitioner's shift was split into two buildings of roughly 23-24 employees per building. (Tr. p. 64). She testified that fabrication, the department in which Petitioner himself worked, has the lowest density of any other production line because it is one machine, with one person operating that machine. (Tr. p. 64). On cross-examination, Ms. Ortega testified that it might not be a common practice, but it is possible that employees from the different buildings in the facility might enter the other building for one reason or another. (Tr. p. 70). She did state the ideal scenario was for each building to operate independently. (Tr. p. 70-71).

On cross-examination, Ms. Ortega was questioned about another employee on second shift, in his building, tested positive for COVID-19 on April 20, 2020 (two days prior to Petitioner testing positive). (Tr. p. 82-83). That employee, she admitted, would have been walking to and from the time clock and exiting through the door right by Petitioner's workstation. (Tr. p. 82-83). She testified that through their COVID-19 tracing questionnaire, it was determined that person was not deemed a close contact with Petitioner. (Tr. p. 83).

Ms. Ortega testified that in February 2020 they began formal contingency planning on what to do if it reached pandemic level, developing planned phases in case the virus spread to the United States and into their employee communities. (Tr. p. 44-45) These discussions included the leadership team of Respondent and those of Respondent's ownership with Legrand, a global organization that was in the process of purchasing Respondent, a privately owned company, in March 2020. (Tr. p. 45-46) Under this purchase, Respondent continued to operate fairly autonomously for the first twelve months after the purchase before falling under the more direct control of the new ownership. (Tr. p. 46) In spite of this autonomous operation, Respondent received a tremendous amount of guidance in the handling of this pandemic from Legrand, including its COVID-19 Safety Committee, which issued guidelines on March 13, 2020. Respondent adopted these policies to prevent or at least reduce the spread of COVID-19 at the facility and for the safety of its employees, which Ms. Ortega testified are of the Respondent's upmost importance. (Tr. p. 46-47, 49; RX. 1)

Respondent, however, began implementing these policies on March 11, 2020, two days before they were published by Legrand, and began monitoring closely the CDC guidelines and recommendations they were issuing as well as those recommendations issued by World Health Organization (WHO). (Tr. p. 48) Effective March 11, 2020, all employee business travel was cancelled, and meetings were restricted to no more than twenty people at an indoor setting and social distancing measures were implemented. PPE efforts were added, including hand sanitizer and additional hand washing stations, and employees were updated on the policies through postings and virtual meetings as their traditional townhall meetings were cancelled. (Tr. pp 49-50)

One of the policies put in place by Respondent included optional attendance for work. (Tr. p. 54) This meant that Respondent waived its attendance point penalties for employees that

chose not to come into work after the stay-at-home Order was issued. (Tr. p. 54) She testified that attendance did dip to about 70% after this policy was first implemented and dropped as low as 50% at one point during the following months. Those who stayed home were not paid. (Tr. p. 55, 74)

Ms. Ortega identified Respondent's Exhibit 2 (RX. 2) as Respondent's COVID-19 Timeline showing the timing of its preparations for the pandemic. (Tr. p. 50) This document reflects all of the preventative measures implemented by Respondent and by its ownership, Legrand, from early March 2020 through September 2020 as well as those recommended by the CDC. These items are color-coded in blue to show when Respondent implemented certain preventative measures, for example showing that social distancing was mandated on March 16, 2020 and that new cleaning procedures within the facility were implemented on March 9, 2020 along with several other measures taken prior to April 13, 2020. (Tr. p. 50; RX. 2) This timeline also reports the CDC recommendations in red and shows that Respondent was ahead of the CDC in implementing COVID safety protocols on every recommendation from the CDC, with the exception of the change from paper towels in restrooms to hand dryers, for which the CDC issued the recommendation on March 21, 2020 that Respondent implemented two days later. (Tr. p. 50; RX. 2)

Ms. Ortega testified that due to the nationwide shortage of masks in early 2020, Respondent was only able to encourage employees to wear masks, that they would have to find on their own. Once Respondent was able to provide masks to their employees, Respondent would then mandate the wearing of masks within the facility. (Tr. p. 52) Respondent actually partnered with some stay-at-home moms to begin sewing masks for the employees ensuring that those were then washed and bagged individually so that they could begin distributing these to their employees on April 7, 2020, after which masks were encouraged and then mandated on April 7,

2020. (Tr. p. 52-53, 55) Prior to them supplying masks, many employees used handkerchiefs or brought their own masks. (Tr. p. 53)

In addition to these initial safety measures taken by Respondent, Respondent engineered and redesigned areas of its facility to create social distancing within its facilities where it may not have existed previously. (Tr. p. 64) This was not necessary for Petitioner's workstation because he was working on a CNC machine in a fabrication area that has a lower density of employees than the production lines. (Tr. p. 64) This is because his machine and others like it only had one operator thus creating a pre-existing social distancing. (Tr. p. 64)

Ms. Ortega recalled the general meeting to which Petitioner testified as occurring at Respondent's facility around April 7, 2020 or that of the first week of April 2020. She recalled meeting because she helped lead that meeting. (Tr. p. 53) The meeting would have had 20-23 employees from the second shift in attendance and because of the number and to maintain proper social distancing under its COVID-19 policies, this was set up and conducted in the Respondent's parking garage, not indoors. (Tr. p. 53-54) She recalled this clearly because she had to use a microphone and speaker to project to the socially distanced employees in that outdoor covered parking lot. (Tr. p. 72) Ms. Ortega did not present any documentation or notes regarding the meeting.

In addition to monitoring infections within its facility, Ms. Ortega testified that Respondent was also monitoring the spread of the virus within the community and State of Illinois using data provided by the Illinois Department of Health and the Cook County Health Department. (Tr. p. 59-60) The reason for this is that Respondent had concerns that high exposure rates of employees in the community created a higher risk of those employees bringing the virus into their facility. (Tr. p. 63) The area code with the highest positivity rate in the State of Illinois was the 60632-area code in which both Respondent's facility is located and where

Petitioner testified he resided. (Tr. p. 60, 29) Ms. Ortega identified Respondent's Exhibit 3 (RX. 3) as a cumulative positivity line graph showing positivity rates of residents with COVID over a one-month period from April 19, 2020 through May 19, 2020 by comparison of Respondent's facility's positivity levels (lowest graph on the chart), Illinois' statewide positivity levels (second highest rate charted), Chicago's and Cook County's cumulative rates (third highest on the chart) and Chicago's 60632 positivity rate in red at the top of the line graph. Data shown on this chart was obtained by Respondent from daily reporting published by the Illinois Department of Public Health and the Cook County Health Department on their websites. (Tr. p. 61-62) The chart of Respondent's positivity rates began on April 28, 2020, after they had the results of the first facility testing. Ms. Ortega testified that the 10% positivity rate at that time was all first-shift employees only. (Tr. p. 77-78)

Although Ms. Ortega was wearing corrective eye glasses, she had difficulty reading the date of April 29, 2020 on Respondent's Exhibit 6, which is an email of an HR specialist memorializing a call from Petitioner's wife informing them that Petitioner was COVID-19 positive. She had difficulty reading it because her "vision is so bad". (Tr p. 66, 68) The Arbitrator further notes that Ms. Ortega testified that she had reviewed Petitioner's file and as well as the file regarding the 2nd shift to help refresh her memory before testifying and yet did not bring the documents nor Petitioner's employment file to trial to corroborate her testimony, (Tr p. 60, p. 65-66, 68)

Ms. Ortega also identified Respondent's Exhibit 4 (RX. 4) as a chart that indicates the average household size for every thousand reported cases in Chicago and does so by zip code. (Tr. p. 62; RX. 4) The data for this chart that was created from was from the Illinois Department of Health and the U.S. Census data, and on this chart she pointed to the 60632 zip code marked on the chart as having one of the highest positivity rates with average household size about 3.6 or

3.7 persons. (Tr. p. 62; RX. 4) Ms. Ortega also identified Respondent's Exhibit 5 (RX. 5), which is a printout from the Illinois Department of Health website showing both a Chicago and Cook County map as well as a second map of the State of Illinois. These are color-coded to show the positivity rates throughout Chicago, Cook County and Illinois in what Ms. Ortega referenced as a "heat map," where the higher positivity rates are labeled in red and milder colors for those areas having lower positivity rates. (Tr. p. 65; RX. 5) The 60632-zip code is seen in this exhibit in red. (RX. 5)

Ms. Ortega testified that Respondent first became aware of Petitioner's positive COVID diagnosis when Petitioner's wife contacted Respondent on April 29, 2020, to inform them. (Tr. p. 66) This is documented in Respondent's Exhibit 6 identified by Ms. Ortega in her testimony. (RX. 6) It is confirmed in this April 29, 2020 email that Petitioner last worked on April 13, 2020 and was admitted to a hospital a week later with symptoms that his wife reported started on April 17, 2020. (RX. 6)

Petitioner's medical records exhibits confirm the following medical history:

Petitioner presented to the emergency department of Mt. Sinai Hospital around 6:13 a.m. on April 20, 2020, with complaints of fever, bad cough and shortness of breath that had been worsening over the past week. (PX. 2) In a subsequent history, he reported symptoms beginning three weeks earlier. In a later history with Dr. Devon, the Petitioner reported a cough and shortness of breath for the past three months but acutely worse about three weeks earlier. He reported a syncopal episode the day before admission and a near syncopal episode on the day of admission. Petitioner was in mild respiratory distress at the time of admission and his pulse oxygen rate was at 87. He was admitted with differential diagnoses of COVID, influenza, pneumonia, ACS, CHF, sepsis, electrolyte abnormality, AKI or anemia. Dr. Debruin

recommended they consider COVID-19 testing "if clinically appropriate" and "given the ongoing pandemic." Chest x-ray films on April 20th showed findings of new bilateral airspace disease (as compared to films from June 18, 2019). A rapid COVID test in the emergency room was negative. However, the doctors stated they had a "high suspicion" that he had contracted the virus.

During his hospitalization through April 22, 2020, the Petitioner's condition worsened such that he was placed in COVID-19 isolation by the end of the first day for precautionary reasons and a code blue was called at 8:04 a.m. on April 21, 2020, when his oxygen saturation rate dropped to the mid-80's. They improved initially but then dropped again later in the day such that he had to be intubated. An x-ray of the lungs on April 21, 2020, showed interval worsening from the films taken the day before.

On April 22, 2020, Petitioner's condition deteriorated rapidly, with Petitioner deemed unresponsive. *Id*. He had to be intubated for oxygenation as well as being chemically paralyzed and sedated, and he had to be catheterized. *Id*. Given the worsening nature of his condition, he was transferred to Rush University Medical Center's intensive care unit. *Id*. The notes of the ambulance personnel that transferred him note that he was intubated and, on a ventilator, and they also noted he was unresponsive to any stimuli due to his sedated/paralyzed state. (PX 3, P. 2861).

The Petitioner arrived by medical transport to Rush University Medical Center around 4:00 p.m. on April 22, 2020, medically paralyzed and ventilated. (RX. 3) Petitioner remained in this hospital until he was discharged to Kindred Hospital for rehabilitative care on May 26, 2020. The records are consistent with ICU care for various medical abnormalities the Petitioner developed from his COVID-19 infection. Reviewing these records for any relevant medical history bearing on how and when the Petitioner developed his symptoms and any potential

contact he had to anyone who had tested positive for COVID-19, the Arbitrator finds that they repeated the history documented in the Mt. Sinai records without any additional pre-admission history. The May 26, 2020 discharge reports confirm that the Petitioner received a Remdesivir trial for 10 days (4/26/20 – 5/5/20). He tested negative for COVID-19 on 5/17/20 and again on 5/20/20.

Upon his arrival at Rush University Medical Center on April 22, 2020, Petitioner was tested for COVID-19 via nasal swab, but the swab came back negative. (PX 3, p. 212). Given his persistent symptoms and their mirroring of those of COVID-19, a bronchoscopy was performed that returned positive for COVID-19. *Id*. According to a discharge summary by Rush University physician, Dr. Audrey Naa-Adobea Bampoe, Petitioner's condition worsened to the point that the doctors ordered a tracheostomy on May 15, 2020, wherein an opening was created at the front of Petitioner's neck so a breathing tube could be inserted into the trachea. (PX3, p. 214). The treating physicians began discussions with his family regarding the filing of a DNR (Do Not Resuscitate) order on May 15, 2020. *Id*. Petitioner had fevers through May 23, 2020. (PX3, p. 212). He was weaned off of the sedative medications on May 23, 2020, some 31 days after being initially sedated. *Id*. On May 26, 2020, Petitioner's condition stabilized to the point where he could be discharged from intensive care and into a long-term care facility. *Id*.

In a COVID-19 Service Consult note at Rush, the Petitioner's wife reported that the Petitioner had a chronic, non-productive cough for the last year that had worsened over the last eight weeks or so and that prior to admission he had been undergoing a work-up with his primary care physician. In addition, over the last seven days prior to his admission, he developed fevers at 102 and 103, general malaise, body aches and poor appetite. He did not complain of abdominal pain, diarrhea, or changes of smell and taste. His wife noticed that during the last week he has lost some weight associated with poor food intake. But she denied that it has been noticeable.

She reported that she and their adult son who lived with them were asymptomatic. She also reported that Petitioner worked as a Machine Operator on an assembly line where "there's been at least six people who tested positive at work for COVID-19."

Dr. Shivanjali Shankaran, an Infectious Disease physician, stated as his impression that in addition to concern for COVID-19 (for which at this point Petitioner had tested negative), because the Petitioner had a history of a chronic cough and had moved here from Guatemala in 1989, there was also some concern he may have blastomycosis (a fungal infection from inhaling Blastomyces dermatit idis spores) and MTB (Mycobacterium tuberculosis). Dr. Shankaran recommended testing to rule out those conditions as well. The COVID-19 testing was ordered first. The Petitioner did test positive for COVID-19 on April 24, 2020. (PX. 3, p. 185)

Petitioner's wife reported to Petitioner's medical providers at Rush that Petitioner is bi-lingual in the Spanish and English language, although Spanish is the preferred language. (Px 3, p. 201)

Petitioner was admitted to Kindred Hospital – Chicago Central on May 26, 2020, for continued care of multiple medical problems following his initial hospitalization for COVID-19. (PX. 4) According to the history reported in the records: on 4/20/20 the Petitioner presented to Mount Sinai Hospital complaining of shortness of breath, fever, weakness and malaise. Chest x-ray showed evidence of pneumonia and an initial "self-Browning COVID-19 PCR test" was negative, so he was initially admitted for IV antibiotic treatment for "community-acquired pneumonia." As his oxygen saturation rates worsened during that admission, he was intubated on April 22nd and transferred to Rush where a bronchoscopy test was positive for COVID-19. He then remained admitted there until his transfer to Kindred on May 26. The list of medical conditions for which he was treated during his month at Kindred included: type II diabetes mellitus, hypertension, cough, congestion, weight loss, decreased O2 saturation and general

malaise. Prior to arriving at Kindred Hospital, he had been intubated with a tracheotomy until his condition stabilized for transfer to Kindred Hospital. His condition improved slowly, and he tested negative for the virus on May 31st, June 8th and June 20th. Due to multiple negative tests, his COVID-19 isolation at Kindred was discontinued on June 11th. He remained admitted there through June 23, 2020, when he was then discharged home. The discharge diagnoses were listed as follows: acute hypoxemic respiratory failure secondary to COVID-19 pneumonia, viral pneumonia, critical illness polyneuropathy, type II diabetes mellitus, hypertension, anxiety, and major depressive disorder single episode. He was instructed to follow up with his primary care physician in 7-10 days and to report any fevers in the meantime.

Following Petitioner's discharge from Kindred Hospital, Petitioner underwent pulmonary rehabilitative care with physicians at Sinai Health System under the direction of Dr. Zelna Ibrahim at that facility and on referral from Drs. Devon Paul and Maximiliano Luna at Esperanza Health. (PX. 1) From June 25, 2020, his discharge date from Kindred, through August 6, 2020, Petitioner also received home health care services, including eight occupational therapy sessions, twelve physical therapy sessions and four skilled nursing visits, from Lexington Home Health Care. At the time of discharge from Lexington Home Health Care, he remained dependent on oxygen but was trained to use this and his medications without assistance and was no longer homebound. (PX. 1) As of March 8, 2021, the most current treating record in evidence, Petitioner continued to use supplemental oxygen at home and that his assessment was dyspnea with a history of COVID-19 as well as pneumonia and obstructive sleep apnea for which he had been issued a CPAP. Ongoing medications included fluticasone propionate, quetiapine, Symbicort, albuterol inhaler, Virtussin and Spiriva. (PX. 1)

Petitioner followed up with his primary care physician at Esperanza Health Centers, via telehealth, on June 29, 2020. (PX1a). It was noted he could not walk more than 10 feet without

fatigue and shortness of breath. *Id*. He was still using oxygen all-day to combat his shortness of breath. *Id*. He was prescribed medication and given a pulmonology referral. He continued to treat with Esperanza Health Centers regularly while treating with his cardiologist and pulmonologist. *Id*.

On August 18, 2020, Petitioner was seen by Dr. Zeina Ibrahim, MD, a cardiologist with Sinai Health Systems. (PX1b). Dr. Ibrahim ordered a Holter monitor for Petitioner to rule out atrial fibrillation, citing the increased risk of atrial arrhythmias with COVID-19 infection. She also made a referral to pulmonology. *Id*.

On August 18, 2020, Petitioner was examined by Dr. Joseph Rosman, M.D., a pulmonologist affiliated with Sinai Health Systems. (PX1b). This consultation was done via telehealth. *Id*. Dr. Rosman noted that Petitioner still had regular dips in his oxygen saturation ,as low as the 70's and that Petitioner was not yet capable of going back to work. *Id*. The doctor ordered Petitioner to continue to monitor his symptoms and follow up in six weeks.

Petitioner followed up with the cardiologist, Dr. Ibrahim, on September 22, 2020. (PX1b). Review of the Holter Monitor results showed no sustained arrhythmias, and he was told to follow up with Dr. Ibrahim as needed. *Id*.

Petitioner was seen by Dr. Anuj Behal, a colleague and fellow pulmonologist with Dr. Rosman, on November 23, 2020. (PX1b). Dr. Behal noted that Petitioner's activity levels were increasing, and that he was no longer requiring regular oxygen use. *Id*. The doctor filled out FMLA paperwork for Petitioner and advised him to follow up in two months. *Id*.

Petitioner followed up with Sinai Health pulmonology on January 11, 2021. (PX1b). It was noted that he still had shortness of breath problems, but his oxygen levels were in the 90's. *Id*. Petitioner still regularly used Symbicort and Albuterol inhalers, using the Albuterol with increased activity. *Id*. Petitioner stated he did have good days where he would not require the

Albuterol at all. *Id*. Petitioner still had trouble with sleeping, often waking up short of breath or gasping for air. *Id*. The doctor continued to fill out Petitioner's FMLA paperwork, and he instructed Petitioner to return in two months. *Id*.

Petitioner followed up with Dr. Behal on March 8, 2021. (PX1b). Petitioner was not using the oxygen at home as often. *Id*. He still used his Albuterol inhaler when his activities were increased. *Id*. Petitioner followed up with his primary care physician at Esperanza Health on March 10, 2021, and he was released to full duty work. (PX1a).

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 Comm'n*, 79 Ill. 2d 249, 253 (1980) including that there is some causal relationship between his employment and his injury. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 63 (1989) It is well established that the Act is a humane law of remedial nature and is to be liberally construed to effect the purpose of the Act - that the burdens of caring for the casualties of industry should be borne by industry and not by the individuals whose misfortunes arise out of the industry, nor by the public. *Shell Oil v. Industrial Comm'n,* 2 Ill.2nd 590, 603 (1954). 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)*

The Arbitrator, as the trier of fact in this case, has the responsibility to observe the witnesses testify, judge their credibility, and determine how much weight to afford their testimony and the other evidence presented. *Walker v. Chicago Housing Authority*, 2015 IL App (1st) 133788, ¶ 47. Petitioner's testimony is found to be credible. The Arbitrator finds Petitioner's testimony to be straight forward, truthful, and consistent with the records as a whole. He does appear to be an unsophisticated individual and any inconsistencies in his testimony are not attributed to an attempt to deceive the finder of fact. Whereas, Ms. Ortega's testimony and exhibits, for reasons stated below, do not persuade the Arbitrator.

WITH RESPECT TO ISSUE (C), WHETHER PETITONER WAS LAST EXPOSED TO AN OCCUPATIONAL DISEASE ON APRIL 13, 2020 THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

It is evident that Petitioner contracted COVID-19 on or before April 13, 2020, his last day of employment, which is also the day in which his symptoms began. Petitioner alleged April 17, 2020, his first date of medical treatment, as the date of accident or manifestation date. The April 17th date is consistent with the ODA, as amended, and *Durand v. Industrial Comm'n* 224 Ill. 2nd 53 (2007). The date of accident is not pivotal to the outcome of this case.

The fact that Petitioner contracted COVID-19 is not in dispute and clearly corroborated by the medical evidence. Whether Petitioner contracted the COVID-19 virus from an exposure arising out of and in the course of his employment with Respondent is in dispute.

This COVID-19 ODA claim is one of first impression to this Arbitrator and to the Commission. However, the legal principles involved to address the claim under the ODA are not.

It is well-established that a Petitioner is required to prove by a preponderance of the evidence all elements of his claim, including whether he had an accidental exposure arising out of and in the course of his employment on or before April 13, 2020 and whether that alleged exposure is the cause of his COVID-19 illness.

The ODA provides benefits for employees who establish that they have contracted an occupational disease while working. An "occupational disease" is a disease arising out of and the course of employment which has become aggravated and rendered disabling as a result of the exposure at employment. Such aggravation must arise out of a risk "peculiar to or increased by employment and not common to the general public."

On June 5, 2020, the Illinois Legislature amended the ODA to provide benefits for certain class of workers who may have contracted COVID-19 at the workplace. The COVID-19 amendment is contained in paragraph 1(g) of the Act.

Section 1(g) creates a rebuttable presumption in favor compensability for certain "first responders and frontline workers" who contract COVID-19. Front line workers include those employed by "essential businesses and operations: as defined in the Governor's Executive Order 2020-10 (dated March 20, 2020) whose work requires them to encounter members of the general public or to work in locations with more than 15 employees."

The COVID-19 presumption provides that any such worker that develops any injury or occupational disease that resulted from the exposure to a contraction of COVID-19, "the exposure and contraction shall be rebuttably presumed to have arisen out of and in the course of the employee's … employment." Simply stated, exposure and contraction are presumed to have arisen from the work environment and the occupational disease is presumed to be causally connected to the hazards or exposures of employment. As such, the presumption creates a *prima facie* case that the injury arose out of and in the course of employment. If not rebutted, the

worker wins and is entitled to benefits afforded under the ODA. If rebutted, Petitioner loses the benefits of the presumption, and must prove his case in same manner as required under the ODA.

On March 21, 2020, Governor Pritzker issued an Executive Order essentially shuttering all business in Illinois and recommending all persons stay at home and to the extent possible, work from home unless employed as a first responder, medical provider or with an "essential business." The evidence in this case is undisputed that Respondent's business qualified as an "essential business" as it remained open and operational at all times relevant hereto after that Order was issued. However, employees were permitted to decline coming in to work if they chose do so, without penalty, but without compensation. In other words, no work, no pay.

This COVID-19 presumption was enacted on June 5, 2020 and applied retroactively to cases filed by qualified workers who contracted COVID-19 between March 9, 2020 and through a sunset date of December 31, 2020. The presumption was later extended through June 30, 2021.

The presumption applies to qualified workers who were diagnosed between March 9, 2020, and June 30, 2021. For cases occurring on or before June 15, 2020, a worker must provide either confirmed by a licensee medical practitioner medical or a positive laboratory test. For cases occurring on or after June 15, 2020, a positive laboratory test is required.

The COVID-19 presumption is an ordinary presumption. The employer need only introduce "some evidence" that the employee's occupation was not the cause of the injury or disease. The legislation creates a rebuttable presumption similar to the rebuttable presumption that already exists within the Illinois Occupational Disease Act. The COVID-19 Amendment to the Illinois Workers' Occupational Diseases employs established precedent found in the in *Kevin Johnston v. Illinois Workers' Compensation Commission* to support the addition of this Act. In *Johnston*, the Appellate court found in order to rebut the presumption, "some evidence

sufficient to support a finding that something other than the claimant's occupation caused his condition" is sufficient. In that event, the presumption will cease to operate, and the issue will be determined on the basis of evidence admitted at trial as if the presumption never existed. The presumption merely shifts the burden of production, not the burden of persuasion. It operates in the employee's favor only if the employer provides no evidence to rebut causation. An employer may rebut the presumption by:

1. Demonstrating that it complied with recommended CDC or Illinois Public Heath guidelines in the 14 days prior to the diagnosis (including sanitation, masks, other protective gear, barriers, social distancing, etc.);
2. Presenting some evidence that the claimant contracted the virus somewhere else; or
3. Showing that the claimant worked from home or was off work in the 14 days prior to diagnosis.

Once the presumption is rebutted, the Petitioner will have to establish, by a preponderance of the evidence, the COVID-19 disease was contracted at work.

The facts of this case raise many questions. There is no dispute that Petitioner contracted the COVID-19 virus, nor is there a dispute as to the severity of his illness or reasonableness of his treatment. The controversy at bar arises from the question of where or how Petitioner contracted the virus.

The amendment to the ODA does in fact give Petitioner the rebuttable presumption that his contraction of COVID-19 arose in the course and scope of his employment, which therefore shifts the burden to Respondent to rebut that presumption. Respondent, through its questioning of Petitioner and the evidence submitted in its case-in-chief, seems to be arguing that it should not be held liable based on its purported COVID-19 protocols in place (Subsection 15(g)(1)(B)), and

alternatively, that it should not be held responsible on a theory that Petitioner was exposed to COVID-19 by an alternate source (Subsection 15(g)(1)(C)).

Further, as this case is one of first COVID-19 cases to proceed to hearing, there is no precedent as to what exactly qualifies as an employer engaging in safety protocols to the best of their ability, or what that might look like at any given time throughout the pandemic, as the guidance from government health officials was fluid throughout. The Arbitrator first looks at Subsection B, focusing on the actions Respondent took to curb the spread of the virus in its facilities. Respondent's witness, Ms. Marlen Ortega, testified extensively about the different procedures and protocols Respondent, and its parent company, Legrand, put into place during the COVID-19 pandemic. Ms. Ortega testified that in February of 2020, discussions were held by the executive committee of Respondent and the parent company, Legrand. (Tr. at p. 44). Interestingly, Ms. Ortega later testified that Legrand did not officially purchase Respondent until March of 2020 (Tr. at p. 46), so the timeline of these meetings seems to be murky at best. Nonetheless, Ms. Ortega testified that Respondent began discussing contingencies about the COVID-19 pandemic in February of 2020. (Tr. at p. 44).

Ms. Ortega presented three exhibits detailing the efforts of Respondent in combating the spread of the virus. Respondent's Exhibit 1 was a list of General Policies implemented by Legrand, the parent company of Respondent, as of March 13, 2020. (RX1). Ms. Ortega testified that Respondent actually implemented these protocols two days prior, on March 11, 2020. (Tr. at p. 48). Of note, policies contained in Exhibit 1 include recommendations that employees avoid public transportation when possible, mandating that surfaces in the cafeterias and break rooms are to be cleaned frequently and lunch times to be staggered where practical, employees with COVID-19 symptoms (such as fever) are to stay at home, non-essential employee travel was banned for 60 days, and most importantly to the case at bar, all in-person meetings of more than

20 people were banned. (RX1). The guideline stated specifically: "For the next 30 days, in-person meetings of more than 20 people are banned. In-person meetings below this threshold must be held in rooms that can accommodate social distancing requirements of at least 3 feet apart from one another."

Respondent's Exhibit 2 was a chart created by Respondent in roughly September of 2020. (Tr. at P. 50-51). It should be noted that none of the figures contained in Respondent's Exhibit 2 can be independently verified, so they are open to scrutiny. According to Respondent's Exhibit 2, in almost every instance (save for the implementation of paper towels over air-hand-dryers), Respondent and its parent company Legrand exceeded the CDC or Illinois Department of Health, including but not limited to: social distancing mandates, temperature scanning, face mask requirements, and many other mandates/recommendations. (RX2). The Arbitrator finds this exhibit to be self-serving, almost too good to be true, taking issue with Respondent's purported mask mandate for several reasons. First, Petitioner testified that prior to him becoming ill on April 13, 2020, masks had not been mandated by the company. (Tr. at p. 17). That directly contradicts the testimony of Ms. Ortega, who testified masks were mandated on April 7, 2020. (Tr. at p. 53). She stated that prior to that, masks had been highly recommended, but the mandate did not go in place until April 7th. (Tr. at p. 52). Given the contradictions in the testimony of Petitioner and Ms. Ortega, and given the actual guidance given by federal and local health authorities, the Arbitrator finds it unlikely that masks were fully mandated by Respondent on April 7, 2020.

Further, Respondent's Exhibit 2 states that on March 16, 2020, social distancing of three (3) feet was recommended throughout Respondent's facility. (RX2). Petitioner testified that his workstation, a laser cutting machine, was located roughly three feet from the door to the parking lot, and that the time clock was located even closer to his workstation. (Tr. at p. 16). That would

mean the employee time clock, which would be used by roughly 20-25 people a shift, would be located less than three feet from Petitioner's workspace. Further, given the lack of floating shift schedules, that would mean the entirety of that shift would be congregating around Petitioner's workspace while waiting to clock in or out. This would be a direct violation of any social distancing practice. Also, Petitioner's unrebutted testimony was that his workspace was not moved at all prior to him becoming ill with the virus. (Tr. at p. 17). Respondent may have stated that it mandated social distancing practices on March 16, 2020, but the evidence submitted at trial directly contradicts that assertion. Additionally, the recommended social distancing between employees was only 3 feet.

The Arbitrator next turns to the evidence Respondent submitted regarding its on-site COVID-19 testing that was allegedly conducted on April 25, 2020. Of note, this testing was done almost two weeks after Petitioner had been in the facility. Further, by the point in time that the testing was undertaken, Petitioner and two other individuals had been out of work due to testing positive for the virus. That said, there are peculiarities in the Exhibit 3 produced by Respondent and how it relates to Ms. Ortega's testimony. Respondent's Exhibit 3 alleges that from the initial batch of COVID-19 tests performed on April 25, 2020, the positivity rate of those tests was somewhere between 10 and 15% of all tests completed. (RX3). She testified that of the 46 individuals on the second shift, on which Petitioner worked, none tested positive for the virus, nor had antibodies present. (Tr. at p. 59). That would mean that of those 10-15% positive tests, all would have to have been on a single shift. The virus' ability to spread from person-to-person is not limited to a shift, which might be believed, but for the fact that these individuals were not only spread across two buildings, but as Petitioner testified, they often interacted with one another. The April 2020 meeting alone was attended by first and second shift employees as well as maintenance workers. (Tr. at p. 18). Any of those individuals would have been touching the

same surfaces, using the same time clock, and more importantly, breathing the same air, regardless of the shift. The Arbitrator finds it highly unlikely that not a single test from the second shift came back positive. A positive test is not evidence against Respondent's efforts, but the evidence and testimony Respondent offered through Ms. Ortega seems disingenuous, which does raise concerns about Respondent's efforts. The virus clearly spread throughout the United States, often times in spite of best efforts by many. Respondent can rebut the presumption by showing best efforts were made, but the Arbitrator is concerned that some of the testimony and evidence offered by Respondent are inconsistent with other parts, and otherwise seems too good to be true. Respondent's Exhibit 3 in fact alleges that the Respondent's factory setting in the most infected area in Illinois, and area where its employees live, is safer than the immediate surrounding area, safer than Chicago, safer than Cook County and safer than the State of Illinois. This allegation does seem too good to be true and is logically inconsistent. Moreover, Respondent's charts contain assertions without any supporting or corroborating evidence. None.

Much of the trial testimony centered on a meeting that occurred in early April of 2020, roughly a week before Petitioner became ill. Both Petitioner and Ms. Ortega agree that the meeting took place to discuss the diagnosis of an employee at Respondent's facility and to discuss some retrofitting of the facility that would be taking place that day, and that there were roughly 20-25 people at the meeting. After that, the parties diverge on the details of the meeting. Petitioner contends the following: the meeting took place indoors, was near the fabrication area, and that half of those attending the meeting did not have a mask or face covering. (Tr. at p. 20-21) Petitioner testified further that the meeting included not only people from his second shift, but also people from the first shift and from maintenance. (Tr. at p. 36). His testimony contradicts Ms. Ortega's testimony that there was a one-hour gap between shifts. This was the

only meeting Petitioner attended. Whereas it is fair to infer that Ms. Ortega conducted many other meetings in order to reach the entire work force.

Ms. Ortega testified on the other hand that the meeting took place outdoors in the parking lot, with her using a microphone to speak to the socially distanced employees. (Tr. at p. 72). Ms. Ortega was questioned on cross-examination about the fact that the meeting of 20 or more people would seemingly contradict the mandate put in place in Respondent's Exhibit 1, to which she replied that the mandate only pertained to indoor meetings. (Tr. at p. 81). Again, the Arbitrator takes issue with this testimony. The plain and clear language outlined in the policy stated that all meetings over 20 people were prohibited. (RX1). While Ms. Ortega may have interpreted that to rule to apply to indoor meetings only, the plain reading of the text would state otherwise. The Arbitrator questions, then, if Ms. Ortega or Respondent would allow themselves room for interpretation with any of the other purported guidelines offered by the parent company. Lastly, the mere fact that the meeting occurred directly contradicts Ms. Ortega's own testimony about how the employees of Respondent were notified about the COVID-19 protocols a month prior. She stated that they could no longer use their normal method of town-hall style meetings to notify the employees of the new COVID-19 protocols, so they had to get creative with postings. (Tr. at p. 49-50). The fact that a meeting of any sort, indoor or outdoor, would occur, directly contradicts that directive. Regardless of where the meeting took place, Respondent was clearly not following their own stated guidelines regarding the virus.

It is not the intention of the Arbitrator to necessarily condemn the practices of Respondent, but rather, when Respondent offers evidence that it made its best efforts, that evidence must be consistent. The contradictions in the testimony paints a picture where Respondent is, after the fact, trying to portray itself in a better light than is truly accurate.

Respondent can also rebut the presumption by showing evidence that Petitioner contracted the virus from an outside source. The evidence submitted at trial regarding Petitioner's life outside of work tends to make that unlikely. Petitioner testified that he lived 2.7 miles from Respondent's facility with his wife. (Tr. at p. 13). His two adult children lived in a separate flat above his residence. (Tr. at p. 13-14). Petitioner did admit that his children had access to his flat, but that they had limited interactions. (Tr. at p. 32-34). Both of his adult children worked, but his wife did not. (Tr. at p. 30-31). He further testified that in the period preceding his diagnosis, neither of his children showed symptoms or tested positive for COVID-19. (Tr. at p. 39). Petitioner drove his own vehicle to and from work, his wife did the grocery shopping, and he did not go anywhere else, save for a trip to the gas station, where he paid outside at the pump. (Tr. at p. 12-15). As Petitioner put it in his testimony, "[There] was really nowhere else to go." (Tr. at p. 15). On cross-examination, Petitioner was testified about whether he had family or friends in the area, to which he replied he did not. (Tr. at p. 34-35). He testified that he did not often have meals with his family, as the children's work schedules and eating habits conflicted with his. His testimony is consistent with a second shift worker who comes home when most are sleeping or about to do so. (Tr. at p. 33 and 38-39).

Respondent submitted evidence through Exhibits 4 and 5 purportedly showing that Petitioner's zip code was a "hot spot" for the virus in May of 2020. It should be noted that this data would be for a period *after* Petitioner had already been hospitalized for close to two weeks. Further, Petitioner's credible testimony about his habits went unrebutted and was consistent with the facts. Respondent cannot show any evidence that a member of Petitioner's family or inner circle outside of work contracted the virus. They cannot show evidence that Petitioner was otherwise going out and about within his community where his risk for contracting the virus would be greater. Lastly, the Arbitrator notes that Respondent's facility is located in the same zip

code. It cannot be said how many employees of Respondent shared similar living circumstances to Petitioner, wherein they lived in the same zip code where the virus was spreading at a high rate. However, Respondent did hire from the immediate community. That said, Respondent did not present persuasive evidence that Petitioner contracted the virus from another source sufficient to negate that he contracted the virus in the course and scope of his employment. To the contrary, the evidence submitted at trial shows that at least two co-workers of Petitioner had the virus within days of him contracting the virus, and that 10-15% of Respondent's entire workforce tested positive for the virus less than two weeks after Petitioner's last day of work.

The Arbitrator finds that it is reasonable to infer that at least 10% of the work force would have tested positive earlier in the month, especially considering the lack of reliability of the COVI-19 testing with unacceptable false negative results. The Arbitrator is mindful that COVID-19 tests in Petitioner's case had an error rate of 75%, three out of four tests were found to be negative when he was clearly positive. Rather than pointing to an outside source, the evidence submitted at trial shows that virus was very much present and active within Respondent's facilities in April of 2020.

The Arbitrator finds that Respondent presented some evidence to rebut the presumption under the first prong and second prong outlined by the amendment to the ODA but not the third. It is undisputed that the Petitioner had not worked a home nor was off work in the 14 days prior to his diagnosis. As noted above, Respondent's Exhibit 2 shows the efforts made by Respondent beginning on March 3, 2020 to implement safety and preventative measures from the admission and spread of the COVID-19 virus within its facility. Ms. Ortega testified as to the measures Respondent began taking after beginning contingency planning in February 2020. Petitioner testified to being last exposed to his work environment of April 13, 2010 and that he developed symptoms on April 13, 2020. Petitioner's testimony is not rebutted. According to Respondent'

Exhibit 2, Respondent had the following preventative measures in place: hand sanitizers increased, additional PPE's (except masks) in place, signage posted, COVID policies (RX. 1) implemented, office work from home mandated, new cleaning and frequency protocols, handwashing stations added, paper towels replace with dryers, social distancing, and communal kitchenware was removed. This apparently meets some evidence standard.

In addition, Respondent provided some evidence of possible alternate sources of exposure by submitting evidence of the high positivity rates within the community outside and around its facility which also happens to be the same community in which the Petitioner and his family reside. (RX. 3, RX. 4 and RX. 5) The Petitioner shared a home with his wife as empty nesters. He would see his adult children occasionally, about once a week. His children worked outside the home during this same time. No evidence was introduced as to the adult children's work schedule. Petitioner testimony that he had infrequent brief encounters with his children is consistent with the fact that Petitioner worked on the second shift and consistent with being an empty nester,

Based upon the evidence presented and the record as a whole, the Arbitrator finds that Respondent rebutted the COVID-19 ODA presumption. It did so because it produced some evidence to rebut the presumption. Respondent attempted to introduce evidence to negate Petitioner's work exposure of the COVID-19 virus. It could not and did not. Respondent did not produce persuasive evidence that Petitioner contracted the COVID-19 virus outside work and clearly not enough evidence to negate Petitioner's work related COVID-19 virus exposure. The Arbitrator finds that the combination of the inconsistent testimony and evidence from Respondent's witness, the clear evidence of a significant number of COVID-19 cases at Respondent's facility in the month Petitioner became ill and the lack of any likely outside factor that could have caused Petitioner to become ill from the COVID-19 virus, create a situation

where it is increasingly likely that Respondent's facility was the only place Petitioner could have contracted the virus..

The Arbitrator finds that the Respondent efforts to prevent employee exposure were admirable and well-intended, but the Arbitrator finds that Petitioner contracted the virus before they were fully implemented. The Arbitrator finds that it is more likely than not, more probable than not, that Petitioner contracted the COVID-19 virus at work and not by one of his family members or the community.

Having found that Petitioner's COVID-19 claim should be adjudicated under the ODA, and after considering the entire record, the Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that his contracted COVID-19 resulted from his exposure to the virus up to his last day of work and, thus, his last day of exposure was on April 13, 2021. Thus, the Arbitrator concludes that Petitioner's exposure to the COVID -19 virus arose out of and in the course of his employment with the Respondent.

WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

To establish causation a claimant must prove that some act or phase of his employment was a causative factor in his ensuing injury. It is not necessary to prove that the employment was the sole causative factor or even that it was the principal causative factor, but only that it was a causative factor. *Tolbert v. Ill. Workers' Comp. Comm'n*, 2014 IL App (4th) 130523WC, ¶ 1, 11 N.E.3d 453. An injury arises out of a claimant's employment where it "had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the

employment and the accidental injury." *Sisbro, Inc. v. Industrial Comm'n,* 207 Ill. 2d 193, 203 (2003).

Having found that Petitioner's contraction of COVID-19 arose out of the course and scope of his employment, and there being no medical evidence submitted to show that Petitioner's current condition of ill-being is from any source other than his original COVID-19 related illness, the Arbitrator finds the Petitioner's current condition of ill-being to be causally related to the work related COVID-19 virus exposure. The Arbitrator finds that Petitioner's was first diagnosed as suffering from COVID-19 on April 17, 2020 and that his illness and condition of ill-being was confirmed as a COVID-19 disease shortly thereafter. Therefore. the Arbitrator concludes that the Petitioner is the entitled to benefits under the ODA.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator adopts his findings of fact and conclusions of law contained above and incorporates them by reference as though fully set forth herein. Petitioner's medical bills incurred are not in dispute. The parties stipulated that all medical charges have been paid by Petitioner's group health insurance obtained through his employment with Respondent. (Arb. Ex. 1) Respondent is entitled to Section 8 (j) credit for the paid bills and shall be given a credit for medical benefits that have been paid. Respondent shall hold the Petitioner harmless for any subrogation or reimbursement claim by or on behalf of the group health insurance carrier.

WITH RESPECT TO ISSUE (L), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

Having found Petitioner sustained a compensable condition of ill-being arising out of in in the course and scope of his employment and that his condition of ill-being is causally related to his exposure to the COVID-19 virus at work, any periods of temporary total disability incurred would be the responsibility of Respondent. Petitioner alleges, and the medical records support, that Petitioner was temporarily and totally disabled for the period of April 17, 2020 through March 16, 2021, a period of 46-5/7 weeks. Respondent did not pay any TTD benefits for the time which the Petitioner was authorized off work and did not work. No evidence was introduced that Petitioner was able to work or did work for said time. Respondent's dispute as to TTD is liability based. Therefore, the Arbitrator finds that Petitioner is owed 46-5/7 weeks of TTD benefits or the period of April 17, 2020 through March 16, 2021.

WITH RESPECT TO ISSUE (O), WHETHER PETITONER IS ENITLED TO ADDITIONAL MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator adopts the above findings of fact and conclusions of law and incorporates them by reference as though fully set forth herein. The Arbitrator finds that Petitioner has not reached maximum medical improvement. Petitioner continues to require medical care to cure and relieve him from his coronavirus disease related condition of ill-being.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC014004
Case Name	BEDOY, MAGDALENA MARIA v. THE DRAKE HOTEL
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0232
Number of Pages of Decision	26
Decision Issued By	Christopher Harris, Commissioner

Petitioner Attorney	Ian Elfenbaum
Respondent Attorney	Michael Chalcraft II

DATE FILED: 6/23/2022

/s/Christopher Harris, Commissioner

Signature

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

MAGDALENA MARIA BEDOY,

Petitioner,

vs. NO: 17 WC 14004

THE DRAKE HOTEL,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed under Section 19(b) of the Act by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, prospective medical care and temporary total disability (TTD) 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. 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. Indus. Comm'n*, 78 Ill. 2d 327 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 15, 2021 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.

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.

June 23, 2022

/s/ *Christopher A. Harris*
Christopher A. Harris

CAH/pm
O: 6/16/22
052

/s/ *Carolyn M. Doherty*
Carolyn M. Doherty

/s/ *Marc Parker*
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC014004
Case Name	BEDOY, MAGDALENA MARIA v. THE DRAKE HOTEL
Consolidated Cases	
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	23
Decision Issued By	Raychel Wesley, Arbitrator

Petitioner Attorney	Ian Elfenbaum
Respondent Attorney	Peter Havighorst

DATE FILED: 11/15/2021

THE INTEREST RATE FOR THE WEEK OF NOVEMBER 9, 2021 0.06%

/s/ Raychel Wesley, Arbitrator

Signature

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)

Magdalena Maria Bedoy Case # **17** WC **14004**
Employee/Petitioner

v.

The Drake Hotel
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 **Raychel A. Wesley**, Arbitrator of the Commission, in the City of **Chicago**, on **8/27/2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, April 28, 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 $**37,237.35**; the average weekly wage was $**1,215.82**.

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

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

Respondent shall be given a credit of $**7,461.12** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**7,461.12**.

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

ORDER

Respondent shall authorize and pay for **the cervical fusion surgery prescribed by Dr. Salehi**, along with reasonable post-operative care.

Respondent shall pay the further sum of **$19,428.97** for necessary medical services as provided in Section 8(a) of the Act and subject to the fee schedule provisions thereof.

Respondent shall pay **$183,184.30** in temporary total disability benefits for the **226** weeks from **4/29/2017 – 8/27/2021**. Respondent shall receive credit for **$7,461.12 in TTD** benefits that the parties agreed have already been paid.

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

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

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

/s/ Raychel A. Wesley **NOVEMBER 15, 2021**

Signature of Arbitrator

ICArbDec19(b)

State of Illinois)
)
County of Cook)

BEFORE THE
ILLINOIS WORKERS COMPENSATION COMMISSION

Magdalena Bedoy,	)	
	)	
Petitioner,	)	**Setting: Chicago**
	)	
v.	)	**Arb. Raychel A. Wesley**
	)	
The Drake Hotel,	)	**IWCC No. 17WC 14004**
	)	
Respondent.	)	

Hearing under Sections 19(b) and 8(a)
ARBITRATOR'S FINDINGS OF FACT AND CONCLUSIONS OF LAW

The matter was heard on August 27, 2021. The central issues in dispute were accident, causal connection, average weekly wage, TTD, medical bills and prospective medical care (cervical spine surgery by Dr. Salehi). Arb. Exh. 1.

A. FINDINGS OF FACT

1. Petitioner's Work History and Job Duties

Petitioner credibly testified that she had worked as a banquet server since 2005. She was first hired by the Hilton, the same corporation that owns the Respondent Drake Hotel, and began working in 2005 at the Hilton Towers on Michigan Avenue. In 2007 she was hired at the Hyatt, having heard about the job opening from coworkers at the Hilton. Tr. 11-12. Petitioner testified that all of her jobs were as a banquet server. She served food on a tray, which could weigh up to 50 pounds, and retrieved the dishes. She also helped to set up and take down tables and chairs. She testified that a usual shift was four to six hours. Tr. 13-14. Petitioner's account of her duties was consistent with Px 13, which contained a job description for Banquet Servers at Hyatt hotels. Petitioner testified that the work was similar at both the Hyatt and Hilton hotels. Tr. 13.

Petitioner testified that in April 2017 she was working both jobs, but mainly the Hyatt. Tr. 14. She had reviewed the wage statements in Px 2(a), and agreed with the $389.74 average weekly

wage calculation for her part-time work at the Drake. Petitioner testified that she had worked far more hours at the Hyatt, and believed that the $31,391.09 submitted was an accurate estimate of her earnings there. Tr. 17.

Petitioner testified that the Hyatt would issue her a work schedule every month. Her supervisor at the Drake, a banquet captain named Oscar, would call her once a week to work out her schedule. Oscar would tell her the events scheduled at the Drake, and she'd tell him which ones she could work. Because the Hyatt was her primary employer, Oscar knew that she would put her Hyatt jobs first. Tr. 14-15.

On the date of accident she had worked at both locations: a lunch buffet at the Hyatt, followed by a dinner at the Drake. Tr. 46. Petitioner also testified that at the time of her accident she was working regular duty on both jobs, and was not under any work restrictions. Tr. 17.

2. <u>Date of Accident: April 28, 2017</u>

Petitioner testified that on the evening of April 28, 2017 she worked as a dinner waitress at the Drake. She was carrying a tray of desserts up the stairs. Tr. 17. The tray had about nine plates on it, and she was carrying it in one hand when she fell. *Id*. Petitioner testified that she fell forward at first, landing on her knees, then she tried to grab the stair railing and missed. She lost her balance and fell backwards down the stairs. Tr. 17-18. Petitioner recalled that the stairs were concrete and had about 15-16 steps. She estimated that she fell down seven or eight stairs. Tr. 18.

Petitioner testified that when she fell, she felt pain all over, but especially in her neck and her right knee. She remained at the foot of the stairs, and a manager came to help her. Someone called an ambulance, which took her on a stretcher to Northwestern Memorial Hospital. Tr. 19.

An accident report from the Drake, completed and signed by "Felix" was Respondent's Exhibit 5 (Rx 5). It verified that Petitioner fell down stairs in the main kitchen. Felix stated that she told him the plates on the tray had shifted, and she lost her balance. The report was not signed by Petitioner and noted that "team member went immediately to the hospital via ambulance." *Id*., p. 3. A diagram had circles on both knees, both hands, the back and the right side of the face. *Id*., p. 4. An email from executive chef Rene Luna dated May 11, 2017 was attached. Luna stated that he and Jared, a coworker, had not seen Petitioner fall but saw her shortly afterwards, sitting at the bottom of the stairs. They noticed she was wearing "sketcher shape ups" shoes and had mentioned to her that it was "not a good idea to wear those to work in the kitchen." *Id*., p. 13.

3. Initial medical care

Records from Northwestern Hospital indicate that Petitioner was treated in the emergency room for injuries in a fall down stairs that night at work. Px 5, p. 3. She reported pain in both knees along with right shoulder and upper back pain. The staff also noted a contusion on the right knee, along with cervical spine tenderness. Petitioner was placed in a cervical collar and given an ice pack for the right side of her face. *Id*. A cervical CT scan noted mild degenerative changes, most pronounced at C5-6, but was otherwise unremarkable. A brain CT was read as normal. *Id*., pp. 38-39. Petitioner was in severe pain and unable to walk. *Id*., p. 7. Petitioner testified that she was admitted to the hospital for about five days. Tr. 20; Px 5.

An MRI of Petitioner's cervical spine was performed April 29, 2017. Px 5, p. 47. It was read by the hospital radiologist as showing a moderate-sized posterior disc osteophyte complex at C5-6, with some spinal stenosis and loss of disc height. Mild right foraminal stenosis was also noted at C3-4. *Id*. Petitioner also received physical and occupational therapy to improve mobility. *Id*., pp. 20, 24. Petitioner testified that she was unable to walk when admitted, but was able to use a walker when she left. Tr. 20. She was discharged on May 2, 2017 with prescriptions for pain medication and physical therapy from Dr. Poluzny of Northwestern. *Id*., p. 32.

On May 18, 2017 Petitioner began physical therapy at ATI. Px 10, p. 193. This was ordered by Dr. Posluzny for her knees, shoulders and back, however, Petitioner also reported pain in the back of her neck when lifting her arms. *Id*. By June 9, 2017, after 11 visits, her arm strength and range of motion had improved; however, she still reported 6-7/10 pain. *Id*., pp. 234-35. She could not carry a tray on her shoulder or do overhead tasks. *Id*., pp. 176-77.

4. Treatment by neurosurgeon, Dr. Salehi for cervical spine

On June 12, 2017 Petitioner consulted Dr. Sean Salehi, a neurosurgeon. She reported neck pain radiating into both arms, middle and low back pain, and pain in both knees since her April 2017 accident. Px 6, p. 3. Dr. Salehi noted a history of a fall at work, first forward onto her knees, then backwards down a flight of stairs. He also noted that prior to the accident she had no history of neck, back or knee complaints, and no prior surgeries. *Id*. She worked as a hotel banquet server, a job whose physical demands Dr. Salehi described as "medium duty." *Id*., p. 4. His physical exam noted cervical, lumbosacral and lower thoracic tenderness. Petitioner's strength was normal, but her cervical and lumbar range of motion were both limited by pain. *Id*., pp. 4-5.

Dr. Salehi also reviewed the films of Petitioner's April 29, 2017 cervical MRI. Px 6, p. 6. His diagnosis was a moderate cervical disc herniation at C5-6, along with a thoracolumbar strain and aggravation of lumbo-sacral spondylosis. Petitioner's neck and low back pain, he opined, were "secondary to the described work injury." *Id*. Dr. Salehi prescribed four to six more weeks of physical therapy for her spinal symptoms, maintained her off-work status, and referred her to an orthopedic surgeon, Dr. Kevin Tu, for evaluation of her bilateral knee pain. *Id.*

5. Referral to orthopedic surgeon Dr. Tu for knee injuries

Petitioner consulted Dr. Tu on June 21, 2017. Px 4, p. 16. Dr. Tu noted a history of falling on stairs at work with her knees hyper-flexed. Petitioner reported problems completing leg exercises in physical therapy due to knee pain; she also reported some giving out of her knees, along with problems when standing up after sitting and using stairs. Dr. Tu's examination found medial tenderness and slight lateral tenderness in both knees. *Id*.

Dr. Tu ordered MRI's of both knees, performed June 5, 2017. The right knee scan showed an oblique tear of the posterior horn of the medial meniscus, along with anterior edema and a probable ACL sprain. *Id*., p. 177. The left knee scan showed signs of a lateral contusion with some edema, but was otherwise read as normal. *Id*., p. 175. On July 12, 2017 Dr. Tu discussed the MRI results with Petitioner, who wanted to try non-surgical treatments. Dr. Tu gave Petitioner cortisone injections in both knees and prescribed physical therapy. *Id*., p. 14.

On August 9, 2017 Dr. Tu noted that Petitioner's left knee symptoms had substantially improved with therapy. However, her right knee pain was still severe, and her range of motion had actually decreased. Px 4, p. 15. Dr. Tu prescribed surgery for the right knee to repair the meniscal tear. In the interim, he prescribed work restrictions, including no kneeling or squatting and no lifting over ten pounds. *Id*., p. 16.

6. Dr. Salehi orders pain treatment by Dr. Pontinen

On July 24, 2017 Petitioner returned to Dr. Salehi, who noted that her spinal pain was unimproved. It was worse

in the mid-back, where Petitioner reported a stabbing sensation. Px 6, p. 7. Dr. Salehi opined that this could be referred pain from the C5-6 disc herniation. He prescribed cervical epidural steroid injections, while noting that Petitioner "may eventually require a C5-6 fusion." Dr. Salehi also prescribed light duty "desk work" with no lifting over ten pounds, no overhead work and limited bending or twisting. *Id*., p. 9.

On July 27, 2017 Petitioner was evaluated by pain specialist Thomas Pontinen, M.D., who concurred with Dr. Salehi's recommendation for cervical injections. Px 7, pp. 16-17. Dr. Pontinen also prescribed Tramadol and meloxicam for pain, and Flexeril for muscle spasm. To limit the use of those pills and minimize their side effects, he also prescribed topical medications (terocin patches and dendracin cream), and a cold compression device for back and knee pain. *Id*., p. 17. Dr. Pontinen opined that Petitioner's neck, back and knee pain resulted from her work injury, and not from a chronic pain disorder. *Id*.

7. <u>Respondent's first Section 12 examiner, Dr. Lieber (Right knee)</u>

On August 31, 2017 Respondent had Petitioner examined by Dr. Lawrence Lieber, an orthopedic surgeon. Rx 4, Exh. 2. Dr. Lieber noted that on April 28, "while walking up some stairs carrying a tray of desserts," Petitioner slipped and fell, injuring her neck area and both knees. His exam found medial and lateral joint line tenderness in Petitioner's right knee, with restricted range of motion, while finding none of these features in her left knee. Dr. Lieber reviewed Petitioner's right and left knee MRI's, and concurred with the radiologist's report on the left knee. As to the right knee, he disagreed with both the radiologist and Dr. Tu: he found no "significant intra-articular pathology except for subcutaneous swelling." *Id*., p. 5. Dr. Lieber's diagnosis for both knees was "status post contusion," with anterior swelling in the right knee. He opined that Petitioner was at MMI for all knee injuries related to "the alleged April 28, 2017 event." *Id*. p. 6.

Dr. Lieber also examined Petitioner's neck, noting some tenderness of the cervical muscles and decreased range of motion. He opined that her cervical MRI showed no "disk herniation or nerve root impingement." Dr. Lieber diagnosed "degenerative cervical disk disease that has no relationship to the alleged April 28, 2017 event, but it certainly contributes to her current symptoms." *Id*. There was no "isolated acute injury to her cervical spine that can be related to the alleged April 28, 2017 event," in his opinion, and no need for further treatment of such. *Id*., p. 7.

Dr. Lieber testified by evidence deposition on March 4, 2020. Rx 4. He testified that he had received medical records for Petitioner from ExamWorks, along with a cover letter from Jonathan Svitek, an attorney for Respondent. *Id*., pp. 16-18. Mr. Svitek's letter contained a summary of the records which was "his record review, not mine," and Dr. Lieber did not independently recall which records he had seen. *Id*., p. 20. He had not seen any accident reports, and did not know the mechanics of Petitioner's fall. *Id*., pp. 19, 22. He assumed that she had simply fallen straight forward, because the MRI's noted anterior swelling. *Id*., p. 23. Dr. Lieber's physical

exam had found both medial and lateral joint line pain in her right knee. *Id.*, p. 24. In reading Petitioner's right knee MRI, however, he "wasn't overly convinced" that she had a medial meniscal tear. *Id*., p. 27. Because only a medial tear was suspected, he had regarded the lateral joint line pain as an "inconsistent" finding, and therefore less important. *Id*., p. 25. Dr. Lieber also testified, however, that he had not seen the operative report of Petitioner's right knee surgery subsequent to his exam. If it confirmed both medial and lateral meniscal tears, that would be consistent with his own exam findings. *Id*. It also "changes my opinion as far as what was wrong with the knee." *Id*., p. 27.

Regarding his examination of Petitioner's cervical spine, Dr. Lieber testified that he has never done spinal fusions, and has not performed any spinal surgery in the last 10-15 years. *Id*., pp. 33, 38-39. If a patient has ongoing cervical spine complaints, he refers them to a spine surgeon in his practice. *Id*., p. 34. Dr. Lieber was not aware that Petitioner had had an epidural steroid injection two days prior to his examination. If the injection were in her cervical spine area, he testified, that would affect how he would interpret his exam findings. *Id*., pp. 34-35.

8. <u>Dr. Salehi recommends cervical fusion surgery</u>

On August 29, 2017, Petitioner received the first cervical epidural spinal injection recommended by Dr. Salehi and Dr. Pontinen. Px 7, p. 24. Dr. Pontinen also ordered MRI's of Petitioner's thoracic and lumbar spine to evaluate her mid-back "stabbing" pain and low back symptoms. *Id*., p. 29, 32, 75-78. On October 2, she returned to Dr. Salehi, reporting that the injection had helped her pain for about five days. Px 6, p. 15. She reported constant neck pain radiating to both shoulders and to the mid-back or interscapular region. Dr. Salehi recommended a second injection, which was administered November 11, 2017. *Id*., p. 16; Px 7, p. 47. He also reviewed the thoracic and lumbar MRI's and found no significant pathology, which indicated that Petitioner's mid-back pain was likely referred from her C5-6 disc herniation. *Id*., p. 16.

On December 11, 2017 Dr. Salehi noted that Petitioner reported no improvement from the second injection; in fact, the pain was a little worse. Px 6, p. 20. He found diffuse tenderness throughout the cervical spine and right trapezius. *Id*., p. 21. Dr. Salehi recommended a C5-6 anterior fusion surgery, citing Petitioner's "ongoing pain despite the passage of time, physical therapy, oral analgesics and two epidural steroid injections." *Id*., p. 22. In the interim, she could work light duty as previously outlined: "desk work" with no lifting over ten pounds, no overhead

work and limited bending or twisting. *Id*., p. 23. At her next appointment on February 2, 2018, Dr. Salehi noted that he was waiting for insurance approval for the surgery. *Id*., p. 26. On June 11, 2018, Dr. Salehi again recommended a cervical fusion. He opined that Petitioner's need for this surgery was related to her April 2017 work accident, noting that "prior to this injury she had no complaints of neck pain, arm pain or knee pain." *Id*., pp. 31, 33.

9. <u>Respondent's second Section 12 examiner, Dr. Ghanayem</u>

On April 23, 2018, Respondent obtained a second Section 12 examination of Petitioner by Dr. Alexander Ghanayem, a spinal surgeon. Petitioner testified that this lasted for 10-15 minutes, with a limited physical exam: "He only had me lift my arms and move my head. And that was it." Tr. 28. Dr. Ghanayem's report stated that Petitioner's cervical range of motion was "normal," but that she showed tenderness to "very light palpation." Rx 3, Exh. 2. Dr. Ghanayem found "grade 3 weakness" in both arms, "from the deltoid to fine finger function," and also found "breakaway weakness." *Id.* He reviewed Petitioner's cervical CT scan from "after her injury" which he assessed as normal. He also reviewed thoracic and lumbar MRI scans obtained in September 2017, "which also goes up into her cervical spine." The cervical spine, he stated, showed some mild degenerative changes but "nothing compressive," and no disk herniations. *Id*.

Dr. Ghanayem diagnosed Petitioner's work injury of April 28, 2017 as a simple neck strain. He opined that her current complaints represented symptom magnification, because the pattern of bilateral upper extremity weakness he had found was "anatomically not possible." However, he also found that Petitioner's treatment to date, including physical therapy and injections, had been reasonable and necessary. Dr. Ghanayem agreed with the opinion of Dr. Lieber, Respondent's first examiner, that Petitioner was at MMI in regard to her cervical spine and could return to full-duty work. She would have reached MMI "as of the date Dr. Lieber determined," he wrote. *Id*., p. 2.

Dr. Ghanayem testified by evidence deposition on December 11, 2019. Rx 3. Asked which of Petitioner's medical records he had reviewed, Dr. Ghanayem replied, "Whatever was provided." *Id*., p. 8. Counsel for the insurer had provided him with records and a cover letter, but those items had been returned. *Id*., p 16. Dr. Ghanayem did not recall seeing the medical records of Dr. Salehi, or of Northwestern Medical Center. *Id*., pp. 8, 19. He did, however, recall reviewing Dr. Lieber's Section 12 report. *Id*., p. 18. He testified that he knew Dr. Lieber, but was not sure whether he performed any spine surgery. *Id*., p. 19.

Dr. Ghanayem also confirmed that he had never seen Petitioner's cervical MRI of April 29, 2017. *Id*., p. 18. He testified that Petitioner's thoracic MRI of September 2017 "went up into her cervical spine," and his review of those films had been the basis of his opinion that Petitioner did not have any cervical disc herniations or other compressive findings. *Id*., p. 11. In addition, he knew from reviewing her CT scan that there were no fractures. *Id*. Dr. Ghanayem could not confirm that he saw no disc bulges or annular tears in Petitioner's cervical spine. Any such findings, he testified, would have been included in his statement that he found "mild degenerative changes." He did not recall whether those changes were at C5-6, or at some other level of her spine. *Id*., p. 24. In general, Dr. Ghanayem stated, he included the contents of medical records in his reports only if the information was "newsworthy" or important. *Id*., p. 32.

10. <u>Right knee surgery by Dr. Tu and post-operative care</u>

On May 15, 2018, Respondent approved the right knee surgery recommended by Dr. Tu. Px 4, p. 128. Petitioner underwent the surgery on June 15, 2018. Dr. Tu's operative report confirmed the presence of a complex medial meniscal tear, and found a similar tear of the lateral meniscal tear. Px 3. Both were repaired, and impinging synovial tissue was removed from all three compartments of the knee. *Id*. Following surgery Petitioner began physical therapy, and Dr. Tu noted "gradual but slow improvement" in her symptoms. Px 4, p. 8. On October 3, 2018 he prescribed a work hardening program. *Id*., p. 7.

On October 31, 2018 Dr. Tu noted that Petitioner was making limited progress in work hardening, and still had significant right knee pain. Px 4, p. 6. A status report from Athletico Physical Therapy found that Petitioner could function within her current ten-pound restrictions; however, her neck pain limited further progress with lifting, and she was meeting only 15% of her job requirements as a Banquet Server. *Id*., pp. 63-65. Dr. Tu discontinued work hardening. *Id*., p. 69. He wrote that a Functional Capacity Evaluation (FCE) would be indicated

> … to determine if permanent restrictions were required. However, she is being treated for her cervical spine and if we performed a functional capacity evaluation now, ***the results would be erroneous as she has continued issues with her cervical spine***. At this point reasonable restrictions include no walking or standing than tolerated and no lifting greater than 15 pounds. A functional capacity evaluation would be recommended at the completion of her cervical spine treatment. *Id*., p. 6. (emphasis added)

On November 2, 2018, Respondent's case manager, Deborah Brundage, RN, informed Dr. Tu that "the neck was not an accepted body part for this claim," and he should proceed with the FCE. *Id*., p. 52. On December 3, 2018, Ms. Brundage contacted Dr. Tu by fax to note that

Petitioner had still not completed an FCE, and to ask "how the doctor plans to proceed." Dr. Tu's office faxed her the order the following day. *Id*., pp. 52, 54.

11. Functional Capacity Evaluation (FCE) and subsequent medical care

Petitioner's FCE was performed December 11, 2018. Her work tolerance was rated at a Sedentary level, well below the Medium level of her job with Respondent. Px 12, p. 2. The examiner noted that Petitioner had refused to complete frequent-lift and positional-tolerance tests due to neck and right knee pain, and opined that her FCE performance represented her "minimum functional ability level." *Id*. Limiting factors had included her "pain in right knee and cervical spine, limited cervical, shoulder and right knee ROM and decreased muscle strength in bilateral shoulder and right lower leg." *Id*. On December 26, 2018, Petitioner returned to Dr. Tu to discuss the FCE results. Px 4, p. 5. She agreed that she had been "unable to perform at her full effort" on the FCE, but that this was due to her cervical pain. Dr. Tu released her from further care for her knees, and prescribed a ten-pound lifting restriction. This restriction would be permanent, he wrote, "until she undergoes treatment for her cervical spine." *Id*.

Dr. Salehi continued to see her, and to recommend cervical fusion surgery. In August 2019, noting some increased right shoulder pain and weakness, he asked Dr. Tu to examine Petitioner to rule out a shoulder injury. Px 6, pp. 51-53. Dr. Tu's exam found no specific shoulder injury, and he referred her back to Dr. Salehi for further cervical spine treatment. Px 4, p. 3.

12. Dr. Salehi's deposition

Dr. Salehi testified by evidence deposition October 1, 2019. Px 1. He is a board-certified neurosurgeon, and testified that 90% of his practice involves treatment of spinal injuries, both surgical and non-surgical. *Id*., p. 5. When he first saw Petitioner in June 2017, she had neck pain with cervical tenderness and some tingling in her hands. She also had mid-back pain and lumbar pain radiating into her buttocks. *Id*., p. 6. Dr. Salehi opined that Petitioner's injuries were causally related to her fall at work on April 28, 2017. Petitioner's backwards fall down the stairs, after first falling forward and losing her balance, was sufficient in his opinion to cause a significant spinal injury. *Id*., p. 9. Moreover, she had no history of neck or back pain prior to the accident. *Id*.

Based on his review of Petitioner's cervical MRI, Dr. Salehi diagnosed that injury as a C5-6 disc herniation, moderate in size, with an annular tear. Px 1, pp. 7, 9. The disc herniation, he testified, was likely caused by the fall, although the disc-osteophyte complex also seen on her MRI would be pre-existing. *Id*., p. 22. The annular tear on the C5-6 disc was the main source of

Petitioner's neck pain. *Id*., p. 10. Her mid-back pain, in Dr. Salehi's opinion, was likely referred pain from the cervical injury. *Id*., p. 19. This was a common pattern, he testified, just as pain from a heart attack was often referred to the left arm. It was supported by the lack of any significant disc injury seen on Petitioner's thoracic spine MRI of September 2017. *Id*., pp. 19, 26. The temporary pain relief produced by Petitioner's first cervical injection also suggested the C5-6 herniation as the pain source.

Dr. Salehi had reviewed Dr. Lieber's report, and questioned his reading of Petitioner's cervical MRI as essentially normal, with no herniation. This was at odds with Dr. Lieber's later diagnosis of degenerative disc disease, he noted. *Id*., p. 14. Dr. Salehi also noted that Dr. Lieber agreed that Petitioner's neck symptoms were genuine but could not explain their source. He testified that as far as he knew Dr. Lieber did not treat spinal injuries. *Id*., p. 15. Regarding Dr. Ghanayem's report, which he also reviewed, Dr. Salehi testified that it offered no explanation for Petitioner's symptoms other than malingering. He testified that he had examined Petitioner many times and had never seen the "give-way weakness" alleged by Dr. Ghanayem, or any other non-organic signs. *Id*., p. 16. Dr. Salehi explained that he had prescribed only physical therapy and medications at Petitioner's first visit, because it was best to avoid surgery whenever possible. He began to consider surgery only when these measures produced no improvement. *Id*., pp. 27-28. A single-level cervical fusion, he testified, would stabilize Petitioner's spine, remove the disc pathology and reduce her pain. *Id.,* pp. 16-17. Dr. Salehi estimated that she would reach MMI after about four months of post-operative treatment. *Id*., p. 17.

13. <u>Petitioner's current condition</u>

Petitioner testified that her last appointment with Dr. Salehi, in 2020, was via telehealth due to Covid-19 restrictions. She continues to see Dr. Larson for pain medication. Tr. 33-34. Her current prescriptions are Tramadol and gabapentin; the gabapentin hurts her stomach, but she cannot sleep without them. Tr. 35. Petitioner testified that her neck pain was still quite bad and limited her daily activities. She avoids bending over because when she tries to raise her head the pain is very bad – "like somebody stabbing me with a nail." Tr. 35-36. Her husband goes with her to the grocery store, because she can only lift a small bag. Tr. 36. She avoids driving unless it's an emergency. She had travelled downtown to the hearing on the train, with her daughter's help. Tr. 56. Petitioner confirmed that she had never had these symptoms prior to her April 2017 workplace accident. She testified that she has had no further neck injuries since that time. Tr. 36.

In addition, she has had no auto accidents, no surgeries other than the knee surgery by Dr. Tu, and no other workers' compensation claims. Tr. 53, 55.

Petitioner testified that she has not worked since her injury. Respondent had called her about six weeks ago regarding banquet work, and Hyatt called in 2020 just before the pandemic started; however, she testified that she could not say yes, because she could not do any heavy lifting. Tr. 50. Petitioner testified that all of her prior work experience has been as a banquet server. Tr. 57. She has not looked for other jobs, because she is still on pain medication. Tr. 51. She has not applied for unemployment. She has been getting Social Security Disability for the past two years, about $530 per month. Tr. 53, 55.

Petitioner testified that she still wanted the surgery Dr. Salehi prescribed. Tr. 36. She has tried to get the surgery using other insurance, including Medicare, but was turned down. Tr. 37.

B. CONCLUSIONS OF LAW

The Arbitrator adopts the opinions of the treating surgeons, Dr. Salehi and Dr. Tu, and concludes that Petitioner's current neck and right knee symptoms are causally connected to her April 28, 2017 workplace accident. In support of said decision, the Arbitrator incorporates the preceding findings of fact.

As to issue "C", the occurrence of an accident, the Arbitrator finds as follows:

Petitioner credibly testified that she fell backwards down a flight of concrete stairs at Respondent's hotel on April 28, 2017 while carrying a tray of desserts. Respondent's accident report (Rx 5), completed and signed by Respondent's safety manager, confirms Petitioner's account. The medical records of Northwestern likewise confirm that Petitioner arrived by ambulance from Respondent's hotel that evening and was treated for injuries attributed to a fall while working. No testimony or evidence was presented either to deny that Petitioner's fall occurred, or to indicate that she was present on Respondent's kitchen stairs for any reason apart from the performance of her job duties as a banquet server. Respondent offers an email in which a kitchen manager opines, two weeks after the fact, that Petitioner's choice of work shoes was "not a good idea." However, no evidence was offered that the employer either required a certain type of footwear, or had ever advised Petitioner to wear different shoes. Moreover, even if Petitioner had been shown to have violated some work rule, the fact that she was climbing stairs with a tray

of food balanced on one arm when she fell renders the issue moot for purposes of finding accident. The Arbitrator therefore finds that on April 28, 2017 Petitioner sustained an accident that arose out of and in the course of her employment.

As to issue "F", whether Petitioner's present condition of ill-being is causally related to his injury, the Arbitrator finds as follows:

The Petitioner testified clearly and credibly to having worked continuously as a hotel banquet server since 2005. Her description of the job, which included serving meals to large gatherings, retrieving the plates and helping to set up and take down furnishings, was consistent with the job description in Petitioner's Exhibit 13, which classified the job as "medium duty." Lifting requirements of 20-50 pounds occasionally and 10-25 pounds frequently were noted. It also specified that banquet servers would "handle up to 10 plates on a tray at each time utilizing a one-hand lifting technique, occasionally resting the tray on the shoulder." Petitioner's credible testimony that she had performed such work for eleven years, up to and including the date of accident, was not refuted. She also testified unrebutted to an absence of any prior neck, back or knee complaints, prior surgeries, or workers' compensation claims.

Causation in a workers' compensation case may be established by a chain of events showing prior good health, an accident and a subsequent injury. *Gano Electric Contracting v. Industrial Comm'n*, 260 Ill.App.3d 92, 96-97 (1994); *see also Darling v. Industrial Comm'n*, 176 Ill.App.3d 186, 193 (1988). The medical evidence in this case, along with Petitioner's own credible testimony, shows just such a chain of events. Immediately following Petitioner's April 28, 2017 accident, Respondent's managers called an ambulance to take her to Northwestern Hospital. She was admitted for five days on the basis of severe pain and inability to walk. Following discharge, Petitioner promptly entered medical treatment for her injuries. In June 2017 she was referred to two surgeons who assumed her care thereafter: orthopedic surgeon Dr. Kevin Tu for her knees, and neurosurgeon Dr. Sean Salehi for her cervical spine. Both doctors ultimately recommended surgery, and neither one to date has released her for regular-duty work.

Petitioner's knee injuries

Dr. Tu diagnosed Petitioner with right knee meniscal tears following a fall down a flight of stairs at work, with similar but milder findings in the left knee. His diagnosis was based on a

review of her MRI films, along with the lack of prior symptoms or medical treatment for knee pain. Dr. Tu's careful history also noted that Petitioner first fell forward with her knees hyper-flexed, then twisted and fell backwards. Dr. Tu also noted the steady improvement in Petitioner's left knee with physical therapy, while her right knee symptoms actually worsened, and prescribed right knee surgery as a result. His operative report both confirmed a complex tear of the medial meniscus, and found a similar tear of the lateral meniscus. It also confirmed his opinion that Petitioner had "injured her right knee at work." Px 3, p. 1.

The Arbitrator finds Dr. Tu's diagnoses, which were confirmed by the results of surgery and treatment, to be more persuasive than the opinions of Respondent's examiner, Dr. Lieber, that Petitioner's knee complaints were due to age-related degeneration. Dr. Lieber testified that his opinions were based on the incorrect assumption that Petitioner's accident had been a simple forward fall onto her knees, and agreed that he knew of no medical records supporting his diagnosis of a longstanding "degenerative" knee condition. He also testified that the findings in Dr. Tu's operative report would have changed his opinion as to the source of Petitioner's knee problems. The Arbitrator therefore finds that Petitioner's bilateral knee symptoms, and her need for right knee surgery, are causally connected to her work accident of April 28, 2017.

Petitioner's cervical spine injuries

Dr. Salehi, Petitioner's treating surgeon, opined that her cervical spine injuries were causally related to her April 2017 work accident. Dr. Salehi's causal opinion was based on Petitioner's lack of any prior neck or spine complaints and her ability to perform medium-duty work prior to her accident. He also opined that the mechanism of accident—a backwards fall down stairs, after first falling forward and failing to regain her balance—was capable of causing a cervical disc injury. Based on his reading of Petitioner's cervical MRI films, Dr. Salehi diagnosed a moderate C5-6 disc herniation with an annular tear. The disc herniation was likely caused by her fall, he opined, and Petitioner's neck pain was due primarily to the annular tear in the C5-6 disc. The disc-osteophyte complex also seen on her MRI, however, was more likely pre-existing. Dr. Salehi also reviewed the thoracic and lumbar MRI's ordered by Dr. Pontinen. Based on his clinical experience, he attributed the stabbing pain in Petitioner's mid-back to referred pain from her cervical disc, rather than to any thoracic spine pathology. Dr. Salehi explained that he regarded non-surgical treatments as the first option for spinal injuries. He had recommended surgery only

after Petitioner's symptoms did not respond to "the passage of time, physical therapy, oral analgesics and two epidural steroid injections." (Px 4, p. 22). A cervical fusion, he testified, would stabilize her spine and provide pain relief by removing the damaged C5-6 disc.

While both Respondent's Section 12 examiners denied any causal connection between Petitioner's fall at work and her subsequent neck and back symptoms, neither offered adequate evidence to justify their opinions. Dr. Lieber admitted that he had no knowledge of Petitioner's accident, and assumed she had simply fallen forward onto her knees. He also admitted he was unaware that she had had a cervical epidural injection two days before he examined her, which would have affected his exam results. Finally, Dr. Lieber confirmed that he has never done spinal fusion surgery, has not performed spinal procedures of any kind for over a decade, and refers all patients with spinal complaints to one of his partners.

Respondent sought a second Section 12 opinion from a spinal specialist, Dr. Ghanayem. However, Dr. Ghanayem's brief report relied heavily on the prior report of Dr. Lieber; while he testified that he had reviewed other medical records, he could recall only Dr. Lieber's report. As a result, he was unable to respond to the findings and opinions of Dr. Salehi, or his recommendation for cervical fusion surgery. Dr. Ghanayem's report also contained no reference to Petitioner's work history or her medical history prior to the April 28, 2017 accident.

Unlike Dr. Lieber and Dr. Salehi, Dr. Ghanayem had never reviewed Petitioner's cervical MRI. He nonetheless opined that her cervical spine showed only "mild degenerative changes." Dr. Ghanayem testified that he based his opinion on Petitioner's September 2017 thoracic MRI, which had "gone up into her cervical spine," enabling him to use those films to analyze her cervical problems. However, Petitioner's thoracic MRI was also reviewed by Dr. Salehi and by Dr. Pontinen (Px 6, p. 16; Px 7, p. 32), neither of whom noted any cervical findings. The radiologist's report likewise gave no cervical findings, although it reported her lumbar spine condition in detail. (Px 7, p. 75) Finally, while Dr. Ghanayem opined that those films showed only degenerative bulging rather than a herniated disc, he could not identify where in the cervical spine this bulging occurred. Given Dr. Ghanayem's failure either to review the Petitioner's cervical MRI films or to reference any of her extensive treatment records, the Arbitrator finds his opinions unpersuasive.

Finally, Dr. Ghanayem reported bilateral and "breakaway" weakness in Petitioner's arms, in every muscle group from shoulder to fingertips. This was an anatomically impossible finding, he testified, which proved her complaints were feigned or exaggerated. However, Dr. Ghanayem's

findings of arm weakness, like the alleged cervical findings on Petitioner's thoracic MRI, were contradicted by the reports of Dr. Salehi and all of her other treaters (as well as those of Respondent's first examiner, Dr. Lieber, who likewise found normal arm strength). This discrepancy further detracts from the credibility of Dr. Ghanayem's findings and conclusions.

The Arbitrator therefore adopts the opinion of Dr. Salehi that Petitioner's cervical spine complaints are causally connected to her fall at work on April 28, 2017. Dr. Salehi's opinion is based on repeated examinations of Petitioner over the course of three years, along with consideration of her work abilities and medical history prior to the accident. In addition, it is consistent with the sequence of events established by Petitioner's own credible testimony and the documentary evidence.

As to issue "G", Petitioner's earnings in the 52 weeks prior to her accident, the Arbitrator finds as follows:

The parties agreed that Petitioner earned $5,846.26 from her work for Respondent in the year prior to her injury, and that her average weekly wage in that position was $389.74. This agreed AWW was calculated on the basis of weeks and parts of weeks worked, rather than on a 52-week basis. *See, e.g., D.J. Masonry Co. v. Industrial Comm'n,* 295 Ill. App. 3d 924 (1998); *Sylvester v. Industrial Comm'n*, 197 Ill.2d 225 (2001). Respondent argued that this sum represented Petitioner's entire AWW for purposes of the current claim. Arb. Exhibit 1.

Petitioner presented additional evidence of $31,222.55 in earnings from concurrent employment as a banquet server at the Hyatt. Px 2(b). Section 10 of the Act provides that "when the employee is working concurrently with two or more employers and the respondent employer has knowledge of such employment prior to the injury, his wages from all such employers shall be considered as if earned from the employer liable for compensation." 820 ILCS 305/10 (West 2006). Earnings from concurrent employment must therefore be included in the claimant's average weekly wage, unless the respondent employer was unaware of the concurrent employment at the time of the injury. *Flynn v. Industrial Comm'n*, 211 Ill.2d 546, 554 (2004).

Petitioner testified that Respondent's supervisors were not only aware of her employment with the Hyatt, but allowed her to arrange her weekly schedule at the Drake around the more extensive hours she worked at the Hyatt. Her credible testimony on this point was unrebutted.

Petitioner also submitted a copy of her job application at Hyatt, which indicated that Hyatt's personnel department had contacted Respondent to verify her employment. (Px 2(c))

In *Flynn v. Industrial Comm'n*, 211 Ill.2d 546 (2004), our Supreme Court upheld the concurrent-employment provisions of Section 10 even when the hours worked in the two jobs did not closely overlap in time. The claimant in *Flynn* was injured on his second, part-time job while on seasonal layoff from his full-time job in road construction. Notably, the Court also found that calculating benefits "based solely on the AWW of the employment in which the employee was injured" would impose an unacceptably severe hardship on a full-time worker injured during part-time employment, which would defeat the remedial purpose of the Act. 211 Ill.2d 546 at 559. The Petitioner in this case would suffer a similar hardship if compensated solely for her wages from Respondent, which were merely supplemental to her far more extensive earnings from the Hyatt. (Moreover, unlike in *Flynn*, the "overlap" between Petitioner's two jobs is beyond doubt; in fact, she testified that she had worked for both employers on the date of accident.)

The Arbitrator therefore finds that Petitioner's average weekly wage of $826.08 at the Hyatt (as calculated from the wage statements in Px 2(b)) should be added to her average weekly wage of $389.74 for Respondent, for a total average weekly wage of $1,215.82.

As to issue "J", the reasonableness and necessity of medical care provided, the Arbitrator finds as follows:

Petitioner's Exhibit 14 lists outstanding medical bills for injury-related care prescribed by her treating physicians. Having found Petitioner's right knee and cervical spine conditions to be causally related to her work accident, the Arbitrator finds the medical care for those conditions prescribed by Dr. Salehi and Dr. Tu to be reasonable and necessary. Dr. Tu's prescription for right knee surgery was based on the results of Petitioner's MRI and his own examinations. Dr. Tu also noted that while her left knee had improved with physical therapy and injections, her more severe right knee symptoms had not. The care prescribed by Dr. Salehi was likewise based on objective evidence and aimed at relieving Petitioner's neck and back symptoms without surgery if possible. The Arbitrator notes that even Respondent's Dr. Ghanayem, who denied that Petitioner had a herniated disc and needed surgery, nonetheless agreed that her spinal treatment to date, including injections and physical therapy, had been reasonable.

Respondent submitted utilization-review reports regarding two medical expenses. The first was Dr. Salehi's initial prescription on June 12, 2017, for six more weeks of physical therapy. Rx 1. Respondent's reviewer argued that "ODG guidelines" called for ten weeks of therapy, and a progress note dated 6/9/2017 had already reported "marked improvement" after 11 weeks. The Arbitrator notes that the records of Petitioner's first course of PT (Px 10), prescribed by physicians at Northwestern Hospital, contain separate notes for her shoulder, knees and low back. The ten-week guideline cited in the review is for "lumbar strain," while the report describing a decrease in pain is for "pain: shoulder." Px 10, pp. 176-77. It also notes that strength testing is limited by high pain levels, and sets Petitioner's new goal as "decreasing pain score to 4/10." A separate 6/9/2017 note for back pain reports "high levels of pain in her mid and low back" that limit most activities. *Id.,* pp. 234-35. Finally, a letter from the physical therapist explains that Petitioner is now seeing Dr. Salehi for neck and low back pain with a herniated cervical disc. *Id*., p. 90. Based on this evidence, the Arbitrator concludes that the review was based on a limited understanding of Petitioner's multiple injuries, and continued physical therapy was reasonable and necessary.

The second utilization review questions the need for topical pain medication (Terocin patches and dendracin cream) and a cold-compression device ordered by Dr. Pontinen, the pain specialist who performed Petitioner's cervical injections. Rx 2. The reviewer argues that these should not be prescribed for pain unless anticonvulsants and antidepressants have first been tried without success. *Id*., p. 8. The Arbitrator notes that Dr. Pontinen prescribed these topical agents on July 24, 2017 to minimize side effects of the oral medications, Tramadol, Flexeril and Meloxicam. Px 7, p. 17. Dr. Pontinen's notes state that anticonvulsants and antidepressants are typically used on a permanent basis for chronic pain. Noting that Petitioner's pain was the result of acute injuries, and would hopefully improve with physical therapy and injections, he declined to start such long-term medications unless the planned treatments fail. *Id.*. In reply to Respondent's review, he also noted that both topical analgesics and injections are indicated by ODG guidelines when pain is unresolved after four weeks of physical therapy and oral medications. *Id*., p. 20. The Arbitrator also notes Petitioner's testimony that she currently relies on oral medications which upset her stomach, but are necessary so that she can sleep. Tr. 35. Accordingly, the Arbitrator accepts the topical medications and cold-compression device prescribed by Dr. Pontinen as reasonable and necessary care for Petitioner's pain complaints. They are therefore Respondent's

liability, subject to the fee schedule, along with all outstanding bills listed in Px 14. Respondent is granted credit for any of said expenses which it can show it has already paid. *See* Rx 10.

As to issue "K", prospective medical care, the Arbitrator finds as follows:

Having found a causal connection between Petitioner's workplace accident and her ongoing neck pain, the Arbitrator will order Respondent to authorize and pay for the cervical fusion surgery recommended by Dr. Salehi, along with reasonable post-operative care. Such treatment is considered to have been "incurred" when ordered by Petitioner's treating physician, as set forth in *Plantation Mfg. Co. v. Industrial Comm'n*, 294 Ill. App. 3d 705 (1997).

Dr. Salehi's prescription for cervical fusion surgery was based on Petitioner's cervical MRI images and his own repeated exam findings, as well as the failure of her symptoms to respond to extensive conservative care, including medications, epidural steroid injections and physical therapy. Dr. Ghanayem's opinions were based on a single brief exam; in addition, he failed to review Petitioner's cervical MRI or to respond to the extensive records of her treating neurosurgeon. In weighing conflicting medical testimony, the Commission may accord greater weight to the opinion of a treating physician over that of an examiner. *Int'l Vermiculite v. Industrial Comm'n*, 77 Ill.2d 1, 4 (1979). In this case, Dr. Ghanayem's opinions should clearly be accorded less weight than those of Dr. Salehi, the treating surgeon, who examined Petitioner repeatedly over the course of three years' treatment.

As to issue "L", regarding Petitioner's entitlement to Temporary Total Disability benefits, the Arbitrator finds as follows:

In determining ongoing eligibility for TTD, the dispositive question is whether the claimant's condition has stabilized, including whether further curative measures are prescribed. *Interstate Scaffolding v. IWCC*, 236 Ill.2d 132 (2010); *Westin Hotel v. Industrial Comm'n*, 372 Ill. App. 3d 527, 542 (2007) ("an employee is temporarily totally incapacitated from the time an injury incapacitates him for work until such time as he is as far recovered or restored as the permanent character of his injury will permit"). TTD is properly discontinued when claimant reaches Maximum Medical Improvement, is found medically capable of full duty work, or refuses an offer of light duty within her medical restrictions.

The Petitioner testified that she has not worked since April 28, 2017, the date of her accident. The medical records show that she has been continuously under the care of Dr. Salehi

and/or Dr. Tu, and was still awaiting further surgery. Neither physician has cleared Petitioner to resume full-duty work; they have either ordered her off work, or authorized essentially sedentary light duty with minimal lifting or overhead work. Respondent offered no evidence that it had ever made such light-duty work available to Petitioner.

Respondent argues that it paid TTD through October 29, 2018, and that its obligation ended at that time. Rx 9; Arb. Exh. 1. This corresponds to the date when Dr. Tu ordered a halt to work hardening treatment due to Petitioner's significant pain and lack of progress. Petitioner completed an FCE and was released from care by Dr. Tu on December 26, 2018. However, Dr. Tu's records show that he explicitly declined to find Petitioner at "MMI," because she was still under Dr. Salehi's care for her cervical spine injury and awaiting surgery. Dr. Tu had urged that Petitioner's FCE be postponed until she finished her cervical treatment. After the FCE was performed at the insistence of Respondent's case manager, Dr. Tu opined that the results were invalid, as he had predicted; Petitioner had been unable to demonstrate a "full effort" because of her ongoing neck and back pain. Dr. Tu released her from care for her knee injuries, while finding her in need of further cervical treatment. He imposed a ten-pound lifting restriction, which he noted would be "permanent until she undergoes treatment for her cervical spine." Px 4, p. 5.

As of the date of trial, Petitioner continued to seek the cervical surgery repeatedly prescribed by Dr. Salehi since December 2017, over three and one-half years ago. In the interim she has been approved for Social Security Disability. Tr. 53. She testified that she had tried to obtain the surgery using Medicare or other insurance, but had been unsuccessful. She had not looked for alternate employment while awaiting surgery, because she was on daily medications for her pain. Tr. 51. Petitioner also testified that all of her prior work experience was as a banquet server, a medium-level job which was well above the sedentary restrictions prescribed by Drs. Tu and Salehi, and supported by her December 11, 2018 FCE.

Respondent, for its part, did not follow up its October 30, 2018 TTD cutoff by scheduling Petitioner to report for work, either in her former position or on a modified-duty basis. It also did not pay maintenance contingent on a search for alternate work, much less offer Petitioner any assistance in finding work. Moreover, in the absence of a light-duty offer, mere evidence that the claimant may be capable of some sort of work activity does not end eligibility for TTD, if she has not reached MMI and is in need of further care. *See Archer Daniels Midland v. Industrial Comm'n, 138 Ill.2d 120* (1990); *Zenith v. Industrial Comm'n*, 91 Ill.2d 278 (1982). Respondent's conduct

demonstrated that in fact it recognized Petitioner was not at MMI. Rather, its denial of benefits was based on its assertion that "the neck was not an accepted body part for this claim," and that her ongoing disability was not causally related to her accident.

Having found causal connection, the Arbitrator therefore awards Temporary Total Disability benefits for a total of 226 weeks, from April 29, 2017 through August 27, 2021, the date of trial. Respondent is awarded credit for the $7,461.12 in TTD benefits which the parties agreed it has already paid. (Arb. Ex. 1)

IT IS SO ORDERED BY:

/s/ Raychel A. Wesley November 13, 2021

Raychel A. Wesley, Arbitrator
Illinois Workers' Compensation Commission

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC025489
Case Name	RODRIGUEZ, ANDRES v. CREATIVE RESOURCE PERSONNEL
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0233
Number of Pages of Decision	34
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	John Castaneda
Respondent Attorney	Robert Smith

DATE FILED: 6/24/2022

/s/ Deborah Baker, Commissioner

Signature

22IWCC0233

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ANDRES RODRIGUEZ,

Petitioner,

vs. NO: 18 WC 25489

CREATIVE RESOURCE PERSONNEL,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b) of the Act having been filed by the Respondent herein, and notice given to all parties, the Commission, after considering the issues of whether Petitioner's current cervical and lumbar spine conditions of ill-being are causally related to his accident, Petitioner's entitlement to medical expenses subsequent to the March 18, 2019 Section 12 examination, Petitioner's entitlement to temporary total disability benefits and temporary partial disability benefits, and Petitioner's entitlement to prospective cervical spine surgery recommended by Dr. McNally and being advised of the facts and law, changes the Decision of the Arbitrator as set forth below, but 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 (1980).

The Commission hereby incorporates by reference the findings of fact and conclusions of law contained in the Decision of the Arbitrator, which delineate the relevant facts and analyses. However, as it pertains to temporary partial disability, the Commission changes the Decision of the Arbitrator. In the "Findings" section of the Decision of the Arbitrator, Respondent was awarded credit for temporary partial disability benefits in the amount of $12,786.38, but the time period for which this credit was given was not indicated. The Commission relies on the record to rectify this omission.

Petitioner began working light duty on July 26, 2018, the day after the accident. On the

"Request for Hearing" form, the parties stipulated that temporary partial disability benefits owed includes the period from July 26, 2018 through at least December 15, 2019.[1] The record reflects that these benefits were paid at a rate of $180.09/week from July 26, 2018 through December 12, 2018, and January 8, 2019 through December 23, 2019.[2] The record also reflects that Petitioner was terminated by Respondent on December 16, 2019, while working light duty. Accordingly, the temporary *total* disability period began on December 16, 2019, although it temporarily paused from December 20, 2019 through January 7, 2020.[3]

Based on the above, Petitioner was entitled to temporary partial disability benefits from July 26, 2018 through December 12, 2018, temporary *total* disability benefits from December 16, 2019 through December 19, 2019, and no benefits from December 20, 2019 through January 7, 2020.

Based on the payments made by Respondent, which are memorialized in the record, the Commission finds that temporary partial disability payments have already been tendered as follows:

-July 26, 2018 through December 12, 2018; and January 8, 2019 through December 15, 2019 (68 & 6/7ths weeks working light duty);
-December 16, 2019 through December 19, 2019 (4/7ths week temporary partial disability overpayment, as these days were already paid via temporary total disability).
-December 20, 2019 through December 23, 2019 (4/7ths week of temporary partial disability overpayment, as Petitioner was not entitled to any temporary benefits for these days).

This equals 70 weeks of temporary partial disability payments, only 68 & 6/7ths weeks of which was actually owed to Petitioner.

The Commission notes that, contrary to the $12,786.38 awarded in the Decision of the Arbitrator, the temporary partial disability amount actually paid was $12,606.29. The record reflects that a stop payment was issued on check #594838 for the week of April 16, 2019 through April 22, 2019, which was then re-issued at a later date. The Commission surmises that the Arbitrator mistakenly counted two of these checks in calculating the total amount of temporary partial disability benefits paid. Since Petitioner is owed 68 & 6/7ths weeks of temporary partial disability benefits at a rate of $180.09/week ($180.09 x 68.86 = $12,400.99), but Respondent paid 70 weeks worth of benefits in the amount of $12,606.29, which exceeds the actual amount owed by $205.30, the Commission hereby modifies the award for temporary partial disability benefits as follows:

Respondent is entitled to a credit in the amount of $12,606.29 from July 26, 2018 through December 12, 2018, and January 8, 2019 through December 23, 2019 for temporary partial disability benefits paid, $205.30 of which is an overpayment for the period December 16, 2019 through December 23, 2019.

All else is affirmed.

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1 Respondent claims these benefits extend through December 23, 2019.
2 Petitioner requested time off work from December 13, 2018 through January 7, 2019.
3 Petitioner requested time off work again from December 20, 2019 through January 7, 2020.

IT IS THEREFORE FOUND BY THE COMMISSION that the Decision of the Arbitrator filed May 7, 2021, as changed above, is hereby affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary medical services of $17,465.26, as provided in §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for the surgical procedure prescribed by Dr. Thomas McNally, including but not limited to all attendant hospital, surgical, preoperative and postoperative requirements, therapeutic and other related medical and prescriptive medication, modalities, DMG, etc.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $320.00 per week for a period of 42 weeks, from December 16, 2019 through December 19, 2019; and January 8, 2020 through October 23, 2020, these being the periods of temporary total incapacity for work under §8(b) of the Act, and that as provided in §19(b), 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 temporary partial disability benefits in the amount of $180.09 per week for a period of 68 & 6/7ths weeks, from July 26, 2018 through December 12, 2018; and January 8, 2019 through December 15, 2019, as provided in §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to temporary total disability credit in the amount of $182.84.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to credit in the amount of $12,606.29 from July 26, 2018 through December 12, 2018, and January 8, 2019 through December 23, 2019 for temporary partial disability benefits paid, $205.30 of which is an overpayment for the period December 16, 2019 through December 23, 2019.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is not liable for penalties or attorney fees.

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 the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

June 24, 2022
O: 4/27/22
DJB/wde
043

/s/*Deborah J. Baker*
Deborah J. Baker

/s/*Stephen Mathis*
Stephen Mathis

/s/*Deborah L. Simpson*
Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC025489
Case Name	RODRIGUEZ,ANDRES v. CREATIVE RESOURCE PERSONNEL
Consolidated Cases	
Proceeding Type	19(b) Petition
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	30
Decision Issued By	Joseph Amarilio, Arbitrator

Petitioner Attorney	John Castaneda
Respondent Attorney	Andrea Carlson

DATE FILED: 5/7/2021

INTEREST RATE FOR THE WEEK OF MAY 4, 2021 0.03%

/s/ Joseph Amarilio, Arbitrator
Signature

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)

Andres Rodriguez
Employee/Petitioner

v.

Creative Resource Personnel
Employer/Respondent

Case # 18 WC 025489

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 Christopher Harris, Arbitrator of the Commission, in the city of Chicago, on October 23, 2020 and decided by Arbitrator Joseph Amarilio, in his stead. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches

DISPUTED ISSUES

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

FINDINGS

On the date of accident, July 25, 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 **$24,960.00**; the average weekly wage was **$480.00**.

On the date of accident, Petitioner was 53 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 **$182.84** for TTD, **$12,786.38** for TPD, $0 for maintenance, and **$0** for other benefits, for a total credit of **$12,969.22.**

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

ORDER

Medical benefits

Respondent shall pay reasonable and necessary medical services of $**17,465.26**, pursuant to Sections 8(a) and 8.2 of the Act.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $**320.00**/week for **42** weeks, commencing **12/16/2019** through **12/19/2019 (4/7th)** and **01/08/2020** through **10/23/2020 (41-3/7th)**, as provided in Section 8(b) of the Act.

Penalties

Respondent is not liable for penalties or attorney fees.

Prospective Medical Care

Respondent shall authorize and pay for the surgical procedure prescribed by Dr. Thomas McNally including, but not limited to all attendant hospital, surgical, preoperative and postoperative requirements, therapeutic and other related medical and prescriptive medication, modalities, DMG, etc.

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.

Joseph D. Amarilio
Signature of Arbitrator JOSEPH D. AMARILIO

MAY 7, 2021

ICArbDec19(b)

STATE OF ILLINOIS)
)
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Andres Rodriguez,	)	
	)	
Employee/Petitioner,	)	
	)	
v.	)	18 WC 025489
	)	
Creative Resource Personnel,	)	
	)	
Employer/Respondent.	)	

ADDENDUM TO DECISION OF THE ARBITRATOR

Procedural History

Petitioner filed an Application for Adjustment of Claim alleging accidental injuries arising out of and in the course of his employment with Respondent on July 25, 2018. On October 23, 2020, this matter was heard by the Honorable Christopher Harris. Before rendering a decision, Arbitrator Harris subsequently became a Commissioner of the Illinois Workers' Compensation Commission. This matter was then assigned by the Commission to Arbitrator Joseph D. Amarilio. The parties agreed to have Arbitrator Amarilio render a decision based on the trial record. The disputed issues addressed in this 19(b) proceeding are (F.) whether the Petitioner's present condition of ill-being is causally related to his alleged accidental injury; (J.) whether the medical services provided to the Petitioner were reasonable and necessary; (K.) whether Petitioner is entitled to prospective medical care. (L.) what amount of Temporary Total Disability is due, if any, to the Petitioner; and, (M.) whether the Respondent is liable for penalties and fees.

FINDINGS OF FACT and CONCULSIONS OF LAW

FINDINGS OF FACT

Petitioner testified through an interpreter. (T: 6). Respondent hired Petitioner as a laborer in May of 2007 to perform different job duties. (T: 7). On July 25, 2018, the Respondent assigned Petitioner a job of putting on and taking off injection molds. (T: 8). Petitioner's scheduled work hours were from 6:00 a.m. to 2:30 p.m. (T: 8). On July 25, 2018, Petitioner pulled a mold and because of water and oil on the floor he slipped and fell. His head bounced against the wall, and he struck his back on the floor. He also injured his right wrist. (T: 8). Petitioner explained that his lower back and buttocks hit the floor. (T: 9-10).

Petitioner stopped working after this happened and after notifying his supervisor Mr. Honorio Trujillo. Mr. Trujillo sent him to Tyler Medical Services for evaluation. (T: 10-11). The records of Tyler Medical Services revealed the following:

> "The patient presents today for an initial evaluation of an injury to his head and neck. . . . While at work today, at approximately 10:45 a.m., he fell and struck the back of his head. Apparently, there was a mix of oil and water on the floor at work. He fell backwards. He did not lose consciousness. He did strike his head, first on a fence behind him, and then on the ground. He has pain rated at 8/10 on the pain scale in the head and neck areas. The neck pain is mainly right sided. He is having headaches . . . . He did state about 2 years ago he had a head/neck injury from a slip and fall. He was diagnosed with an injury to the cervical discs at C5-C6. He underwent physical therapy and received 3 epidural injections which helped him at that time. He had had no recurrent problems with his neck since then, up until this injury today."
>
> (PX1: 4).

Petitioner recalled providing the history of the three prior epidural injections noted in the Tyler Medical Services records but never had surgery to his neck. (T: 12). Petitioner recalled two prior surgeries to his back in April of 1998 and December of 2017. (T: 14). Petitioner confirmed that just prior to the accidental injury of July 25, 2018, he was not experiencing any

neck pain. (T: 14). Petitioner also confirmed just prior to the accidental injury of July 25, 2018, he was not experiencing any back pain. (T: 14). Petitioner noted just prior to the accidental injury of July 25, 2018, he was not on any medication. (T: 14).

On Petitioner's second visit to Tyler Medical Services the attending physician allowed Petitioner to return to work light duty. (T: 16). Petitioner returned to work for the Respondent cleaning offices, including desks, and vacuuming carpets. (T: 16). The attending physician limited Petitioner to "(n)o lifting over 5lbs, sit down work only with no work at unguarded heights. No operating of machinery or forklifts. No driving due to the medications." (PX1: 6). Petitioner noted he only allowed by the Respondent to work four hours a day, five days a week while on these restrictions. (T: 16). Petitioner worked light duty in this capacity with these hours until his termination of employment on December 16, 2019. (T: 17).

Petitioner confirmed that the attending physician at Tyler Medical Services recommended MRI scans of his neck and back. (T: 17), (PX1: 8). At Petitioner's final visit with Tyler Medical Services on August 4, 2018, the attending physician diagnosed Petitioner as suffering from "(b)lunt/closed head trauma with resolved, (p)osttraumatic cephalagias, posttraumatic cervical strain and spasms, (r)adiculopathy in the right upper extremity, (l)umbar strain, (and) (r)ight wrist sprain." The diagnosis of lumbar strain was first recorded on August 4, 2018. (PX1: 8).

Thereafter, Petitioner sought a second medical opinion with Dr. Thomas McNally on August 24, 2018. (PX2: 1). Dr. McNally is a board-certified orthopedic surgeon who completed a spinal surgical fellowship at the University of Chicago Hospitals and a second spinal fellowship at Rush University Medical Center. (PX3: 6). Dr. McNally noted Petitioner's injury and symptoms and diagnosed Petitioner with "strains of the neck and back . . . and

cervical radiculopathy (and) . . . lumbar stenosis with radiculopathy." (PX3: 9). Dr. McNally explained cervical radiculopathy as "pain radiating down the arm." (PX3: 9). Dr. McNally opined that the "strains and the neck pain and the radiculopathies, not the spinal stenosis" were attributed to the Petitioner's accidental injury. (PX3: 10).

Petitioner confirmed Dr. McNally agreed with allowing Petitioner to continue to work light duty. (T: 18-19). Petitioner also confirmed Dr. McNally agreed that Petitioner should undergo MRI images of his neck and back. (T: 19). Petitioner underwent the MRIs on September 15, 2018 at Suburban Orthopaedics. (PX2: 121-124). Dr. McNally also recommended Petitioner initiate physical therapy which began on October 15, 2018. (PX2: 149-150). Petitioner revealed that the physical therapy did not alleviate his symptoms. (T: 20). Dr. McNally also referred Petitioner for pain management with a Dr. Novoseletsky and for Petitioner to undergo an EMG/NCS of both upper extremities. (PX2: 103).

On September 28, 2018, Petitioner consulted with Dr. Dmitry Novoseletsky. (PX2: 91-95). On November 6, 2018, Petitioner underwent the EMG/NCS which revealed "(e)lectrodiagnostic evidence consistent with mild left C7 radiculopathy." (PX2: 126). On November 30, 2018 Petitioner underwent a second set of MRIs of his neck and back. (PX2: 53-54).

Petitioner confirmed that Dr. Novoseletsky prescribed and completed three (3) epidural injections into Petitioner's neck. (T: 21). The first epidural injection of the neck occurred on December 11, 2018. (PX2: 111). Petitioner reported to Dr. Novoseletsky on his next visit of January 10, 2019, that he had 40-50% improvement on the left side of his neck but continued with pain on the right side of his neck. (PX2: 79). Petitioner underwent his second injection on January 29, 2019. (PX2: 110). Petitioner reported to Dr. Novoseletsky on his next visit of

February 14, 2019 that he had 50% improvement of pain. (PX2: 73). Petitioner has his third and final epidural injection on March 5, 2019. (PX2: 109). Petitioner reported to Dr. Novoseletsky on the next visit of March 21, 2019 that Petitioner had 80% relief for one week. (PX2: 65).

On March 18, 2019, Petitioner appeared for a Section 12 examination before Dr. Jay Levin at Respondent's request (RX1: DepEx#2). Dr. Levin is a board-certified general orthopedic surgeon with a claimed specialty in spinal conditions. (RX1: 7-8). Dr. Levin noted the following accidental injury history:

> ". . . the examinee described that on July 25, 2018, he was placing one of the molds onto a machine which was enclosed in an area with fencing around it. The mold that he was trying to place on the machine was at a three and a half inch height level from the ground. He pulled the mold towards him to fit it correctly on the machine. As he did this, he slipped on water/oil mixture on the ground causing him to fall back on to his buttock, and then he fell on his right side, hitting the right side of his head on the fencing. . . ."

(RX1: 12-13). Dr. Levin noted the Petitioner's prior medical history and performed a physical examination, but Dr. Levin wanted to review additional medical records prior to rendering any opinions. (RX1: 25-26).

After his review of the medical records, including the MRI imaging, Dr. Levin reached a diagnosis of: cervical myofascial strain and lumbar myofascial strain related to the injury of July 25, 2018 (Rx.1. P. 39). Dr. Levin reviewed MRI images. The imaging included an imaging of the lumbar spine dated October 13, 2017 wherein he opined that this imaging initially showed a large left L4-L5 disc herniation. The Petitioner subsequently underwent lumbar discectomy on December 6, 2017. (Rx. 1. P. 37). An imaging of the lumbar spine dated December 15, 2017 wherein Dr. Levin opined that the imaging demonstrated postoperative prior change on the left at L4-L5, with diffuse disc bulge with postoperative changes. (Rx. 1 P. 37-38).

He also reviewed the MRI Imaging performed after the July 25, 2018 incident including imaging dated December 15, 2018 of the cervical spine. An MRI dated December 15, 2018 of the lumbar spine. Imaging dated March 18, 2019, MRI of the lumbar spine demonstrating no significant interval change compared to a prior study (Rx. 1 P. 39). Following his review of the MRI imaging, Dr. Levin opined that there was a left-sided laminectomy at L4-L5 with findings suggestive of arachnoiditis similar to that seen on a prior study. He opined that in addition to the postoperative changes to the lumbar spine, the findings of the imaging demonstrated progressive age changes not associated with acute events. (Rx.1. P.38).

When addressing the cervical spine, Dr. Levin reviewed the MRI performed on June 27, 2019. He opined that the imaging demonstrated some multiple level degenerative changes; represent progressive age changes not associated with acute events (Rx.1 P. 39). In all, Dr. Levin concluded: The event of July 25, 2018 resulted in a lumbar and cervical myofascial strain. (Rx. 1 P. 42) The lumbar and cervical myofascial strains had resolved from at least 0-8 weeks post injury (Rx. 1 P. 43). The findings of the EMG of November 6, 2018 are not related to the event of July 25, 2018 (Rx. 1 P. 45). There is no medical necessity for further treatment (Rx. 1 P. 43). The anterior cervical discectomy and fusion surgery at C5-C6 and C6-C7 is not necessary as it relates to the work injury nor is the surgery related to the work injury (Rx. 1 P. 46) The Petitioner is at maximum medical improvement. (Rx. 1 P. 48). Dr. Levin also performed an AMA impairment rating of 4% person whole person impairment. (Rx. 1 P.52).

Petitioner followed up with Dr. McNally on June 11, 2019 and advised Dr. McNally that the three epidural injections only provided temporary relief. (PX2: 50). Dr. McNally maintained Petitioner on light duty, requested a copy of Dr. Levin report, and prescribed an updated cervical MRI. (PX2: 55). On June 27, 2019, Petitioner underwent an MRI of the cervical spine which the radiologist interpreted as indicating "slightly progressive disc protrusion at C5-C6 causing mild canal narrowing. Severe left-sided foraminal narrowing and (sic) C5-C6 and C6-C7." (PX2: 119). On July 9, 2019, Dr. McNally reviewed the MRI results and noted to "begin to plan for C5-C6 and C6-C7 anterior cervical discectomies." (PX2: 36, 38).

Petitioner confirmed that on July 9, 2019 and his subsequent and last evaluation with Dr. McNally on September 10, 2019, that Dr. McNally continued to recommend neck surgery. (T: 23), (PX2: 13). Petitioner desires to have the surgery because he is not feeling well, and he continues to have pain on his head, neck, shoulders and pain down his arms. (T: 23).

Petitioner continued to consult with the pain management physician Dr. Dimtry Novoseletsky on November 4, 2019. (PX2: 1). Dr. Novoseletsky continued Petitioner on light duty status as of November 4, 2019 and continued to recommend medication including gabapentin, cyclobenzaprine and tramadol. (PX2: 6).

Petitioner confirmed that on December 16, 2019, the Respondent terminated his employment. (T: 24-25). Petitioner understood he was terminated because he had a problem with his supervisor. (T: 25). Petitioner confirmed that since his termination from employment he has not worked anywhere. (T: 25). Since January 11, 2020 Petitioner no longer received compensation benefits from the insurance company. (T: 26). Petitioner confirmed that he

continues to take the pain medication prescribed by Dr. Novoseletsky of Gabapentin and Cyclobenzaprine. (T: 26).

Petitioner testified that since his accidental injury he continues to have pain in his head and neck with bilateral radicular pain down both arms and low back pain with bilateral leg pain, on his neck, his shoulders, his arms and upper back. (T: pp. 27= 28). Petitioner has difficulty sleeping because his head hurts a lot and he sleeps sitting with support on his neck. (T: 28). Petitioner confirmed that since his accidental injury of July 25, 2018 he has suffered no further accidents or trauma to his neck. (T: 28). Petitioner described his normal job as a laborer as being heavy work as he has to lift between twenty-five to fifty pounds. (T: 30).

On cross-examination, Petitioner confirmed that he had two prior back surgeries – one work-related and one not related to work. (T: 32-33). Petitioner also confirmed that he had a prior neck injury that was work-related that occurred on July 11, 2016. (T: 33). Petitioner confirmed that following his injury of July 11, 2016 he did report pain down his arms and numbness in his hands. (T: 34). Petitioner also received three injections into his neck and underwent physical therapy. (T: 34). Petitioner also confirmed that he missed six months of work after his July 11, 2016 injury. (T: 34). Petitioner denied that he continued to experience pain in his neck after the July 11, 2016 injury. (T: 34-35).

Petitioner confirmed that while he was working light duty for the Respondent, he requested to be off work from December 13, 2018 through January 7, 2019. (T: 38), (RX4). Petitioner also confirmed that he would not be available to work light duty for the period from December 20, 2019 through January 7, 2020. (T: 40-41).

On redirect examination Petitioner confirmed that he requested permission from the Respondent to be off of work for two periods of time starting in December of 2018 and

December of 2019 for a few weeks. (T: 43). Petitioner also confirmed regarding his prior neck injury of July 11, 2016, that although he was off work for six months, he did not receive any workers' compensation benefits. (T: 44).

On recross examination Petitioner confirmed that the medical bills for his neck injury of July 11, 2016 were paid by workers' compensation. (T: 44-45).

CONCLUSIONS OF LAW

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (F.) WHETHER THE PETITIONER'S CONDITION OF ILL-BEING IS CAUSALLY RELATED TO HIS ACCIDENTAL INJURY, THE ARBITRATOR FINDS AND CONCLUDES AS FOLLOWS:

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 or her 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 (1989). It is well established that the Act is a humane law of remedial nature and is to be liberally construed to effect the purpose of the Act - that the burdens of caring for the casualties of industry should be borne by industry and not by the individuals whose misfortunes arise out of the industry, nor by the public. Every injury sustained in the course of the employee's employment, which causes a loss to the employee, should be compensable. *Shell Oil v.*

Industrial Comm'n, 2 Ill.2nd 590, 603 (1954). 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)

In instant case, the Arbitrator must determine whether Petitioner's preexisting conditions to his neck and back were aggravated or accelerated by the July 25, 2018 work accident, or whether his current conditions of ill-being are solely attributable to the natural progression of his preexisting condition. Dr. Levin opined that current conditions of ill-being to his neck and back are solely attributable to the natural progression and that Petitioner had only temporarily aggravated his preexisting conditions of ill-being to his neck and back. Whereas, Dr. McNally opined that his current conditions of il-being to Petitioner's neck, back and need for cervical surgery are causally related to Petitioner's work accident.

It is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine the weight to give to testimony, and resolve conflicts in evidence, particularly medical opinion evidence. *Berry v. Industrial Comm'n*, 99 Ill.2d 401, 406-07 (1984). Not only may the Commission decide which medical view is to be accepted, it may attach greater weight to the opinion of the treating physician. *International Vermiculite Co. v. Industrial Comm'n*, 77 Ill.2d 1 (1979). In this case, the Arbitrator finds the factual findings and opinions of the treating physicians to be more persuasive than Respondent's Section 12 examiner.

To obtain compensation under the Act, a petitioner must prove that some act or phase of his or her employment was a causative factor in his ensuing injuries. *Land & Lakes Co. v. Industrial Comm'n,* 395 Ill.App.3d 582, 592 (2005). Petitioner is not required to eliminate all possible causes of his cervical spine and lumbar spine conditions as long as the Petitioner can demonstrate that work was a factor in the development of the

condition. Thus, even if the petitioner had a preexisting degenerative condition which made him more vulnerable to injury, recovery for an accidental injury will not be denied as long as he can show that his employment was also a causative factor. *Sisbro v. Industrial Comm'n,* 207 Ill.2nd 193, 205 (2003). Further, "[e]very natural consequence that flows from an injury that arose out of and in the course of the claimant's employment is compensable unless caused by an independent intervening accident that breaks the chain of causation between a work-related injury and an ensuing disability or injury." *Vogel v. Ill. Workers' Comp Comm'n*, 354 Ill.App.3d 780,786 (2005) Based upon the unrebutted testimony of the Petitioner and a review of the medical testimony and medical records, the Arbitrator relies on the opinion of Dr. Thomas McNally in finding that Petitioner's condition of ill-being – namely the cervical strain, cervical spinal stenosis, cervical radiculopathy, the lumbar strain and lumbar radiculopathy, might or could be casually related to his accidental injury of July 25, 2018. Initially, the Arbitrator finds Dr. McNally more persuasive than Dr. Levin for the reasons outlined below. Second, the Arbitrator also concludes the treating medical records support the Petitioner's claim that the accidental injury of July 25, 2018 resulted in the injuries described by Dr. McNally as noted below. Finally, the treating medical records demonstrate that the Petitioner's cervical and lumbar symptoms became progressively worse necessitating MRI imaging, physical therapy and eventually epidural injections to the Petitioner's cervical spine. Thus, the Arbitrator finds and concludes that Petitioner's condition of ill-being of the cervical and lumbar spine are causally related to his accidental injury of July 25, 2018.

Neither party submitted to the Arbitrator complete medical records of the Petitioner's cervical or lumbar treatment that occurred prior to July 25, 2018. Dr. Levin's

report contains a recitation and some records exist in the Suburban Orthopedic records. (PX2: 112-113, 115, 117, 137-138). With regard to his lumbar condition, the Petitioner confirmed that he had two prior back surgeries before his accidental injury of July 25, 2018. The first back surgery occurred in 1998 and the second surgery occurred in 2017. Petitioner claimed that just prior to his accidental injury of July 25, 2018 he was not suffering from any pain or symptoms related to his low back. Dr. Levin, Respondent's Section 12 examiner, when asked whether Petitioner had "fully healed" from his prior back surgeries by the time of his July 25, 2018 accident testified:

> "Well, the family described to me on March 18, 2019, that in December of 2017 he had an injury to his lumbar spine, which was not work related. He had pain in his lower back, down his left leg to his foot. He attended physical therapy. He was off work for five to six months. He stated he improved thereafter. So in regard to - - I need further clarification on what you mean by the word fully healed." (RX1: 58-59)

Despite this non-responsive answer, Dr. Levin noted in his written report that Petitioner advised Dr. Levin "(h)e returned back to work in May of 2018 and he had no back pain and was able to return to work full duty." (RX1, DEP.EX2: 1). Following the Petitioner's accidental injury of July 25, 2018, the medical records noted that Petitioner had documented and increased back pain by the time of his fourth visit with Tyler Medical Services. (PX1: 8). On that visit the attending physician added to the Petitioner's diagnoses a lumbar strain and prescribed a lumbar MRI. (PX1: 8).

Dr. Thomas McNally saw Petitioner approximately three weeks later and documented Petitioner's complaints of right leg pain attributed to his lower back strain and radiculopathy (PX2: 101). Both Dr Levin and Dr. McNally agreed that the spinal stenosis was not directly related to the accidental injury of July 25, 2018. (RX1: 60), (PX3: 10). However, Dr. McNally testified that the onset of Petitioner's symptoms

subsequent to the accidental injury supported his opinion that the lumbar strain and lumbar radiculopathy were causally related to his accidental injury of July 25, 2018. (PX3: 10). Dr. McNally noted that the Petitioner's lumbar radiculopathy existed on the right side which was completely different from Petitioner's prior surgeries wherein Petitioner had left-side complaints as noted in Dr. Levin's report of March 18, 2019:

> "In April of 1998 he had a work comp injury to his lumbar spine. An MRI was obtained. He had pain in his low back down his *left leg* to his foot. Surgery was performed. He is unsure of the name of the doctor. He believes the level was at L4-L5. . . In December of 2017 he had an injury to his lumbar spine which was not work related. He had pain in his low back down his *left leg* to his foot."

(RX1, DEP.EX1: 1) (emphasis added).

Dr. McNally noted in his deposition that he disagreed with Dr. Levin that the Petitioner *only* suffered from a lumbar strain from his accidental injury without inclusion of the lumbar radiculopathy. (PX3: 24). Dr. McNally noted that Petitioner's lumbar condition would be addressed after attention to the cervical condition. (PX3: 27).

With regard to the cervical condition, Petitioner testified he suffered a pre-existing accidental work injury on July 11, 2016 to the cervical spine. (T: 33-34). Petitioner also confirmed that he received three epidural injections into his neck and physical therapy. (T: 34). Again, no prior medical records of the cervical spine were submitted into evidence but Dr. Levin noted the following in his March 18, 2019 report:

> "(H)e had a work related injury on July 11, 2016 referable to his cervical spine. An MRI was obtained. He had pain down both of his arms and numbness into both of his hands. Injections were given and he attended physical therapy. *His neck healed well.* He was off of work for approximately 6 months. He had no reason to see a doctor referable to his cervical spine for the past year."

(RX1: DepEX1: 1) (emphasis added). Petitioner confirmed he had no pain or symptoms referable to his neck just prior to the accidental injury of July 25, 2018. (T: 14). When

Petitioner presented to Tyler Medical Services on the date of his accident, the attending physician noted Petitioner had pain in the neck 8/10 and that the neck pain was mainly on the right side. (PX1: 4). Petitioner also advised the attending physician he had no recurrent problems with his neck since his prior injury in 2016 until his injury on July 25, 2018. (PX1: 4). The attending physician diagnosed Petitioner as suffering from "post-traumatic cervical strain." (PX1: 5). On August 4, 2018, the attending physician noted Petitioner had posttraumatic cervical strain and spasms. (PX1: 8). Dr. Levin agreed that "(m)uscle spasms have an objective finding if they have spasm. If you actually touch it and there's spasm, I'd agree that that's an objective finding." (RX1: 59). The attending physician also noted that Petitioner had cervical radiculopathy into the right upper extremity. (PX1: 8). On that visit, the attending physician prescribed a cervical MRI. (PX1: 8).

Dr. McNally first saw Petitioner on August 24, 2018 and noted that Petitioner's neck and arm pain were worse than his right leg pain. (PX2: 96). Dr. McNally disagreed with Dr. Levin that Petitioner *only* suffered from a cervical strain from the Petitioner's accidental injury of July 25, 2018. (PX3: 24). Dr. McNally opined that Petitioner also suffered from cervical radiculopathy attributable to the accidental injury. (PX3: 9-10). Dr. McNally again noted that Petitioner did not have or experience these symptoms prior to his accidental injury and that only afterward were they evident. (PX2: 96). Dr. McNally prescribed a cervical MRI and upper extremity EMG as a result of these diagnoses. (PX2: 101). Dr. McNally referred Petitioner for pain management treatment with a Dr. Dimtry Novoseletsky. (PX2: 101). Dr. McNally did not consult with Petitioner again until June 11, 2019. (PX2: 50). In the interim, Petitioner underwent the following

diagnostic testing and treatment: Cervical MRI of September 15, 2018 indicated degenerative annular bulging at C4-C5 and C5-C6. (PX2: 121-122); EMG/NCS of bilateral upper extremities on November 6, 2018 indicated "electrodiagnostic evidence consistent with mild left C7 radiculopathy." (PX2: 131-132); Cervical MRI of November 30, 2018 indicated bulging discs at C4-C5 and C5-C6 without stenosis or cord compression and abnormal lordosis. (PX2: 54); Cervical epidural injection at C7-T1 on December 11, 2018 by Dr. Dmitry Novoseletsky. (PX2: 111); Cervical epidural injection at C7-T1 on January 29, 2019 by Dr. Dmitry Novoseletsky. (PX2: 110); and, a Cervical epidural injection at C7-T1 on March 5, 2019 by Dr. Dmitry Novoseletsky. (PX2: 109).

On June 11, 2019, Dr. McNally noted Petitioner's main complains were neck pain, bilateral hand numbness and tingling. (PX3: 13). Petitioner complained of a lot of pain with movement of his neck, throbbing, pain down his arms and into his hands. (PX3: 13). Dr. McNally opined that the EMG results confirmed Petitioner's cervical radiculopathy. (PX3: 14). Dr. McNally prescribed another cervical MRI because Petitioner's symptoms were increasing. (PX3: 15). Petitioner underwent a Cervical MRI on June 27, 2019. (PX2: 119). The radiologist noted the following:

Impression: Slightly progressive disc protrusion at C5-C6 causing mild canal narrowing. Severe left-sided foraminal narrowing at C5-C6 and C6-C7.

(PX2: 119). Dr. McNally explained that the "bulge" at C5-C6 had become bigger. (PX3: 17). At the next visit of July 9, 2019, Dr. McNally noted upon examination of the Petitioner:

"We recorded that when he moved his neck to the right he would almost instantly feel symptoms in his right hand. When he was working, his hand would go numb after 15 minutes. . . (the numbness in his fingers is) consistent with the narrowing that I just

pointed out on the MRI . . . . Him turning his head to the right and feeling it in his hand, that's the C6 irritation or across the C7."

(PX3: 18). Dr. McNally planned on C5-C6 and C6-C7 anterior cervical discectomies and fusion. (PX3: 19). Dr. McNally explained that the cervical strains were superimposed upon the patient's pre-existing conditions which caused the conditions to become symptomatic and require treatment. (PX3: 20). Dr. McNally explained the mechanism of injury as follows:

> "So this is the MRI again from two months after the injury or almost two months after the injury. There's a little bit of wear and tear on the front of this disc, and that's the C5-6 disc, and a little bit at C6-7. And again, just to show you a normal foramen, normal, normal, normal, a little smaller, but the two that I'm talking about are in here. They were already narrowed to begin with on the left and they were already narrowed to begin with on the right (indicating). And because of the fall where he fell and extended his neck and I believe he hit his head as well, that caused those narrowed spaces where the nerves were running to have increased motion than typical, and they kind of irritated the nerve and caused them to become symptomatic and require treatment."

(RX3: 21).

Dr. Levin testified Petitioner's accidental injury of July 25, 2018 "resulted in lumbar and cervical myofascial strain." (RX1: 40-41). Dr. Levin stated "I believe there are some comments from Dr. McNally at some point about having cervical spine surgery. I do disagree with that." (RX1: 44). Dr. Levin further stated "I don't agree with (anterior cervical discectomy and fusion surgery at C5-C6 and C6-C7). Certainly I respect the doctor who made that recommendation and his right to have his opinion." (RX1: 45-46).

On cross-examination Dr. Levin admitted that he did not review the MRI reports of November 30, 2018 of the lumbar and cervical spine. (RX1: 53-54). Dr. Levin agreed that since the Petitioner continued to suffer from cervical complaints as of the date of Dr. Levin's examination on March 18, 2019 his cervical complaints fit the definition of

chronic pain. (RX1: 58). Dr. Levin also agree with Dr. McNally that pain radiating down Petitioner's right arm may be a symptom of cervical radiculopathy. (RX1: 59-60). Dr. Levin also agreed with Dr. McNally's opinion that numbness in the fingers could be consistent with narrowing occurring in the cervical spine, (RX1: 61-62), which can irritate nerves in the spine. (RX1: 62).

Dr. Levin confirmed on cross-examination that 50% of his orthopedic practice involves the shoulder, elbow, hips and knees. (RX1: 64). Dr. Levin also confirmed that he still performs 200 Section 12 examinations per year and 36 depositions per year (not including this year due to Covid-19). (RX1: 65). Dr. Levin charges $1, 395.00 per Section 12 examination and $1,950.00 per hour with a two-hour minimum for depositions. (RX1: 65-66). Dr. Levin is a board-certified general orthopedic surgeon with a claimed specialty in spinal conditions but only performed 25 spinal surgeries per year, when he was performing surgeries in the years past.

The Arbitrator does not find the findings and opinions of Dr. Levin persuasive regarding Petitioner's cervical and lumbar conditions of ill-being. Dr. Levin failed to review the MRI scans of the lumbar and cervical spine dated November 30, 2018; failed to explain how Petitioner's persistent ongoing symptoms and complaints referable to the lumbar spine and cervical spine existed if Petitioner only suffered from cervical and lumbar myofascial strains; failed to explain why a did not agree with Dr. McNally that Petitioner was suffering from cervical radiculopathy as confirmed by an EMG nerve study at C7, other than stating that an EMG test is a subjective test (Rx1, p.60) ; and, Dr. Levin admitted that a reasonable medical opinion of Dr. McNally could find that Petitioner's condition of ill-being of the cervical spine necessitated surgery. (RX1: 45-

46). For all of the foregoing, the Arbitrator finds that Dr. McNally's opinions are more persuasive. The Arbitrator finds that Dr. McNally explained in a clear and straight forward manner why the Petitioner was experiencing his symptoms, why his symptoms have not improved, and why they are causally related to the accident. Dr. Levin did not.

The Arbitrator finds Dr. Levin's opinions on Petitioner's diagnosis to be unpersuasive because Dr. Levin did not review all of the diagnostic testing; because he conceded that the Petitioner's cervical complaints were chronic as his evaluation of March 18, 2019; because he noted and accepted Petitioner's history that he had fully recovered from any pre-existing lumbar or cervical issues prior to his accidental injury of July 25, 2018; and, because he agreed that Dr. McNally's opinion could be respected and reasonable. (RX1, p. 46**)** Despite being aware of Petitioner's symptoms and Petitioner's objective findings, Dr. Levin opined Petitioner needed no further treatment and could return to work full duty. (RX1: 47). The Arbitrator concludes that the opinions of Dr. Levin are not persuasive nor reasonable.

The "chain of events" legal theory also supports a finding of causation. It is well established under the law that prior good health followed by a change immediately following an accident allows an inference that a subsequent condition of ill-being is the result of the accident. *Navistar International Transportation Co. v. Industrial Comm'n*, 315 Ill. App.3d 1197, 1205 (2000). An accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury. *Int'l Harvester v. Indus. Comm'n*, 93 Ill. 2d 59, 63-64 (1982). In *Price v. Industrial Comm'n*, 278 Ill. App. 3d 848 (1996), the Appellate Court considered the applicability of the chain of events principle to a case involving a preexisting condition The rationale justifying the use of the chain of events analysis to demonstrate the existence of an injury would also support its use

to demonstrate an aggravation of a preexisting injury. The Appellate Court reversed the original decision of the Commission that affirmed and adopted the decision of the Arbitrator. The Commission found that Petitioner's preexisting back problems and three-month history of foot numbness prior to the accident precluded a chain of events analysis to prove a causal connection. The Appellate Court noted that no authority exists for the proposition that a 'chain of events' analysis cannot be used to demonstrate the aggravation of a preexisting injury nor did the Court in *Price v. Industrial Comm'n* see any logical reason why it should not and reversed the Commission.

The Arbitrator notes that at the time of his accident, and for some time prior thereto, he was in good health, not on prescribed or over the counter medications relating to his neck and back, and that there has been no superseding, intervening accident to break the chain of causation. Therefore, based on the foregoing, the Arbitrator concludes that Petitioner's current condition of ill-being relative to his neck and low back and are causally connected to the work accident.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (J.) WHETHER THE MEDICAL SERVICES PROVIDED TO THE PETITIONER WERE REASONABLE AND NECESSARY, THE ARBITRATOR FINDS AND CONCLUDES AS FOLLOWS:

The Arbitrator, having found that the Petitioner's conditions of ill-being as diagnosed by Dr. McNally are causally related to his accidental injury of July 25, 2018, and noting that no Utilization Review report or testimony was submitted into evidence regarding the efficacy of the Petitioner's medical treatment, and Dr. Levin's admission that the treatment received by the

Petitioner was not unreasonable or excessive, (RX 1, pp. 54-55) the Arbitrator finds and concludes that the Respondent is liable and shall pay Petitioner for the unpaid medical charges delineated in Petitioner's Exhibit Four: 1. Persistent RX in the amount of $2,924.68; 2. Suburban Ortho in the amount of $ $878.58; Persistent Labs in the amount of $3,905.00; and, 1800 McDonough Road Surgery in the amount of $9,757.00 for a total of $17,465.26. The Arbitrator orders that the Respondent shall pay the medical expenses in the amount of $17,465.26, pursuant to Sections 8(a) and 8.2 of the Illinois Workers' Compensation Act.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (K.) WHETHER THE PETITIONER IS ENTITLED TO PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AND CONCLUDES AS FOLLOWS:

The Arbitrator finds and concludes that the cervical discectomies to C5-C6 and C6-C7 and fusion surgery prescribed by Dr. Thomas McNally to be reasonable and medically necessary to alleviate the Petitioner's condition of ill-being. Dr. McNally opined that Petitioner has a 90% chance of improvement with surgery. Dr. McNally explained the surgery in his deposition:

"Q All right. And what is the procedure that's called C5-6 and C6-7 anterior cervical discectomies and fusion with local allograft and allograft?

> A It's where we come in through the -- this is the MRI again from June 27, 2019. We come in through the anterior portion of the neck, which on this image is right this way. And on this image it's coming from the front. We take out the disc. We trim away these spurs that are causing the narrowing and we put a little cage. The bone that we remove, there's a little bit of bone here, a little bit of bone here we take out, we put that inside the cage at both levels, and then we put a plate and screws that come across (indicating).
> Q Okay. And what would you anticipate this would provide for the patient?
> A More than 90 percent of the time when you unpinch a nerve in the neck, the upper extremity symptoms get much better, often the neck pain gets better. And his condition, as you noted, there is some double crush component. He may still require a carpal tunnel release."

(PX3: 19-20). The Petitioner confirmed that he still wants to undergo the procedure. (T: 23). The Arbitrator notes that Dr. Levin does not appear to dispute the need for surgery but opined, in finely parsed words, that he would not recommend cervical surgery as "it relates the occurrence of July 25, 2018….) (RX1, p. 47). Again, the Arbitrator notes that no utilization review report or other evidence was submitted into evidence regarding this procedure. Having reviewed the medical evidence, and considering the Petitioner's testimony at arbitration, the Arbitrator finds the surgery recommended by Dr. Thomas McNally should be authorized by Respondent and Respondent should pay all related reasonable and necessary medical charges pertaining to such medical treatment. *Bennett Auto Rebuilders v. Industrial Comm'n*, 306 Ill.App.3d 650 (1999).

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (L.) WHAT, IF ANY TEMPORARY TOTAL DISABILITY BENEFITS ARE DUE, THE ARBITRATOR FINDS AND CONCLUDES AS FOLLOWS:

The Arbitrator notes Respondent disputed Petitioner's conditions of ill-being were causally related to his accidental injury of July 25, 2018. (ARBX1, p.1). The Arbitrator has concluded that Petitioner proved by a preponderance of the evidence that his cervical and lumbar conditions as diagnosed by Dr. McNally are causally related to his accidental injury of July 25, 2018. Respondent accommodated Petitioner's restrictions as prescribed by his treating physicians and paid temporary total and partial disability benefits until he was terminated by his employer on December 16, 2019. (Arb. X 1, p. 2)

The Petitioner testified that he was paid workers' compensation benefits by Respondent while he was limited to 4 hours of light duty work per day. (Tr. P. 7). Furthermore, he testified that he informed his employer he would not be working from December 13, 2018 through

January 7, 2019 (Tr. P. 39). The Petitioner was presented with a signed waiver of light duty marked as Respondent's Exhibit 4. He confirmed his signature on the document.

The Petitioner also testified that he told his supervisor that he would not be available for work for from December 20 of 2019 to January 7, 2020 due to travel. (Rx. P. 40-41). The parties stipulated that there was no claim to TTD benefits for these two separate time periods based on the Petitioner's not being available to work light duty.

The Petitioner testified that he was ultimately terminated on December 16, 2019 (Tr. P. 17). The termination resulted from a problem with his supervisor. Petitioner testified that as of the date of trial, he had not worked since he was discharged from employment. Petitioner still had restrictions as prescribed by Dr. McNally at the time of his termination.

The Arbitrator notes that Respondent claimed Petitioner was temporarily and totally disabled from January 10, 2020 through October 23, 2020. (Arb X 1, p. 2). Petitioner originally claimed he was temporarily and totally disabled from December 16, 2019 through October 23, 2020 but Petitioner's counsel reduced the weeks claimed based upon Petitioner's testimony that Petitioner requested a leave of absence from his employment from December 20, 2019 through January 7, 2020. (Tr: 40). The Arbitrator calculated this period as 2 and 5/7ths weeks. The Arbitrator also noted that on December 16, 2019, the Respondent terminated Petitioner from his employment due to a personal issue that Petitioner had with his supervisor.

Petitioner is entitled to receive temporary total disability benefits until his condition has stabilized or reached maximum medical improvement. Petitioner's entitlement to TTD benefits is a completely separate issue and may not be conditioned on the propriety of the discharge. *Interstate Scaffolding v. Illinois Workers' Compensation Comm'n,* 236 Ill. 2d 132 (2010). Temporary total disability benefits may only be suspended or terminated if the Petitioner

unreasonably refuses to submit to medical essential to recovery, or refuses work falling within the physical restrictions prescribed by petitioner's doctor or fails to cooperate with rehabilitation.

At the time of his employment termination, Petitioner had not reached maximum medical improvement based upon the treatment recommendations of Dr. McNally. As in *Interstate Scaffolding,* Petitioner's termination from employment had no connection to Petitioner's stipulated accidental injury and the light duty restrictions of Petitioner remained intact.

The Arbitrator finds that Petitioner met his burden in proving that he is entitled to additional temporary total disability benefits. Thus, the Arbitrator finds and concludes that the Petitioner is entitled to temporary total disability benefits from December 16, 2019 through December 19, 2019 (4/7th weeks) and from January 8, 2020 through October 23, 2020 a period of 41- 3/7th weeks for a total of 42 weeks of TTD benefits the rate of $320.00 per week as provided in Section 8(b) of the Act. The Arbitrator having excluded the time periods in 2018 and 2019 where the Petitioner voluntarily requested a leave of absence for personal reasons.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (M.) WHETHER PENALTIES OR FEES SHOULD BE IMPOSED UPON THE RESPONDENT, THE ARBITRATOR FINDS AND CONCLUDES AS FOLLOWS:

An employer's reasonable and good faith challenge to liability ordinarily will not subject it to penalties under the Act. *Matlock v. Industrial Comm'n*, 321 Ill.App.3d 167 (1st D. 2001). Further, penalties are generally not imposed when there are conflicting medical opinions or when an employer acts in reliance upon responsible medical opinion. *Matlock v. Industrial Comm'n,* 321 Ill.App.3d at 173. Here, the Respondent asserts that its reliance on the Section 12 reports of Dr. Jay Levin and the 10-day delay in the company clinic medical records recording Petitioner's

back pain. However, the Arbitrator notes that Dr Levin opined that Petitioner sustained a lumbar back strain due to the accident. So the 10 day delay is not a material concern.

The Arbitrator has found that Dr. McNally's opinions and recommendations to be more persuasive than those of Dr. Levin. Nonetheless, the Arbitrator must determine, for purposes of whether to impose penalties and fees, if the Respondent reasonably relied upon Dr. Levin's opinions.

Here, the Arbitrator finds Dr. Levin's opinions on Petitioner's diagnosis to be unpersuasive. Dr. Levin did not review all of the diagnostic testing. He agreed that the Petitioner's cervical complaints were chronic as his evaluation of March 18, 2019. He noted the history of Petitioner that he had fully recovered from any pre-existing lumbar or cervical issues prior to his accidental injury of July 25, 2018.He agreed that Dr. McNally's opinion could be respected and reasonable. (**See** RX1: 46**)** Despite being aware of Petitioner's ongoing symptoms and Petitioner's objective findings and complaints Dr. Levin opined Petitioner needed no further treatment and could return to work full duty. (RX1: 47).

The Illinois Supreme Court has long recognized the imposition of penalties is a question to be considered in terms of reasonableness. *Avon Products, Inc. v. Industrial Comm'n*, 82 Ill.2d 297 (1980); *Smith v. Industrial Comm'n*, 170 Ill.App.3d 626 (3rd Dist. 1988). In the *Avon* case, the Court looked to Larson on Workmen's Compensation for guidance, noting that penalties for delayed payment are not intended to inhibit contests of liability or appeals by employers who honestly believe an employee is not entitled to compensation. 3 A. Larson, Workmen's Compensation sec 83.40 (1980).

Penalties and attorneys' fees under Section 19(k) and Section 16 are discretionary. Section 19(k) of the Act provides, in pertinent part, as follows:

> "In case where there has been any unreasonable or vexatious delay of payment or intentional underpayment of compensation then the Commission *may* award compensation 12 additional to that otherwise payable under the Act equal to 50% of the amount payable at the time of such award." (Emphasis added). 820 ILCS 305/19(k) (West 2006).

Section 19(k) penalties and section 16 fees are "intended to address situations where there is not only delay, but the delay is deliberate or the result of bad faith or improper purpose." *Id.* The Supreme Court has held 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 to award Penalties under Sections 19(k) and 16. *McMahan v. Industrial Comm'n*, 183 Ill. 2d 499 (1998). The standard for awarding Penalties and Attorneys' Fees under Sections 19(k) and 16 is higher than the standard for awarding Penalties under Section 19(l). *Id.*

Respondent does not appear to have been acting in bad faith by disputing benefits following the Section 12 examination and corresponding reports from Dr. Levin. Dr. Levin opined that the Petitioner sustained a myofascial strain of the cervical and lumbar spine, and that he should have reached Maximum Medical Improvement from 0 to 6 weeks post injury. As such, Respondent had a basis for suspending TPD and TTD benefits. Prior to the Section 12 examination, the Respondent paid TPD benefits to account for the Petitioner's work restrictions and limited 4 hour work days and Respondent paid some of the medical bills.

Respondent's reliance on its expert's clinical assessment did not rise to the threshold level of callousness required for an imposition of penalties and fees under Sections 19(K), 19(l) and 16.

Additionally, Respondent paid $182.84 in temporary total disability, $12,786.38 in temporary partial disability and various medical benefits while they investigated this claim and

prior to Dr. Levin's Section 12 examination. Respondent's Exhibit 2 demonstrates consistent payment history in this case.

The Arbitrator concludes that the cumulative actions of the Respondent came near to, but did not rise the a level of callousness and bad faith required for an imposition of penalties and fees under Sections 19(K), 19(l), and 16 of the Act. Accordingly, the Arbitrator declines to impose penalties and fees upon Respondent.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC031363
Case Name	PANTOJA, EVA v. CROWN LINEN SERVICES
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0234
Number of Pages of Decision	17
Decision Issued By	Maria Portela, Commissioner

Petitioner Attorney	Keith Short
Respondent Attorney	Emilie Miller

DATE FILED: 6/27/2022

/s/Maria Portela, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

EVA PANTOJA,

Petitioner,

vs. NO: 18 WC 31363

CROWN LINEN SERVICE, INC.,

Respondent.

DECISION AND OPINION ON REVIEW

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

On the 5th page of the Arbitrator's decision, the Commission strikes "or trigger finger" in the last sentence of the third paragraph.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 25, 2021 is hereby affirmed and adopted with the modification as 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 $19,530.00. 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.

June 27, 2022

/s/ *Maria E. Portela*

/s/ *Thomas J. Tyrrell*

/s/ *Kathryn A. Doerries*

MEP/dmm
O: 051022
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ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC031363
Case Name	PANTOJA, EVA v. CROWN LINEN SERVICES
Consolidated Cases	
Proceeding Type	19(b) Petition
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	14
Decision Issued By	Linda Cantrell, Arbitrator

Petitioner Attorney	Keith Short
Respondent Attorney	Emilie Miller

DATE FILED: 5/25/2021

INTEREST RATE FOR THE WEEK OF MAY 25, 2021 0.03%

/s/ Linda Cantrell, Arbitrator
Signature

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Eva Pantoja
Employee/Petitioner

v.

Crown Linen Services
Employer/Respondent

Case # **18** WC **31363**

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 **Linda J. Cantrell**, Arbitrator of the Commission, in the city of **Collinsville**, on **March 24, 2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the 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, **8/11/2018**, 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 $**25,259.52** ; the average weekly wage was $**485.76**.

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** 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

Based on the findings as to causal connection, the Arbitrator finds that the care and treatment Petitioner received with regard to her cervical spine has been reasonable and necessary. The parties stipulated that the only disputed injury subject to this Section 19(b) hearing is Petitioner's cervical spine and the Arbitrator makes no findings as to Petitioner's right shoulder and right long finger. Therefore, Respondent is ordered to pay the medical expenses outlined in Petitioner's Exhibits 12 and 17, as provided in Section 8(a) and Section 8.2 of the Act. Respondent shall be given a credit for any amounts previously paid under Section 8(a) of the Act for medical benefits and Respondent shall hold Petitioner harmless from claims by any providers of the services for which Respondent is receiving this credit.

The Arbitrator further finds Petitioner has not reached maximum medical improvement with regard to her cervical spine and is entitled to receive the additional care recommended by Dr. Taylor, including, but not limited to, fluoroscopic-guided injections with Dr. Kaylee Boutwell.

Respondent shall pay Petitioner temporary total disability benefits of $**323.84**/week for **60 weeks** for the period **1/30/20 through the date of arbitration, 3/24/21**, as provided in Section 8(b) of the Act.

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

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

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

MAY 25, 2021

Arbitrator Linda J. Cantrell

ICArbDec19(b)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

EVA PANTOJA,	)	
	)	
Employee/Petitioner,	)	
	)	
v.	)	Case No.: 18-WC-31363
	)	
CROWN LINEN SERVICES,	)	
	)	
Employer/Respondent.	)	

FINDINGS OF FACT

This claim came before Arbitrator Linda J. Cantrell for trial in Collinsville on March 24, 2021 pursuant to Section 19(b) of the Act. On 12/24/19, Petitioner filed an Amended Application alleging injuries to her right shoulder, body as a whole, right hand, right trigger finger, and cervical spine as a result of lifting materials onto a shelf on August 11, 2018. The parties stipulated that Petitioner sustained accidental injuries that arose out of and in the course of her employment with Respondent on August 11, 2018. The parties further stipulated that arbitration is limited to Petitioner's cervical spine only and Petitioner's right shoulder and trigger finger is not in dispute in this Section 19(b) hearing. Therefore, the issues in dispute are causal connection with regard to Petitioner's cervical spine only, medical bills incurred after 6/26/19, temporary total disability benefits, and prospective medical care with regard to Petitioner's cervical spine only. All other issues have been stipulated.

TESTIMONY

Petitioner was 53 years old, single, with no dependent children at the time of accident. Petitioner does not speak English and her testimony was interpreted by an independent, court-approved Spanish interpreter agreed to by the parties.

Petitioner testified she was employed by Respondent on 8/11/18 and operated a linen machine when she lifted materials onto a shelf and felt a pop in her right arm/shoulder. She testified she did not have any injuries, symptoms, or treatment for her right arm/shoulder prior to that date. She testified that after 8/11/18 her neck, right shoulder, and right arm hurt.

Petitioner testified she was referred by her employer to Occupational Medicine at St. Anthony's Hospital. Occupational Medicine sent her to Dr. Nathan Mall, an orthopedic surgeon specializing in shoulder injuries, who performed surgery on 11/8/18. Despite post-operative

physical therapy, Petitioner continues to experience numbness throughout her right arm and her pain is 7 out of 10. In August 2019, Dr. Mall limited her activities to no repetitive lifting with her right arm and no lifting greater than 5 pounds overhead. She last treated with Dr. Mall on 8/7/19.

On 11/6/19, Petitioner was examined by Dr. Taylor at her attorney's request for cervical pain. Dr. Taylor ordered an MRI and recommended cervical injections. She testified her right arm symptoms have never resolved since the accident and she has complained of neck and right upper extremity symptoms since the accident. She has not worked since Dr. Taylor placed her off work. She wants to undergo the recommended injections.

MEDICAL HISTORY

Petitioner presented for treatment to Dr. Mohammad Jamil at St. Anthony's Urgent Care on 8/13/18. Petitioner reported, through an interpreter, pain in her right shoulder after putting up folded towels in an overhead cabinet. X-rays of Petitioner's shoulder revealed no acute abnormalities and she was diagnosed with a right shoulder strain, prescribed Voltaren, Parafon Forte, and a Medrol Dose Pack. Petitioner was placed on light duty restrictions of no lifting more than five pounds with the right hand, limited use of the right hand, and no overhead reaching with the right arm, through 8/20/18.

On 8/20/18, Petitioner returned to Dr. Jamil and reported significant improvement in pain and range of motion in her right shoulder. Dr. Jamil continued Petitioner's restrictions, medications, and instructed her to return on 8/28/18. On 8/28/18, Petitioner reported her pain returned and she was not able to raise her arm above her head. Dr. Jamil continued Petitioner's restrictions until 9/6/18 and ordered an MRI of the right shoulder. On 9/12/19, Petitioner advised she was still awaiting the MRI and her restrictions were continued until 9/20/18. On 9/18/18, the MRI was performed that revealed a partial thickness tear of the superior subscapularis and anterior supraspinatus tendons, biceps tendonitis/tendinopathy, and mild degenerative glenohumeral joint space narrowing. Dr. Jamil referred Petitioner to Dr. Nathan Mall for orthopedic consultation and continued Petitioner's restrictions. No report of neck pain was noted at any visit with Dr. Jamil's office.

On 10/10/18, Petitioner was examined by Dr. Nathan Mall. She gave a consistent history of injury with pain in her right shoulder and trapezius. Dr. Mall diagnosed right shoulder upper border subscapularis tear and anterior border supraspinatus tear, along with biceps tendon injury and likely superior labral tearing. Dr. Mall recommended right arthroscopic shoulder surgery, biceps tenodesis, and rotator cuff repair. He opined that Petitioner's right shoulder condition was causally related to her repetitive overhead lifting activities at work. Pending surgery, Dr. Mall released Petitioner to return to work with light duty restrictions of no repetitive use of the right upper extremity, left hand work mostly, and no lifting, pushing, or pulling more than five pounds.

On 11/8/18, Dr. Mall performed surgery and the post-operative diagnosis included right shoulder subscapularis tear, biceps tendon tearing, large subcoracoid spur, subacromial spur, and subacromial bursitis, extensive synovitis, and rotator cuff tearing of the spring of the supraspinatus. On the day of surgery, Dr. Mall completed a work status report allowing Petitioner to work light

duty as of 11/10/18 with restrictions of no repetitive use of the right upper extremity, left hand work only, no reaching across the body or overhead, no use of vibratory tools, and no pushing or pulling with the right upper extremity. Petitioner was instructed to always use a sling. Petitioner engaged in post-operative physical therapy. On 1/9/19, Petitioner returned to Dr. Mall and reported stiffness in her shoulder. Dr. Mall recommended aggressive physical therapy four times a week, along with home stretching.

On 2/19/19, Dr. Rodney Herrin at the Orthopedic Center of Illinois performed a records review at the request of Respondent. Dr. Herrin opined Petitioner's shoulder condition was causally related to her work activity and that her treatment to date had been reasonable and necessary.

Petitioner completed physical therapy and Dr. Mall referred her to work conditioning on 3/27/19. Petitioner continued to have symptoms in her shoulder, including mild entrapment syndrome in the fingers of her right hand. Despite work conditioning, Petitioner continued to report ongoing symptoms in her right shoulder radiating to her hand. On 5/8/19, Dr. Mall ordered an MRI arthrogram to evaluate for new pathology. The MRI arthrogram revealed tendinopathy changes affecting the supraspinatus tendon with possible minimal partial undersurface tear, with fluid in the subdeltoid bursa suggestive of bursitis, and degenerative changes at the AC joint.

On 6/10/19, Dr. Mall noted Petitioner was still having pain in her hand and pain in her neck radiating down her right arm. Dr. Mall recommended Petitioner be evaluated by a cervical spine specialist. Dr. Mall also noted an ongoing pulley/trigger finger condition in Petitioner's right long finger that interfered with therapy. Dr. Mall recommended two additional weeks of work conditioning followed by a full duty release.

Dr. Herrin performed a physical examination of Petitioner on 6/13/19 and reviewed updated medical records. Dr. Mall noted Petitioner's surgery and post-operative therapy and MRI arthrogram. He testified he only reviewed the arthrogram radiology report and not the actual films. Petitioner reported pain with lifting, pain in the back of her neck, and pain and catching in her right long finger. Petitioner continued to work light duty and was taking OxyContin. Dr. Herrin's physical examination revealed pain with motion of her cervical spine, right trapezius tenderness, and mild decreased range of motion in the right shoulder.

On 7/17/19, Petitioner returned to Dr. Mall and reported burning in her right arm into her hand and finger, and pain in her neck. Dr. Mall injected Petitioner's trigger finger and continued her on light duty. Petitioner was last seen by Dr. Mall on 8/7/19. Dr. Mall noted Petitioner was working light duty but still had difficulty with gripping and grasping with pain and swelling in her finger. Petitioner reported the pain in her finger was impairing her ability to complete the work conditioning prescribed for her shoulder and Dr. Mall recommended a trigger finger release. He also continued Petitioner on light duty restrictions pending completion of her trigger finger release. He did not believe Petitioner was at maximum medical improvement from her shoulder injury as the trigger finger was still affecting therapy.

On 11/6/19, Petitioner was examined by Dr. Brett Taylor at the request of her attorney. Dr. Taylor is an orthopedic spine surgeon. Petitioner reported that on 8/11/18 she was working for

Respondent and was reaching over head with her right arm placing ten pounds on a shelf when she felt a pop in her shoulder with immediate pain in her right shoulder, neck, and right arm. Dr. Taylor noted Petitioner had undergone right shoulder arthroscopic surgery with Dr. Mall. Petitioner reported ongoing pain at the base of her neck and into the right shoulder and arm since her initial injury. Dr. Taylor noted that throughout her cervical questionnaire Petitioner reported 100% pain in the right arm and pain in the upper back, right shoulder, right upper arm, right hand, and right finger.

Dr. Taylor's physical examination showed a positive Spurling sign on the right. Plain x-rays revealed stenosis. Dr. Taylor diagnosed cervical instability at C4-5, cervical congenital stenosis, and Dupuytren's contracture of the right hand. He recommended a 3T MRI of the cervical spine with foraminal and dynamic views and evaluation of her Dupuytren's contracture by a hand specialist.

On 11/30/19, Petitioner presented to the emergency room at Anderson Hospital complaining of right shoulder pain. Petitioner reported she struggled to perform her job that she worked two days a week and comes home with a fever in her shoulder, and that her right middle finger locks up at times. Petitioner was diagnosed with right shoulder pain and muscle spasm and prescribed cyclobenzaprine, acetaminophen, and ibuprofen.

The 3T MRI was performed on 1/13/20 that revealed central annular tears and protrusions at C4-5 and C5-6, the C5-6 protrusion extending laterally into both foramina and the C4-5 protrusion extending into the right foramen minimally to the left; bilateral foraminal stenosis and mild central canal stenosis at both levels; right lateral recess-foraminal protrusion with spurring at C3-4 resulting in moderate right foraminal stenosis but no central stenosis or left foraminal stenosis; right paracentral disc protrusion at C3-4 with mild foraminal stenosis; critical central stenosis at C4-5 measuring 9.6 mm. and central hyper intensity consistent with an annular fisher and right foraminal stenosis; and critical central stenosis at C5-6 measuring 9.3 mm.

On 1/30/20, Dr. Taylor diagnosed Petitioner with cervical instability at C4-5, cervical radiculopathy at C4-5 and C5-6, and cervical congenital stenosis. He recommended fluoroscopic-guided injections at C4-5 and C5-6 with Dr. Kaylee Boutwell and took Petitioner off work.

On 2/28/20, Petitioner was examined by Dr. Timothy VanFleet pursuant to Section 12 of the Act. Dr. VanFleet is a spine specialist that opined Petitioner's cervical condition was not causally related to her accident of 8/11/18. Dr. VanFleet noted pain with motion of Petitioner's cervical spine, tenderness along the right trapezius, and mild limitation on range of motion. Dr. VanFleet noted weakness in Petitioner's deltoid muscle but felt it was secondary to pain. He noted good biceps strength and no evidence of long track signs or compression of the spinal cord. Dr. VanFleet's interpretation of the 1/13/20 MRI showed evidence of disc degeneration at C4-5 and C5-6 but no evidence of foraminal stenosis. He could not find any cervical explanation for Petitioner's right arm pain and opined it was secondary to her right shoulder surgery. He noted that in her pain diagram, Petitioner did not describe pain extending past the elbow evidencing no cervical radiculopathy. He felt she had a mild cervical strain, reached maximum medical improvement, and did not require further medical care.

Dr. Nathan Mall testified by way of evidence deposition on 10/9/19. Dr. Mall is a board-certified orthopedic surgeon whose practice primarily focuses on knees and shoulders. Dr. Mall testified consistently with his medical records. Dr. Mall confirmed that intraoperatively he did not observe a tear of the supraspinatus but only of the subscapularis, and a split tear down the biceps. Dr. Mall testified that Petitioner first reported issues with her neck to him on 6/10/19 when she reported pain traveling up her right arm to her neck. Dr. Mall confirmed by MRI arthrogram no ongoing pathology in Petitioner's shoulder at that time that would explain Petitioner's shoulder pain. Dr. Mall suggested a cervical-related issue due to Petitioner's right arm and hand pain. However, Dr. Mall testified that as of 6/10/19, Petitioner required additional treatment to build up her endurance in her shoulder in order to return to full duty work.

Dr. Mall testified that on 7/17/19 Petitioner complained of burning in her right shoulder, right upper extremity with pain radiating to her hand and fingers, and pain in her neck. Dr. Mall testified his impression was Petitioner's symptoms related to a cervical condition. Petitioner's range of motion and strength were good in her right shoulder at that time; however, he would not release Petitioner at MMI with regard to the shoulder because she had not returned to full duty work due to conditions unrelated to her shoulder. Dr. Mall does not deem patients at MMI until they have returned to full duty work and it is determined the patient does not require any additional treatment. Dr. Mall testified he is not currently recommending ongoing treatment for Petitioner's right shoulder.

On 8/7/19, Dr. Mall continued her restrictions of no repetitive lifting with the right upper extremity, no lifting more than 10 pounds from floor to waist, no pushing or pulling more than 10 pounds at waist level, and no lifting more than 10 pounds overhead. Dr. Mall testified Petitioner would have reached MMI some time ago but for other conditions, i.e. trigger finger, that has impeded her rehabilitation of the shoulder. Dr. Mall did not offer any causation opinions with regard to Petitioner's cervical spine or trigger finger.

Dr. Rodney Herrin testified by way of evidence deposition on 11/14/19. Dr. Herrin is a board-certified orthopedic surgeon whose practice primarily focuses on knees, shoulders, and hips. Dr. Herrin performed a records review on 2/8/19. Dr. Herrin testified that Petitioner's job duties could have contributed to her right shoulder condition, including the subscapularis, biceps, and supraspinatus. Dr. Herrin testified Petitioner's treatment was reasonable and necessary and he recommended additional post-operative treatment.

Dr. Herrin testified his initial diagnosis did not really change after performing a physical examination of Petitioner. He did not find any objective evidence that Petitioner's right shoulder limited her function in any way as her "range of motion strength" was satisfactory. He opined that Petitioner's shoulder and cervical conditions were separate and she was not getting referred pain from her neck. He testified the additional medical treatment received by Petitioner between February 2019 through 6/13/19 was reasonable and necessary. He agreed with Dr. Mall's recommendation on 6/10/19 that Petitioner should undergo two additional weeks of work hardening to address stiffness in Petitioner's shoulder and remain on light duty restrictions. Dr. Herrin opined Petitioner would reach MMI following work hardening.

Dr. Herrin testified Petitioner could work full duty as it relates to her shoulder condition and she does not require any further treatment. Dr. Mall had no opinions as to causal connection with regard to Petitioner's cervical spine. He testified there can be overlap between cervical and shoulder issues.

Dr. Brett Taylor testified by way of evidence deposition on 8/18/20. Dr. Taylor is a board-certified orthopedic spine surgeon. Dr. Taylor's testimony was consistent with his medical records. Dr. Taylor testified Petitioner had a positive Spurling's test and she reported 100% pain in the right arm, upper back, shoulder, upper arm, hand, and fingers. Petitioner's neck disability index was 56 evidencing significant pathology. He testified that the need for the 3T MRI was causally connected to Petitioner's accident of 8/11/18. The MRI was of diagnostic quality that showed critical stenosis at C4-5and C5-6 which is determined by measuring the space available for the spinal cord. He stated that values less than 10 mm were diagnostic for critical stenosis. He also found hyperintensity in the annulus suggestive of a tear. Dr. Taylor testified that the congenital stenosis was aggravated by the work activities and the tear was caused by the lifting incident. He stated the objective MRI findings were consistent with Petitioner's subjective complaints.

Dr. Taylor testified that Petitioner suffers from cervical instability at C4-5, cervical radiculopathy at C4-5 and C5-6, critical central stenosis at C4-5 and C5-6, and cervical congenital stenosis, as confirmed by MRI. Dr. Taylor testified he is recommending nonoperative treatment in the form of fluoroscopic-guided injections with Dr. Kaylee Boutwell. He opined that the current condition of Petitioner's cervical spine was caused or aggravated by her work accident. On cross-examination, Dr. Taylor testified his causation opinion is based on the understanding that Petitioner experienced pain in her neck following her accident that persisted up until the time of his evaluation. Dr. Taylor also testified that people who have complaints of pain in their shoulder can either have shoulder or neck pathology. However, Dr. Taylor testified Petitioner reported pain in her neck since her accident, not just her shoulder.

Dr. Timothy VanFleet testified by way of evidence deposition on 10/21/20. Dr. VanFleet is an orthopedic spine surgeon and practices in the same clinic as Dr. Herrin. Dr. VanFleet testified that Petitioner is suffering from cervical degenerative disc disease as confirmed by MRI that is not causally related to her work accident. Dr. VanFleet testified that while it is possible for a work injury like Petitioner's to aggravate degenerative disc disease in the cervical spine, it is his opinion that did not happen in this case given Petitioner did not report any pain in her neck for almost a year after her accident. Dr. VanFleet concluded Petitioner's neck pain is most likely related to normal age-related progression of her degenerative cervical condition.

Dr. VanFleet disagrees with Dr. Taylor's diagnosis of cervical radiculopathy. Dr. VanFleet testified that upon physical examination Petitioner did not show any findings consistent with radiculopathy. He testified that radiculopathy is consistent with compression of a cervical nerve root and that each nerve root is associated with pain in a specific dermatome going down the arm, which Petitioner did not show signs of on examination. Dr. VanFleet explained that with compression of the C5-6 nerve root you would see pain extending past the elbow, the C4-5 nerve root pain extending down the lateral aspect of the arm, not past the elbow, C5 radiculopathy weakness in the deltoid and biceps, and C6 radiculopathy weakness in the extensors on the side of the wrist.

On cross examination, Dr. VanFleet was asked about the intake form completed by Petitioner wherein she indicated her pain extended past her right elbow into her fingers. Dr. VanFleet testified Petitioner never complained of pain past the elbow. Dr. VanFleet was also shown studies from Cleveland Clinic, Harvard, and Johns Hopkins that confirmed it is difficult for patients to differentiate between neck and shoulder pain. Dr. VanFleet's interpretation of the MRI differed from that of Dr. Taylor and the radiologist. Dr. VanFleet was shown a record from Dr. Herrin wherein Dr. Herrin stated, "on physical examination she has some pain with motion of her cervical spine. When she goes to flex, she notes pain in her neck." Dr. VanFleet omitted this comment when he performed his records review. Additionally, Dr. Herrin noted, "she may potentially have a problem with her cervical spine which would not be related to her previous shoulder problems." Dr. VanFleet disagreed with Dr. Herrin's conclusion that Petitioner's symptoms were suggestive of a cervical spine injury.

CONCLUSIONS OF LAW

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

In addition to or aside from expert medical testimony, circumstantial evidence may also be used to prove a causal nexus between an accident and the resulting injury. *Gano Electric Contracting v. Indus. Comm'n*, 260 Ill.App.3d 92, 631 N.E.2d 724 (1994); *International Harvester v. Indus. Comm'n*, 93 Ill.2d 59, 442 N.E.2d 908 (1982). A chain of events showing a claimant's ability to perform manual duties before accident but decreased ability to still perform immediately after accident is sufficient to satisfy the claimant's burden. *Pulliam Masonry v. Indus. Comm'n*, 77 Ill. 2d 469, 397 N.E.2d 834 (1979); *Gano Electric Contracting v. Indus. Comm'n*, 260 Ill.App.3d 92, 96–97, 631 N.E.2d 724 (1994); *International Harvester v. Indus. Comm'n*, 93 Ill.2d 59, 442 N.E.2d 908 (1982).

The record is clear that Petitioner was working full duty without incident prior to the undisputed accidental injury on August 11, 2018. Petitioner credibly testified that after 8/11/18 she experienced pain in her neck, right shoulder, arm, and hand. There is no evidence that Petitioner sustained injury or sought treatment for her cervical spine prior to 8/11/18. The only reasonable explanation for Petitioner's current condition of ill-being in her cervical spine is the work accident on 8/11/18.

The Arbitrator also notes that the Commission has acknowledged that there is overlap between shoulder injuries and cervical spine conditions. *See Tiffany Molton v. Red Bud Reg'l Care*, 18 I.W.C.C. 0381. The initial primary focus of Petitioner's treatment related to her right shoulder injury, which required surgery and extensive post-operative therapy. Despite physical therapy and work conditioning, Petitioner continued to report ongoing symptoms in her right shoulder radiating to her hand resulting in an MRI arthrogram. On 6/10/19, Dr. Mall noted Petitioner was still having pain in her hand and had pain in her neck radiating down her right arm. Dr. Mall testified he believed Petitioner's right upper extremity radiculopathy was related to her cervical spine and referred her to Dr. Taylor for consult.

On 11/6/19, Dr. Brett Taylor noted Petitioner complained of pain at the base of her neck and into the right shoulder and arm despite undergoing shoulder surgery. Based on the results of a 3T MRI, Dr. Taylor diagnosed cervical instability at C4-5, cervical radiculopathy at C4-5 and C5-6, and cervical congenital stenosis. He recommended fluoroscopic-guided injections at C4-5 and C5-6 with Dr. Kaylee Boutwell and took Petitioner off work.

Respondent's Section 12 examiner, Dr. Rodney Herrin performed a physical examination of Petitioner on 6/13/19 and noted Petitioner reported pain with lifting, pain in the back of her neck, and pain and catching in her right long finger. Dr. Herrin's physical examination revealed pain with motion of Petitioner's cervical spine, right trapezius tenderness, and mild decreased range of motion in the right shoulder. Dr. Herrin testified that Petitioner's shoulder and cervical conditions were separate and she was not getting referred pain from her neck. However, he also opined that there can be overlap between cervical and shoulder issues.

The Arbitrator relies on the credible opinions of Dr. Brett Taylor in finding causal connection between Petitioner's cervical spine condition and the 8/11/18 work accident. Dr. Taylor testified that the congenital stenosis was aggravated by the work activities and the tear was caused by the lifting incident. He stated the objective MRI findings were consistent with Petitioner's subjective complaints. His working diagnosis is cervical instability at C4-5, cervical radiculopathy at C4-5 and C5-6, critical central stenosis at C4-5 and C5-6, and cervical congenital stenosis, as confirmed by MRI. Dr. Taylor testified that people who have complaints of pain in their shoulder can either have shoulder or neck pathology.

The Arbitrator does not find Dr. Timothy VanFleet's testimony as persuasive. Dr. VanFleet testified that Petitioner is suffering from cervical degenerative disc disease as confirmed by MRI that is not causally related to her work accident because she did not complain of neck pain until almost one year after the accident. Dr. VanFleet admitted it is possible for a work injury like Petitioner's to aggravate degenerative disc disease in the cervical spine, but due to the absence of any neck complaints for months following the accident, it is his opinion that an aggravation did not occur in this case. However, he testified it is difficult for patients to differentiate between neck pain and shoulder pain.

Dr. VanFleet disagrees with Dr. Taylor's diagnosis of cervical radiculopathy as he claims Petitioner did not show any signs of radiculopathy. Dr. VanFleet explained that with compression of the C5-6 nerve root you would see pain extending past the elbow, the C4-5 nerve root pain extending down the lateral aspect of the arm, not past the elbow, C5 radiculopathy weakness in the deltoid and biceps, and C6 radiculopathy weakness in the extensors on the side of the wrist. However, Petitioner indicated on the questionnaire form her pain extended past her right elbow into her fingers. Dr. VanFleet also omitted from his report Section 12 examiner, Dr. Herrin's, note that stated Petitioner had pain with motion of her cervical spine upon physical examination. Dr. VanFleet disagreed with Dr. Herrin's opinion that Petitioner's complaints were suggestive of a cervical spine injury.

Based upon the objective findings on Petitioner's imaging studies, the history in Petitioner's medical records, Petitioner's lack of any cervical spine injuries or symptoms prior to her accident on 8/11/18, and her persistent complaints of pain in her cervical spine and

radiculopathy in the right arm despite undergoing shoulder surgery, the Arbitrator finds Petitioner met her burden of proof regarding causal connection. The chain of events and the medical evidence establishes that Petitioner's current condition of ill-being in her cervical spine is causally related to her work injury of 8/11/18.

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): Is Petitioner entitled to any prospective medical care?

Upon establishing causal connection and the reasonableness and the necessity of recommended medical treatment, employers are responsible for necessary prospective medical care required by their employees. *Plantation Mfg. Co. v. Indus. Comm'n*, 294 Ill.App.3d 705, 691 N.E.2d. 13 (1997). This includes treatment required to diagnose, relieve, or cure the effects of claimant's injury. *F & B Mfg. Co. v. Indus. Comm'n*, 325 Ill. App. 3d 527, 758 N.E.2d 18 (2001).

Based on the findings as to causal connection, the Arbitrator finds that the care and treatment Petitioner received has been reasonable and necessary. The parties stipulated that the only disputed injury subject to this Section 19(b) hearing is Petitioner's cervical spine. Therefore, Respondent is ordered to pay the medical expenses outlined in Petitioner's Exhibits 12 and 17, as provided in Section 8(a) and Section 8.2 of the Act. Respondent shall be given a credit for any amounts previously paid under Section 8(a) of the Act for medical benefits and Respondent shall hold Petitioner harmless from claims by any providers of the services for which Respondent is receiving this credit.

The Arbitrator further finds Petitioner has not reached maximum medical improvement and is entitled to receive the additional care recommended by Dr. Taylor, including, but not limited to, fluoroscopic-guided injections with Dr. Kaylee Boutwell.

Issue (L): What temporary benefits are in dispute? (TTD)

Based upon the above finding as to causal connection and the stipulation that the only disputed injury subject to this Section 19(b) hearing is Petitioner's cervical spine, the Arbitrator finds Respondent liable for payment of temporary total disability benefits. The parties stipulated that Petitioner's average weekly wage is $485.76, resulting in a TTD rate of $323.84.

On 1/30/20, Dr. Taylor diagnosed Petitioner with cervical instability at C4-5, cervical radiculopathy at C4-5 and C5-6, and cervical congenital stenosis. He placed Petitioner off work pending fluoroscopic-guided injections at C4-5 and C5-6 with Dr. Kaylee Boutwell. Respondent shall pay temporary total disability benefits for the period 1/30/20 through the date of arbitration, 3/24/21, for a total of 60 weeks.

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

Arbitrator Linda J. Cantrell

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	09WC050849
Case Name	VAUGHN, JEFFREY v. RICHARDS WILCOX
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0235
Number of Pages of Decision	22
Decision Issued By	Maria Portela, Commissioner

Petitioner Attorney	Kurt Niermann
Respondent Attorney	Daniel Swanson

DATE FILED: 6/27/2022

/s/Maria Portela, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JEFFREY VAUGHN,

Petitioner,

vs. NO: 09 WC 50849

RICHARDS WILCOX,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission affirms the Arbitrator's finding that Petitioner failed to prove that he sustained a compensable accident arising out of and in the course of his employment on February 7, 2007. However, we make several modifications and clarifications.

One of the confusing aspects of this case is that it is unclear where the connector valve for Petitioner's previous shunt catheter had been installed. Much of the evidence indicates that it was located at the base of the skull behind Petitioner's right ear. Petitioner testified, "the shunt had a connector at the neck and then more tubing that ran down to the abdomen." *T.18*. The July 13, 2006 x-ray report of Petitioner's chest, skull and neck states:

> There is a segment of a shunt catheter extending from the midline in the frontal area to a burr-hole in the posterior right parietal area. There are no metallic components identified. **The shunt is disrupted at this point with a few small radiopaque densities at the base of skull on the right side. There is no shunt catheter identified within the neck or the chest.** The distal end or the shunt is looped within the abdomen. (*Emphasis added.)*

The examination findings in Dr. Deutsch's January 15, 2007 record indicate:

> **Posterior to the right ear is induration consistent with the shunt valve placement.** There also appears to be a slightly red indented area with some mild erythema and minimal tenderness posterior over the shunt tubing. (*Emphasis added.)*

Dr. Deutsch's February 7, 2007 operative report states:

> **Subsequently, he has also developed a pustule over the incision site in his neck, as well as redness around the area of the shunt valve. There was also some breakage of the skin over the shunt valve.** No evidence of meningitis was noted so far. Because of the skin breakdown, erythema, swelling around the shunt tubing, and the fact that the shunt has been disconnected, the decision was made to remove the shunt material.
> …
> Technique: …
> He **was positioned supine [face upward]** and the **head turned towards the left.**
> **The 3 incisions on his head, neck. and abdomen were prepped** and draped in the usual sterile fashion and marked.
>
> **We initially opened the cranial incision.** A sharp scalpel was used to open up the cranial incision. Monopolar was used to extend the incision through the scar tissue and galea. The bur hole was identified. The shunt tubing was also identified. The valve was identified. **We disconnected the valve from the ventricular catheter. Because this was a flange lip, the decision was made not to pull the catheter.** We noted clear CSF. CSF was sent for appropriate studies, including cell count and cultures.
>
> **We then removed the valve. We noted that the lumboperitoneal catheter was not attached.**
>
> **We then explored the cervical wound. We failed to find the lumboperitoneal catheter in direct relation to the cervical wound.**
>
> The abdominal wound was also opened using a sharp scalpel. Again, the lumboperitoneal catheter was not identifiable. … (*Emphases added.)*

On March 12, 2007, Dr. Deutsch wrote a letter to Dr. Stallter stating, "**The valve and tubing in the neck were removed**. We noted that the distal part of the shunt was missing." (*Emphasis added.)* Dr. Deutsch testified:

> Q. What is the distal catheter? Is that what leads down into the body cavity?
> **A.** So he had the shunt in the head and he had the catheter going into the brain and then **there is a catheter that extended from the brain down into the neck and then this was a connector where you connected to another catheter going into the abdomen, but the part going from the neck down we didn't see anything.** *Px1 at 11. (Emphasis added.)*

All of the above indicate the shunt valve was located somewhere in Petitioner's neck and, most likely, posterior to his right ear. However, Dr. Deutsch then testified:

> Q. So the part that had been pulled out through the apron use according to his history was **the part that connected down near the sternum?**
> A. Right. Theoretically, yes. *Id. at 12. (Emphasis added.)*

This is confusing because, as mentioned above, Dr. Deutsch's January 15, 2007 record indicates that the shunt valve was "posterior to the right ear" and the operative report indicates that the valve was removed from the "cranial incision" before the "cervical wound" was explored. However, Petitioner's attorney asked Dr. Deutsch if the part that had been pulled out was "connected down near the sternum" and the answer was, "Right. Theoretically, yes." However, there does not seem to be any medical records to support the testimony that Petitioner had a valve near his sternum.

The only other reference to the valve being located near the sternum was during the deposition of Respondent's §12 physician, Dr. Salehi, who mistakenly believed that Petitioner's previous catheter was one long tube that ran from a valve over Petitioner's skull down to his abdomen. *Rx2 a 19-20*. On cross-examination, Dr. Salehi gave the following testimony:

> **Q. Okay. Dr. Harel Deutsch told us in his deposition that there was an auxiliary catheter that was attached at the neck level. Did you see that when you read his deposition?**
> **A. No. Let me see that.**
> Q. Okay. And he said that the part that was actually detached was from the neck down. Right there (indicating).
> A. "Shunt in the head ... "
> …
> **Yeah. I mean, it's -- it's an unusual construct. Usually, unless there was a -- so there is usually one catheter going from the valve to the distal end.**
> Q. Right, right. **And that's what you had in mind when you did your analysis, correct?**
> **A. Yes.**
> **Q. Okay. You can see there, though, that there was actually an auxiliary catheter attached at the sternum.**
> **A. It looks like there was a connection -- there was a disruption of this distal catheter that connected the two ends using an auxiliary --**
> Q. All right.
> **A. Yeah.**

Rx2 at 20-21. (Emphases added.) However, this testimony is inconsistent with Dr. Salehi's own examination findings, about which he testified:

> He had two incisions in the parietal and frontal region on the right side. The area around the valve was not swollen. The valve pumped and refilled well. He had another incision behind the ear and had a four-centimeter abdominal incision. *Rx2 at 11*.

Therefore, it appears that Petitioner had two incisions in the parietal and frontal region on the right side and another incision behind the ear. There was no mention of any incision located in the area of Petitioner's sternum.

We find it most likely that Dr. Salehi agreed there had been an "auxiliary catheter" at Petitioner's sternum based on Petitioner's attorney's leading question and showing him the section in Dr. Deutsch's deposition where Petitioner's attorney also led Dr. Deutsch by using the word "sternum."

Regarding the location of the valve, Petitioner testified that he went to Dr. Stallter on June 14, 2006 because:

Q. What brought you to go see Doctor Stallter?
A. Well, I had one of the ties was – it caused an opening in my neck, a small opening.
Q. This tie, it went around the neck. Correct?
A. Yes.
Q. Talking about the top tie for the apron?
A. Yes.
Q. And did it sit on the connector?
A. No. Well –
…
Q. How did -- **did the tie for the apron lay on any portion –**
A. Yes.
Q. -- of the catheter –
A. Yes.
Q. -- coming off the shunt?
A. Cause it was up here and it laid on the tubing, and the tubing had like a connection to it. (Indicating)
Q. In your neck?
A. Yes. In my neck. And every now and then that tie around my neck would rub, and I mean over a period of time, something is going to give.
Q. So, in any event, you noticed that it's starting to cause -- what did you notice it was starting to cause in June --
A. I noticed I felt like -- started feeling back there because it was rubbing, and I felt back there and I look at it. It looked like it was some oil so constantly kept on working, you know, and then got to the point I felt back there and I seen blood.
Q. Now, that was June of 2006?
A. Something like that.
Q. Right before you saw Doctor Stallter?
A. Yes.
Q. That's what brought you to Doctor Stallter?
A. Yes.
Q. Was that rubbing or the bloody area or the irritation, was that at the location where the connector was?
A. Yes.
Q. That's where the neck portion of the tie rode up on the neck?

A. Yes. Yes. *T.19-21.*

Petitioner's testimony is confusing because he initially stated the neck tie of the apron did not sit on the shunt connector (*T.19*) but it did lay on the "tubing" that had "like a connection to it." *T.20*. However, immediately after that, Petitioner testified that the "rubbing or the bloody area or the irritation" *was* at the location of the connector and this was also where the neck portion of the tie rode up on his neck. *T.21.*

First, Petitioner did not testify that the connector had been located near his sternum, so this supports our conclusion that it was not located there. Second, since the medical evidence seems to indicate that the connector was located behind Petitioner's right ear, we question how the apron neck tie could ride up that high; especially when the apron was also tied behind Petitioner's lower back. Third, even if we have interpreted the evidence incorrectly and Petitioner's connector was lower on his neck (e.g., just above the clavicle) at a location where a neck tie could possibly cause an abrasion or irritation, we find the evidence still does not support a finding of accident.

Despite Petitioner's attorney characterizing the weight of the apron as the "reddest of herrings," there is simply no medical evidence to support a finding that an apron that weighed less than one pound could be a competent mechanism of injury to cause Petitioner's shunt tubing to dislodge from the connector. This is true whether Petitioner claims that his injury began in 2006 and developed over time, based on repetitive rubbing of the apron's neck tie, or whether he claims a specific date of accident on February 7, 2007.

Dr. Deutsch gave a causation opinion that it is "certainly reasonable that wearing something on your shoulder at the site of the shunt could cause it to disconnect I guess, yes." *Px1 at 18*. However, this was based on his understanding that Petitioner wore "heavy aprons" on his neck. *Id. at 6-7*.

Bruce Hankins, Petitioner's supervisor, testified that he knew the exact weight of the work aprons[1] supplied to Respondent's employees, an example of which was admitted as *Rx1*. *T.82-83*. He testified that it weighed "point 7" pounds. *Id. at 83*. Petitioner testified that the apron he wore was similar to the one admitted into evidence as *Rx1* and was "about the same weight." *T.15, 38-39*. However, he testified that it would get heavier than three-quarters of a pound if it got "oily or something like that." *T.42*. It was this "same apron" that he wore when he told Dr. Deutsch on August 7, 2006, that he wore a "heavy apron" at work. *Id.*

Dr. Qadir testified it was "technically" possible for "heavy aprons" to disconnect a catheter (*Px2 at 18*), but he was not aware that it occurred in Petitioner's case because "this is the first time ever I am hearing about the heavy apron" and he "can't really comment on that because that's not my area of expertise." *Px2 at 32*.

---

[1] A denim apron similar to the one worn by Petitioner was admitted into evidence without objection as *Rx1*. *T.123*. However, in preparation for Oral Arguments on Review, this exhibit was not located in the Commission file boxes. The parties agreed that the testimony about the apron was sufficient and chose to move forward with Oral Arguments without the physical apron.

Dr. Salehi testified:

I have never seen disconnection of a catheter from a -- you know, an apron, a lead apron, weighing 15 or 20 pounds.

I see disconnections of a catheter for multiple reasons, so I think it's more likely, then, that the catheter disconnection would have happened regardless of the apron situation.
…
What I cannot correlate is that wearing an apron would result in a shunt disconnection. I have never seen it. It just clinically doesn't make sense. The shunt is running in the lateral and anterior aspect of the neck. The weight of the apron -- I wear it all the time -- is distributed over your shoulder.
…
It is not sitting on the catheter. So I don't -- I don't -- physically I don't know why Dr. Deutsch is saying that the apron caused the disconnection.

Rx2 at 13-15. (Emphases added.)

On cross-examination, Dr. Salehi testified that he assumed the apron weighed 15 to 25 pounds because "that's the average weight of an apron" similar to what he, himself, wears while performing x-rays even though Petitioner never told him the weight and he never saw the apron that Petitioner wore. *Rx2 at 15-17*. As discussed above, Dr. Salehi also admitted that he incorrectly believed Petitioner's previous catheter was one long tube without an "auxiliary connector." However, he then testified:

Q. Okay. So that could be consistent with a heavy apron sitting over that area and pulling on the tissues while he's working, correct?
A. You know, my opinion still is – anything is possible, but it's more likely than not that the dislodgement of the catheter, the disconnection of the catheter, it happened spontaneously.
Q. Okay.
A. The reason for that is the catheter is not traveling on the shoulder.
Q. Okay.
A. The lead is sitting on your shoulder. The catheter is traveling in your neck.
Q. Okay.
A. So how would the pressure of the apron on the shoulder result in dislodgement of the catheter in your neck?
Q. Okay.
A. That I cannot scientifically prove.
I mean, how would you -- how would you transmit forces into the catheter if the shoulder is what's carrying the weight?
Q. I assume his apron is not a shoulder pad apron. I assume that he has got weight from the lead -- or, the heavy apron, whatever it is, across his chest, also.
A. Yes. I mean, you strap it in order to distribute the weight.
Q. Yes.
A. I mean, you strap it –
Q. Sure.

A. -- you know, in two places, in upper thoracic and one in the lower back, to distribute the weight evenly.
Q. Yes. So you said it commonly can happen that it becomes disconnected, correct?
A. So, I mean, my logic –
…
Q. How does it become disconnected?
A. So a lot of times the catheter disconnection happens because the catheter loses its flexibility and gets disconnected. Sometimes the -- yes, it loses its elasticity and if there is a connecting point here -- actually, you know what?

The use of a connector in a catheter where it's supposed to be a single catheter --

Q. Right.
A. -- puts it at the more likelihood that it would get disconnected spontaneously than if it was a single catheter.
Q. Because it's a weak point --
A. It's a specific point.
Q. -- apparatus.
A. That's right.
Q. Okay. So if it's a weak point, it's more likely to dislodge with pressure or movement to the area.
A. If it's a weak point, it's more likely that it would disconnect spontaneously.
Q. By history, though, if we don't ignore the records, and the history in the records, it occurred when?
A. I'm sorry. It occurred when?
Q. The disconnection occurred when? While he was wearing the apron doing his work activities, correct?
A. I mean, that's what everybody is saying, but -- but to me it just doesn't make sense.
Q. Okay.
A. But what I said is that -- is it possible? Yes, anything is possible.
Q. Okay. All right.
A. But is it more likely than not? No, I cannot say that.
Q. Okay. So what we do know is we have a weak spot in the apparatus at about the sternum location. And according to his history, he's wearing heavy aprons over that area while he's doing his work activity, correct?
A. Yes.
Q. And even without heavy pressure over that area, that kind of a set-up, that construction of that type of a catheter is more likely to fail at that location anyway.
A. That's correct.

Rx2 at 21-25.

Petitioner focuses on Dr. Salehi's admission that it is "possible" that the apron could have dislodged the catheter if it was a "weak area." However, this possibility still presumes that the apron was heavy. Dr. Salehi assumed Petitioner was wearing a heavy lead apron weighing 15 to 20 pounds and, even with this assumption, he opined that the catheter being dislodged by the apron "just doesn't make sense."

The Commission concludes that, regardless of where Petitioner's shunt valve may have been located, there is simply no medical opinion to support a finding that a light, denim apron could even be a "possible" cause of its dislodgment. Since Petitioner's claim is based on medical opinions that assumed Petitioner's apron was "heavy," we do not find those causation opinions persuasive at all. If Petitioner's theory of accident was that an apron weighing less than a pound caused his shunt catheter to dislodge, then it was his burden to obtain a medical opinion to support that mechanism of injury.

To the extent that Petitioner might be arguing a repetitive trauma theory where a lightweight apron could cause his catheter to dislodge, this is not supported by the medical evidence either. We find it speculative to find that a light apron that weighs less than a pound could cause the disconnection of the shunt tubing. Even if the apron might have, at times, weighed more than one pound when it became wet, Petitioner had the burden to prove that the weight of that allegedly wet apron weighed enough to be considered "heavy" by the medical doctors who gave their causation opinions.

In addition to the lack of persuasive causation opinions, we also find Petitioner's testimony about the timeline of events not credible because it is not supported by the evidence. Petitioner testified that he felt the oily/bloody area on his neck right before his visit with Dr. Stallter on June 14, 2006. *T.21, 23*. However, Dr. Stallter's record does not mention any oozing, oily discharge, blood, abrasion or any skin breakage on Petitioner's neck. It does mention, however, that Petitioner had a ringworm rash on the top of his right foot.

The Arbitrator incorrectly found "the records document that he first saw Dr. [Stallter] in June 2006 noting he could not feel the catheter in his neck" (*Dec. 8)* and "the medical records document that he saw Dr. [Stallter] in June 2006 [and] alleged the apron had disconnected his catheter." *Dec. 9.* However, the June 14, 2006 record only states that Petitioner had a shunt 30 years ago and is "starting to have problems…like a sharp pain" that he noticed a "couple weeks ago." There was no mention of any work apron or disconnection of the catheter. Significantly, this record does *not* state that Petitioner was no longer able to feel the catheter tubing. That symptom was not documented until August 7, 2006, almost two months later, when Dr. Deutsch recorded:

> More recently, he used to be able to palpate the shunt catheter in his neck and recently noticed he has not been able to palpate the shunt catheter. He notes that he has been doing some work involving heavy aprons that would sit on his neck and the pull of the aprons may have dislodged the shunt catheter.
> …
> More recently, he has noted that he has been unable to palpate his shunt tubing in the neck. I was not able to palpate the shunt tubing either.

In other words, Petitioner did not mention to Dr. Stallter, on June 14, 2006, that the apron disconnected his catheter. Rather, it was mentioned to Dr. Deutsch on August 7, 2006 (almost two months later) that he was no longer able to palpate the shunt tubing and he had been working with "heavy aprons" that "may" have dislodged the shunt catheter.

The Arbitrator also wrote, "Petitioner had previously been seen in March 2006 for a rash with itchy red bumps." *Dec. 3*. We point out that this visit to Dr. Stallter on March 3, 2006, was for a rash on the "abd" [abdomen] and not for any rash related to Petitioner's neck.

After a thorough review of the evidence, we find that Petitioner failed to prove his shunt catheter became dislodged due to the apron he wore. While we will not engage in speculation, we are mindful that a few months prior to Petitioner's first visit to Dr. Stallter with complaints of head pain, Petitioner had visited Dr. Stallter on February 27, 2006, for lumbar pain after "moving/pushing 300# equipment @ work on Friday." On April 21, 2006, Dr. Stallter again noted Petitioner's diagnosis for "acute low back strain" and that Petitioner had been returned to work on March 1, 2006, but that his "next visit" was to be "with PT only." It would be speculative to find that Petitioner's shunt became dislodged at the time he sustained the acute back strain or during the exertion involved in subsequent physical therapy. However, it is even more speculative, based on the evidence, to find that that Petitioner's apron, which weighed less than a pound and was similar to ones he had worn at Respondent for 22 years, somehow rubbed his neck so hard in June 2006 that it caused his catheter tubing to dislodge. Regardless of the exact location of the catheter tubing and valve and even if the apron neck tie rested on any part of the shunt, we find that Petitioner's shunt was not dislodged in any way by wearing the work apron.

We also strike the entire first paragraph on Page 9, which cites tort law cases regarding "the inference of the nonexistence of a fact."

Given our affirmance of the denial of accident, we strike the remainder of the Arbitrator's conclusions regarding notice and causation as all other issues are moot.

All else, not otherwise inconsistent with this decision, is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed March 27, 2020, is hereby affirmed and adopted with the modifications noted above.

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.

June 27, 2022

/s/ *Maria E. Portela*

SE/
O: 5/10/22
49

/s/ *Thomas J. Tyrrell*

/s/ *Kathryn A. Doerries*

22IWCC0235

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

VAUGHN, JEFFREY
Employee/Petitioner

Case# **09WC050849**

RICHARDS WILCOX
Employer/Respondent

On 3/27/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.80% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5122 PORRO NIERMANN LAW GROUP LLC
KURT NIERMANN
821 W GALENA BLVD
AURORA, IL 60506

2097 KRAKER & OLSEN
DANIEL K SWANSON
300 S RIVERSIDE PLZ SUITE 2050
CHICAGO, IL 60606

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jeffrey Vaughn
Employee/Petitioner

v.

Richards Wilcox
Employer/Respondent

Case # **09** WC **50849**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Geneva**, on **October 10, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **February 7, 2007**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 $**45,500,00**; the average weekly wage was $**875.00**.

On the date of accident, Petitioner was **48** years of age, ***married*** with **3** dependent children.

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

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

Respondent shall be given a credit of $**0.00** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**4,800.00** for other benefits, for a total credit of $**4,800.00**.

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

ORDER

BECAUSE PETITIONER FAILED TO PROVE BY A PREPONDERANCE OF THE EVIDENCE THAT HE SUSTAINED ACCIDENTAL INJURIES ARISING OUT OF AND IN THE COURSE OF HIS EMPLOYMENT ON FEBRUARY 7, 2017, FAILED TO PROVE THAT ANY CONDITION OF ILL-BEING WAS CAUSALLY CONNECTED TO HIS EMPLOYMENT WITH RESPONDENT AND FAILED TO PROVE THAT HE PROVIDED NOTICE TO RESPONDENT WITHIN THE TIME LIMITS PROVIDED IN THE ACT, PETITIONER'S CLAIM FOR COMPENSATION IS HEREBY DENIED.

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

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

Signature of Arbitrator

March 25, 2020
Date

MAR 27 2020

Statement of Facts

Petitioner Jeffrey Vaughn testified that he worked as a machine operator for Respondent Richards Wilcox for 22 years before his injury. He wore a company-provided apron during to keep the dirt off his clothes during work. He identified RX 1 as similar to the apron he used. The apron was constructed of blue denim and it had ties around the waist and neck to hold the apron in place. The apron may have weighed less than a pound. He wore an apron for years before his accident, up to six days a week. His practice was to fashion the ties around the neck first and then secure the ties around his back. This would secure the apron close to him during work. The tie around the belly also held the tie down against his neck. Regarding the heaviness of the apron, he tied the apron around the center which pulled the neck ties tight against his neck. He was also turning his head constantly while doing his job while he checked the parts throughout the shift. Many of the machines in the plant had to be lubricated and the water from the lubrication splashed back on the apron making it heavier.

Petitioner had previously had a drainage shunt installed into his skull at age 17 with the catheter running down to his abdomen. The shunt system had a connector at the neck with tube running from the neck down to the abdomen. Petitioner performed all work activities without the need for treatment for the 22 years between age 17 and 2006.

Petitioner testified that he saw Dr. Stalter on June 14, 2006. He testified the apron tie was rubbing. This tie was laying on top of the tubing and the connector and rubbing against the connector. The tie rubbed through the skin and drew a little blood. Petitioner testified that he notified his boss Bruce Hankins when he saw the blood on his finger. He told Bruce "I have a problem" and showed Bruce him the blood on his finger. Petitioner did not recall how Bruce responded to the information. Petitioner testified that he detected the rubbing and blood on the neck before discovering the connector had come loose. He did not know the exact date the connector became disconnected. The first notice he had of any issue was the blood on the neck.

On June 14, 2006, Dr. Stalter noted a chief complaint of head pain that Petitioner noticed a couple of weeks ago as well as a rash on his foot (PX 6). Petitioner had previously been seen in March 2006 for a rash with itchy red bumps. Dr. Stalter ordered x-rays and an MRI of the brain performed July 13, 2006. The x-rays noted the shunt was disrupted. No shunt catheter was identified in the neck or the chest. The distal end of the catheter is looped within the abdomen. The MRI showed no evidence of acute intercranial pathology (PX 6). Petitioner was referred to Dr. Deutsch. On August 7, 2006, Petitioner's history was that he used to be able to palpate the shunt catheter in his neck and recently noticed he has not been able to. He notes he has been doing work involving heavy aprons that would sit on his neck and the pull of the aprons may have dislodged the shunt (PX 8). Petitioner advanced no complaints and the physical examination was without any findings. Dr. Deutsch's assessment was that he may have outgrown the need for the shunt. As long as Petitioner is asymptomatic, there is no need for further intervention (PX 8).

Petitioner returned to Dr. Stalter on December 26, 2006 for dermatitis around the shunt for 1 to 2 months. He noted it was irritated and itches. He was given Keflex and told to report to a neurosurgeon. On January 8, 2007, he reported drainage. The assessment was shunt infection. Petitioner was scheduled for a CT scan. On January 19, 2007, he reported bloody drainage. The assessment was superficial dermatitis (PX 6, p 10-18). Petitioner saw Dr. Deutsch on January 15, 2007. He noted the reddened slightly red indented area with some mild erythema and minimal tenderness posterior over the shunt tubing. He states the inflammation appears very superficial. His impression was the shunt was not working. He planned to remove it (PX 8, p 5-6). On January 23, 2007, Petitioner signed disability forms checking that the disability is not a result of employment

(RX 3). Dr. Deutsch removed the shunt on February 7, 2007 (PX 8, p 9-10). Petitioner was seen post operatively on February 22, 2007 and March 12, 2007. Dr. Deutsch noted Petitioner had developed a pustule over the shunt site. Intra-operatively, we found the shunt had become disconnected. The distal part of the shunt was missing. The valve and tubing were removed. The proximal cranial catheter was left in place. Petitioner had no symptoms. The cultures had grown Staph epi and Petitioner had been given antibiotics. Dr. Deutsch planned a repeat CT in a few months. He stated that Petitioner does not need further ventricular shunting (PX 8).

Petitioner testified he returned to work March 12, 2007 and worked for two years. He did not follow up with Dr. Deutsch. He testified that when he returned to work, he found a different way to tie the apron around his back rather than around the neck. He started developing a severe headache on May 24, 2009. On May 26, 2009, he was taken from the plant by ambulance. He testified that he was making dividers. He would normally make 2,400 per day. In the two hours he was at work that morning, he did not make any. Bruce Hankins approached him and asked why he was not producing. Petitioner testified he told Mr. Hankins he was not feeling good. Petitioner did not recall how he got into the ambulance or his conversations from that day.

Bruce Hankins testified that he has been the fabrication supervisor at Respondent for 30 years. In June 2006, Mr. Hankins supervised 28 employees and currently supervises 23 employees. He testified that Petitioner worked in his department. He assigned him to work machines including a coil line, a press break, a turret press and a 14-gauge support line. Respondent provides work aprons in order to protect people's clothing, but only half of the workers in his department wore them. Mr. Hankins denied having any conversation with the Petitioner on June 7, 2006 regarding experiencing difficulties with his work apron rubbing against his neck, causing him irritation which drew blood. Respondent has a procedure for reporting work-related injuries. He never filed any report on behalf of Petitioner for any incident that occurred on either June 7, 2006 or February 7, 2007. He testified that even if there was no accident, blood would have required a "close call" report.

Mr. Hankins testified that on the morning of May 26, 2009, Petitioner manufactured nothing in two hours. He approached Petitioner and had a conversation. Petitioner indicated that his lack of productivity was based on the fact that he had a headache. Later that day, Mr. Hankins learned Petitioner had gone to the hospital for his headache while he was in the production meeting. Petitioner never returned to work at Respondent. He never spoke again to Mr. Hankins. Mr. Hankins testified that he recalls Petitioner told him that he had a metal plate in his head when he first started working. Petitioner, although he was slow, had been a dependable worker.

The May 26, 2009 EMT report notes that Petitioner started having pressure in his head and headaches the previous day (PX 11, p 1410). Petitioner was admitted to Rush Pres. St. Luke's Hospital on May 26, 2009 with a history of a bad headache yesterday and a horrible headache this morning with nausea and vomiting. A brain CT suggested a stable appearance when compared to the 6/12/07 scan (PX 6, p 91). On May 27, 2009, Dr. Deutsch performed surgery to insert a right frontal ventriculoperitoneal shunt. His operative note states Petitioner was doing fine until severe headaches started 3 days ago. The headaches were relieved with a high volume tap (PX 11). The operative diagnosis was "hydrocephalus" (PX 11, p 156). A May 27, 2009 brain CT found the new drainage system as well as mild dilation of 3rd and lateral ventricles (PX 6, p 94). An MRI was done on May 28, 2009 to assess left hemianopsia (PX 8, p 21). The MRI identified a possible small focus suggesting acute infarct in lateral right posterior temporal region (PX 6, p 95). An ophthalmology consultation documented decreased peripheral vision in the left visual field which had sudden onset a few days ago. The eye exam was normal. The CT was interpreted as showing no intracranial hemorrhage or cerebral vascular accident. The attending physician thought the visual issue was suggestive of a retrochiasmatic lesion, but the

CT was normal. The diagnosis was left homonymous hemianopsia (PX 11, p 151-153). Petitioner was discharged from the hospital on May 29, 2009, with Dr. Deutsch reporting an uneventful post-operative course, aside from the nonspecific eye symptoms (PX 6, p 97).

Petitioner was readmitted to Rush on May 31, 2009 to assess worsening left sided weakness (PX 11, p 459). A CT angiogram of the brain was performed on June 1, 2009 (PX 6, p 99). A neurology consult documented that the left arm weakness was worse than left leg. A neurological History & Physical documented the left sided weakness, mental status changes and two seizures the previous night (PX 11, p 459). An MRI revealed: 1) a small focus restricted diffusion seen in lateral right posterior temporal region suggesting acute infarct likely due to microvascular ischemic change; 2) a marginal decrease in lateral and 3rd ventricles (in comparison to 5/27/09 study); 3) a decreased degree of pneumocephalus in right frontal region; 4) changes in chronic microvascular ischemic disease, most pronounced in posterior mid-convexity right frontal cortex. Since this area appears to be cortical, it could explain seizures (PX 11, p 463-464). Petitioner underwent multiple testing including MRIs and EEGs. On discharge, Petitioner was noted to have 4/5 left sided weakness and persistent apraxia (PX 11, p 511).

Petitioner was transferred to a rehabilitation facility to address gait, transfers, ADLs, balance and safety. Cognitive issues and potential seizure activity were identified as potential barriers to successful rehabilitation. (PX 11, p 1496). A June 12, 2009 psychological testing revealed impairments on cognitive testing and deficits in concentration and motor sequence (PX 11, p 1509).

Petitioner signed short term disability forms on June 11, 2009 stated the disability was not from employment (RX 4). Petitioner's position with Respondent was terminated when his FMLA expired on August 18, 2009 (RX 5). Petitioner testified that he did not know who filled out either of the short-term disability requests and admitted he may have signed them while they were still blank. He did not realize that he had a possible workers compensation case until he consulted with an attorney at the end of 2009.

Neuropsychological testing performed June 18, 2009 and June 19, 2009 identified significantly impaired executive function, visuospatial abilities and cognitive processing speed in the context of intact confrontation naming, basic attention and verbal memory. The impairments were consistent with dysfunction of the frontal lobes, or "frontal systems" resulting in reduced awareness of his functional impairment, inefficient learning of new material, and slowed processing speed. His behavior during testing also suggested left hemispatial inattention or neglect. There was a concern about a continuing contributing issue over a limited visual field. Overall, the condition was consistent with hydrocephalus, microvascular ischemic change, his prior brain tumor and radiation for that tumor. Given his functional impairment, reduced awareness and potential visuoperceptual impairment, he needed daily supervision, and ongoing occupational, physical and speech therapies (PX 11, p 1511-1513). The June 19, 2009 Occupational Therapy Discharge Evaluation documented noted that Petitioner attended his sessions, but his progress was impaired by his somnolence and decreased attention. His potential for rehabilitation was characterized as "fair" due to his decreased attention, lethargy and left sided weakness. Petitioner was discharged home and in-home rehabilitation services were undertaken (PX 11, p 1571).

Petitioner developed abdominal pain and was admitted to Presence Mercy Medical Center between June 15, 2012 and June 18, 2012 (PX 3, p 49). A CT scan and ultrasound revealed two very large fluid collections in the region of the shunt tubing. A CT with contrast found the end of the new catheter draining into the fluid collection. The findings were most consistent with cerebral spinal fluidoma. The liver also had hypodense regions which were thought to be due to parenchymal injury or necrosis caused by the adjacent mass effect

from the CSF collections (PX 3 p 143-148). The fluid collections were drained. A June 21, 2012 repeat CT found that the fluid was increasing again as compared to the immediate post-drainage images (PX 3, p 258). Dr. Deutsch repositioned the catheter in the abdomen on November 7, 2012, identifying a pseudocyst at the distal end of the tube (PX 11, p 1996-1997).

Limb weakness persisted. Petitioner was sent for a brain and brainstem MRI on April 17, 2014 which detected the old right basal ganglia lacunar infarct. Therapy was started at Mercy on May 16, 2014 to address continuing weakness in bilateral lower extremities attributed to obstructive hydrocephalus (PX 3). The functional assessment identified a slow paced gait, he was slower now on stairs. He sometimes lost balance when moving from a sitting to standing position. Strength deficits were identified in the lower half of the body, with deficits in hip muscles and movement and hamstring deficits. The primary diagnosis was weakness in the bilateral lower extremities from obstructive hydrocephalus and balance issues. His mobility was assessed as being 20-39% impaired, mobility was 1-19% impaired. Therapy lasted through August 14, 2014 (PX 3).

On July 4, 2018, Petitioner developed slurred speech and left leg weakness while undergoing a sleep study (PX 10, p 452). He was admitted to Rush Copley for evaluation of a potential stroke. His leg weakness had improved by the time of admission but not the speech. The CT was unremarkable. An MRI revealed a focus of late subacute ischemia in the right side of the midbrain. An EKG was normal, and he was cleared to undergo physical, occupational and speech therapy. The therapy course last until July 30, 2018. The discharge note reported significant gains with therapy and Petitioner returning to his previous level of function. He was instructed to do home exercises and issued a rolling walker (PX 10). Home healthcare services were provided through September 24, 2018. The last note indicates he had met his therapy goals and improved functional mobility and stability (PX4).

Petitioner testified that his condition had not materially improved since the 2009 surgery. He was probably worse since the 2009 surgery. Petitioner began using a cane for stability after his 2009 surgery and now uses a walker. He testified that the headaches cleared up after Dr. Deutsch reinstalled the shunt system in 2009. He has been treating with Dr. Qadir for a decade. Dr. Qadir was aware of his medical condition. No doctor ever released him to return to work since May 26, 2019. Petitioner never returned to work for Respondent. He has not worked or looked for work since. He applied for and received Social Security Disability effective May 26, 2009. Public aid and Medicare started picking up his treatment.

Dr. Harel Deutsch testified by evidence deposition taken September 11, 2015 (PX 1). He is a board certified neurosurgeon. On August 7, 2006, Petitioner was seen with a history of headaches. Petitioner reported that he wore heavy aprons during work which sat on the neck, which Petitioner thought helped dislodged the catheter. X-rays showed that the shunt catheter was dislodged. Petitioner had some recent headaches which had resolved. Dr Deutsch concluded that he had outgrown the need for the shunt. Petitioner returned January 15, 2007 with swelling and irritation near the shunt tubing. Dr. Deutsch recommended that they evaluate, possibly remove the shunt, and check for possible infection. Surgery was performed on February 7, 2007. He removed the catheter tubing from the abdomen. He detached what remained of the tubing from the shunt, but he left the catheter tip in the brain as it had an old design tip which was difficult to remove without causing more damage. Surgical exploration confirmed that the connector located at the neck had detached. He sent a sample of fluid for testing for an infection and put in a temporary drain to test whether Petitioner still needed the shunt. Dr. Deutsch explained that Petitioner had no headaches or drainage. He removed the draining catheter. Petitioner was seen May 27, 2009 when he was transferred back for care when he developed blurry vision and had a terrible headache. MRI showed some evidence of a stroke. Dr. Deutsch drew some liquid out the skull noting

that it was high pressure, an indication of hydrocephalus. Dr. Deutsch reinstalled the ventriculostomy on May 27, 2009 (PX 1).

Dr. Deutsch stated that the 2009 shunt issues are related to the 2006 shunt. He testified that it is reasonable that wearing something on your shoulder at the site of the shunt could cause it to disconnect, I guess. He stated that 2009 procedure is related to the need for shunting. It always needs maintenance. The need for shunting is related to the brain tumor (PX 1).

Dr. Deutsch testified that Petitioner did well after reinstallation of the catheter until 2012, when had abdominal pain related to the tubing. Dr. Deutsch drained fluid from the abdominal area to relieve the pain and repositioned the distal catheter. Dr. Deutsch testified that Petitioner did not have a stroke from the 2009 hydrocephalus event. The mental status changes which occurred with the increase pressure in the skull seemed to improve after the shunt was reinstalled. He did not believe that Petitioner suffered any long term complication from the 2009 event, rather that he had mild cognitive deficits from the childhood event which led to the original shunt. Dr. Deutsch had not reviewed any records prior to his first visit in 2006. He had not seen Petitioner since the 2012 surgery. He had not checked with any of Petitioner's present doctors about his condition. He thought Petitioner had returned to baseline except during the 2012 surgery, the same as when he saw him in 2006 (PX 1).

Dr. Abdul Qadir testified by evidence deposition taken June 14, 2016 (PX 2). He is board certified in internal medicine. He has treated Petitioner since 2008. He testified that since he has treated him, Petitioner experienced progressive left sided weakness and forgetfulness. He treated Petitioner for diabetes, hypertension, high cholesterol, obstructive sleep apnea. None of these are causally related to his shunting. The left sided weakness was in both the upper and lower extremities which he attributed to the hydrocephalus. He referred Petitioner for therapy. In response to a hypothetical question, he stated he was not aware Petitioner wearing a heavy apron over the shunt pulling and disconnecting the shunt had happened in Petitioner's case as he never obtained that information. He is not aware that this caused it, but it technically could. He testified that this is the first time he has heard of a heavy apron. He cannot really comment because that is not his area of expertise. Dr. Qadir felt that Petitioner was not able to be gainfully employed on account of his weakness, gait balance issues and his memory. He has no explanation for the deterioration other than the hydrocephalus (PX 2).

Dr. Sean Salehi testified by evidence deposition taken June 27, 2017 (RX 2). Dr. Salehi is a board certified neurosurgeon. He examined Petitioner at Respondent's request on April 3, 2017. Salehi obtained a history that a shunt was installed years earlier. Petitioner told him he had to wear an apron at work, and over a period of time, the string wore through his skin and catheter and the catheter started leaking. The shunt was removed and reinstalled. Petitioner claimed to have suffered a stroke. Dr. Salehi reviewed medical treating records and test results and the deposition of Dr Deutsch and performed a physical examination. Petitioner was stable from a neurological standpoint, with some areas of memory deficit and gait being affected, but Petitioner had no deficits in terms of motor strength, sensory loss or cranial nerve issues. Dr. Salehi detected memory issues and gait issues which could be due to the post-hydrocephalus condition assuming Petitioner was fully functional before. Salehi disagreed with Deutsch's opinions on causation. He has never seen a catheter dislodge from a lead apron weighing 15 to 20 pounds. Dr. Salehi had not seen the apron petitioner was wearing at the time of the accident. He wore lead aprons himself. He saw catheters dislodge for many reasons. He opined that more likely than not the catheter dislodged regardless of the apron situation. Salehi described Petitioner's condition as delayed hydrocephalus. Deutsch appropriately reinserted the shunt when symptoms

redeveloped. Dr. Salehi testified an auxiliary connector could be a weak point in the system which would make it more likely to become disconnected spontaneously (RX 2).

Conclusions of Law

In support of the Arbitrator's decision with respect to (C) Accident and (D) Date of Accident, the Arbitrator finds as follows:

To obtain compensation under the Act, a claimant must show, by a preponderance of the evidence, that he suffered a disabling injury that arose out of and in the course of the claimant's employment. An injury is accidental within the meaning of the Act when it is traceable to a definite time, place and cause and occurs in the course of employment unexpectedly and without affirmative act or design of the employee. *International Harvester Co. v. Industrial Comm.*, 56 Ill. 2d 84, 89 (Ill. 1973). An injury occurs "in the course of' employment when it occurs during employment and at a place where the claimant may reasonably perform employment duties, and while a claimant fulfills those duties or engages in some incidental employment duties. An injury "arises out of" one's employment if it originates from a risk connected with, or incidental to, the employment and involves a causal connection between the employment and the accidental injury. For an injury to 'arise out' of the employment its origin must be in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury.

Petitioner is alleging that he suffered a work-related accident because the pressure of the apron he wore at work caused the catheter previously inserted into his neck to disconnect resulting in a cascade of events, including the 2006 treatment, 2007 surgery to remove the catheter and the 2009 hospitalization and subsequent treatment, resulting in his present disability. The Arbitrator heard Petitioner's testimony and reviewed the extensive exhibits and medical opinions offered and finds this unpersuasive.

The Arbitrator notes that Petitioner's testimony, consistent with the history he provided to Dr. Salehi is not supported by the treating medical records. He testified that he first noticed the problem when he found blood on his neck, reported this to Mr. Hankins and sought treatment. But the records document that he first saw Dr. Stalter in June 2006 noting he could not feel the catheter in his neck. There is no finding of a lesion contradicting his statements to Dr. Salehi that the apron cut through his neck and disconnected the catheter. The evidence demonstrates that the alleged disconnection occurred in 2006, not the alleged date of accident on February 7, 2007. Petitioner's testimony of when he suspected the problem resulted from his use of the apron is similarly contradicted.

The finding of a pustule on his neck did not occur until January 2007. The Arbitrator notes that Petitioner was a poorly controlled diabetic and was seen on multiple occasions for rashes on various body parts. Petitioner's statements that he wore a "heavy apron" are contradicted by RX 1, which weighs less than a pound. The Arbitrator finds Petitioner's statement that he tied it so tight that it cut into his skin and his statement that it became heavy from water unpersuasive.

Dr. Deutsch provided a tepid causation opinion, that he "guessed" a heavy apron worn over the site of the catheter could result in the disconnection of the catheter. Even in his testimony, the event alleged occurred in 2006, not February 7, 2007. Dr. Qadir testified that while it was hypothetically possible for the heavy apron to disconnect the catheter, this was not in his area of expertise. Dr. Salehi testified that more probably that not, the catheter disconnected spontaneously.

Where the evidence allows for the inference of the nonexistence of a fact to be just as probable as its existence, the conclusion that the fact exists is a matter of speculation, surmise, and conjecture, and the inference cannot reasonably be drawn. *Carter v. Azaran*, 332 Ill.App.3d 948, 961, 266 Ill.Dec. 294, 774 N.E.2d 400 (2002); *Wiegman v. Hitch–Inn Post of Libertyville*, 308 Ill.App.3d 789, 795–96, 242 Ill.Dec. 335, 721 N.E.2d 614 (1999).

Based upon the record as a whole, the Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that he sustained accidental injuries arising out of and in the course of his employment with Respondent on February 7, 2007.

In support of the Arbitrator's decision with respect to (E) Notice, the Arbitrator finds as follows:

Petitioner's notice to Respondent is the conversation he alleges to have had with Mr. Hankins when he noticed the blood on his neck. The Arbitrator finds this testimony unpersuasive and contradicted by the evidence presented. As discussed above in the Arbitrator's finding with respect to Accident, Petitioner testified that his first knowledge of the catheter disconnect was when he felt moisture on his neck and saw blood on his finger. Yet the medical records document that he saw Dr. Stalter in June 2006 alleged the apron had disconnected his catheter. He did not report anything at this time. It was not for over 6 months that he noticed the pustule on his neck and returned to Dr. Stalter. The Arbitrator does not find that simply showing blood to your supervisor would constitute notice of an accident. The Arbitrator finds Mr. Hankins testimony that he had not knowledge of any problem in 2007 persuasive and supported by the disability forms signed by Petitioner denying any work related cause of his disability.

Based upon the record as a whole, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he provided Respondent notice of the accident within the time limits stated in the Act.

In support of the Arbitrator's decision with respect to (F) Causal Connection, the Arbitrator finds as follows:

A Workers' Compensation Claimant bears the burden of showing by a preponderance of credible evidence that his current condition of ill-being is causally related to the workplace injury. *Horath v. Industrial Commission*, 449 N.E.2d 1345, 1348 (Ill. 1983) citing *Rosenbaum v. Industrial Com.* (1982), 93 Ill.2d 381, 386, 67 Ill.Dec. 83, 444 N.E.2d 122).

Petitioner is alleging his current condition of ill-being is causally connected to the alleged work-related disconnect of his catheter. As noted above in the Arbitrator's finding with respect to accident, the Arbitrator does not find that Petitioner proved that this event was arising out of and in the course of his employment. The Arbitrator notes that Petitioner had no ongoing disability after Dr. Deutsch removed the catheter in February 2007. Petitioner's first symptoms began with the headaches and hospitalization which occurred in May 2009 over 2 years later. Petitioner offered testimony by Dr. Deutsch and Dr. Qadir. Respondent offered the opinions of Dr. Salehi.

It is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony, and resolve conflicts in the evidence, particularly medical opinion evidence. *Berry v. Industrial Comm'n*, 99 Ill. 2d 401, 406-07, 459 N.E.2d 963, 76 Ill. Dec. 828 (1984);

Hosteny v. Illinois Workers' Compensation Comm'n, 397 Ill. App. 3d 665, 675, 928 N.E.2d 474, 340 Ill. Dec. 475 (2009); *Fickas v. Industrial Comm'n*, 308 Ill. App. 3d 1037, 1041, 721 N.E.2d 1165, 242 Ill. Dec. 634 (1999). Expert testimony shall be weighed like other evidence with its weight determined by the character, capacity, skill and opportunities for observation, as well as the state of mind of the expert and the nature of the case and its facts. *Madison Mining Company v. Industrial Commission*, 309 Ill. 91, 138 N.E. 211 (1923). The proponent of expert testimony must lay a foundation sufficient to establish the reliability of the bases for the expert's opinion. *Gross v. Illinois Workers' Compensation Comm'n*, 2011 IL App (4th) 100615WC, 960 N.E.2d 587, 355 Ill. Dec. 705. If the basis of an expert's opinion is grounded in guess or surmise, it is too speculative to be reliable. Expert opinions must be supported by facts and are only as valid as the facts underlying them. *In re Joseph S.*, 339 Ill. App. 3d 599, 607, 791 N.E.2d 80, 87, 274 Ill. Dec. 284 (2003). A finder of fact is not bound by an expert opinion on an ultimate issue, but may look 'behind' the opinion to examine the underlying facts. A treating doctor's findings and opinions can be undermined, or even disregarded, through reliance on inaccurate or incomplete information." See *Ravji v. United Airlines*, 2012 WL 440353 at 13 (Ill. Indus. Comm'n) interpreting *Horath v. Industrial Commission*, 96 Ill.2d 349 (Ill. 1983).

Having heard the testimony and reviewed the exhibits including the deposition testimony, the Arbitrator finds the opinion of Dr. Salehi persuasive. As noted above in the Arbitrator's finding with respect to Accident, the Arbitrator finds that Dr. Salehi's opinion that the catheter disconnected spontaneously is persuasive and that the cascade of events thereafter would consequently not been causally related to any work related event.

The Arbitrator also finds that the condition of ill-being which developed in May 2009 would further be unrelated to the disconnect of the catheter in 2006. Dr. Deutsch's causation opinion contradicts his own opinions expressed in his medical records. He noted Petitioner was asymptomatic in August 2006 and that he had outgrown the need for the catheter. In 2007, he again noted no symptoms and elected to remove the catheter, not reattach it or reinstall it. Thereafter, Petitioner had no symptoms for over 2 years. The Commission has considered such a gap in care in determining causal connection. See: *Richard Olcikas v. Dominick's Finer Foods, Inc.*, 2009 Ill. Wrk. Comp. LEXIS 1098, affirmed *Olcikas v. IWCC*, 2012 Ill. App. Unpub. LEXIS 26; 2011 IL App (1st) 103274WC-U; 2012 WL 6951575; *Jacob Haltom v. Center for Sleep Medicine*, 2013 Ill. Wrk. Comp. LEXIS 509; 13 IWCC 563, affirmed *Haltom v. IWCC*, 2015 IL App (1st) 133954WC-U; 2015 Ill. App. Unpub. LEXIS 1568; *Jose Ruben Meraz vs. Minute Men Staffing*, 2015 Ill. Wrk. Comp. LEXIS 30; 15 IWCC 30.

Dr. Qadir notes Petitioner's condition resulted from the hydrocephalus, which pre-existed the catheter disconnect. Dr. Salehi stated that Petitioner's issues could be due to the post-hydrocephalus condition assuming Petitioner was fully functional before. Given Dr. Deutsch's opinions that the catheter was not necessary in 2006 and 2007, the subsequent problems developing almost 3 years after the disconnect and 2 years after the catheter removal are related to the underlying pre-existing conditions from Petitioner's childhood.

Based upon the record as a whole, the Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that his condition of ill-being in causally related to any incident arising out and in the course of his employment with Respondent in 2006 or 2007.

In support of the Arbitrator's decision with respect to (J) Medical, (K) Temporary Compensation, (L) Nature & Extent, (M) Penalties, and (N) Credit, the Arbitrator finds as follows:

Based upon the Arbitrator's findings with respect to Accident, Causal Connection and Notice the remaining issues of Medical, Temporary Compensation, Nature & Extent, Penalties, and Credit are moot.

Petitioner's claim for compensation is denied.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	11WC025874
Case Name	WEATHERALL, IRENE v. THE CATALYST SCHOOL
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0236
Number of Pages of Decision	22
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	Nancy Shepard
Respondent Attorney	James Mirro

DATE FILED: 6/27/2022

/s/ Deborah Baker, Commissioner

Signature

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 Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

IRENE WEATHERALL,

Petitioner,

vs. NO: 11 WC 25874

THE CATALYST SCHOOL,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 25, 2021 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the reasonable and necessary medical expenses for treatment to the left leg only and incurred through December 17, 2014 only, pursuant to §8(a) and subject to §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 §8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $311.45 per week for a period of 131 2/7 weeks, representing November 16, 2009 through January 18, 2010 and representing August 15, 2012 through December 17, 2014 , that

being the period of temporary total incapacity for work under §8(b) of the Act. Respondent shall have a credit of $42,713.13 for temporary total disability benefits already paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $280.30 per week for a period of 75.25 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 35% loss of use of the left leg.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $19,270.00. 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.

June 27, 2022
o061422
DJB/ldm
043

/s/*Deborah J. Baker*
Deborah J. Baker

/s/*Maria E. Portela*
Maria E. Portela

/s/*Kathryn A. Doerries*
Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	11WC025874
Case Name	WEATHERALL, IRENE v. THE CATALYST SCHOOLS
Consolidated Cases	
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	19
Decision Issued By	Molly Mason, Arbitrator

Petitioner Attorney	James Mirro
Respondent Attorney	Nancy Shepard

DATE FILED: 5/25/2021

INTEREST RATE FOR THE WEEK OF MAY 25, 2021 0.03%

/s/ Molly Mason, Arbitrator

Signature

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

Irene Weatherall
Employee/Petitioner

v.

The Catalyst Schools
Employer/Respondent

Case # **11** WC **25874**

Consolidated cases: D/N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **April 26, 2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **July 2, 2009**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Respondent does not dispute causation as to the left knee condition and the need for the two left knee surgeries. For the reasons set forth in the attached decision, the Arbitrator finds that Petitioner failed to establish causation as to her claimed right lower extremity condition.

In the year preceding the injury, Petitioner earned $**24,292.84**; the average weekly wage was $**467.17**.

On the date of accident, Petitioner was **42** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**42,713.13** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**42,713.13**.

Respondent is entitled to a credit of $**TBD** under Section 8(j) of the Act. Arb Exh 1. Respondent shall hold Petitioner harmless against any claims made against Petitioner by reason of payments made by its group carrier.

ORDER

Medical benefits

Respondent shall pay reasonable and necessary medical services for the left leg only, and incurred through 12/17/2014 only, as provided in Sections 8(a) and 8.2 of the Act.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $311.45/week for 131 2/7 weeks, from 11/16/2009 through 1/18/2010 and from 8/15/2012 through 12/17/2014, as provided in Section 8(b) of the Act.

Credits

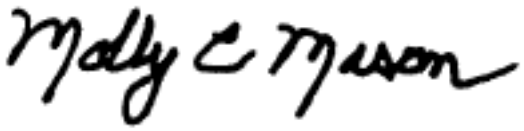
Respondent shall be given a credit for $42,713.13 for temporary total disability benefits paid under Section 8(b) of the Act.

Permanent Partial Disability: Schedule injury (For injuries before 9/1/11)

Respondent shall pay Petitioner permanent partial disability benefits of $280.30/week for 75.25 weeks, because the injuries sustained caused the 35% 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.



Signature of Arbitrator

MAY 25, 2021

Irene Weatherall v. The Catalyst Schools
11 WC 25874

Summary of Disputed Issues

The parties agree that Petitioner, a school paraprofessional, sustained an accident on July 2, 2009. Petitioner testified she was exiting a bathroom on that day when she slipped on water and fell. She claims injuries to both lower extremities. The initial Emergency Room records reflect that she complained only of left knee pain and denied other injuries. The Emergency Room physician diagnosed a knee strain. Petitioner apparently saw her primary care physician three weeks after the accident but no records from this physician are in evidence. The next provider, Dr. Crovetti, an orthopedic surgeon, documented right knee and ankle complaints when he first saw Petitioner but this appears to be an error on his part as he ordered a left knee MRI. Following the MRI, he recommended a course of physical therapy. He later referred Petitioner to his partner, Dr. Romano.

Detailed therapy notes from the summer and fall of 2009 reference only left knee and left ankle complaints. After Dr. Romano performed a left knee arthroscopy, in November 2009, the therapist described Petitioner's right knee strength and range of motion as good. PX 3, p. 70. Dr. Romano discharged Petitioner from care on June 22, 2010. On that date, he noted intermittent left knee popping and some mild joint line tenderness. He did not document any right-sided complaints. He allowed Petitioner to continue full duty. PX 3, p. 36.

The first clear evidence of right lower extremity complaints is a bill in PX 4, which reflects Petitioner underwent a Doppler ultrasound study of that extremity at West Suburban Hospital on February 12, 2011. PX 4, p. 41. The report concerning this study is not in evidence.

On July 15, 2011, Petitioner consulted a different orthopedic surgeon, Dr. Silver. In his note of that date, Dr. Silver made no mention of right knee complaints. He indicated that Petitioner injured her left knee on July 2, 2009 when she slipped on water and fell, hyperextending and striking her left leg in the process. He indicated that Petitioner remained symptomatic despite having undergone an arthroscopy. He recommended a repeat left knee MRI. PX 5, p. 37. Based on the results of this repeat MRI, he prescribed a second left knee surgery and imposed restrictions. PX 5, p. 24.

On March 14, 2012, Respondent's Section 12 examiner, Dr. Levin, reviewed the repeat left knee MRI and opined that some of the images showed a possible medial meniscal tear. Dr. Levin agreed with the need for restrictions and found it appropriate for Petitioner to undergo the repeat left knee arthroscopy recommended by Dr. Silver. RX 5. Petitioner underwent this surgery in April 2014, after a delay that resulted from necessary treatment of her underlying anemia.

Dr. Silver first documented right knee complaints on August 10, 2012. He recommended a right knee surgery on September 8, 2012, following an MRI, but Petitioner

never underwent this surgery due to lack of authorization. Respondent's Section 12 examiner, Dr. Levin, did not find causation with respect to the right knee. RX 2. Dr. Levin found Petitioner to be capable of full duty and at maximum medical improvement on December 17, 2014.

The disputed issues include causal connection, medical expenses (with Respondent stipulating only to certain expenses relative to left knee care), temporary total disability and nature and extent. Arb Exh 1.

Arbitrator's Findings of Fact

Petitioner testified she worked as a paraprofessional at Respondent's school as of July 2, 2009. Her duties included observing students, accompanying students to various classes and assisting teachers. T. 11-12.

Petitioner testified she was exiting a bathroom on July 2, 2009 when she slipped on water. She testified she began to fall, slid toward the door, went up in the air, came down on her right side and slid again. T. 12. On direct examination, she testified her right knee "extended out," "popped" and then hit the floor. T. 12. Under cross-examination, she clarified she struck her left knee. Following the accident, she experienced bilateral lower body pain and pain in both ankles, knees and legs. Her worst symptoms were in her left leg between the ankle and thigh. T. 13.

Petitioner testified she went to the Emergency Room at Rush Presbyterian Medical Center the same day the accident occurred. T. 13. The Emergency Room records reflect that Petitioner "fell at work." The records set forth the following history and complaints:

> "42 y/o female without significant PMHx complains of left knee pain after an injury earlier today. She slipped on a wet floor twisting her left knee as she fell on her right side. She complains of pain and swelling to left knee. Pain is worsened to the medial aspect of the knee. Denies focal weakness or numbness. Denies other injuries or areas of pain."

The records also reflect that Petitioner was able to walk and denied neck and back pain. PX 2, pp. 9-10. The examining physician, Dr. Belmont, described the left hip, right knee and left ankle as normal. On left knee examination, he noted an effusion, a decreased range of motion, medial joint line tenderness, no ecchymosis and no ligamentous laxity. He ordered left knee X-rays, which demonstrated no fractures, a joint effusion and a well corticated osseous fragment just lateral to the patella. PX 2, p. 13. He diagnosed a knee sprain and discharged Petitioner.

Petitioner testified she worked subject to restrictions following her Emergency Room visit. On July 29, 2009, she saw Dr. Crovetti at Trinity Orthopaedics. T. 13-14. The doctor described her as having a "twisting type fall" on July 2nd, "injuring her right ankle and right knee." He noted that Petitioner had been taking Ibuprofen but had been unable to get any

definitive care. He also noted that Petitioner presented him with knee X-rays, which he reviewed. He obtained right ankle X-rays and indicated the films showed no fractures or dislocations.

Dr. Crovetti indicated he found it difficult to examine Petitioner "due to her pain and her guarding." He noted a "very small effusion of the knee" (without specifying which knee), tenderness with palpation in the medial aspect of the knee and some swelling and tenderness of the ankle. He felt that Petitioner had an ankle sprain and a possible medial meniscus tear. He dispensed a hinged knee brace and an ASO ankle brace. Petitioner testified these were for her left leg. T. 14. He started Petitioner on DayPro, recommended ice applications and Tylenol and prescribed a knee MRI. He imposed restrictions of sedentary duty only. PX 3, p. 32.

Petitioner testified she continued working after seeing Dr. Crovetti because Respondent was able to accommodate the doctor's restriction. T. 14.

Petitioner underwent a left knee MRI on August 1, 2009. T. 14. The MRI, performed without contrast, showed a small effusion, no evidence of meniscal tearing, mild thickening in the anterior aspect of the medial collateral ligament "which could be the sequela of prior injury" and degenerative changes in all three compartments "including subchondral areas of edema in the lateral femoral condyle anteriorly and posteriorly and thinning most prominent in the medial compartment." PX 3, pp. 53-54.

Petitioner returned to Dr. Crovetti on August 3, 2009 and indicated her knee and ankle pain was improving to some degree. The doctor interpreted the MRI images as showing a bone contusion but no meniscal tears. He administered a knee injection and prescribed therapy for both the knee and ankle. He continued the work restrictions and directed Petitioner to return in two weeks. PX 3, p. 32.

Petitioner testified she continued working within Dr. Crovetti's restrictions after August 3, 2009. T. 15.

Petitioner underwent an initial physical therapy evaluation on August 4, 2009. The evaluating therapist recorded the following history:

> "Pt states that she slipped on a wet floor at work, sustaining injuries to her left knee and left ankle because her 'left leg went straight out and then bent backward.'"

The therapist noted edema in the left knee, left ankle/foot and lower left leg. He described Petitioner's gait as antalgic. PX 3, p. 55.

A subsequent therapy note, dated August 6, 2009, reflects that Petitioner was walking without assistive devices but still exhibiting an antalgic gait pattern. The therapist advised her to use the orthoses when walking outside her home. PX 3, pp. 56-57.

On August 10 and 12, 2009, the therapist noted that Petitioner was fully weight bearing without assistive devices but was still exhibiting an antalgic gait pattern. He also noted that knee extension was limited. PX 3, p. 57.

On August 13, 2009, Petitioner returned to Dr. Crovetti. The doctor noted that, while Petitioner described herself as "significantly better," she was still walking with her leg in a flexed position and experiencing pain in the hamstrings and anterior quadriceps. On examination, he noted negative straight leg raising, tenderness to palpation of the SI joint, tenderness to palpation of the distal hamstrings and "some mild effusion about the knee." He prescribed a Medrol Dosepak and continued therapy, indicating Petitioner needed to be "aggressive with stretching." PX 3, p. 32.

Subsequent therapy notes reflect that Petitioner's knee extension remained limited, with the therapist indicating that Petitioner was not stretching at home as instructed. PX 3, p. 58.

On August 31, 2009, Petitioner returned to Dr. Crovetti and indicated she was still experiencing leg pain and now starting to have left hip pain as well. She continued to exhibit an extension lag of about 30 degrees. The doctor noted that there was "significant hypersensitivity with light touch to the medial aspect" of the knee. He felt Petitioner had a bone contusion and "some signs of RSD." He prescribed Lyrica and Soma, along with continued therapy. PX 3, pp. 32-33.

A therapy note dated September 4, 2009 reflects that Petitioner's knee extension was slowly improving but that she was still experiencing significant discomfort and swelling. On September 8, 2009, the therapist noted that Petitioner was wearing non-supportive flat dress shoes. He gave her a note asking her employer to allow her to wear athletic shoes at work, noting that such shoes were not normally allowed. PX 3, p. 60.

On September 14, 2009, Dr. Crovetti noted significant tenderness over the medial aspect of the knee as well as significant atrophy of the quadriceps "due to injury and disuse." He expressed concern that "there might be medial meniscus tear that was not visualized on the MRI." He referred Petitioner to his partner, Dr. Romano. He recommended continued therapy and a TENS unit. PX 3, p. 33. T. 16.

Petitioner first saw Dr. Romano on September 22, 2009. T. 16. The doctor indicated that Petitioner reported injuring her left knee and ankle when she fell on July 2, 2009. He interpreted the left knee MRI as showing mild degenerative changes and a partial medial collateral ligament tear. He noted that Petitioner had undergone therapy and injections and was seeking a second opinion.

On initial left knee examination, Dr. Romano noted no swelling, tenderness to palpation along the medial collateral ligament and medial joint line, no instability and +/- McMurray's

testing. He concluded that Petitioner's symptoms were due to either a partial medial collateral ligament tear or a meniscal tear not seen on MRI. He recommended additional therapy rather than an arthroscopy since Petitioner was improving. He also prescribed a venous Doppler examination since Petitioner complained of leg swelling, especially when standing. He indicated that Petitioner could continue working but imposed restrictions of limited bending and squatting and no lifting over 10 pounds. PX 3, p. 33.

The Doppler study, performed on September 24, 2009, showed no evidence of deep venous thrombosis in the visualized veins of the left lower extremity. PX 3, p. 52. PX 4, p. 34. T. 17.

A therapy note dated October 8, 2009 reflects that Petitioner reported having "a little accident" the previous day. Petitioner indicated that a "kid ran right into" her knee and that her knee hurt. The therapist noted that Petitioner's extension lag persisted. PX 3, p. 64.

On October 20, 2009, Petitioner returned to Dr. Romano. T. 17. The doctor noted that Petitioner complained of persistent pain "in the right knee" and that therapy was "only helping a little bit." On examination, he noted "5 to 95 degrees of flexion of the knee," without specifying which knee he examined. He also noted tenderness in the medial joint space and a positive McMurray's sign. He concluded that Petitioner had a meniscal tear not seen on MRI. He recommended an arthroscopy and partial medial meniscectomy. He directed Petitioner to continue therapy pending surgery. He released her to light duty with minimal stairs and limited standing and walking. PX 3, p. 33. His work status note of October 20, 2009 reflects that Petitioner was scheduled to undergo left knee surgery. PX 3, p. 45.

Dr. Romano operated on Petitioner's left knee on November 16, 2009, performing an arthroscopy and two-compartment synovectomy. In his operative report, he described the medial meniscus, lateral meniscus, medial femoral condyle, lateral femoral condyle and tibial plateau as normal. PX 3, pp. 50-51. PX 4. At discharge, Dr. Romano prescribed Vicodin and directed Petitioner to use crutches and keep her leg elevated. PX 4, p. 20.

Petitioner testified that Dr. Romano took her off work following the surgery. T. 18.

Petitioner resumed physical therapy at Trinity on November 19, 2009. T. 17-18.

Petitioner returned to Dr. Romano on December 1, 2009. T. 18. The doctor noted that Petitioner was using one crutch and still exhibiting some limitations with extension. He directed her to discontinue the crutch while walking and work more aggressively with home stretching. He refilled the Norco prescription and continued the Naprosyn. He continued to keep Petitioner off work "secondary to her poor ambulatory status." PX 3, p. 34. T. 18.

On December 22, 2009, Dr. Romano's assistant noted persistent left knee complaints. He offered to aspirate the knee but Petitioner declined. He prescribed Indocin and Norco, along with a TENS unit. He continued to keep Petitioner off work. PX 3, p. 34.

On January 12, 2010, after additional therapy, Dr. Romano released Petitioner to restricted duty, with no vehicle operation and limited stair climbing, as of January 18, 2010. PX 3, p. 42. He added restrictions in February 2010 but subsequently released Petitioner to full duty starting March 22, 2010. PX 3, p. 40. He later noted improvement but continued to prescribe therapy due to persistent left leg weakness. PX 3, pp. 35-36.

A therapy note dated June 3, 2010 reflects that, after the therapist recommended that Petitioner be discharged to home exercises, Petitioner "became visibly agitated and stated she did not want to sever the link between herself and PT secondary to self motivation being limited." The therapist reduced the frequency of therapy to one session per month. PX 3, p. 91. Petitioner was a "no show/no call" at the next session, on July 6, 2010. The last therapy note is dated July 13, 2010. Petitioner reported that she was living out of her van and unable to perform all of her home exercises. The therapist discharged her from formal therapy and recommended she continue her home exercise program independently. PX 3, p. 92.

Petitioner last saw Dr. Romano on June 22, 2010. T. 21. On re-examination, the doctor noted a good range of motion, no effusion, some mild joint line tenderness and a negative McMurray's sign. Petitioner complained of some popping, which the doctor attributed to lubrication of the knee. The doctor continued the Glucosamine. He instructed Petitioner to continue her home exercise program and advance her activities. He allowed her to continue full duty. He released her from care on a PRN basis. PX 3, p. 36.

Petitioner testified she remained symptomatic as of her last visit to Dr. Romano. Her left knee hurt and she had to "pop" it every two to three seconds. She lacked mobility. T. 21-22. She was also experiencing left ankle and right ankle, knee and hip pain. Up to that point, she had not undergone any care for her right-sided symptoms but she had relayed those symptoms to the doctors she saw. She testified that, each time she mentioned her right leg, the doctors told her they wanted to focus on her left leg until it was healed and then address the right leg. T. 23.

An itemized bill in PX 4 reflects that Petitioner underwent a venous Doppler ultrasound study of her right leg at West Suburban Hospital on February 12, 2011. PX 4, p. 41. The report concerning this study is not in evidence. The bill identifies Dr. Bielanski as the ordering physician. No records from Dr. Bielanski are in evidence.

On July 15, 2011, Petitioner saw Dr. Silver, an orthopedic surgeon. Petitioner testified she continued working for Respondent between her last visit to Dr. Romano and her first visit to Dr. Silver. T. 24.

On July 15, 2011, Dr. Silver noted persistent left knee symptoms. He made no mention of the right knee. He described Petitioner's left knee as normal before the July 2, 2009 work accident. On left knee examination, he noted a mild effusion, medial joint line tenderness, patellofemoral crepitation, a positive McMurray's test, stable ligaments and a full range of

motion. He wrote to adjuster Gary Connor the same day, outlining these findings and recommending a repeat left knee MRI. He expressed the opinion that Petitioner "has persistent cartilage damage in her left knee due [to the work accident] which has never resolved." PX 5, p. 37.

Petitioner testified it took time for the repeat left knee MRI to be authorized. T. 25.

Petitioner returned to Dr. Silver on December 7, 2011. The doctor noted that Petitioner's left knee remained symptomatic and was "popping and clicking." He indicated he noted crepitation, a mild effusion and a positive McMurray's test on examination. He noted he was awaiting approval of the previously recommended repeat left knee MRI. He allowed Petitioner to continue her work activities, "pain permitting," and prescribed Vicodin and Mobic. PX 5, p. 35.

The repeat left knee MRI, performed without contrast on December 29, 2011, showed osteoarthritis, chondromalacia at the patellofemoral compartment, a "tiny, curvilinear, partial tear and ganglion cyst formation at the proximal, posterior patellar tendon fibers" and a small joint effusion. PX 5, pp. 63-64.

On January 6, 2012, Dr. Silver wrote to adjuster Gary Connor and informed him of the MRI results. He causally linked the pathology demonstrated on the MRI to the July 2, 2009 work fall, noting that Petitioner was performing full duty prior to this fall and denied undergoing previous left knee treatment. He indicated Petitioner would require arthroscopic surgery. PX 5, p. 25.

On January 11, 2012, Dr. Silver wrote to adjuster Gary Connor again and indicated that Petitioner was "limited to no squatting, kneeling, crawling or climbing." PX 5, p. 24.

At Respondent's request, Dr. Levin, an orthopedic surgeon, conducted a Section 12 examination of Petitioner on March 14, 2012. T. 27. In his report of that date, Dr. Levin indicated the examination was "referable to [the] left knee." He noted that Petitioner denied injuring her left knee before the work fall of July 2, 2009 but acknowledged injuring her left calf area in a CTA bus accident in 1990. He also noted that Petitioner reported falling backwards on July 2, 2009, landing with her left leg bent outward and striking her left ankle and right hip in the process. He further noted that following the initial Emergency Room visit of July 2, 2009, Petitioner saw her primary care physician three weeks later and was then referred to Trinity Orthopaedics. [The Arbitrator notes that no post-accident 2009 primary care records are in evidence.]

Dr. Levin indicated that Petitioner noticed some improvement in her left knee following the initial surgery of November 2010 but was still experiencing clicking, popping, swelling, stiffness and locking of the left knee after seven to eight months of post-operative therapy. He noted that Petitioner had then seen Dr. Silver on her own, for a second opinion, with that physician recommending additional left knee surgery following a repeat MRI.

Dr. Levin documented multiple left knee complaints affecting Petitioner's ability to stand, walk, squat and kneel. He also noted complaints of posterior left thigh and calf pain, numbness and tingling in the left foot and intermittent swelling of the right knee. He indicated that Petitioner was currently taking medication, including Mobic and Vicodin, and working with restrictions. He documented a history of anemia.

Dr. Levin described Petitioner as 5 feet, 2 inches tall and weighing 150 pounds. He noted complaints of pain with heel and toe walking. On right knee examination, he noted no significant effusion, a range of motion from 0 to 120 degrees, tenderness over the medial aspect, stability to varus/valgus stress testing and negative Lachman and Apley grind. On left knee examination, he noted no local tenderness, a range of motion from 0 to 105 degrees, stability to varus/valgus stress testing, negative Lachman (with Petitioner complaining of medial knee joint pain with this maneuver), no significant effusion, medial joint line tenderness, anteriolateral joint line tenderness, posteromedial corner tenderness and minimal patellofemoral discomfort.

Dr. Levin indicated he personally reviewed the left knee MRI images of December 29, 2011. He noted that, while Dr. Romano described the medial meniscus as normal in his operative report, there were changes on certain images that were consistent with a possible small medial meniscal tear.

Dr. Levin diagnosed Petitioner with "status post left knee arthroscopy with two-compartment synovectomy." After noting that Petitioner denied injuring her left knee at any point after July 2, 2009, he opined that a repeat arthroscopy, with inspection of the patellofemoral joint and medial meniscus, was appropriate. He linked the need for this repeat procedure to the July 2, 2009 work accident. He agreed with the restrictions outlined in Dr. Silver's note of January 11, 2012, pending the repeat surgery. RX 5.

Petitioner testified that, in May 2012, she received a letter from Respondent indicating her employment was not being renewed and she was being terminated as of August 15, 2012. She was still performing restricted duty for Respondent when she received this letter. T. 28. She believes she stopped working for Respondent sometime in the last week of June 2012, when the school year ended. She never resumed working for Respondent thereafter. T. 28-29.

Petitioner failed to appear for a scheduled appointment with Dr. Silver on July 20, 2012. PX 5, p. 23.

Petitioner returned to Dr. Silver on August 10, 2012. T. 29. Petitioner testified she was experiencing bilateral knee problems as of that date. She was also experiencing right hip and left thigh problems. T. 29-30.

Dr. Silver dictated two notes on August 10, 2012. In one note, he indicated that Petitioner's left knee pain had worsened and that he was prescribing Vicodin and Meloxicam.

In the second note, he indicated that Petitioner had been "having pain in her right knee for quite some time and she has been diagnosed with a Baker's cyst by ultrasound" (apparently referencing the Doppler study performed in 2011). He noted that Petitioner's right knee range of motion was limited due to pain and that she had medial joint line tenderness and some patellofemoral clicking. He obtained right knee X-rays. The results were normal. PX 5, p. 61. He then ordered a right knee MRI. PX 5, p. 23.

The right knee MRI, performed without contrast on August 14, 2012, revealed osteoarthritis, chondromalacia, a small, 2 millimeter loose body, a Baker cyst, popliteus tendinosis and a mild lateral head gastrocnemius muscle strain. The interpreting radiologist described the medial and lateral menisci as intact. He also described the anterior cruciate ligament, posterior cruciate ligament, medial cruciate ligament and extensor mechanism as intact. PX 5, p. 57.

On September 8, 2012, Dr. Silver wrote to adjuster Gary Connor, indicating that the left knee arthroscopy was delayed due to Petitioner's severe anemia and that Petitioner remained temporarily disabled. Dr. Silver also informed the adjuster of the right knee MRI results. He attributed the pathology seen on the MRI to "the overuse [Petitioner] has placed on the right knee over the past three years since her work injury," indicating Petitioner would need a right knee arthroscopy once her left knee had healed.

On November 21, 2012, Dr. Silver wrote to adjuster Gary Connor, indicating he was still awaiting clearance for surgery pending the anemia-related treatment. He stated that Petitioner remained temporarily totally disabled. PX 5, p. 20.

On January 21, 2013, Dr. Sharma of AMCI evaluated Petitioner and ordered various laboratory studies. On January 22, 2013, Dr. Sharma notified Dr. Silver that Petitioner was "not cleared for surgery." Dr. Silver recommended that Petitioner immediately go to Stroger Hospital for an anemia-related work-up. PX 5, pp. 15, 50-52.

On January 31, 2013, Dr. Levin re-examined Petitioner. He addressed both knees in separate reports. With respect to the left knee, he noted that surgery had been scheduled and cancelled on several occasions, due to Petitioner's anemia and emergencies that Dr. Silver had to address. He also noted that Petitioner reported persistent left knee pain, locking and giving way. After examining Petitioner, he again recommended a left knee arthroscopy with possible patellofemoral chondroplasty and medial meniscectomy. He again causally linked the need for this surgery to the work accident. RX 4. With respect to the right knee, Dr. Levin noted that Petitioner reported having relayed right knee complaints to Dr. Romano "but her left knee was the main concern." He also noted that Petitioner had undergone a right knee MRI in 2012 and that Dr. Silver was recommending right knee surgery. He documented complaints of pain in the right knee and right hip, right leg numbness, bilateral foot numbness and difficulty standing and walking. On right knee examination, he noted a range of motion from 0 to 110 degrees, stability to varus/valgus stressing, tenderness over the patellar tendon, tenderness over the medial and lateral joint lines and tenderness over the medial proximal gastrocnemius and

popliteal area. He indicated he would need to review the right knee MRI before rendering any opinions. RX 3.

Dr. Levin issued another report on February 19, 2013, after reviewing numerous records (dating back to the work accident) and the right knee MRI. He indicated he considered Dr. Crovetti's July 29, 2009 reference to the right ankle and knee as a typographical error, given that the doctor ordered a left knee MRI. He stated that the first clear documentation of right knee complaints appeared in Dr. Silver's note of September 18, 2012. He noted that Dr. Silver attributed those complaints to overuse. He interpreted the August 14, 2012 right knee MRI as showing patellofemoral arthritis with chondromalacia, a Baker's cyst, a minimal loose body in the joint space posterior to the posterior cruciate ligament and degenerative changes in the distal femur.

In response to a question concerning causation, Dr. Levin indicated he saw no evidence suggesting that Petitioner injured her right knee in the July 2, 2009 work fall. He reiterated that the first clear documentation of right knee complaints appeared in late 2012. He then addressed Dr. Silver's assertion that the right knee complaints stemmed from overuse or a gait abnormality: "James Talmage, M.D.'s presentation at the 14th annual AAOS 2012 Occupational Orthopedics and Workers' Compensation course would not support that altered gait of the left knee would be a cause of the examinee developing arthritis and subsequent cartilage fragmentation of the right knee." RX 2.

On July 31, 2013, Dr. Silver wrote to adjuster Gary Conner, indicating that Petitioner remained temporarily disabled and that he planned to operate once Petitioner's hemoglobin levels were appropriate. PX 5, p. 19.

On March 12, 2014, Dr. Silver wrote to adjuster Gary Conner, indicating that Petitioner's anemia had improved, that Petitioner remained temporarily disabled and that he planned to proceed with surgery. PX 7, p. 18. PX 5, pp. 13, 120.

Dr. Silver operated on Petitioner's left knee on April 22, 2014, performing four arthroscopic procedures: partial lateral meniscectomy, tricompartmental synovectomy, abrasion arthroplasty and debridement of the patellofemoral compartment. In his operative report, he documented a Grade IV articular cartilage fracture of the patella, a Grade III-IV articular cartilage fracture of the trochlea and tearing of the lateral third of the lateral meniscus. PX 7, pp. 27-28.

On April 30, 2014, Dr. Silver prescribed physical therapy and directed Petitioner to remain off work. PX 5, p. 119.

On June 11, 2014, Dr. Silver noted that Petitioner had 110 degrees of flexion, full extension and a mild effusion. He recommended additional therapy. He released Petitioner to sedentary work only as of June 12, 2014. PX 5, pp. 11, 118.

On July 16, 2014, Dr. Silver noted that Petitioner's effusion was gone and that she had full extension. He recommended additional therapy and medication. PX 5, p. 140. He released Petitioner to sedentary duty, with occasional walking and standing, as of July 17, 2014. PX 5, p. 117.

On August 15, 2014, Dr. Silver noted that Petitioner had 125 degrees of flexion, full extension and 1.5 centimeters of quadriceps atrophy. He recommended additional therapy and medication. PX 5, p. 139. He released Petitioner to restricted duty, with no climbing, crawling, kneeling or squatting, as of August 18, 2014. PX 5, p. 116.

On September 19, 2014, Dr. Silver wrote to adjuster Gary Connor and indicated Petitioner was still experiencing "giving way of the left knee." He prescribed additional therapy and continued the restrictions. PX 5, p. 138. Hartford's utilization review provider approved the additional therapy. PX 5, p. 69.

On October 31, 2014, Dr. Silver wrote to adjuster Tanya Zagrzebeski, indicating that Petitioner's left quadriceps atrophy was at .05 centimeters and that the episodes of giving way had lessened. He upgraded Petitioner's restrictions to "no squatting or kneeling" and renewed the medication. He directed Petitioner to continue therapy. PX 5, p. 136.

At Respondent's request, Dr. Levin re-examined Petitioner, relative to the left knee, on December 17, 2014. In his report of that date, Dr. Levin indicated that Petitioner had undergone a second left knee surgery and that she reported 65% improvement of her left knee symptoms. He noted that Petitioner was still experiencing left kneecap pain, occasional locking of the left knee and difficulty with squatting, stairs and extended walking. He noted a left knee range of motion of 0 to 120 degrees versus 0 to 115 degrees on the right. With respect to the left knee he also noted posterolateral joint line tenderness, negative Lachman and pivot shift, stability to stress testing and negative Apley grind. He obtained bilateral knee X-rays, which revealed degenerative changes.

Dr. Levin indicated he reviewed Dr. Silver's operative report along with several post-operative letters.

Dr. Levin cited ODG guidelines indicating that twelve therapy sessions are recommended following a knee arthroscopy. He stated that twelve sessions "should have been sufficient for [Petitioner's] symptoms" and indicated that Petitioner required no additional left knee care. He saw no need for work restrictions. He opined that Petitioner "should have been off narcotic pain medication within two weeks post-surgery" and that the use of anti-inflammatory medication for four to six weeks "would have been medically appropriate." He found Petitioner to be at maximum medical improvement and indicated he would provide an AMA Guides impairment rating if desired. RX 1.

On January 30, 2015, Dr. Silver wrote to adjuster Tanya Zagrzebeski, indicating that Petitioner's left quadriceps atrophy was "almost gone" and that the episodes of giving way had

lessened. He upgraded Petitioner's restrictions to "no squatting," renewed the medications and directed Petitioner to continue therapy. PX 5, p. 134.

On March 13, 2015, Dr. Silver wrote to adjuster Tanya Zagrzebeski and indicated Petitioner was now ready for a work conditioning program. He informed Ms. Zagrzebeski that Petitioner would remain temporarily disabled while engaging in the program. PX 5, p. 133.

On several dates between May 2015 and June 2016, Dr. Silver wrote to various adjusters, indicating that Petitioner remained off work and that he was still awaiting authorization of the work conditioning program. PX 5, pp. 128-132, 191-199.

On November 2, 2016, Dr. Silver wrote to adjuster Dygreski [sic] indicating that Petitioner remained off work and would be starting work conditioning "over the coming weeks." PX 5, p. 190.

Records in PX 8 reflect that Petitioner began a course of work conditioning at ATI on November 9, 2016. On November 29, 2016, her therapist, Brian Conroy, ATC, indicated that Petitioner had started "interval jogging on the treadmill on her own accord" but was awaiting right knee surgery. PX 8, p. 17. Conroy discharged Petitioner from work conditioning on December 28, 2016, indicating that Petitioner was functioning at a medium to heavy physical demand level and had met the demands of her job, which was classified as light based on the Dictionary of Occupational Titles. The therapist commented that the light classification contradicted Petitioner's "self-reports of being required to lift up to 60 lbs. occasionally." PX 8, p. 13.

Petitioner testified she last saw Dr. Silver on January 18, 2017. In his note of that date, the doctor described Petitioner as continuing with work conditioning (despite the discharge note referenced above). He indicated that Petitioner's pain remained at 6/10 and that he had weaned her to a low dose of Hydrocodone. He continued to find her temporarily disabled "during her work conditioning program." PX 5, p. 188.

Petitioner testified she has not undergone any knee-related care since her last visit to Dr. Silver. She never underwent the right knee surgery that Dr. Silver recommended. Both knees remain symptomatic. She experiences swelling in both knees at least twice per week. She also experiences pain and swelling in her right hip. She takes over the counter medication for her bilateral knee symptoms. She also applies topical pain medication and uses heat and ice to reduce the swelling. She rated her current left knee pain at 6-7/10 and her current right knee pain at 8/10.

Under cross-examination, Petitioner acknowledged that the work accident occurred almost twelve years ago. She also acknowledged that, after she landed, she struck her left knee, not her right. At the Emergency Room, she told providers she fell onto her right side and twisted her left knee. Drs. Crovetti and Romano treated her left knee. When she first saw Dr. Silver, in July 2011, she told him she struck her left knee. He recommended a repeat left knee

MRI. If Dr. Silver's 2011 records contain no mention of the right knee, she has no reason to dispute those records. Respondent authorized the second left knee surgery. That surgery was originally scheduled for May 11, 2012 but it did not proceed due to other complications. It was not until September 2012 that Dr. Silver prescribed a right knee MRI. The second left knee surgery did not proceed until April 2014. She worked until the end of the school year in 2012. The letter she received from Respondent indicated her employment was being terminated as of August 15, 2012. She underwent therapy, on and off, between April 2014 and 2017.

On redirect, Petitioner testified she complained to Dr. Silver about her right knee. She does not know what Dr. Silver wrote in his notes. She was subject to restrictions until August 2012. Respondent accommodated those restrictions until June 2012.

Under re-cross, Petitioner testified that the letter she received from Respondent indicated she would continue to receive medical benefits.

No witnesses testified on behalf of Respondent.

Arbitrator's Credibility Assessment

On direct examination, Petitioner testified to striking her right leg when she fell. Under cross-examination, however, she readily agreed that she struck her left leg. The Arbitrator recognizes that the fall in question took place almost twelve years before the hearing but this change seemed odd.

Overall, the Arbitrator found Dr. Levin's causation-related opinions more persuasive than those of Dr. Silver. Dr. Levin was unaware of the February 2011 right leg Doppler study and mistakenly stated that right knee complaints were first documented in September 2012 (when he himself had noted intermittent right knee swelling in March 2012), but correctly noted a delay in documentation of right-sided complaints. Dr. Silver expressed awareness of the 2011 study but there is no evidence suggesting he reviewed other records pre-dating his initial encounter with Petitioner. He attributed the right-sided complaints to overuse but that is not what Petitioner testified to. She claimed she had bilateral complaints from the outset and that her providers chose to focus on the left knee. The available treatment records do not support this claim. See further below.

Arbitrator's Conclusions of Law

Did Petitioner establish causal connection as to her claimed current bilateral knee condition of ill-being?

As noted at the outset, Respondent does not dispute causation with respect to Petitioner's left knee condition and the need for the two left knee surgeries.

The Arbitrator turns to the question of whether Petitioner established causation as to her right knee. There is no dispute that Petitioner slipped and fell at work on July 2, 2009. Petitioner described sliding and landing awkwardly. On direct examination, she testified she struck her right knee. Under cross-examination, however, she clarified that she struck her left knee, not her right. Her earliest records, from her Emergency Room visit on July 2, 2009, do not reflect any right-sided complaints. Based on the history Dr. Levin recorded, it appears Petitioner saw her primary care physician about three weeks after her Emergency Room visit but no records from that physician are in evidence. Petitioner's initial treating orthopedic surgeon, Dr. Crovetti, documented right knee and ankle complaints but this appears to be a mistake on his part, since he ordered a left knee MRI. Dr. Crovetti's partner, Dr. Romano, repeated the error and also mentioned right-sided complaints (while reviewing the left knee MRI) but he never diagnosed a right knee condition and eventually operated on Petitioner's left knee.

The Arbitrator acknowledges that a hospital bill in PX 4 reflects Petitioner underwent a venous Doppler study of her right leg on February 12, 2011, apparently at the recommendation of Dr. Bielanski. However, neither the Doppler report nor any records from Dr. Bielanski are in evidence. The Arbitrator has no information as to why the study was ordered. Regardless, the study did not take place until a year and a half after the work accident. When Dr. Levin first examined Petitioner, in March 2012, he noted a complaint of intermittent right knee swelling and tenderness over the medial aspect of the right knee on examination. RX 5, pp. 3-4. When Dr. Silver specifically addressed causation as to the right knee, on September 8, 2012, he attributed the right-sided complaints to overuse rather than the accident itself. PX 5, p. 22. Petitioner, in contrast, asserted that she voiced right-sided complaints from the outset.

The Arbitrator, having considered the entire available record, finds that Petitioner failed to prove causation as to her claimed right knee, ankle and hip complaints. The Arbitrator further finds that Petitioner failed to establish causation as to the need for the right knee surgery Dr. Silver recommended in September 2012.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claims unpaid medical expenses totaling $47,913.40. Some of the claimed expenses relate to right knee treatment. Some relate to treatment rendered after December 17, 2014. PX 1.

As noted earlier, Respondent does not dispute causation with respect to Petitioner's left knee condition and the need for the two left knee surgeries. The Arbitrator has found that Petitioner failed to establish causation with respect to her right lower extremity. The Arbitrator has also found that Petitioner reached maximum medical improvement with respect to her left knee as of December 17, 2014, the date of Dr. Levin's last examination. The Arbitrator finds that Petitioner is entitled to reasonable and necessary medical expenses relating to left knee treatment through December 17, 2014, subject to the fee schedule and with Respondent receiving credit for any expenses previously paid.

Is Petitioner entitled to temporary total disability benefits?

Petitioner claims she was temporarily totally disabled during two intervals: from November 17, 2009 through January 12, 2010 and from June 27, 2012 through January 18, 2017. Respondent maintains that Petitioner was temporarily totally disabled from November 16, 2009 through January 18, 2010 and from August 15, 2012 through December 17, 2014. The parties agree that Respondent paid $42,713.13 in temporary total disability benefits. Arb Exh 1.

With respect to the first interval, the Arbitrator finds that Petitioner was temporarily totally disabled from November 16, 2009 (the date of the first left knee arthroscopy) through January 18, 2010 (based on the work status note of January 12, 2010, PX 3, p. 42.)

With respect to the second interval, the Arbitrator finds that Petitioner was temporarily totally disabled from August 15, 2012 (the last date of employment offered by Respondent) through December 17, 2014, the date on which Respondent's examiner, Dr. Levin, found that Petitioner was capable of full duty and at maximum medical improvement with respect to the left knee. It is not clear to the Arbitrator why Dr. Silver recommended work conditioning in January 2015 based on Petitioner's testimony concerning the relatively sedentary nature of her job duties.

What is the nature and extent of the injury?

Since the accident occurred prior to September 1, 2011, the Arbitrator is not required to address the five factors set forth in Section 8.1b of the Act.

The Arbitrator awards permanency only for the left knee condition. The left ankle condition resolved following therapy and the Arbitrator has found that Petitioner failed to establish causation with respect to her claimed right-sided conditions.

In assessing permanency, the Arbitrator notes the following: 1) there is no dispute as to the relatedness or necessity of the two left knee surgeries; 2) Respondent's examiner, Dr. Levin, found Petitioner to be at maximum medical improvement and capable of full duty as of December 17, 2014; 3) when Dr. Levin examined Petitioner on December 17, 2014, he noted a better range of motion in the left knee than the right but also documented joint line tenderness; 4) the therapist who oversaw Petitioner's work conditioning rated her paraprofessional occupation as light; and 5) Petitioner testified she has not undergone any knee-related care since her last visit to Dr. Silver on January 18, 2017. The Arbitrator also notes Petitioner's testimony that her left knee still hurts and swells, especially with extended walking and standing, and that she takes over the counter medication two to three times per day.

The Arbitrator finds that Petitioner established permanency equivalent to 35% loss of use of her left leg, equivalent to 75.25 weeks of permanency benefits under Section 8(e) of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	20WC029949
Case Name	MEDRANO, EDWIN v. CITY OF CHICAGO, DEPT OF WATER MANAGEMENT
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0237
Number of Pages of Decision	26
Decision Issued By	Deborah Simpson, Commissioner, Deborah Baker, Commissioner

Petitioner Attorney	Michael Youkhana
Respondent Attorney	Elaine Newquist

DATE FILED: 6/27/2022

/s/ Deborah Simpson, Commissioner

Signature

DISSENT: /s/ Deborah Baker, Commissioner

Signature

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

Edwin Medrano,

Petitioner,

vs. NO: 20 WC 29949

City of Chicago-Department of Water Management,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 24, 2021, 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.

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.

June 27, 2022
o4/27/22
DLS/rm
046

/s/*Deborah L. Simpson*
Deborah L. Simpson

/s/*Stephen J. Mathis*
Stephen J. Mathis

DISSENT (IN PART)

I agree with the majority's decision to affirm the Decision of the Arbitrator with respect to the finding that Petitioner sustained accidental injuries arising out of and in the course of his employment with Respondent on December 2, 2020. However, I disagree with the majority's decision to affirm the finding of no causal connection. I believe that Petitioner proved by a preponderance of the evidence that his current cervical spine and lumbar spine conditions of ill-being are causally related to the December 2, 2020 work accident. I find that the adverse credibility assessment is unsupported by the record.

With respect to the issue of whether Petitioner sustained a work-related accident, I note that the Arbitrator found Petitioner proved he sustained accidental injuries arising out of and in the course of his employment with Respondent on December 2, 2020, at which time Petitioner experienced immediate pain to his neck, lower back, elbow, and abdomen. I concur with this determination.

Turning to the issue of causal connection, it is undisputed that Petitioner had pre-existing cervical spine and lumbar spine conditions. Petitioner's claim rests on whether the December 2, 2020 work accident aggravated his pre-existing cervical spine and lumbar spine conditions. As such, we begin our analysis with a review of the applicable legal standard.

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. *Sisbro, Inc. v. Industrial Commission*, 207 Ill. 2d 193, 205 (2003). Furthermore, an employer takes its employees as it finds them (*St. Elizabeth's Hospital v. Illinois Workers' Compensation Commission*, 371 Ill. App. 3d 882, 888 (5th Dist. 2007)), and a claimant with a pre-existing condition may recover where employment aggravates or accelerates that condition. *Caterpillar Tractor Co. v. Industrial Commission*, 92 Ill. 2d 30, 36 (1982). As the Appellate Court held in *Schroeder v. Illinois Workers' Compensation Commission*, 2017 IL App (4th) 160192WC, the inquiry focuses on whether there has been a deterioration in the claimant's condition:

> That is, if a claimant is in a certain condition, an accident occurs, and following the accident, the claimant's condition has deteriorated, it is plainly inferable that the intervening accident caused the deterioration. The salient factor is not the precise previous condition; it is the resulting deterioration from whatever the previous condition had been. *Schroeder* at ¶ 28.

With this standard in mind, we turn to consideration of the medical evidence and the competing causation opinions of Dr. Sokolowski and Dr. Coleman.

Of note, the Arbitrator found Petitioner only sustained a temporary exacerbation and aggravation of his preexisting conditions based primarily on "finding that Petitioner was not a credible witness and reasonable and persuasive opinions of Dr. Matthew Coleman." I disagree with the credibility assessment, and I find that Petitioner's testimony was credible, persuasive, and corroborated by the medical records. Additionally, I disagree with the amount of weight placed on the credibility assessment in analyzing the issue of causal connection as causal connection was proved based on Dr. Sokolowski's expert opinions as well as a chain of events analysis.

To address Petitioner's credibility, Petitioner readily acknowledged having prior lumbar spine and cervical spine injuries. While he may have had difficulty remembering specific dates, doctors' names, or settlement details, Petitioner confirmed the relevant details of his major diagnoses and treatments. In the Commission's view, the medical records support Petitioner's credible testimony and there is no evidence that Petitioner was untruthful during his testimony. *See R & D Thiel v. Illinois Workers' Compensation Commission*, 398 Ill. App. 3d 858, 866 (1st Dist. 2010) (When evaluating whether the Commission's credibility findings which are contrary to those of the arbitrator are against the manifest weight of the evidence, "resolution of the question can only rest upon the reasons given by the Commission for the variance.")

In making an adverse credibility determination, the Decision of the Arbitrator states Petitioner failed to disclose his prior history of lumbar and cervical problems to physicians. However, I read Dr. Coleman's report differently. Dr. Coleman's report states: "He does have a history of lumbar surgery and L5-S1 fusion, which was related to a work injury, which he had about 5 years ago; however, he states that was successful surgery and he had no issues of low back pain just prior to the 12/02/2020 injury." Petitioner readily acknowledged his prior lumbar spine

injury and lumbar fusion and his testimony that he had no low back pain just prior to the December 2, 2020 work accident is consistent with his testimony. While the report does state "He reports no history of any neck issues in the past and has never had neck pain previously, per the patient," it should be noted that this is the only record that states Petitioner had no prior cervical spine problems. Petitioner readily acknowledged his prior cervical spine problems at the arbitration hearing (T. 31) and Dr. Sokolowski's notes indicate the same.

Additionally, I disagree with several negative inferences in the Decision of the Arbitrator. The Decision of the Arbitrator noted various medical appointments and medical evaluations that Petitioner "did not testify about," however, I note that Petitioner was not specifically asked about many of these treatment dates and thus, could not testify to treatment he was not asked about. Further, I note that it would have been unnecessary for Petitioner to testify as to every doctor's appointment and all medical treatment as the medical records were submitted into evidence by the parties. Further, the assessment that Petitioner withheld information from Drs. Zerilli and Sokolowski is unsupported by the record and is ultimately, irrelevant. Petitioner treated with Dr. Sokolowski for the cervical and lumbar spine conditions only, and he treated with Dr. Zerilli for the elbow condition only. Petitioner was not required, nor would it have been expected of Petitioner, to discuss his elbow condition with Dr. Sokolowski, and vice versa. Further, Dr. Sokolowski's December 15, 2020 note indicates that Petitioner intended to treat with a specialist for his right elbow, indicating that Petitioner told Dr. Sokolowski he planned to treat for his right elbow separately. Moreover, the record is devoid of any evidence indicating Petitioner withheld relevant or material facts from Dr. Sokolowski. In fact, Dr. Sokolowski treated Petitioner prior to the instant work accident and his medical records note Petitioner's previous cervical and lumbar spine treatment. Thus, I find Dr. Sokolowski's opinions to be credible, persuasive, and based on a complete understanding of Petitioner's medical history.

Dr. Sokolowski opined that Petitioner's cervical pain and radiculopathy, and his lumbar pain and radiculopathy are related to the December 2, 2020 work injury. Additionally, on May 26, 2021, Dr. Sokolowski noted that "In the interim, Mr. Medrano continues to work despite his pain," which is consistent with Petitioner's testimony that he requested a full duty work release as Respondent was not paying benefits and he needed to support his family. (T. 36.) I find Dr. Coleman's opinions unpersuasive as his positive physical examination findings belie his opinion that Petitioner only sustained cervical and lumbar strains/sprains, which had resolved. Further, Dr. Coleman did not explain why he believed that Petitioner's lumbar and cervical spine conditions had resolved as of January 17, 2021. Dr. Coleman's opinion that any treatment after January 17, 2021 was not reasonable or necessary appears arbitrary as there is no objective support for finding Petitioner's conditions had resolved as of that date. Interestingly, however, Dr. Coleman found no signs of secondary gain or malingering and specifically noted "pain is not out of proportion to examination."

I find that the preponderance of the evidence demonstrates Petitioner's current cervical spine and lumbar spine conditions are causally related to the December 2, 2020 work accident. I would have awarded the medical expenses incurred by Petitioner, temporary total disability

benefits as claimed by Petitioner for the time periods Petitioner was placed off work by Dr. Sokolowski (or had unaccommodated light duty restrictions), and prospective medical treatment as recommended by Dr. Sokolowski, including cervical and lumbar spine epidural steroid injections.

For the reasons set forth above, I respectfully dissent.

/s/ *Deborah J. Baker*
Commissioner Deborah J. Baker

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	20WC029949
Case Name	MEDRANO, EDWIN v. CITY OF CHICAGO DEPT OF WATER MANAGEMENT
Consolidated Cases	No Consolidated Cases
Proceeding Type	19(b) Petition
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	20
Decision Issued By	Steven Fruth, Arbitrator

Petitioner Attorney	Michael Youkhana
Respondent Attorney	Elaine Newquist

DATE FILED: 9/24/2021

THE INTEREST RATE FOR THE WEEK OF SEPTEMBER 21, 2021 0.04%

/s/Steven Fruth, Arbitrator

Signature

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)

Edwin Medrano Case # **20 WC 029949**
Employee/Petitioner

v. Consolidated cases: _____

City of Chicago-Department of Water Management
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 **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **7/26/2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the 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 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 **12/02/2020**, Respondent ***was*** operating under and subject 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 $**90,588.68**; the average weekly wage was $**1,742.09**.

On the date of accident, Petitioner was **55** years of age, ***married*** with **2** dependent children.

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

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

Respondent shall be given a credit of $**27,672.85** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**27,672.85**.

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

ORDER

The evidence established that Petitioner sustained a temporary aggravation of pre-existing conditions on December 2, 2020 and that Petitioner reached MMI January 17, 2021. Therefore, the Arbitrator finds that Petitioner failed to prove that his claimed current condition of ill-being is causally related to the work accident on December 2, 2020 and further finds that Petitioner failed to prove that he is entitled to prospective medical care.

Petitioner's medical care through January 17, 2021, except for a cervical epidural steroid injection, was reasonable and necessary. Respondent shall pay for such medical care pursuant to §8(a) and adjusted in accord with the Medical Fee Schedule provided in §8.2 of the Act.

Petitioner is entitled to 6 & 3/7 weeks temporary total disability, from December 3, 2020 through January 17, 2021.

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.

SEPTEMBER 24, 2021

Signature of Arbitrator

EDWIN MEDRANO v. CITY OF CHICAGO – DEPT. OF WATER MANAGEMENT
20 WC 29949

INTRODUCTION

This matter proceeded to hearing before Arbitrator Steven Fruth. The disputed issues were: ***C:*** Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?; ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***J:*** Were the 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 prospective medical care?; ***L:*** What temporary benefits are in dispute? TTD

FINDINGS OF FACT

On December 2, 2020 Petitioner Edwin Medrano worked as a construction laborer for Respondent City of Chicago. He had worked in this capacity for Respondent for 24 years. His duties consisted of unloading trucks, hitch his box on and off the truck, excavate, dig, mix cement mud, and sweep and clean up the work site.

Petitioner testified that he was injured on December 2, 2020. He was injured as he was unloading his "box" off a truck while on the hitch. The Arbitrator assumes the "box" contained tools and materials. He testified that the box weighed between 300 and 350 pounds. Petitioner was lifting the box because the wheel on the "hitch" was too high and did not reach the ground. As he was picking up the box from the hitch, he injured his neck, lower back, elbow, and abdomen.

Petitioner testified that he reported the accident to his supervisor, who also witnessed the accident. He had been working full duty and without restrictions up to the time of the accident.

Petitioner testified that he sought immediate medical treatment at Concentra Urgent Care (PX #3). Petitioner presented to Dr. Steven Zerilli of Concentra, complaining of lower back pain, neck pain, pain in his elbow, and pain in his abdomen. Dr Zerilli noted Petitioner's complaints of right-sided neck pain radiating down to the right elbow. He also had right lower back pain without lower extremity numbness,

weakness, or tingling. Petitioner reported a history of prior spinal surgery where a disc was removed and a history of multiple abdominal hernia surgeries.

On physical examination there was tenderness in the right elbow with full range of motion. There was tenderness in the right trapezius with full motion of the cervical spine. There was limited range of motion of the lumbar spine, but no tenderness. Right and left straight-leg raise were normal. Dr. Zerilli diagnosed lumbar and cervical strain, abdominal hernia, and right lateral epicondylitis.

Petitioner testified that he was referred to a specialist for his neck and lower back issues. The notes indicate that Dr. Zerilli referred Petitioner for a general surgery evaluation and a neurosurgery evaluation. Dr. Zerilli also referred Petitioner for physical therapy and prescribed 800 mg ibuprofen. He released Petitioner to modified work with 8-pound lifting restrictions. Petitioner testified that Respondent did not accommodate his restrictions.

Petitioner testified that he followed up at Concentra on December 10, 2020. Concentra records, PX #3, indicate the follow-up was on December 4. The December 4 chart notes reiterated Petitioner's complaints from December 2, although back pain was the primary complaint. It was noted that Petitioner was not working due to the unavailability of light duty work. Petitioner reported that he was 10% improved. He wanted to see the doctor who had operated on his back before but could not get an appointment until March.

Concentra records, PX #3, contain a December 10, 2020 general surgery consultation report by Dr. Stephen Boghossian. Petitioner did not testify about this consultation. Dr. Boghossian noted Petitioner's complaints of neck pain radiating down to the lower back. Petitioner also complained of some shoulder pain and upper abdominal pain. Petitioner reported 8-9/10 pain. Petitioner history of multiple hernia surgeries as well as an anterior lumbar fusion was noted. The physical exam was unremarkable. Dr. Boghossian diagnosed cervical and lumbar strain but found no evidence of a hernia.

Concentra records, PX #3, contain a December 10, 2020 neurosurgery consultation report by Dr. Sean Salehi. Petitioner did not testify about this consultation. Dr. Salehi noted Petitioner's complaints of neck pain radiating down to the low back. Petitioner also complained of pain radiating into his left shoulder and upper arm. Pain radiated into the right buttock but no further. Petitioner denied extremity weakness. Dr. Salehi suspected a hernia.

On exam Dr. Salehi noted cervical and lumbar spine tenderness. Cervical and lumbar motion was diminished. There was deceased sensation over the left lateral arm. Dr. Salehi diagnosed cervical strain, lumbar strain, right elbow pain, left shoulder pain, and abdominal hernia. He related Petitioner's injury to the reported work accident. Dr. Salehi recommended physical therapy and follow up with orthopedics for the right elbow.

Petitioner testified that he consulted Dr. Mark Sokolowski on December 15, 2020 (PX #1). Dr. Sokolowski's records document his consultation with Petitioner on Dec 15; however, the records also document a physical therapy assessment on Dec 14, 2020 at Dr. Sokolowski's practice.

On December 15 Dr. Sokolowski noted Petitioner's complaints of 7-8/10 neck pain radiating to the left subscapular region, 7-8/10 lumbar pain radiating to the buttocks and right elbow pain subsequent to a work accident. He noted that Petitioner was in his usual state of health when he had pain from lifting a toolbox. Petitioner had had one session of physical therapy. Dr. Sokolowski also noted Petitioner's history of an L5-S1 fusion for which he had been released to unrestricted work two years prior and Petitioner's history of cervical symptoms "four years ago." Medications were Norco, ibuprofen, and muscle relaxants.

On examination Dr. Sokolowski noted increased pain with cervical extension, maximal over the bilateral C5-7 facet joints. Left-sided Spurling's was positive for periscapular pain. Upper extremity strength was normal except for antalgic weakness about the right elbow. There was right epicondylar pain and pain with resisted wrist extension. There was tenderness over the lumbar spine and buttocks. Straight-leg raise was positive for buttock pain bilaterally. Strength and sensation were intact in the lower extremities.

Dr. Sokolowski diagnosed cervical and lumbar pain with radiculopathy. He prescribed physical therapy and cervical and lumbar MRIs. He noted Petitioner's Norco prescription and added a topical nonnarcotic alternative.

The physical therapy assessment by PT Derick Russell on December 14, addressed to E. Koch, MD, noted Petitioner's complaints of 6-7/10 neck pain and 7-8/10 lower back pain. There were no radicular complaints. Right elbow pain was 7-8/10. Physical therapy consisted of manual therapy, stabilization/strengthening, flexibility exercises, functional retraining, postural education, gait/balance training,

cardiovascular conditioning, and neuromuscular re-education. The course of therapy continued from December 17, 2020 through May 11, 2021.

Another physical therapy evaluation was performed on February 12, 2021. Petitioner's complaints and presentation was essentially the same as on December 14, 2020. There was improved cervical range of motion but no improvement in lumbar range of motion. Goals and treatment plan were essentially the same as before.

Petitioner's Exhibit #2 is Dr. Sokolowski's billing records for Petitioner. The billing records note charges from July 2014 through 2015, 2016, 2017, and up to September 19, 2018 (primarily for physical and occupational therapy).

Petitioner was seen by Dr. Janette Maldonado at Swedish Covenant Hospital December 18, 2018 for a gastrointestinal consultation (PX #4). Petitioner did not testify about this consultation. Petitioner presented with mild constant upper abdominal pain since lifting a 200-pound toolbox. She noted Petitioner's history of multiple hernia repairs. Dr. Maldonado noted some upper abdominal bulging. An abdominal CT scan revealed surgical mesh in the periumbilical anterior abdominal wall. Dr. Maldonado diagnosed pain in the upper abdomen.

Petitioner returned to Dr. Zerilli at Concentra on December 18, 2020 with right elbow pain. The elbow was tender on examination, but motion was full. Deep tendon reflexes at the elbows were equal and symmetrical. Motor strength was normal bilaterally, as was range of motion. The musculoskeletal exam revealed normal range of motion and strength in the extremities. There were no documented complaints of neck or lower back pain. Petitioner testified that he received a pain injection in his elbow. The records refer to a corticosteroid injection in the right elbow but there was no clinical note of the procedure.

Petitioner had cervical and lumbar MRIs December 21, 2020, at Bright Light Imaging (PX #1). The cervical MRI revealed a 2 mm shallow broad-based central posterior disc displacement with effacement of the thecal sac at C2-3, a 2.5 mm shallow broad-based central posterior disc displacement with effacement of the thecal sac at C3-4, a 2 mm shallow broad-based central posterior disc displacement with effacement of the thecal sac at C4-5, a 2 mm shallow broad-based central posterior this displacement with effacement of the thecal sac at C5-6, a 2.5 mm shallow broad-based central posterior disc displacement with effacement and flattening of the thecal sac at C6-7. There was generalized facet hypertrophy throughout the cervical spine. There was no comparison to previous imaging.

The lumbar MRI revealed post-surgical fusion changes at L5-S1 with transpedicular screws, interconnecting rods, and an intervertebral disc spacer. There was also a 2 mm shallow broad-based central posterior disc displacement with effacement of the thecal sac at L2-3, a 2 mm shallow broad-based central posterior this displacement with effacement of the thecal sac at L3-4, a 3 mm shallow broad-based central posterior disc displacement with effacement of the thecal sac at L3-4. There was no comparison to previous imaging.

Petitioner returned to Dr. Zerilli at Concentra the December 29, 2020 with 6–7/10 right elbow pain. Petitioner did not testify about this consultation. Petitioner's presentation and examination were essentially unchanged from December 18. There were no documented complaints of neck or low back pain. There was no documentation that Petitioner had consulted with Dr. Sokolowski or that he had had cervical and lumbar MRIs or that he had had physical therapy under the supervision of Dr. Sokolowski. Dr. Zerilli diagnosed lateral epicondylitis of the right elbow. He opined that Petitioner was at MMI but with permanent restrictions or partial disability, without specifying what the restrictions were.

On January 28, 2021, Petitioner followed up with Dr. Sokolowski, complaining of neck pain radiating to the left periscapular right, lumbar pain, and right elbow pain. Petitioner reported improvement in his neck and back with therapy. Dr. Sokolowski's reviewed the cervical MRI images and noted disc hernations at C3-4 and C6-7 resulting in mild central stenosis. His review of the lumbar MRI images noted a shallow protrusion at L4-5 along with prior laminectomy and fusion at L5-S1.

There was no documentation of Petitioner's follow up at Concentra or of Dr. Zerilli's injection of Petitioner's right elbow in Dr. Sokolowski's records, PX #1.

Dr. Sokolowski diagnosed cervical pain, lumbar pain, cervical radiculopathy, lumbar radiculopathy, and right elbow pain. He recommended active exercise in physical therapy, continue pain medication, and to follow up in 4 - 6 weeks. Dr. Sokolowski also kept Petitioner off work.

On March 4, 2021, Petitioner followed up with Dr. Sokolowski with complaints of neck pain radiating to the periscapular regions and right arm and lumbar pain radiating to the right leg. Dr. Sokolowski noted an antalgic gait. The physical examination revealed back pain radiating to the buttocks and right leg with extension. Spurling's test reproduced bilateral periscapular pain and right arm pain. Shoulder range of motion

was full. Straight-leg raise reproduced right buttock and leg pain. Leg strength was intact. There was right lateral epicondylar tenderness but strength and sensation throughout both arms was intact.

Dr. Sokolowski diagnoses were unchanged from before. He recommended a cervical epidural steroid injection, continued physical therapy and pain medication. He kept Petitioner off work. Dr. Sokolowski also considered a lumbar epidural steroid injection, if necessary.

Petitioner initially testified that he did not have a pain injection in his neck. He then testified that he did have an injection. Petitioner testified that it helped temporarily but the pain returned.

On April 14, 2021, Petitioner returned to Dr. Sokolowski complaining of neck and lumbar pain with radicular symptoms. Findings on physical examination were unchanged from before except for straight-leg raise on the right reproduced leg pain but straight-leg raise on the left was negative. Dr. Sokolowski continued recommending the cervical injection and physical therapy for the lumbar spine and cervical spine. He also noted that if the lumbar pain with radiculopathy remained significant, then consider a lumbar epidural injection. Dr. Sokolowski still kept Petitioner off work.

On May 4, 2021, Petitioner presented to orthopedic surgeon Dr. Matthew Coleman for a § 12 IME (RX #6). In addition to performing a physical examination Dr. Coleman reviewed Petitioner's medical records with Drs. Zerilli, Patodia, Boghossian, Salehi, and Sokolowski. He also reviewed records and imaging cervical and lumbar X-rays and MRIs.

Petitioner gave a history of lifting a 300-pound toolbox work on December 2, 2020. He reported immediate bilateral neck pain radiating down the shoulders into both upper extremities and into the lower back. Petitioner reported that he was still in physical therapy but had realized no significant benefit. He reported a cervical epidural steroid injection a week before the IME which provided no significant improvement. Petitioner complained of pain radiating into both shoulders and into the triceps and fingers diffusely. His pain was now concentrated more so in the right lower back which radiated down the lateral aspect of his right leg. Petitioner reported that despite conservative treatment he had realized no improvement, and "actually feels worse." Petitioner had a history of an L5–S1 fusion about five years before. He reported the surgery was successful and had had no issues with low back pain up to the December 2, 2020 injury. He denied any history of neck issues or neck pain in the past.

The physical examination revealed lumbar flexion limited to 70° and lumbar extension limited to 20°, both limited by pain. There was no significant tenderness over the cervical or lumbar spines. There was no pain with axial loading. There were no signs of secondary gain. Strength and sensation to light touch were intact throughout C5 through T1 and throughout L2 through S1, except for tingling sensation in the left S1 distribution. There was a positive Spurling's on the left. Straight-leg raise and Hoffman's were negative. Dr. Coleman noted the cervical MRI showed moderate degenerative changes, anterior osteophytes, right-greater-than-left foraminal stenosis at C3-4, and bilateral foraminal stenosis at C5-6 and C6-7. He noted the lumbar MRI showed no significant stenosis.

Dr. Coleman diagnosed a cervical sprain/strain and transient exacerbation of significant underlying degenerative disc disease which had resolved. He also diagnosed a lumbar sprain/strain which had been resolved. Dr. Coleman opined that the sprains and aggravation of the degenerative disease were directly related to the December 2, 2020 work accident. He did not detect any signs of secondary gain or malingering but noted that the diagnoses had resolved. Dr. Coleman opined that treatment consisting of physical therapy and medication was reasonable.

Dr. Coleman stated a cervical epidural injection was a reasonable option for the underlying degenerative condition but was not related to the December 2, 2020 accident. He noted that Petitioner never had a dermatomal pattern of radicular pain, particularly noting Petitioner complained of numbness and tingling in all fingers. Because of this a targeted cervical epidural injection would not attributable to any work-related diagnosis. He added that the physical therapy of 18 sessions beyond January 17, 2021 was not reasonable or necessary to treat the accident-related injuries. Dr. Coleman opined that Petitioner was at MMI regarding the accident-related injuries, which was approximately 6 weeks after the accident. He further opined that Petitioner could return to work without restrictions and did not require additional treatment.

Petitioner testified that the examination lasted about 5 or 10 minutes. He testified that Dr. Coleman asked questions while his assistant examined him.

On May 26, 2021, Petitioner followed up with Dr. Sokolowski by telephone, complaining of neck and lower back pain with radicular symptoms in the right leg. Video was unavailable for this consultation. Petitioner reported short term relief form his recent cervical epidural steroid injection (ESI). There is no clinical note for that procedure in PX #1. Petitioner did not testify to what date that occurred. Dr.

Sokolowski reviewed the May 4, 2021 IME report. He reiterated Dr. Coleman's findings and opinions without comment.

Dr. Sokolowski recommended an additional cervical ESI as well as an L4-5 transformational ESI. Dr. Sokolowski returned Petitioner back to work full duty without restrictions. Petitioner testified that he asked Dr. Sokolowski to release him back to work because he could not stay off work without receiving any income and he needed to provide for his family.

Petitioner testified that his symptoms had not improved by the trial. He has sharp pain going down his left shoulder to elbow, sharp pain going down his right leg, lower back pain, and neck pain. Petitioner testified that work has been hard for him. He testified that he cannot perform his duties at 100% and that his co-workers have been helping him out. He testified that he had not reinjured his lower back or neck since his work accident. He testified that he has not had the epidural injections to his neck or lower back because Respondent denied them.

On cross-examination Petitioner testified that he had injured his left arm and work accident in August 2007 and June 2010. He also had a right small finger injury at work in December 2011. Petitioner testified that his initial hernia injury was in July 2012. He added that he has had multiple hernia surgeries.

On further cross-examination Petitioner admitted to a low back injury in June 2013 but did not believe he hurt his neck at that time. He did not recall how he hurt his back in June 2013. He did not remember if this was the injury that led to his fusion surgery. Petitioner had another low back injury in August 2017. It was either the June 2013 or the August 2017 low back injury that resulted in fusion surgery. Petitioner did not remember a trial before this Arbitrator for his prior hernia and low back injuries or that he was awarded 40% of a person.

The Arbitrator's decision from the prior trial was not admitted in evidence.

Petitioner admitted to having epidurals for low back pain and right leg pain and then lumbar fusion surgery by Dr. Sokolowski in March 2015. He acknowledged treating for neck and right arm pain with Dr. Sokolowski after a car accident in September 2016. Petitioner acknowledged having cervical epidural steroid injections and physical therapy from Dr. Sokolowski after that accident. Petitioner developed low back and left leg complaints after lifting a manhole cover in August 2017, as well as left elbow problems and another hernia.

Petitioner acknowledged that Dr. Theodorakis, who treated him for his hernias, gave him 10-pound lifting restrictions in March 2014. In addition, Dr. Patodia, his primary physician, gave 10-pound permanent lifting restrictions in June 2015, with the suggestion in July 2016 of lifting no more than 25 - 30 pounds. Petitioner further acknowledged that Dr. Sokolowski imposed a permanent no return to full duty work release in January 2016. In September 2018 Dr. Sokolowski told Petitioner to avoid bending, twisting, lifting, or prolonged standing or walking on a permanent basis. Dr. Patodia agreed with these restrictions in August 2019.

Petitioner did not remember when he returned to full duty work after his fusion surgery. He testified that he asked to return to work because he was not getting paid. He added that he had been put in vocational training but that sitting at a computer hurt his back.

On further cross-examination Petitioner testified that he did not deadlift his toolbox. He tried but was unable to lift the box because of his injury. Petitioner acknowledged that he had continued to see Dr. Patodia in 2020 for his low back, right shoulder, and abdomen every month or so. This was primarily for Norco and Lidoderm refills. He also testified that he was off work in May 2020 for suspected COVID-19 infection, which proved negative. Petitioner did not recall reporting increasing low back pain in Summer 2020, although he followed up for medication June 11, July 14, July 30, September 8, September 22, October 6, and October 19, 2020. He acknowledged consulting with Dr. Patodia on December 1, 2020 for medication refill because he was using medication more frequently.

Petitioner also testified that Dr. Zerilli referred him to Dr. Salehi, who he thought he saw for his abdomen. Petitioner then acknowledged Dr. Salehi evaluated his neck and low back. He agreed that the records reflect that Dr. Salehi told him he had strains in his neck and back from the work accident. Petitioner also admitted to seeing Dr. Maldonado for his hernia and having a CT scan at Swedish Covenant Hospital. Dr. Maldonado said he did not need any further hernia repairs. He also admitted that Dr. Zerilli's records show he was at MMI I with regard to his right elbow on December 29, 2020.

Petitioner did not recall telling Dr. Coleman on May 4, 2021 that he had not had low back symptoms after his fusion surgery in 2015. He further testified that he did not recall having continuing complaints of low back pain before December 2, 2020, but acceded to "what the record shows." Petitioner also admitted that he told Dr. Coleman

he had not had any prior neck or right arm injuries or symptoms, but admitted that he obviously had prior neck and right arm symptoms for which he was treated with a cervical epidural. Petitioner acknowledged that Dr. Coleman told him that he was at MMI, "but I wasn't."

Petitioner testified that he returned to work 2 ½ months before his December 2 accident. He worked with the same job title, construction laborer, with duties including digging trenches, dismantling, concrete, excavating and grading, and lifting up to 100 pounds.

Respondent's Exhibit #1, Respondent's job description for Construction Laborer, was admitted without objection. Among the qualifications and requirements was the requirement to be able to lift to up to 100 pounds.

Respondent's Exhibit #2, records of Dr. Mark Sokolowski, were admitted without objection. Dr. Sokolowski's records document his care of Petitioner's orthopedic conditions prior to the claimed work accident on December 2, 2020.

Dr. Sokolowski's records document treatment of low back and right leg pain since July 2014 following work injuries in 2011 and 2013, along with diagnosed hernias and surgical repair. Dr. Sokolowski had diagnosed aggravation of pre-existing degenerative disc disease at L5-S1 for which ongoing Norco plus Lidoderm patches, or a fusion, were considered. A January 2015 lumbar MRI noted multilevel spondylosis, a 2.5 mm diffuse bulge at L4-5 flattening the thecal sac and bilateral neural foraminal stenosis, and a 2 mm diffuse bulge at L5-S1 with osteophyte complex and facet joint hypertrophy causing bilateral neural foraminal stenosis.

Petitioner underwent an anterior-posterior fusion at L5-S1 March 11, 2015. Post operatively he reported left leg and abdominal symptoms. Petitioner also underwent another hernia repair during this time for an incisional hernia. He was given a bone stimulator. Routine post-surgical X-rays were taken. He underwent a FCE that cleared him for heavy duty October 27, 2015, but he reported to Dr. Sokolowski he was only able to do the testing after taking two Norco, and that afterward he was "in severe pain for several days." By November 11, 2015 Dr. Sokolowski noted Petitioner was developing arthrodesis at L5-S1. On March 25, 2016 he cleared Petitioner for full duty but noted Petitioner might have restrictions without specifying what the restrictions might be.

On September 13, 2016 Petitioner sought care from Dr. Sokolowski for neck pain into the right shoulder after a car accident. A September 23, 2016 MRI showed a

herniation with bulge at C3-4, bulging with osteophytes at C5-7, and bulging with osteophytes at C2-3 and C4-5.

On May 5, 2017 Petitioner had a lumbar CT scan, which demonstrated multilevel spondylosis, diffuse bulging at L3-4 and L4-5 without significant stenosis, and post-surgical changes at L5-S1. The imaging was compared to imaging on May 1, 2017.

Petitioner returned to Dr. Sokolowski August 29, 2017 with lumbar and right buttock pain, left elbow pain, and abdominal pain after lifting a manhole cover August 17, 2017. A September 5, 2017 CT of the lumbar spine showed post-surgical changes at L5-S1 and multilevel spondylosis. Dr. Sokolowski ordered "permanent pain management" and restrictions of no bending, twisting, lifting, prolonged standing or walking" on September 18, 2018. While engaged in computer training classes Petitioner reported increased low back pain from sitting at a computer too long but considered returning to his prior job if he could tolerate it.

Respondent's Exhibit #3, Dr. Shobhana Patodia's records, was admitted without objection. The records reflect care for Petitioner's lumbar, leg and abdominal pain since March 2015. She imposed permanent lifting restrictions in June and again in October 2015, January 2016, October 2017, January 2018, and August 2019. The restrictions varied from no lifting of more than 5 pounds to no more that 25-30 pounds. By January 2020 Petitioner was complaining about the limited supply of Norco he was able to receive, a recurrent ventral hernia for which he wished further surgery, a requested change in work status to less manual or physical work, a new three month history of low back pain, right shoulder pain, and "good and bad days," for which he had to call in sick. These complaints were reiterated on March 12, April 9, and May 8, 2020, and again on July 30, September 8, September 22, October 6, and October 19, 2020. When seen on December 1, 2020, Petitioner reported he was out of medications and needed refills for abdominal and low back pain. Dr. Patodia had Petitioner on Norco 10/325 mg and Lidoderm patches during entire this period through December 1, 2020.

Respondent's Exhibit #4, work restrictions of Dr. Spyridon Theodorakis, was admitted without objection. On March 10, 2014 Dr. Theodorakis gave no lifting, pushing, or carrying over 10 pounds due the high risk of hernia.

Respondent's Exhibit #5 is a summary of Petitioner's Workers' Compensation claims with screenshots from the Illinois Workers' Compensation Commission website of the enumerated claims.

At trial Petitioner admitted to a permanent 10-pound lifting restriction imposed by Dr. Theodorakis in March 2014, a permanent 25 – 30-pound lifting restriction by Dr. Patodia in June 2015, and a permanent "no full duty" release from Dr. Sokolowski in January 2016. He testified that he was never back to full capacity for Respondent, as "I was in pain, so, you know, I can't perform my job."

CONCLUSIONS OF LAW

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

The Arbitrator finds this issue was not genuinely disputed. Petitioner testified that he was injured at an assigned jobsite when he tried to lift a toolbox weighing hundreds of pounds on December 2, 2020. He had immediate pain in his neck, lower back, elbow, and abdomen. He received emergent medical care at Concentra that same day and was diagnosed with abdominal pain, neck pain, lower back pain, and right elbow lateral epicondylitis. No evidence was offered to rebut this evidence.

Accordingly, the Arbitrator finds that Petitioner proved that he was injured in an accident that arose out of and in the course of Petitioner's employment by Respondent.

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

The evidence clearly showed that Petitioner had significant pre-existing conditions in his cervical spine and his lumbar spine, the lumbar spine being more serious. However, the Arbitrator finds that the evidence proved that Petitioner sustained only temporary exacerbations and aggravations of those pre-existing conditions but that Petitioner failed to prove that his claimed current condition of ill-being is causally related to the work accident on December 2, 2010.

The Arbitrator based his findings primarily on finding that Petitioner was not a credible witness and the reasonable and persuasive opinions of Dr. Matthew Coleman.

Petitioner had an extensive history complaints and medical care for his neck and lower back. Petitioner's records with Dr. Mark Sokolowski document he complaints in 2014 of lower back and right leg pain from work accidents in 2011 and 2013. An MRI in January 2015 multilevel spondylosis and bulging discs and neuroforaminal stenosis at L4-5 and L5-S1. Dr. Sokolowski performed an anterior-posterior L5-S1 fusion in March 2015. Dr. Sokolowski noted arthrodesis at L5-S1 in November 2015. Petitioner was

released to full duty work in March 2016.

Petitioner consulted Dr. Sokolowski in September 2016 with neck pain going into the right shoulder after a car crash. A cervical MRI noted a disc herniation at C3-4 and disc bulging with osteophytes at C2-3, C4-5, and C5 through C7.

Petitioner had a lumbar CT scan May 5, 2017 ordered by Dr. Sokolowski, which demonstrated multilevel spondylosis, diffuse bulging at L3-4 and L4-5, and surgical changes at L5-S1. This was compared to imaging on May 1, 2017. The Arbitrator takes note that CT scans are not ordered for asymptomatic individuals. Petitioner reinjured his low back and sustained another hernia from lifting a manhole cover at work in August 2017.

The records of Petitioner's primary physician, Dr. Shobhana Patodia, documented Petitioner's continuing low back pain and refills of Norco throughout 2020 up to December 1. Dr. Patodia had noted Petitioner's complaints of pain in the lower back, leg, and abdomen since March 2015. In January 2020 Dr. Patodia documented Petitioner's complaints of lower back and leg pain for the previous three months.

Despite this extensive history of reinjury and continuing lower back complaints when Petitioner was examined by Dr. Matthew Coleman for an IME May 4, 2021 he denied that history. Compounding that falsehood, Petitioner denied any history of problems or treatment for his neck. Petitioner went further at trial when he claimed to not remember these denials. Petitioner went further still on cross-examination claiming to not recall details of his history of continuing lower back complaints and reinjury, only acceding to "what's in the record" in a disingenuous manner. There were also Concentra visits on December 18 and 29, 2020 with no documented complaints of either neck or lower back pain.

Petitioner's credibility was also undermined by withholding medical information from various treating physicians. Petitioner treated concurrently with Dr. Zerilli at Concentra while also treating with Dr. Sokolowski. Neither physician documented that Petitioner told them about the other's treatment, most importantly not telling Dr. Sokolowski about the elbow injection at Concentra.

In addition, Petitioner had an extensive history of apparent permanent work restrictions imposed by Drs. Sokolowski, Theodorakis, and Patodia, presumably relating to his recurrent hernias. Nonetheless, Petitioner returned to his heavy-duty job, suggestive of the unreliability of his subjective complaints to those physicians and of his reports of his capabilities to his employer.

Petitioner also displayed a remarkably poor recall during his testimony. Petitioner underwent evaluations by Drs. Jannette Maldonado, Stephen Boghossian, and Sean Salehi. Petitioner did not testify to any of these consultations on direct examination. The consultations with Drs. Maldonado and Salehi only came to light from Petitioner's testimony on cross examination. In addition, Petitioner testified that he saw Dr. Salehi, a well-known neurosurgeon, for his hernia.

The Arbitrator's findings here are colored by the unreliability of Petitioner's testimony. As in most cases medical opinions are dependent on the reliability and accuracy of a patient's report of their medical history and present subjective complaints. Those elements of reliability and accuracy are lacking here. Accordingly, the Arbitrator finds Dr. Coleman's opinions reasonable and persuasive. The Arbitrator accepts and adopts Dr. Coleman's diagnoses of temporary sprains/strains of the cervical spine and lumbar spine which aggravated pre-existing conditions, as well as resolved right elbow epicondylitis. It is noteworthy that Drs. Boghossian, and Salehi also diagnosed sprains/strains of the spine.

The Arbitrator finds that Petitioner failed to prove that his claimed current condition of ill-being is causally related to the work accident on December 2, 2020. The Arbitrator finds that the evidence established that Petitioner sustained sprains/strains of his cervical spine, his lumbar spine, and right elbow. The sprains/strains of the cervical spine and the lumbar spine were temporary aggravations of pre-existing degenerative conditions in the cervical spine and lumbar spine and that Petitioner was at MMI approximately six weeks after the accident, which corresponds to January 17, 2021, the date up to when physical therapy was reasonable.

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

As noted above, the Arbitrator found the opinions of Dr. Mark Coleman were reasonable and persuasive. He found that Petitioner was at MMI approximately six weeks after the work accident. He opined that physical therapy beyond January 17, 2021 was not reasonable or necessary to treat Petitioner's accident-related injuries. He also noted that while the cervical epidural injection might have been reasonable but that it was not related to the accident injuries due to lack of a definitive dermatomal pattern to Petitioner's claimed radiculopathy.

Dr. Coleman opined that Petitioner did not require medical care beyond his reaching MMI, which all the evidence indicates was January 17, 2021. He further opined that Petitioner could return to work without restrictions. It is noteworthy how often Petitioner worked full duty with restrictions imposed before the December 2, 2020 accident.

The Arbitrator finds that Petitioner failed to prove that the medical care and intervention he received after January 17, 2021 was reasonable or necessary to cure or relieve the effects of the injuries he claimed as a result of his work accident on December 2, 20102, except for any fees are charges relating to the cervical ESI.

K: Is Petitioner entitled to prospective medical care?

Based on the Arbitrator's finding set forth above, the Arbitrator finds Dr. Coleman's opinion that Petitioner did not require further medical care after reaching MMI reasonable and persuasive. Therefore, the Arbitrator finds that petitioner failed to prove that he is entitle to the prospective medical of another cervical epidural steroid injection or a lumbar epidural steroid injection recommended by Dr. Sokolowski.

As noted above Dr. Sokolowski relied on the reliability and accuracy of Petitioner's reports, which the evidence showed were unreliable and inaccurate. In addition, Petitioner withheld information regarding his concurrent care at Concentra. It is clear that Dr. Sokolowski's opinions were not based on a full and complete picture of Petitioner's condition, and therefore are not persuasive.

L: What temporary benefits are in dispute? TTD

The Arbitrator has found the opinions of Dr. Mark Coleman reasonable and persuasive. Dr. Coleman opined that Petitioner reached MMI approximately six weeks after the work-related accident, which corresponds to January 17, 2021, the date up when physical therapy was reasonable. This corresponds to 6 & 3/7 weeks.

Steven J. Fruth, Arbitrator

Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC035650
Case Name	DIGIOIA, NICK v. VILLAGE OF SCHAUMBURG
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0238
Number of Pages of Decision	22
Decision Issued By	Christopher Harris, Commissioner

Petitioner Attorney	Patrick Serowka
Respondent Attorney	Michael Manseau

DATE FILED: 6/28/2022

/s/ Christopher Harris, Commissioner

Signature

22IWCC0238

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

NICK DIGIOIA,

Petitioner,

vs. NO: 19 WC 35650

VILLAGE OF SCHAUMBURG,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective medical treatment, 8(j) credit, temporary total disability (TTD), and permanent partial disability (PPD), and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission affirms the Arbitrator's finding that the Petitioner sustained an accident arising out of and in the course of his employment on November 16, 2019. The Commission, however, modifies the decision with respect to the issues of causal connection, medical expenses, TTD, PPD and credit. For reasons stated below, the Commission finds that Petitioner's right knee injury and subsequent need for the right knee replacement is causally related to the November 16, 2019 accident. As a result of his injury, the Commission finds that Petitioner was temporary totally disabled for a period of 45-1/7 weeks, November 17, 2019 through September 28, 2020. The Petitioner is entitled to outstanding medical expenses totaling $4,434.88 and shall be held harmless by the Respondent for the Blue Cross/Blue Shield lien totaling $55,852.02. As result of the injury, the Commission finds that the Petitioner sustained 20% loss of use of the right leg pursuant to Section 8(e) of the Act. The Respondent is entitled to a credit of $66,172.08.

The Petitioner sustained a non work-related injury to his right knee on March 8, 2019 while

walking his dog. Petitioner underwent an MRI of the right knee on March 14, 2019. The MRI revealed grade 4 chondromalacia at the central or dominant load bearing medial femoral condyle with subjacent patchy osteoedema. There was moderate degenerative arthrosis with osteophytes at the medial joint line. The impression was a trizonal horizontal tear of the medial meniscus, a micro fracture at the dominant load bearing medial femoral condyle, grade 4 chondromalacia at the medial compartment, and a longitudinal tear.

Dr. Frank Bohnenkamp reviewed the MRI with the Petitioner on March 19, 2019. He diagnosed Petitioner with an acute medial meniscal tear and osteoarthritis of the right knee. Dr. Bohnenkamp indicated that Petitioner understood that his arthritis could not be cured with an arthroscopy.

Dr. Bohnenkamp performed a right knee arthroscopy, partial medial meniscectomy, chondroplasty and partial synovectomy including the infrapatellar fat pad on April 2, 2019. Per the operative report, the diagnostic arthroscopy showed grade 4 to bone-on-bone changes of the medial compartment, mainly on the femoral side and also on the tibial side. He had a large degenerative horizontal cleavage medial meniscus tear. He had chondromalacia of the patella and trochlear groove, grade 2-3 changes. He had hypertrophic inflamed synovitis. Petitioner was aware of his degenerative changes on the x-ray and that he had a degenerative meniscal tear on the MRI. Petitioner was informed that a knee arthroscopy may help alleviate his mechanical symptoms but not his arthritic symptoms. It was further noted that Petitioner was not opting for any kind of arthroplasty at that time.

Petitioner underwent a course of physical therapy and met all his therapy goals except for returning to his prior exercise routine. Petitioner was returned to work without restrictions on May 6, 2019. Following his return to work, Petitioner testified that he was able to complete his job duties with some mild discomfort. He underwent two right knee injections but continued to work.

Petitioner then sustained an undisputed, work-related injury to his right knee on November 16, 2019 when he slipped on black ice while picking up a fire hose. He sought medical treatment following the accident and was diagnosed with a right knee sprain. His right knee was placed in a knee immobilizer and he was given work restrictions of no lifting, pushing or pulling, no bending and no climbing stairs or ladders.

Petitioner underwent an MRI of the right knee on December 3, 2019. The MRI revealed advanced osteoarthritis of the medial compartment with joint space loss and marginal spur formation. There was considerable loss of cartilage from the medial femoral condyle. The impression was a complex tear to the posterior horn and body medial meniscus and osteoarthritis most severely affecting the medial compartment.

Dr. Steven Chudik performed a right total knee arthroplasty on May 13, 2020.

Dr. Chudik was subsequently deposed. He compared the March 14, 2019 MRI to the December 3, 2019 MRI. He noted that the December MRI revealed more significant tearing of the medial meniscus, which was evidence of a new tear. Dr. Chudik acknowledged that Petitioner had some pre-existing degenerative changes in his knee that was definitely susceptible to further injury

and aggravation. Dr. Chudik stated that the edema in the knee, as well as the new pattern of tearing in the medial meniscus, was consistent with Petitioner's presentation of an injury and worsening of symptoms and function that was the result of the injury. The injury increased Petitioner's pain and decreased his function, particularly with walking, bending, stairs, carrying objects and twisting, which all equaled an inability to perform his job duties. The injury accelerated Petitioner's need for future treatment. While Petitioner's knee was already in a compromised state, he was able to function. Dr. Chudik opined that the MRI findings were all consistent with the mechanism of injury and an aggravation of his condition and need for the total knee replacement and subsequent manipulation. Dr. Chudik further opined that the work accident was a contributing factor and the last straw in the course of his knee that required the replacement. He noted that Dr. Bohnenkamp did not recommend a total knee replacement before the work injury.

The Respondent obtained a Section 12 opinion from Dr. Lawrence Lieber on February 20, 2020. Following his examination, he diagnosed Petitioner with degenerative osteoarthritis of the right knee. Dr. Lieber opined that there was no evidence of a causal relationship between the underlying degenerative arthritis of the right knee and the work accident. Before the work accident, the records revealed significant degenerative joint disease in the knee with associated treatment including the arthroscopy in April 2019. Petitioner also underwent gel injections after the surgery. He further noted that the December 2019 MRI did not confirm any new findings indicating any further injury to the knee. Petitioner did not need any treatment or restrictions as a result of the work accident and the knee replacement was related to the preexisting abnormalities. Dr. Lieber stated that Dr. Bohnenkamp did not recommend a total knee replacement prior to the work accident.

To obtain compensation under the Act, a claimant must prove by a preponderance of the evidence that "some act or phase of his employment was a causative factor in his ensuing injuries." *Land & Lakes Co. v. Industrial Comm'n*, 359 Ill. App. 3d 582, 592, 834 N.E.2d 583, 296 Ill. Dec. 26 (2005). A claimant, however, is not required to prove that his employment was the sole causative factor or even that it was the principal causative factor, but only that it was a causative factor. *Republic Steel Corp. v. Industrial Comm'n*, 26 Ill. 2d 32, 45, 185 N.E.2d 877 (1962). An employer takes its employees as it finds them. *Schroeder v. Ill. Workers' Comp. Comm'n*, 2017 IL App (4th) 160192WC, ¶ 28, 414 Ill. Dec. 198, 79 N.E.3d 833 (citing *St. Elizabeth's Hospital v. Workers' Compensation Comm'n*, 371 Ill. App. 3d 882, 888, 864 N.E.2d 266, 309 Ill. Dec. 400 (2007)). "A claimant with a preexisting condition may recover where employment aggravates or accelerates that condition." *Id.* (citing *Caterpillar Tractor Co. v. Industrial Comm'n*, 92 Ill. 2d 30, 36, 440 N.E.2d 861, 65 Ill. Dec. 6 (1982)).

Further, "a chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury." *International Harvester v. Industrial Comm'n*, 93 Ill. 2d 59, 63-64, 442 N.E.2d 908, 66 Ill. Dec. 347 (1982).

"If a claimant is in a certain condition, an accident occurs, and following the accident, the claimant's condition has deteriorated, it is plainly inferable that the intervening accident caused the deterioration." *Schroeder*, 2017 IL App (4th) 160192WC, ¶ 26, 414 Ill. Dec. 198, 79 N.E.3d 833. "The salient factor is not the precise previous condition; it is the resulting deterioration from

whatever the previous condition had been." *Id.*

The evidence establishes that the Petitioner's pre-existing condition deteriorated as a result of the work injury. The Petitioner sustained a non work-related injury that necessitated an MRI. The MRI confirmed that Petitioner had a torn medial meniscus and osteoarthritis in the right knee. The torn medial meniscus was surgically repaired. The surgery did not address the osteoarthritis. Petitioner was eventually returned to work full duty and without restrictions. Petitioner was able to perform his full job duties for 6 months. Despite Petitioner receiving two injections into the right knee and having some complaints of mild discomfort, no doctor provided him with work restrictions or recommended further surgery. After the work injury, the medical records document an increase in his complaints and symptoms. He was provided with a knee immobilizer and given work restrictions of no lifting, no pushing or pulling, no bending, and no climbing stairs or ladders. A total knee replacement was eventually recommended and ultimately performed on May 13, 2020. Both Drs. Chudik and Lieber confirmed that a total knee replacement was not recommended prior to the work-related accident. It was only after the accident that a total knee replacement became necessary.

Drs. Chudik and Lieber both reviewed the pre and post-accident MRIs and offered conflicting opinions as to whether the work accident caused a change in Petitioner's condition. Dr. Chudik opined that there was edema in the knee as well as a new pattern of tearing in the medial meniscus, which was consistent with Petitioner's presentation of an injury and worsening of symptoms and function that was the result of the injury. Dr. Lieber, however, noted there were no new findings on the MRI and the need for the total knee replacement was related to the preexisting abnormalities. It is well established that it is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony, and resolve conflicts in the evidence, particularly medical opinion evidence. *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 675, 928 N.E.2d 474, 340 Ill. Dec. 475 (2009); *Fickas v. Industrial Comm'n*, 308 Ill. App. 3d 1037, 1041, 721 N.E.2d 1165, 242 Ill. Dec.

The Commission finds the opinion of Dr. Chudik more persuasive than the opinion of Dr. Lieber. While Petitioner had arthritis in his right knee, the fact remains that he was able to work full duty and without restriction prior to the work accident. It was only after the undisputed work accident that Petitioner received work restrictions and a total knee replacement was definitively required. Dr. Chudik's opinion that the accident caused a new pattern of tearing and worsening of his symptoms is supported by the record. In this respect, it is plainly inferable that the work accident caused a deterioration in Petitioner's right knee condition.

The Respondent advances several arguments in its brief attacking Petitioner's credibility. While the Commission agrees that there are some instances in the record that have an impact on Petitioner's credibility, those instances do not outweigh the medical evidence or the fact that Petitioner sustained an undisputed accident. The medical evidence coupled with the relevant case law establishes that Petitioner's right knee condition and the total right knee replacement are causally related to his November 16, 2019 work accident.

The Respondent disputes Petitioner's entitlement to TTD benefits based upon there being

no causation. Having found that Petitioner's condition is causally related to the November 16, 2019 work accident, the Commission finds that the Petitioner is entitled to TTD benefits from November 17, 2019 through September 28, 2020.

The Respondent is, however, entitled to a credit in the amount of $66,172.08. Petitioner received TTD benefits totaling $23,422.26 from the employer's group carrier from November 17, 2019 through March 6, 2020. Petitioner then received his full salary through the Public Employee Disability Act (PEDA) from March 7, 2020 through September 28, 2020. The net TTD amount owed during this period was $42,749.82.

Pursuant to Section 5 ILCS 345/1(b), "Whenever an eligible employee suffers any injury in the line of duty which causes him to be unable to perform his duties, he shall continue to be paid by the employing public entity on the same basis as he was paid before the injury . . ." Section (d) of PEDA further states: "Any salary compensation due the injured person from workers' compensation or any salary due him from any type of insurance which may be carried by the employing public entity shall revert to that entity during the time for which continuing compensation is paid to him under this Act." *5 ILCS 345/1(d)*. Therefore, the Commission finds that Respondent is entitled to a credit for PEDA payments made under Section (d) of PEDA, but only up to the amount of temporary total disability benefits that were owed for the relevant period pursuant to Section 8(j)(2) of the Act. Thus, Respondent is entitled to a credit of $42,749.82 for PEDA benefits paid in lieu of TTD benefits. Respondent is also entitled to an 8(j) credit of $23,422.26 for TTD benefits received from the employer's group carrier.

Based upon his injuries, the Commission finds that the Petitioner sustained 20% loss of use of the right leg pursuant to Section 8(e) of the Act. The Commission has considered the five factors under Section 8.1b of the Act:

(i) Impairment Rating: Neither party submitted an impairment rating. As such, the Commission assigns no weight to this factor and will assess Petitioner's permanent disability based upon the remaining enumerated factors.

(ii) Occupation of Injured Employee: The Petitioner worked as a firefighter and voluntarily retired after his injury. As Petitioner retired, his occupation will have no impact on his right knee. The Commission assigns little weight to this factor.

(iii) Petitioner's Age: The Petitioner was 58 years old at the time of his injury. He voluntarily retired after his injury. As the Petitioner's age has no effect on his injury, the Commission assigns little weight to this factor.

(iv) Petitioner's Future Earning Capacity: There is no evidence in the record as to a reduced earning capacity. Therefore, the Commission assigns no weight to this factor.

(v) Evidence of Disability: The Petitioner sustained an undisputed injury to his right knee resulting in a total knee replacement. Following the surgery, Petitioner underwent a right knee manipulation. He then voluntarily retired. The record confirms that Petitioner has some ongoing stiffness and tightness. The records also indicate that

Petitioner can do a lot of his daily activities but has some pain and stiffness. The Commission assigns significant weight to this factor and finds it indicative of increased permanent disability.

In light of the foregoing, with no single enumerated factor being the sole determinant of disability, the Commission awards Petitioner 20% loss of use of the right leg pursuant to Section 8(e) of the Act.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed September 27, 2021, is hereby modified as stated above and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,465.93 per week for a period of 45-1/7 weeks, (November 16, 2019 through September 28, 2020) 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 is entitled to a credit of $23,422.26 pursuant to Section 8(j) of the Act for TTD paid between November 17, 2019 and March 6, 2020.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for payments made under the Public Employee Disability Act (PEDA) in the amount of $42,749.82 for benefits received between March 7, 2020 and September 28, 2020.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $836.39 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 the sum of $4,434.88 for medical expenses under §8(a) of the Act, and subject to the medical fee schedule. The Respondent shall hold Petitioner harmless for the Blue Cross/Blue Shield lien totaling $55,852.02.

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

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

Under Section 19(f)(2) of the Act, no "county, city, town township, incorporated village, school district, body politic, or municipal corporation" shall be required to file a bond. As such, Respondent is exempt from the bonding requirement. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in

Circuit Court.

June 27, 2022
CAH/tdm
O: 6/16/22
052

/s/ *Christopher A. Harris*
Christopher A. Harris

/s/ *Carolyn M. Doherty*
Carolyn M. Doherty

/s/ *Marc Parker*
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC035650
Case Name	DIGIOIA, NICK v. VILLAGE OF SCHAUMBURG
Consolidated Cases	No Consolidated Cases
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	14
Decision Issued By	Kurt Carlson, Arbitrator

Petitioner Attorney	Patrick Serowka
Respondent Attorney	Robert Ulrich

DATE FILED: 9/27/2021

THE INTEREST RATE FOR THE WEEK OF SEPTEMBER 21, 2021 0.04%

/s/Kurt Carlson, Arbitrator

Signature

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

Nick DiGioia
Employee/Petitioner

v.

Village of Schaumburg
Employer/Respondent

Case # **19** WC **35650**

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 **Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **June 14, 2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of 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 [ ] 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. [x] Other **Is Respondent entitled to a credit for sick benefits paid to the Petitioner.**

FINDINGS

On **11/16/2019**, Respondent ***was*** operating under and subject 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 **$115,212.43**; the average weekly wage was **$2,198.89**.

On the date of accident, Petitioner was **58** 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 **$23,422.26** for TTD, $0 for TPD, $0 for maintenance, and **$68,102.71** in sick time benefits for a total credit of **$91,524.97**.

ORDER

THE ARBITRATOR ADOPTS THE MEDICAL OPINION OF DR. LIEBER AND HEREBY DENIES THE PETITIONER'S CLAIM BECAUSE THE PETITIONER FAILED TO PROVE A CAUSAL CONNECTION BETWEEN THE NOVEMBER 16, 2019 ACCIDENT AND HIS RIGHT KNEE REPLACEMENT AND ANY OTHER MEDICAL TREATMENT, LOST TIME OR PERMANENCY.

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

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

Kurt Carlson

Kurt A. Carlson

SEPTEMBER 27, 2021

Nick Digioia v. Village of Schaumburg
Case No.: 19 WC 35650

FINDINGS OF FACT

The Parties

The Petitioner worked as a firefighter for the Respondent from 1988 until November of 2020. (Ar. Tr. p.11). The Respondent is a relatively large suburb that has commercial and residential structures, as well as several highways going through and around it. (Ar. Tr. p.14).

As a firefighter, the Petitioner's job duties included fire suppression, attending EMS calls, responding to car accidents and medical calls where he assists with ambulance calls. In addition, he would conduct fire inspections, home safety inspections and "pre-plans" where he inspects buildings. (Ar. Tr. p.12).

The Petitioner testified that every fire is approached by assessing the building that is on fire, entering the building, fighting the fire (fire suppression) and cleaning up afterward (overhaul). (Ar. Tr. p.15-16). He also described fire suppression, and the differences between residential fires and commercial fires. Commercial fires are generally larger, requiring larger hoses and often involve unknown and possibly hazardous materials.

The Petitioner described the different sized hoses that are used when fighting fires. (Ar. Tr. p. 16). For example, a 50-foot segment of a 1 ¾-inch hose weighs approximately 30 pounds when it is charged. (Ar. Tr. p. 18). Larger hoses, such as 2 ½-inch hoses, weigh approximately 60 pounds for a 50-foot length. He testified that those hoses are generally carried by two people. (Ar. Tr. pgs. 18, 19.)

The Petitioner also testified about the tools used during motor vehicle extractions, such as jaws of life and cutters, that are powered by hydraulics and weigh between 35 and 40 pounds. (Ar. Tr. p. 17).

At all times, firefighters wear personal protective gear, which was described as very heavy. (Ar. Tr. p. 16).

Finally, there is an overhaul stage after the fire is extinguished. This consists of cleaning up the scene, picking up hoses, returning to the firehouse, and preparing for the next fire. (Ar. Tr. pgs. 16, 17). It was during this phase, that the Petitioner slipped and fell.

1. March 8, 2019 accident

On March 8, 2019 the Petitioner injured his right knee while walking his dog. The next day, on March 9, 2019 he started treating with Dr. Bohnenkamp complaining of a sharp right knee pain (8/10 with activity), clicking, giving away, limping, stiffness, swelling, and tightness. (See Petitioner's Exhibit No. 5).

On March 14, 2019 the Petitioner had an MRI scan. It showed a torn medial meniscus, superimposed upon a background of meniscal degeneration, a microfracture of the dominant load bearing medial femoral condyle, Grade 4 chondromalacia at the medial compartment and a intrasubstance longitudinal tear of the proximal tendon. (See Petitioner's Exhibit No. 5)

On March 19, 2019 the Petitioner returned to Dr. Bohnenkamp to discuss the MRI. As a result, Dr. Bohnenkamp diagnosed an acute medial meniscal tear and localized osteoarthritis of the right knee. (See Petitioner's Exhibit No. 5). He also documented a conversation that he had with the Petitioner, "I reviewed the MRI in detail with the patient today" and "The patient understands that we cannot cure arthritis with an arthroscopy." (See Petitioner's Exhibit No. 5)

At arbitration, the Petitioner could not recall if Dr. Bohnenkamp had told him that he had arthritis in the right knee (Ar. Tr. p. 58).

When asked if Dr. Bohnenkamp had told him that the arthroscopic surgery would not cure his arthritis, the Petitioner testified, "I don't recall, because I don't recall him saying I have arthritis." (Ar. Tr. p. 58, 59). Yet, according to Dr. Bohnenkamp's April 2, 2019 operative report:

> He is aware that he has some degenerative changes on x-ray. He does have a degenerative meniscal tear on the MRI, and he is aware that knee arthroscopy may help alleviate his mechanical symptoms, but not his arthritic symptoms.

(See Petitioner's Exhibit No. 5).

The Petitioner also denied that Dr. Bohnenkamp had ever discussed a right knee replacement, even though Dr. Bohnenkamp's April 2, 2019 operative report says, "[the Patient] is not opting for any kind of arthroplasty procedure at this time." (Ar. Tr. p. 38, 39 and Petitioner's Exhibit No. 5).

The degenerative changes that Dr. Bohnenkamp had discussed with the Petitioner were confirmed during the surgery. According to the postoperative diagnosis the Petitioner had a right knee medial meniscus tear, grade 4 bone-on-bone changes of the medial compartment, a hypertrophic, inflamed synovitis, and chondromalacia from the patellofemoral joint. (See Petitioner's Exhibit No. 5).

After the surgery, the Petitioner received physical therapy at Athletico. On direct examination, the Petitioner focused on the April 26, 2019 Athletico record which indicated that he had no pain, normalized quadriceps strength and an increased ease with functional mobility. (Ar. Tr. p. 20).

Although the Petitioner correctly described the April 26, 2019 note from Athletico, he ignored their May 3, 2019 discharge report. According to that report, the Petitioner still had pain, rating it between 0-3, with 3 being the worst pain. (See Petitioner's Exhibit No. 5). It also noted that the Petitioner had not met all of his long-term goals and he was unable to return to his prior exercise routine. (See Petitioner's Exhibit No. 5).

2. <u>Work activities, testing and medical care between the Petitioner's non-work related and work related accidents.</u>

After the Petitioner was discharged from Athletico, he returned to work on May 6, 2019 without any restrictions. (Ar. Tr. p. 22) After returning to work, the Petitioner was required to undergo a series of job specific tests that were required by the Collective Bargaining Agreement between the Respondent and the Firefighters Union. (Petitioner's Exhibit No. 13) The Petitioner testified that he was able to complete all of the required testing. Although he was given six months to complete those tests he completed them in three. (Ar. Tr. p. 25, 26)

The testing included hose crawling on his hands and knees for about 200 feet, while wearing a blacked out mask. (Ar. Tr. pgs. 24, 25). Testing also included dragging a 50 foot, 3-inch hose, for 200 feet, and dragging an uncharged, 50-foot length of hose 200 feet. (Ar. Tr. p. 27). He was also required to get on his hands and knees and roll a 50-foot, 3-inch hose "in and out." (Ar. Tr. p. 27). He also coupled and uncoupled a 4-inch hose, to and from an operating fire hydrant, an activity that included dragging a 4-inch hose off of the firetruck and connecting it to a fire hydrant, turning on the fire hydrant, charging the hose, shutting off the fire hydrant, and then disconnecting the hose. (Ar. Tr. p. 28).

He was also required to carry a 14-foot ladder approximately 10 feet without it touching the ground. He also raised a 24-foot ladder, to the roof of the fire station, and while in full gear, climbed up and down a ladder to the roof while dropping equipment on to the roof, such as (a pipe pole, an ax and a power saw. (Ar. Tr. p. 31).

As part of this testing, the Petitioner also dragged a 140-pound mannequin 40 feet. (Ar. Tr. p. 32). During this, the Petitioner testified that he had some minor discomfort in the right knee, but nothing that kept him from doing his job or responding to any other calls. (Ar. Tr. pgs. 32, 33).

The Petitioner also testified about an October 5, 2019 fire, where he was assigned to place an extension ladder to the second story of a building to rescue a woman who was stuck on a balcony. (Ar. Tr. p. 33, 34). During that fire, he also dragged a 1 ¾-inch hose about 200 feet to the third floor of the adjoining building to check if there was any fire in that building. (Ar. Tr. p. 34). After that, he took a 1 ¾-inch hose up 40 to 50 feet on an extended ladder to help fight the fire. (Ar. Tr. p. 35). After this call, the Petitioner felt some mild right knee discomfort. (Ar. Tr. p. 35).

On October 31, 2020, he went to a 100,000 square foot warehouse because an automatic fire alarm had activated. He walked through the entire building (in full gear) to check for fires (there were none). After this, he reset the alarm, it went off again, and he repeated the search. (Ar. Tr. p. 36).

As the Petitioner was working through the testing that was required by the Collective Bargaining Agreement, he also returned for medical treatment.

Twelve days after returning to work the Petitioner returned to OrthoIllinois on May 17, 2019. Although the Petitioner could not recall if he had stiffness and swelling in the right knee on

May 17, 2019, the medical records documented stiffness and swelling in his right knee and pain at 2/10 with activity. (See Petitioner's Exhibit No. 5)

Because of those complaints, the Petitioner was told to consider anti-inflammatory medication, such as Diclofenac. (See Petitioner's Exhibit No. 5). At trial, the Petitioner confirmed that the Diclofenac was an anti-inflammatory medication that was prescribed to reduce swelling in the right knee. (Ar. Tr. p. 60).

The May 17, 2019 office notes also contain a section called "Current Medications" with two separate categories, "Taking" and "Discontinued." (See Petitioner's Exhibit No. 5) According to this record, the Tizanidine was discontinued.

On June 28, 2019, the Petitioner returned to Dr. Bohnenkamp and was now describing his pain level at 5/10 with activity. As before, the June 28, 2019 report contains a medication section, but this time, Tizanidine had been prescribed, to be taken "by mouth every eight hours as needed for pain and spasms." (See Petitioner's Exhibit No. 5)

By then, Dr. Bohnenkamp, was reporting that arthritis was the source of the Petitioner's pain. According to Dr. Bohnenkamp; "He does have some arthritis in his knee. I think that is his arthritis bothering him. I had a discussion with the patient and due to ongoing symptoms and findings on today's physical exam, I recommend that they consider a cortisone injection to the right knee today." (See Petitioner's Exhibit No. 5)

The Petitioner agreed and had a cortisone injection to the right knee on June 28, 2019. (See Petitioner's Exhibit No. 5).

Over the next five weeks, the Petitioner's condition advanced and by August 1, 2019 he had new symptoms (cramping in the thigh) and new pain medication (Gabapentin). According to the August 1, 2019 report, Gabapentin was now on the active medication list (current/ taking) and he was prescribed Diclofenac and Tizanidine "every eight hours as needed for pain and spasms." (See Petitioner's Exhibit No. 5)

The Petitioner could not recall if he had stiffness or thigh cramping in his right leg on August 1, 2019. (Ar. Tr. p. 61). According to Mr. Finnegan's August 1, 2019 notes, the Petitioner's symptoms included stiffness and thigh cramping. (See Petitioner's Exhibit No. 5). These symptoms generated more treatment and according to Mr. Finnegan, "I had a discussion with the patient, and due to ongoing symptoms and findings on his physical exam, I recommend that he consider an Orthovisc injection to the right knee today."

The Petitioner agreed, and Mr. Finnegan gave the Petitioner an injection. He also wanted to see the Petitioner in a week for another injection. It was Mr. Finnegan's assessment that the Petitioner had unilateral primary osteoarthritis of the right knee and primary localized osteoarthritis of the right knee and after care following surgery. (See Petitioner's Exhibit No. 5).

On August 9, 2019, the Petitioner returned to OrthoIllinois and had a second Orthovisc injection to the right knee. On August 16, 2019, he had a third Orthovisc injection. (See

Petitioner's Exhibit No. 5) After the third injection, the Petitioner was told that he could return for another Orthovisc series of injections in six months, if needed. (See Petitioner's Exhibit No. 5)

Almost exactly six months later, the Petitioner will have another injection, but not from OrthoIllinois, but from Dr. Chudik of Hinsdale Orthopedics.

The Petitioner testified that he did not return to Dr. Bohnenkamp after August 16, 2019. He also testified that Dr. Bohnenkamp never discussed a knee replacement with him. (Ar. Tr. p. 38, 39)

On November 13, 2019 the Petitioner wanted to retire. He asked the Respondent to waive a 45-day retirement notice requirement so that he could retire by the end of November. According to the request, "Due to recent changes within my family, including my mother's health care needs, I am requesting to retire by the end of November. I am asking you to waive the 45-day notice of retirement." (See Petitioner's Exhibit No. 11)

On November 15, 2019 that request was denied by Chief James Walter, "Your request for a waiver on the 45-day notice of retirement has been denied. If you have further information you would like the manager to consider please forward to my attention." (See Petitioner's Exhibit No. 11)

The next day, the Petitioner had this accident.

3. <u>November 16, 2019 accident</u>

The Petitioner testified that on November 16, 2019, his unit was called to a fire at 6:30 in the morning. He testified that after the fire was extinguished and during the overhaul phase, he was picking up a 50-foot length of hose, slipped on black ice, felt a pop in his knee, got a sharp pain, and his knee buckled. (Ar. Tr. p. 39).

The Petitioner testified that after the accident, his knee was swollen and painful and after he reported the accident he was treated at Alexian Brothers Emergency Room. (Ar. Tr. p. 39, 40). There, according to the Petitioner, he gave a history of twisting his leg and feeling a pop in his right knee. (Ar. Tr. p. 40).

The records from Alexian Brothers indicate that the Petitioner "reports twisting right foot when he slipped on ice and felt a pop in right knee." (See Petitioner's Exhibit No. 2). There was nothing in the initial history indicating that the Petitioner had twisted his right knee and although the Petitioner testified that his knee had buckled, there is nothing in the Alexian Brothers records that say his knee had buckled during the accident. (See Petitioner's Exhibit No. 2).

Later, the Petitioner would tell Dr. Jereb of Barrington Orthopedics that he had "developed immediate pain and instability" after the November 16, 2019 accident. (Ar. Tr. p. 42 and Petitioner's Exhibit No. 4, November 25, 2019 report). This statement to Dr. Jereb varies from the Alexian Brothers records, which indicate that the petitioner arrived there at 8:40 a.m., and by 10:00 a.m. (just 80 minutes) he was telling the doctors that he felt better and wanted to go home.

(See Petitioner's Exhibit No. 2, p. 10 of 52). As a result, he was discharged with a final diagnosis of a knee sprain. (See Petitioner's Exhibit No. 2, p. 11 of 52.)

The Alexian Brothers records say nothing about buckling, and instability at the time the Petitioner was discharged and the Petitioner did not seek any medical treatment from November 16, 2019 until November 25, 2019, when he saw Dr. Jereb, who ordered an MRI scan.

The December 3, 2019 MRI scan found a complex tear to the posterior horn and medial meniscus and osteoarthritis, most severely affecting the medial compartment. (See Petitioner's Exhibit No. 4).

On December 9, 2019 the Petitioner returned to Dr. Jereb to discuss the MRI and treatment options. (Ar. Tr. p. 42). Those treatment options included a total knee replacement, which was confirmed by the records from Dr. Jereb, "the only definitive treatment for degenerative arthritis would be a total knee arthroplasty." (See Petitioner's Exhibit No. 5).

At arbitration, the Petitioner was asked to describe the differences between the March 2019 accident while walking his dog and the November 16, 2019 accident while at work. According to the Petitioner, "with this injury, there was definitely a twisting of my knee, a pop, a definite strange pain right away, throbbing pain immediately. There was swelling right away. There was definitely a difference." (Ar. Tr. p. 43).

The Petitioner testified that after Dr. Jereb had recommended a total knee replacement, he went to see Dr. Steven Chudik of Hinsdale Orthopedics on December 13, 2019. (Ar. Tr. p. 47). Petitioner testified that he learned of Dr. Chudik from his attorney. (Ar. Tr. p. 47).

The Petitioner testified that Dr. Chudik recommended physical therapy at ATI, which the Petitioner had until January 31, 2020. (Ar. Tr. pgs. 48, 49). The Petitioner testified that during this period, he was experiencing pain and had difficulty walking, bending, stair climbing, carrying objects, and twisting. (Ar. Tr. p. 48).

On February 3, 2020, the Petitioner returned to Dr. Chudik, telling him that his right knee pain was not improving. (Ar. Tr. p. 49). Dr. Chudik gave the Petitioner an injection into the right knee and then recommended a right knee replacement.

Because of COVID, the Petitioner's surgery was delayed until May 13, 2020, when he had a total right knee replacement. (Ar. Tr. pgs. 50, 51). After that, the petitioner had physical therapy in July and August, resulting in approximately 70 percent improvement in strength in the right knee. (Ar. Tr. p. 51).

The Petitioner testified that in August of 2020, he developed postoperative arthrofibrosis which required an arthroscopic manipulation of the knee to break up and free scar tissue in the knee. He had that procedure on August 25, 2020. (Ar. Tr. pgs. 51, 52).

Petitioner testified that as of April 9, 2021, Dr. Chudik's records reflected some swelling on the outside of the knee and tightness with occasional shin pain. (Ar. Tr. p. 54). As of May 24,

2021, Dr. Chudik's records reflected some tightness in the Petitioner's right knee, but an ability to do all of the activities of daily living with no pain. (Ar. Tr. p. 55).

At arbitration, the Petitioner complained of some stiffness in the knee and tightness in the knee that do not affect this ability to walk, but do affect his ability to work. (Ar. Tr. p. 54). At arbitration, the Petitioner's main complaint appeared to be a reduced range of motion with flexion in the right knee, which he described as about a 70 percent reduction. (Ar. Tr. p. 56).

He testified he was unable to carry ladders or heavy objects going up and down stairs. (Ar. Tr. p. 56).

Dr. Chudik testimony

On October 7, 2020 Dr. Chudik testified for the Petitioner by way of an evidence deposition. Dr. Chudik testified that he first saw the petitioner on December 13, 2019. During this visit, Dr. Chudik took a history which included the petitioner's prior knee surgery on April 2, 2019 and the petitioner's November 16, 2019 accident, when he slipped on ice, while cleaning up after a fire. Dr. Chudik testified he examined the petitioner's right knee and reviewed x-rays which confirmed degenerative arthritis in the petitioner's right knee.

As a result of the petitioner's complaints and examination, Dr. Chudik took the petitioner off work and recommended conservative treatment. Dr. Chudik testified that the petitioner returned on December 18, 2019. He reviewed the petitioner's MRI scan and found a significant loss of cartilage and a torn medial meniscus. As a result of his December 18, 2019 examination, Dr. Chudik recommended physical therapy. If his symptoms persisted, he would administer a cortisone injection.

The petitioner had the physical therapy and returned to Dr. Chudik on February 3, 2020. Dr. Chudik testified that he re-examined the petitioner and found tenderness in the right knee, a full range of motion, normal strength, stability and symmetry. During this examination Dr. Chudik administered a cortisone injection and ordered a CT scan in anticipation of surgery. According to Dr. Chudik they discussed future treatment and the petitioner agreed to a total knee replacement.

Dr. Chudik testified that on May 13, 2020 the petitioner had the recommended total knee replacement. He testified that after surgery he continued to see the petitioner. Eventually the Petitioner showed evidence of stiffening in the right knee and a buildup of scar tissue. Because of that Dr. Chudik performed a second procedure, on August 25, 2020, which was a manipulation of the right knee under anesthesia.

Dr. Chudik agreed that the petitioner had a significant pre-existing condition and he described this accident as the "straw that broke the camel's back." He testified that this accident aggravated the petitioner's preexisting condition, causing the need for a total right knee replacement.

Dr. Lieber testimony

Dr. Lieber testified for the Respondent, also by way of an evidence deposition. He testified that he examined the petitioner on February 20, 2020, and that as part of that examination he reviewed the April 2, 2019 operative report from the Algonquin Road Surgical Center, which confirmed that the petitioner had a partial medial meniscectomy, a chondroplasty and bone-on-bone changes in the right knee in April of 2019.

In addition, Dr. Lieber had reviewed the medical records from Dr. Bohnenkamp, from Dr. Jereb, from Alexian Brothers and the March 9, 2019 x-rays of the petitioner's right knee, the March 14, 2019 MRI of the petitioner's right knee and the December 3, 2019 MRI of the Petitioner's right knee. According to Dr. Lieber the actual MRI films did not show a complex tear of the posterior horn of the medial meniscus.

Regarding causal connection, it was Dr. Lieber's opinion that there was no causal connection between the petitioner's current condition and the accident the petitioner described to him. He also testified that it was his opinion that the petitioner's need for a total right knee replacement is unrelated to this accident but instead is related to the petitioner's long-standing pre-existing condition.

F. Is Petitioner's knee condition causally related to this accident?

After reviewing the trial exhibits, including the medical records, the Petitioner's testimony, and the testimony of each expert, the Arbitrator hereby finds that the Petitioner failed to prove a causal connection between this accident and the total right knee replacement. Therefore, for the following reasons the Petitioner's claim is hereby denied.

The Petitioner's right knee problems started on March 8, 2019 when he injured his right knee while walking his dog. After that accident, the Petitioner started treating with Dr. Bohnenkamp complaining of sharp right knee pain (8/10 with activity), clicking, giving away, limping, stiffness, swelling, and tightness. Subsequent testing (an MRI scan) revealed a host of degenerative conditions in the Petitioner's right knee, including meniscal degeneration and Grade 4 chondromalacia at the medial compartment.

After that accident, the Petitioner had surgery and physical therapy. After returning to work the Petitioner's pain increased, resulting in increased pain medication and treatment recommendations. All because of the Petitioner's preexisting arthritis.

Although the Petitioner could not recall if Dr. Bohnenkamp had told him that he had arthritis, or that the arthroscopic surgery would not cure his arthritis, the medical records are clear, he had arthritis and the first arthroscopic surgery would not help it.

1. According to Dr. Bohnenkamp's March 19, 2019 report "The patient understands that we cannot cure arthritis with an arthroscopy."

2. According to the Dr. Bohnenkamp's April 2, 2019 operative report, "He is aware that he has some degenerative changes on x-ray. He does have a degenerative meniscal tear

on the MRI, and he is aware that knee arthroscopy may help alleviate his mechanical symptoms, but not his arthritic symptoms."

The Petitioner now claims that Dr. Bohnenkamp never recommended a right knee replacement. This misguided notion, would later be relied on by Dr. Chudik, even though it was contradicted by Dr. Bohnenkamp's April 2, 2019 operative report where he indicates that, "[the Patient] is not opting for any kind of arthroplasty procedure at this time." The medical definition of the word "arthroplasty" is the surgical reconstruction or replacement of a joint.

A patient can't opt for or against something, unless it was an option to begin with. Context here is important. This quote is from the Petitioner's exhibit, in a case where he has the burden of proof, yet he said nothing about any of these entries, other than to deny them or not remember them.

The Petitioner's faulty memory can't change what the records say. The degenerative changes that Bohnenkamp had discussed with the Petitioner were also documented during the surgery. According to the postoperative diagnosis the Petitioner had a right knee medial meniscus tear, grade 4 bone-on-bone changes of the medial compartment, a hypertrophic, inflamed synovitis, and chondromalacia from the patellofemoral joint.

When the Petitioner returned to work on May 6, 2019 he immediately had problems. The records from Dr. Bohnenkamp and OrthoIllinois document increased pain complaints, changing complaints, changes to prescribed medications and escalating treatment. It is these conditions that led to the knee replacement, not the November 16, 2019 accident.

a. <u>Increasing pain</u>

The Petitioner's pain continued to escalate after he returned to work. On May 17, 2019 the Petitioner was complaining of stiffness and swelling in the right knee along with pain with activity at 2/10. By June 28, 2019 the Petitioner's pain level had increased to 5/10 with activity. On August 1, 2019 the Petitioner's pain was still at 5/10 with activity but his complaints had now expanded to include thigh cramping.

These increasing complaints were predicted by Dr. Bohnenkamp who indicated the knee arthroscopy would only help alleviate the Petitioner's mechanical symptoms, but not his arthritic symptoms. So, it isn't surprising that Petitioner still had pain coming from the arthritis.

b. <u>Changing medications</u>

The Petitioner's increasing pain also caused changes in the medication he was being prescribed. On May 17, 2019 the Petitioner was prescribed an anti-inflammatory medication, Diclofenac for swelling. The Tizanidine (for pain and spasms) was discontinued, but by June 28, 2019, it re-appeared as an active prescription to be taken, "by mouth every eight hours as needed for pain and spasms."

On August 1, 2019 Gabapentin appeared on the active medication list, along with Diclofenac and Tizanidine every eight hours as needed for pain and spasms.

Because the Petitioner's arthritic condition had not yet been treated, it isn't surprising that he was still symptomatic, and according to his complaints and prescriptions, his condition was not getting better.

c. Increasing treatment

All of this led to ever increasing treatment recommendations. On May 17, 2019 the only treatment that was recommended, was medication, Diclofenac. That changed on June 28, 2019 when Dr. Bohnenkamp was recommending (and administering) a cortisone injection to the Petitioner's right knee. Five weeks later a series of Orthovisc injection were recommended, resulting in three Orthovisc injections (on August 1, 2019, August 9, 2019 and August 16, 2019).

So, contrary to the Petitioner's testimony, his condition was deteriorating from the arthritic condition. The accident did nothing to change a condition that was already requiring more medication and more treatment, despite the Petitioner's faulty memory when it comes to his recovery from the first accident. For example, when he was asked if he had stiffness in the right knee on August 1, 2019, he couldn't recall. (Ar. Tr. p. 61). When he was asked if he had thigh cramping in his right leg on August 1, 2019, he couldn't recall. (Ar. Tr. p. 61) Yet, both conditions were documented in the August 1, 2019 report from OrthoIllinois, where the Petitioner's complaints had included stiffness and thigh cramping. (See Petitioner's Exhibit No. 5)

d. Nature of the Petitioner's accident

This was a minor accident, that had no effect on his arthritic right knee. The Petitioner testified that after the accident, his knee was swollen and painful and that he was immediately treated at Alexian Brothers Emergency Room. Later, the Petitioner would tell Dr. Jereb of Barrington Orthopedics that he had "developed immediate pain and instability" after the November 16, 2019 accident.

That testimony, like other parts of the Petitioner's testimony, merely flirts with the truth, but never makes its acquaintance. The records from Alexian Brothers Medical Center indicate that the petitioner arrived there at 8:40 a.m., and by 10:00 a.m. (just 80 minutes) he was telling the doctors that he felt better and wanted to go home. As a result, he was discharged with a final diagnosis of a knee sprain.

The Alexian Brothers records say nothing about complaints of swelling, buckling, and instability at the time the Petitioner was discharged from Alexian Brothers. The Petitioner did not even seek any medical treatment between November 16, 2019 until November 25, 2019, when he saw Dr. Jereb, who ordered an MRI scan.

After the Petitioner's first accident while walking his dogs, he had immediate symptoms, such as a sharp right knee pain (8/10 with activity), clicking, giving away, limping, stiffness,

swelling, and tightness. After this work accident, the Petitioner was seen for less than two hours, diagnosed with a knee strain and asked to be discharged because he felt fine.

This accident was a minor event, it did not aggravate the Petitioner's preexisting arthritic condition and was not a causative factor for the Petitioner's subsequent knee replacement.

Conclusion

Therefore, the Arbitrator hereby denies the Petitioner's claim and adopts Dr. Lieber's opinion that there was no causal connection between this accident and the petitioner's arthritis, the total right knee replacement, and any other lost time and treatment associated with the petitioner's arthritis and total right knee replacement.

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

Because of the Arbitrator's finding on causation, the Petitioner's claim for past and future medical care is hereby denied.

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

Because of the Arbitrator's finding on causation, the Petitioner's claim for temporary total disability benefits is hereby denied.

O. Is the Petitioner's right knee surgery causally connected to this accident?

Because of the Arbitrator's finding on causation, the Petitioner's claim for future medical care is hereby denied.

(L): What is the nature and extent of the injury?

Because of the Arbitrator's finding on causation, the Petitioner's claim for permanency is hereby denied.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC031248
Case Name	KALEFF, SHERRI v. HELP AT HOME
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0239
Number of Pages of Decision	28
Decision Issued By	Christopher Harris, Commissioner

Petitioner Attorney	Jason Caraway
Respondent Attorney	Michael Bantz

DATE FILED: 6/29/2022

/s/Christopher Harris, Commissioner
Signature

DISSENT: /s/Christopher Harris, Commissioner
Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SHERRI KALEFF,

Petitioner,

vs. NO: 15 WC 31248

HELP AT HOME,

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 applicable law, reverses the Decision of the Arbitrator for the reasons outlined below. The Commission finds that Petitioner proved by the preponderance of the evidence that she sustained accidental injuries that arose out of and in the course of her employment by Respondent on September 4, 2015. The Commission has further considered the parties' arguments with respect to causal connection and worker's compensation benefits and additionally finds in favor of Petitioner on these issues.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner, an in-home healthcare worker, testified that on September 4, 2015, she had been delayed preparing lunch for a client and was rushing to get to her second client's home so she could timely clock-in. (T.14-17). "You have X amount of time from point A to point B so I was in a big hurry to get from point A to point B and I tripped . . ." (T.16).

The September 4, 2015 ambulance report stated that Petitioner was a known diabetic, "but today she was on her way into friendship manor to take care of a resident and she fell in the parking lot hitting a parking block with her elbow." (PX2; RX5). Petitioner's main complaint was to her left elbow wherein a large hematoma, an abrasion and a lot of swelling were noted. (PX2; RX5).

The ambulance report indicated that paramedics reached Petitioner approximately seven minutes after the incident/onset time. Examination revealed that Petitioner's eyes were reactive, she was oriented and had appropriate speech, and obeyed commands with appropriate motor responses. The report further stated that Petitioner's glucose level had been checked and it was at

66. (PX2; RX5). Petitioner testified: "My high is anything over 250, my low is anything below 50." (T.20-22).

Petitioner also testified that on the accident date, she wore an insulin pump attached to her as well as a Dexcom on her right arm. "[M]y Dexcom is hooked to my telephone and when you turn my telephone on it will alert me when my sugars are going low or when my sugars are going too high . . ." Petitioner testified that the Dexcom did not send any signal to her on September 4, 2015. (T.21).

The September 4, 2015 emergency room record of Abraham Lincoln Memorial Hospital noted that Petitioner's injury occurred just prior to arrival and she "[f]ell while standing and landed on a concrete surface; tripped." (PX3). The emergency room record further noted that Petitioner was alert and orientated, and her blood glucose level was 50. The physician examined Petitioner's left elbow and noted severe tenderness, swelling, a large abrasion, ecchymosis and mild deformity. Petitioner's range of motion was limited secondary to pain but her left shoulder and wrist range of motion were full. The medical record also noted that Petitioner had an insulin pump and was diabetic, but there were no additional notes related to Petitioner's diabetic condition. (PX3).

Petitioner followed-up with Dr. David Olysav at Springfield Clinic on September 9, 2015. The history of injury recorded was: "[S]he was going along the sidewalk to a patient's home when she fell onto her left elbow." Dr. Olysav noted that Petitioner was diabetic and insulin dependent. (PX4; RX1). He examined Petitioner's left elbow and noted a deep abrasion in the area of the projected surgical incision for repair of the olecranon fracture. Dr. Olysav suggested that the wound heal first before proceeding with any surgery. (PX4; RX1).

Petitioner next consulted with Dr. Brett Keller at Central Illinois Orthopedic Surgery on September 14, 2015. (T.25; PX5). The office visit note stated that Petitioner was "status post a fall on the left elbow in the parking lot of her employer on 9/4/2015. The patient states she was walking out to her car and suffered the fall." (PX5). Dr. Keller noted Petitioner's history of treatment and that she had developed an infection over the abrasions she suffered on the left elbow. Dr. Keller also noted Petitioner's history of diabetes and "heart trouble." (PX5).

Dr. Keller examined Petitioner's left upper extremity and diagnosed her with a left olecranon interarticular displaced fracture with overlying abrasion over the left elbow. Dr. Keller recommended a left olecranon open reduction internal fixation but first wanted to address Petitioner's infection. (T.25-26; PX5). Petitioner eventually had surgery on September 28, 2015. (PX5; PX8).

After surgery, Petitioner followed-up with Dr. Keller who ordered post-operative physical therapy. Dr. Keller also allowed Petitioner to return to work on October 7, 2015 with restrictions. (T.26; PX5). Petitioner commenced physical therapy at the Neuro Ortho Rehab Center on October 16, 2015. The therapy record noted that Petitioner remained off work because her employer would not allow her to return at this time. (PX5).

On November 3, 2015, Dr. Keller released Petitioner to return to work without restrictions and discontinued therapy. (T.27; PX5).

Petitioner returned to Dr. Keller on March 3, 2016 with a new complaint of left upper arm pain. (T.28-29; PX5). Petitioner denied that she sustained any new trauma. (T.29). Dr. Keller examined Petitioner and diagnosed her with left shoulder adhesive capsulitis, biceps tendinitis and he was concerned that Petitioner may have a rotator cuff tear. He ordered an MRI of the left shoulder and humerus and recommended that Petitioner avoid lifting, pushing or pulling. (T.30; PX5).

Dr. Keller reviewed the MRIs on March 17, 2016, administered a cortisone injection into Petitioner's shoulder and ordered physical therapy. (T.32; PX5). Petitioner commenced physical therapy for the left shoulder at Abraham Lincoln Memorial Hospital on March 24, 2016. (T.32; PX3). The PT Evaluation form noted that Petitioner had fractured her elbow on September 4, 2015 in a fall at work and had surgery on September 28, 2015. "Left arm was immobilized for approx. 2 months total, which MD advised was cause of pt's shoulder problems – led to frozen shoulder." (PX3). The evaluation note further indicated that Petitioner had received a cortisone injection about a week prior and that Petitioner was feeling "so much better." The record also stated that Petitioner had improvement with range and had no functional limitations or range of motion restrictions. Upon assessment, Petitioner demonstrated some mild capsular tightness with range of motion restrictions late in range, but Petitioner reported that she was independent with all work duties and household chores. (PX3).

Petitioner attended two rounds of physical therapy at Abraham Lincoln Memorial Hospital from March 24, 2016 through April 28, 2016 and commenced again on June 13, 2016. (PX3). Petitioner testified that the treatment did not resolve her symptoms. (T.32; PX5). On July 29, 2016, Dr. Keller recommended proceeding with a left shoulder arthroscopy and noted: "The patient has failed all conservative treatment including but not limited to: activity restrictions, anti-inflammatory medications, pain medications, physical therapy/HEP, and cortisone/Synvisc injections . . ." (PX5). Petitioner testified that she had been working up until a day or so before the surgery. (T.32-33).

On August 24, 2016, Petitioner underwent arthroscopic debridement of a partial-thickness, undersurface supraspinatus tear, a distal clavicle excision, lysis of adhesions, a subacromial decompression and manipulation. Petitioner's post-operative diagnoses were left shoulder impingement syndrome, AC joint osteoarthritis, adhesive capsulitis and partial undersurface supraspinatus tear. (T.31-32; PX5).

Petitioner followed-up with Dr. Keller on September 1, 2016 who noted that Petitioner had been attending post-operative physical therapy and doing well. She also informed Dr. Keller that during therapy, she had been instructed to stretch her arm across her body and as she was doing the move, she heard a pop and felt immediate pain. (T.33; PX5). Dr. Keller indicated that Petitioner's pain was in the AC joint region. X-rays of the left shoulder completed at the appointment revealed a small non-displaced anterior acromion fracture. (PX5). Petitioner testified: "[A]ll I could do is wait another six weeks for it to heal so for six weeks I suffered until it healed and now I'm stuck in the one position I'm in . . ." (T.33-34).

On January 24, 2017, Dr. Keller ordered a functional capacity evaluation (FCE) which Petitioner completed at Azer Clinic on February 16, 2017. (T.34; PX5; PX7). The FCE report noted that Petitioner sustained a work-related injury on September 4, 2015 "when she fell in a parking lot at an independent living facility. She caught her toe on a speed bump on the pavement." The remainder of Petitioner's history of complaints and treatment was consistent with the arbitration record. Petitioner's job duties were also noted, and the report further stated that the heaviest Petitioner had to lift or carry was a client/patient. (PX5; PX7).

Dr. Keller reviewed the results of the valid FCE on March 14, 2017. He noted that Petitioner continued to have discomfort with motion and use of the left arm and shoulder. Dr. Keller gave Petitioner permanent restrictions per the FCE and stated that Petitioner was at maximum medical improvement (MMI). He noted that the FCE report indicated Petitioner could work light duty with a 10-pound lifting restriction from waist to shoulder and a 20-pound lifting restriction from floor to waist. Dr. Keller also indicated that Petitioner had limitations in range of motion and strength with near full effort during the FCE. (T.35; PX5; PX7). Petitioner returned to work for Respondent with those restrictions. (T.35).

The Arbitrator found that Petitioner failed to prove that she suffered an accident on September 4, 2015 that arose out of and in the course of her employment by Respondent. The Arbitrator determined that Petitioner sustained a non-compensable, idiopathic fall at work due to her serious, pre-existing diabetic condition.

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 Commission has considered all the testimony, exhibits, pleadings, and arguments submitted by the parties.

Petitioner testified that she was in the parking lot of a client's apartment complex when she tripped on a median, "like a speed bump, that had been taken out." (T.14-15). By Petitioner's testimony, part of a median/speed bump remained and she tripped over it and fell on September 4, 2015. She testified that she had taken a picture of the area where she fell about a month or two after she had returned to work. Petitioner's Exhibit 11 was a photograph that showed a raised asphalt/speed bump in the parking lot. Respondent's witness, Jenifer Persuhn, testified that she did not actually see Petitioner fall. On September 4, 2015, she had parked her car after dropping off a client at the front of the apartment complex and when she started walking back to the building, she saw Petitioner already on the ground, on the sidewalk. Ms. Persuhn testified that she had taken pictures within a few days after the incident. Respondent's Exhibit 12 were various photographs of the sidewalk and area where Ms. Persuhn had seen Petitioner. The photos did not include the parking lot or depict a speed bump. The Commission is neither persuaded by the photographs taken by Ms. Persuhn nor her testimony that there were no defects, damage, or any obstructions or objects in the area where Petitioner allegedly fell. Petitioner did not testify to falling on the sidewalk. She testified to tripping on part of a speed bump in the parking lot.

The Commission is further not persuaded by Respondent's argument that Petitioner's fall was the result of a diabetic episode and that her injuries thus did not arise out of her employment. Petitioner testified that she had been diabetic for 51 years and with respect to her blood glucose levels: "My high is anything over 250, my low is anything below 50." (T.20-22). Certain medical records, specifically the September 4, 2015 emergency room records, indicated that the low end of normal for glucose was around 70. However, Petitioner testified that she did not feel symptoms of hypoglycemia until her blood glucose went below 50 mg/dL. The Commission finds no medical testimony or evidence to rebut this measurement or value as it specifically relates to Petitioner and her diabetic episodes. This number also conforms with the majority of the medical records related to Petitioner's diabetic episodes.

Petitioner testified that when her blood glucose level was low, she may daze off, become sweaty and extremely shaky. "I can't speak, my words become slurred almost as if I was a drunk . . . but still able to walk and carry on." (T.23-24). The September 4, 2015 ambulance report indicated that paramedics reached Petitioner approximately seven minutes after the incident/onset time. Her blood glucose level was at 66 and examination revealed that Petitioner was oriented, had appropriate speech and obeyed commands with appropriate motor responses. The September 4, 2015 emergency room record similarly noted that Petitioner was alert and orientated. There was no indication Petitioner appeared dazed, sweaty, shaky or "drunk." Petitioner's glucose test at the hospital was at 50.

By its Brief, Respondent argued that Petitioner had an ongoing and recurring problem of monitoring and controlling her diabetic condition and that medical records showed that Petitioner experienced issues with falling and having syncopal episodes. The Commission notes the pre- and post-accident medical records related to Petitioner's need for medical attention due to her diabetic and other medical conditions. However, the Commission finds significant that the medical records specifically documenting the fall of September 4, 2015, do not indicate any evidence that Petitioner had a diabetic or syncopal-related episode, or that Petitioner was experiencing issues with her insulin pump on September 4, 2015.

The Arbitrator had found Respondent's witnesses, Ms. Persuhn and Ms. Pate, more credible than Petitioner – especially given Ms. Pate's recorded statement to the insurer which the Arbitrator found consistent with her deposition testimony. The Commission notes that by the testimonies and record, both Ms. Persuhn and Ms. Pate had been good friends with Petitioner but no longer communicate due to considerable personal issues which the Commission finds adversely undermines the credibility of those witnesses.

Ms. Pate testified that Petitioner called her "laughing" on September 5, 2015 and had told her that Petitioner's blood sugar level had been low when she "hit the concrete thing" and fell. (RX10, pg. 9). Ms. Pate also testified to observing Petitioner having diabetic episodes. Ms. Pate noticed that during these episodes, Petitioner appeared disorientated, could not sit up on her own and she did not have good balance. However, the Commission notes that Ms. Pate did not see Petitioner on the date of the fall, September 4, 2015. Ms. Persuhn testified that on September 4, 2015, Petitioner appeared to be disorientated and did not seem to recognize her. Ms. Persuhn also testified to previously witnessing Petitioner having diabetic episodes wherein Petitioner appeared

disorientated, had balance issues and had trouble walking. Notwithstanding, Ms. Persuhn testified that she did not actually see Petitioner fall on September 4, 2015. Petitioner also denied telling Ms. Pate that her sugar had been low when she hit the speed bump and fell and denied that she was laughing as she was in severe pain. Petitioner additionally denied that Ms. Persuhn had witnessed her having five to six diabetic episodes.

Based on the preponderance of the evidence, the Commission finds that Petitioner met her burden of proving that she sustained an accident that arose out of and in the course of her employment with Respondent on September 4, 2015. The Commission finds credible Petitioner's testimony that she was running late, in a hurry, did not notice the speed bump, tripped and fell in the parking lot. Petitioner's evidence is not limited to her testimony but is buttressed by the subsequent medical records, including the September 4, 2015 ambulance report, that make no mention that Petitioner fell following a diabetic episode. The medical records all indicate that she tripped over a speed bump/parking block/concrete surface in the parking lot and fell. The Commission also finds that Ms. Persuhn's testimony and the photographs she took following the accident did not correlate with Petitioner's mechanism of injury.

The Commission further finds the record devoid of any credible evidence that Petitioner sustained a diabetic episode or symptoms which attributed to her fall in any way on September 4, 2015. While Petitioner's glucose levels were checked on September 4, 2015, Petitioner was not treated for low blood glucose levels. The remainder of the medical records corroborate Petitioner's testimony that she does not experience symptoms of hypoglycemia until her blood glucose level is below 50. The information alleging Petitioner had a diabetic episode at the time of her fall on September 4, 2015, came solely from Respondent's two witnesses and their personal recollections of how Petitioner presented during past unrelated diabetic events. In light of the record in its entirety, the Commission finds that this witness testimony does not provide a persuasive basis on which to conclude that Petitioner's fall was due to her diabetic condition and thus did not arise out of her employment. Rather, the Commission finds more persuasive the medical records from the date of the fall which corroborate Petitioner's testimony regarding the circumstances of her trip and fall.

The Commission therefore reverses the Arbitrator's Decision on the issue of accident and finds that Petitioner sustained a fall at work on September 4, 2015 which arose out of and in the course of her employment for Respondent.

With respect to causation, Respondent argued in the alternative in its Brief and stated that if the Commission determined that Petitioner sustained a work-related injury, then it claimed that only Petitioner's left elbow fracture injury was related. Respondent disputed causal connection for Petitioner's left shoulder condition on the basis that Petitioner's left shoulder complaints did not appear until six months after the accident, or on March 3, 2016, and that it may have been caused by one of Petitioner's diabetic episodes when Petitioner had been reportedly combative. The Commission finds no support for Respondent's latter argument as there is no evidence that Petitioner injured her shoulder during any diabetic episode prior to March 3, 2016.

Petitioner claimed that her left shoulder condition was a sequelae of the elbow injury. Following the accident, Petitioner underwent a left olecranon open reduction internal fixation on

September 28, 2015 as well as post-operative physical therapy. By November 3, 2015, Petitioner reported to Dr. Keller that she was doing well and could "do everything now that she could do prior to fracturing the elbow." (T.27). Dr. Keller released Petitioner to return to work without restrictions and he discontinued therapy. It is noted in the therapy records that treatment included active shoulder stretches and on October 19, 2015, the physical therapist indicated that Petitioner was "pleased with her rapid progress but may not fully understand the need to scale back her activity level to allow for full/proper healing." (PX5). Petitioner eventually returned to work for Respondent on December 23, 2015.

On March 3, 2016, Petitioner reported to Dr. Keller that she had had left upper arm pain for about two to three months and it was in the mid-humerus region. The pain was between the elbow and shoulder. Petitioner also reported a palpable lump in the mid-humerus that had been present since the ORIF surgery. Petitioner denied that she sustained any new trauma. Dr. Keller examined Petitioner and diagnosed her with left shoulder adhesive capsulitis, biceps tendinitis and he was concerned that Petitioner may have a rotator cuff tear.

The medical records do not reveal any shoulder issues or complaints until the March 3, 2016 office visit note. All that is noted is that Petitioner had stopped therapy which involved her shoulder in November 2015 and she returned to work in December 2015. Dr. Keller ordered physical therapy for Petitioner which she commenced on March 24, 2016. The PT evaluation note stated that Petitioner had fractured her elbow on September 4, 2015 in a fall at work and had surgery on September 28, 2015. "Left arm was immobilized for approx. 2 months total, which MD advised was cause of pt's shoulder problems – led to frozen shoulder." (PX3).

Petitioner completed an MRI of the left shoulder on March 10, 2016 which revealed mild AC joint osteoarthritis, mild subacromial subdeltoid bursitis, labral tears, and extensive supraspinatus, less prominent infraspinatus and subscapularis intrasubstance contusion and edema. Petitioner also underwent an MRI of the left humerus on March 10, 2016. The impression demonstrated a possible small sebaceous cyst, tendinopathy with small effusions and fixation devices in the proximal ulna. Dr. Keller recommended a left shoulder arthroscopy and noted: "The patient has failed all conservative treatment including but not limited to: activity restrictions, anti-inflammatory medications, pain medications, physical therapy/HEP, and cortisone/Synvisc injections . . ." (PX5).

On August 24, 2016, Petitioner underwent arthroscopic debridement of a partial-thickness, undersurface supraspinatus tear, a distal clavicle excision, lysis of adhesions, a subacromial decompression and manipulation. Petitioner's post-operative diagnoses were left shoulder impingement syndrome, AC joint osteoarthritis, adhesive capsulitis and partial undersurface supraspinatus tear. While performing a maneuver in post-operative physical therapy, Petitioner sustained an injury to the AC joint region. X-rays of the left shoulder completed at the appointment revealed a small non-displaced anterior acromion fracture which healed on its own within six weeks.

There were no formal medical opinions with respect to causation in evidence. However, the Commission finds that the chain of events favor Petitioner in this regard. The timeline of Petitioner's shoulder complaints flow reasonably following her discharge from treatment and her

return to work in November and December 2015. By the medical records, both Dr. Keller and the physical therapist related Petitioner's shoulder condition to her elbow surgery following the September 4, 2015 fall at work. Petitioner testified to no pre-existing shoulder injury or issue and she also denied any subsequent accident to the left shoulder. The record demonstrated that Petitioner was not symptomatic or did not present with left shoulder issues until post-elbow surgery and after she stopped treatment and returned to her unrestricted duties. In light of the preponderance of the foregoing evidence, the Commission finds that Petitioner's left shoulder condition as well as the left elbow condition are causally connected to the September 4, 2015 work injury and as such, Petitioner is entitled to worker's compensation benefits.

Respondent's dispute with respect to benefits centered on its position on the issues of accident and causation. Having determined those issues in Petitioner's favor, the Commission awards the reasonable and necessary medical bills related to the left elbow and shoulder as detailed in Petitioner's Exhibit 13. The Commission further awards TTD benefits from September 5, 2015 through September 8, 2015 and from September 28, 2015 through November 2, 2015. The Commission finds no genuine dispute with respect to the TTD period by the parties' Briefs and the claimed period is supported by the record.

The Commission next awards PPD benefits of 25% loss of use of the left arm pursuant to Section 8(e) of the Act and 12.5% loss of the person as a whole for the left shoulder pursuant to Section 8(d)2 of the Act. The Commission has considered the five factors under Section 8.1b of the Act:

(i) Impairment Rating: The parties did not offer any impairment rating into evidence. The Commission gives this factor no weight.

(ii) Occupation of Injured Employee: On March 14, 2017, Dr. Keller gave Petitioner permanent restrictions per the February 16, 2017 FCE. He noted that the FCE report indicated Petitioner could work light duty with a 10-pound lifting restriction from waist to shoulder and a 20-pound lifting restriction from floor to waist. Dr. Keller also indicated that Petitioner had limitations in range of motion and strength with near full effort during the FCE. Petitioner returned to work for Respondent with those restrictions. Respondent stated that a September 26, 2017 work status indicated that Dr. Keller released Petitioner to work without restrictions. Petitioner confirmed this during cross-examination, but also testified during re-direct that for this work injury she was released with restrictions per the FCE. (T.53-54). Notwithstanding, the September 26, 2017 work status appears to be related to a patella fracture and there is no office visit note explaining this. (RX8). The Commission gives this factor moderate weight.

(iii) Petitioner's Age: Petitioner was 49 years old on the accident date; neither party submitted evidence into the record which would indicate the impact of the Petitioner's age on any permanent disability resulting from the September 4, 2015 accident. Nonetheless, the Commission takes into consideration that Petitioner must still live with this disability and gives this factor some weight.

(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: Evidence of Petitioner's disability is corroborated by the treating medical records. Following the September 4, 2015 trip and fall in the parking lot, Petitioner first sustained an infection with pus drainage and a 7 cm abrasion over her left olecranon which forced her to postpone the recommended left olecranon open reduction internal fixation. Petitioner subsequently underwent surgery and post-operative physical therapy but became symptomatic in her left shoulder a few months after she had stopped treatment, stopped physical therapy and returned to work without restrictions.

Despite conservative measures by way of injections and physical therapy, Petitioner remained symptomatic and Dr. Keller proceeded with left shoulder surgery. Petitioner then underwent post-operative physical therapy and sustained a small non-displaced anterior acromion fracture during one of the therapy movements.

As of the date of arbitration, Petitioner testified that placing her left elbow directly on a desk or laying her arm flat caused pain. She had difficulty putting on a bra and putting her hair in a ponytail. Petitioner was right-handed so she used her right arm to compensate for her left elbow/left shoulder conditions. Petitioner stated that her arm made it difficult to use the ATM, but "job wise I can still do my job, I just have to use my right hand to reach up to the cabinets and grab things. I can't reach high places with my left arm because of course it only goes this high . . ." (T.45-46). The Commission gives this factor significant weight.

In light of the foregoing, with no single enumerated factor being the sole determinant of disability, the Commission finds that Petitioner is entitled to PPD benefits of 25% loss of use of the left arm pursuant to Section 8(e) of the Act and 12.5% loss of the person as a whole for the left shoulder pursuant to Section 8(d)2 of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed on October 4, 2021, is hereby reversed for the reasons stated above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay all reasonable, necessary, and related medical bills as evidenced in Petitioner's Exhibit 13 pursuant to Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner temporary total disability benefits of $395.05 per week for 5 5/7 weeks, from September 5, 2015 through September 8, 2015 and from September 28, 2015 through November 2, 2015, that being the period of temporary total incapacity for work under Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner permanent partial disability benefits of $355.55 per week for 125.75 weeks because the injuries sustained caused twenty-five percent (25%) loss of use of the left arm pursuant to Section

8(e) of the Act and twelve-and-a-half percent (12.5%) loss of the person as a whole for the left shoulder pursuant to Section 8(d)2 of the Act.

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.

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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.

June 29, 2022
CAH/pm
O: 5/5/22
052

/s/ *Carolyn M. Doherty*
Carolyn M. Doherty

/s/ *Marc Parker*
Marc Parker

DISSENT

I respectfully dissent from the Majority's opinion.

The principal issue in this claim is accident and whether Petitioner tripped and fell on a speed bump in the parking lot of her client's apartment complex or whether she fell as a result of a diabetic episode. Petitioner's credibility as well as the credibility of Respondent's witnesses were key on this issue and I find that the Arbitrator was in the best position to make that assessment, especially with respect to Petitioner's testimony at arbitration.

As noted by the Arbitrator, Petitioner testified that as she was cutting through the parking lot on September 4, 2015, a median or speed bump had been taken out, but that her foot still hit part of the speed bump that apparently remained. Petitioner's Exhibit 11, however, was a photograph that Petitioner took herself and depicted a speed bump that appeared permanent with no part removed. Respondent's witness, Ms. Persuhn, testified that although she did not see Petitioner fall, she saw Petitioner lying on the sidewalk. This is consistent with the majority of the histories noted in the medical records, including the September 4, 2015 emergency room records that did not indicate that Petitioner fell as a result of tripping over a speed bump. The records stated that Petitioner fell while standing or fell while walking. The September 9, 2015 office visit note from Dr. Olysav stated that Petitioner "was going along the sidewalk to a patient's home when she fell onto her left elbow." (PX4; RX1). Dr. Keller's record from the initial consultation on September 14, 2015 stated that Petitioner was "status post a fall on the left elbow in the parking lot of her employer on 9/4/2015. The patient states she was walking out to her car and suffered the fall." (PX5). Respondent's other witness, Ms. Pate, testified that Petitioner had told her that she

had "hit the concrete thing where you pull the car up to, and she hit that and fell." (RX10, pg. 9). Ms. Pate never clarified whether "the concrete thing" was a speed bump or the sidewalk.

The evidence not only demonstrated inconsistences with respect to Petitioner's fall, but also revealed the repeated nature and extent of Petitioner's diabetic episodes. Petitioner testified that she did not experience diabetic episodes unless her blood glucose level was below 50. Notwithstanding, the emergency room record and the record of Petitioner's own physician, Dr. Hazard, indicated that 70 was the low end of the blood glucose reference range. A review of Petitioner's medical records related to her diabetic episodes indicated instances where Petitioner's blood glucose level was above 50 yet Petitioner experienced symptoms of hypoglycemia, enough to warrant treatment from paramedics. (RX2, 11/2/2015 ambulance report). The medical records further reflected Petitioner's history of falling due to diabetic episodes and her repeated failure to notice the warnings of her insulin pump indicating low blood sugar. Petitioner's symptoms ranged from being completely unresponsive to combative. Petitioner's history of hypoglycemia unawareness also necessitated the intervention of her husband who would actively step in to prevent Petitioner from driving at times of these low blood glucose levels.

This dissent is not to be interpreted as punishing Petitioner for being diabetic. Instead, it is to acknowledge that there is more than ample evidence in this case to find an idiopathic explanation for Petitioner's injuries on September 4, 2015 – even more so when taken in conjunction with her inconsistent recollection of her falling down as evidenced in the medical records. As such, the preponderance of the evidence with respect to Petitioner's fall is not as clear-cut as Petitioner claims. Petitioner's entire claim with regard to accident rests on her testimony of tripping on a median[1] – which by her own testimony, was not even there.[2] Petitioner's position is in fact undermined not only by her own photograph that contradicts her description of the alleged offending speed bump, but also by the evidence demonstrating a long and serious history of hypoglycemia that is sudden and with varying symptoms at levels below, at or above 50. These diabetic episodes occurred shortly prior to and continued after the September 4, 2015 alleged work accident, and they occurred whether Petitioner was aware of them or not.

I find the Arbitrator's Decision on all these points, including the Arbitrator's credibility determination, to be thorough and well-reasoned. I would affirm and adopt the Arbitrator's Decision in its entirety.

/s/ *Christopher A. Harris*
Christopher A. Harris

[1] Petitioner alleged that she tripped on a median, like a speed bump. It is unclear from my review of the record what Petitioner tripped on, and based on her testimony, whether it was even there for her to trip over. (T.15).
[2] Petitioner acknowledged that these medians were normally removed during the time she fell, and Petitioner's Ex. 11 was purportedly taken during a period wherein the median should have been present. (T.15; T.40-44).

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC031248
Case Name	KALEFF, SHERRI v. HELP AT HOME
Consolidated Cases	No Consolidated Cases
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	16
Decision Issued By	Dennis OBrien, Arbitrator

Petitioner Attorney	Jason Caraway
Respondent Attorney	Michael Bantz

DATE FILED: 10/4/2021

THE INTEREST RATE FOR THE WEEK OF SEPTEMBER 28, 2021 0.05%

/s/ Dennis OBrien, Arbitrator

Signature

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

SHERRI KALEFF
Employee/Petitioner

v.

HELP AT HOME
Employer/Respondent

Case # **15** WC **031248**

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 **Dennis O'Brien**, Arbitrator of the Commission, in the city of **Springfield**, on **June 29, 2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☐ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the 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 4, 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 accident ***was*** given to Respondent.

In the year preceding the injury, Petitioner earned $**30,814.16**; the average weekly wage was $**592.58**.

On the date of accident, Petitioner was **49** years of age, ***married*** with **no** dependent children.

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

ORDER

Petitioner has failed to prove that she suffered an accident on September 4, 2015 which arose out of and in the course of her employment by Respondent.

Petitioner's claim for benefits is therefore 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

OCTOBER 4, 2021

FINDINGS OF FACT:

TESTIMONY AT ARBITRATION

Petitioner

Petitioner testified that she was an employee of Respondent and had been since 2005. She performed in home healthcare, cleaning, cooking, shopping and errands and taking the resident to the doctor, etc.. She was so employed on September 4, 2015, traveling from her first client's home to her second client's home. She was in the parking lot of the second client, Evelyn, walking from her vehicle to the building the client lived in and while walking through the parking lot her foot hit part of a speed bump in the lot and she fell. The speed bump was removeable, had been removed, but this part on the side had remained after the rest was removed. She said that when she fell she landed on her right elbow. She said she was in a hurry to get inside as they had a set amount of time to get from point A to point B, and she was running a little later from her first client as the client did not like to have her lunch ready until 11 o'clock and it took her a few minutes longer to get the lunch ready as it had to be served warm.

After falling, Petitioner picked up her grapes, soda, and ink pen, which she had been carrying, and walked into the building. She said she was in shock, but she heard a person say she was bleeding, and she said she was, went to the elevator and took it to the fifth floor, went to the client's apartment and clocked in.

After viewing the ambulance report, Petitioner's Exhibit 2, she agreed it had come as a result of a call to 911 by the client, Evelyn Johnston. She said the notation on the report about being a diabetic was probably made by the client when she called as she tells all clients she is a diabetic in case anything should happen, and the client must have thought the fall was caused by her diabetes. She said she had worked for Ms. Johnston for about three years. She said the ambulance crew checked her glucose while she was there and found it to be 66, which is within her normal range per her doctors. She noted she had been a diabetic for 51 of her 55 years and had been on insulin her entire life, currently via an insulin pump. She said she had never blacked out due to her diabetes, though she had gone to sleep, had it drop while sleeping and had not regained consciousness. She said when her blood glucose is too high she becomes talkative, nauseated, wants to be left alone, is miserable, and has extreme thirst. She said she was not suffering any of those symptoms on the date of this accident. She said when her blood glucose is too low she gazes off into space, gets sweaty, shaky, her words are slurred as if she were drunk and she can't speak, but she is still able to walk and carry on.

Petitioner was taken by ambulance to Abraham Lincoln Memorial Hospital. She advised that facility that she had fallen, she was advised she had fractured her left elbow, was put in a splint and a sling and, after seeing her family physician she was referred to Dr. Keller who put her on antibiotics as she had an infection, and after the infection subsided surgery on the elbow was performed on September 26, 2015. She said she worked from two days after the fall until the date of surgery. After the surgery she received physical therapy and was eventually released to return to work without restrictions on November 3, 2015. She said she was told by ChrisWolf, who assigned hours, that the computer said Petitioner was not to be given any hours. Petitioner said she called Respondent's home office in Chicago and said that was ridiculous, that if they did not give her

any hours she would have to draw unemployment. She said Chicago immediately called the branch manager, Tina, and the computer message was removed and she began getting work on December 23, 2015.

Petitioner said she saw Dr. Keller on March 3, 2016 complaining of left shoulder pain of two or three months duration. Petitioner said she had not had any other traumatic accident, but when she could not move the shoulder she told her husband she thought the sling had messed up her shoulder. She said Dr. Keller told her she had a frozen shoulder. She said Dr. Keller performed surgery after she had undergone three cortisone injections and had received physical therapy. She said that during that therapy she performed stretching exercises as she had been instructed to do, and while stretching the arm across her body she heard a pop and screamed as it hurt so bad. She said she went to see Dr. Keller again and had x-rays. She said Dr. Keller told her she had broken her acromion tip, so she had to wait six weeks for it to heal.

Petitioner said she underwent a functional capacity evaluation ordered by Dr. Keller. She said that testing resulted in permanent work restrictions of no lifting over 10 pounds waist to shoulder and no lifting over 20 pounds from floor to waist. She said she went back to work with those restrictions and continues to work.

Petitioner said she knew Jennifer Persuhn as they had been neighbors when Petitioner lived in Hartsburg. Petitioner had told Ms. Persuhn that Respondent was a great company to work for, and Ms. Persuhn then went to work for Respondent. She said Ms. Persuhn was walking in front of her when she fell, and it was Ms. Persuhn's client who had noted that Petitioner was bleeding. She said if Ms. Persuhn thought she had fallen on a sidewalk with no defects Ms. Persuhn was wrong, she was in front of Petitioner, had her hand on the door when Petitioner said she fell, and could not have seen Petitioner fall. She said if Ms. Persuhn said she had noted Petitioner having low blood sugar episodes five or six times since they had met Ms. Persuhn would be in error, there was one event, when pushing a car out of a snowy ditch where she fell, and on that occasion she did tell Ms. Persuhn that she was having low blood sugar, needed to get a soda, and went inside. She said they now live 14 miles from each other and do not see each other on a daily basis.

Petitioner identified Petitioner Exhibit 14 as screenshot captures from her phone of text messages between her and Ms. Persuhn which occurred after Petitioner asked Ms. Persuhn for the telephone number of their union representative. She said the two were angry with each other in this text exchange and had not spoken since then.

Petitioner said she knew Carol Pate as Ms. Pate was her boss, she had hired Petitioner. She said Ms. Pate is now one of Respondent's clients. She said on the date of this accident Ms. Pate was no longer working for Respondent, had moved in with Petitioner, had moved out and was a client of Respondent. She said Ms. Pate's deposition testimony that Ms. Pate was in the office when Petitioner called her the day after the accident laughing, saying her sugar was low and he had hit the concrete thing you pulled a car up to and had fallen was not true. She said she did not remember calling Ms. Pate the day after the accident, she did not believe Ms. Pate was working in the office at that point, and she would not have been laughing as the pain she was experiencing was excruciating.

Petitioner identified Petitioner Exhibit 11 as a photo she had taken a month or two after the accident of the bump she tripped on. She marked with an "X" where she tripped, a "C" in the direction where she had parked, and an "O" in the direction of where the door to the building was located.

Petitioner said that as of the date of arbitration she said that due to her left elbow and shoulder she could not put her elbow on a desk as it would hurt too much, that if she laid her arm on a surface she can feel the screws in her arm, that she could not reach behind her to fasten her bra, and she could not put her hair up when it was hot. She noted she was right-handed. She said she could still perform her job, she just had to use her right arm to reach up into cabinets. She said she had difficulty getting money out of an ATM as her arm did not lift up high enough to the side to retrieve the money. She demonstrated her arm when lifted to the side only going up to about chest level. She also demonstrated the right arm going straight up and the left arm going up to about an angle of 135 degrees, about 45 degrees short of going straight above her head.

On cross-examination Petitioner said she returned to work in the September following her accident and continued working until her accident. She said she had called the boss and Tina from the hospital following the accident and asked if she could return to work the following Monday and Tina said to call on Tuesday, as Monday was Labor Day. Petitioner said she called Tuesday and told Tina she had been told her elbow was broken, but she said she could still sweep and do dishes with one hand. She said she returned to work on September 9th and worked until the day before the surgery. Respondent, without objection, then amended Arbitrator Exhibit 1 to reflect periods of temporary total disability from September 5, 2015 through September 8, 2015 and from September 28, 2015 through November 2, 2015, as well as August 25, 2017.

Petitioner said she did not tell the paramedics on the date of the accident that she had diabetic symptoms, indicating that her client, who did not know how the accident occurred, must have told them that. Petitioner said that in the two years prior to this accident she probably had encounters with paramedics because of diabetic episodes possibly two to three times, and that in the two years after the accident she would have had encounters with paramedics or medical professionals because of a diabetic episode fewer than five times.

Petitioner said that Dr. Keller released her to full duty on September 26, 2017.

On redirect examination Petitioner said Dr. Keller put her on the restrictions put on her by the functional capacity evaluation.

On recross-examination Petitioner said she fractured her right wrist in September of 2016 after she fell down her stairs after stepping on a dog bed and the bed sliding out from under her on the hardwood floor. She said that was not due to a diabetic episode, she had been cleaning her grandchildren's room, and as she went over a gate her foot touched the dog bed.

Carol Pate

Carol Pate, formerly known as Carol McLain, was called as a witness by Respondent by deposition. She said she was 65 years of age and was testifying by deposition as she felt she was at an increased risk of contracting the coronavirus, which could be very dangerous for her. She felt relatively safe being deposed with people wearing masks and hand sanitizer handy. She testified that she had worked for Respondent from 2005 until 2014 and went back to work for them again in May of 2015. She said Petitioner was a coworker of hers in September of 2015. Ms. Pate said she gave a recorded interview to Jennifer Hoffman, Respondent's insurance adjuster. She identified Respondent's deposition exhibit #1 as the recorded statement she gave Ms. Hoffman in

September of 2015. She said she had read the transcript of that conversation and that it was accurate, except it misspelled Petitioner's name as Sherry Callows rather than Sherri Kaleff. (RX 10 p.5-8)

Ms. Pate said she spoke to Petitioner on September 5, 2015, the day after this accident, on the phone. She said Petitioner called her on her cell while Ms. Pate was at work. She said Petitioner was laughing and told her that her sugar was low and she hit the concrete thing you pull the car up to, falling. She said it was her understanding that it was a diabetic episode of some kind. She said she was aware Petitioner had diabetes. She said the last time she witnessed Petitioner having a diabetic episode was on November 19, 2019 at 2:00 p.m. in the hallway of the building where Ms. Pate lived. Petitioner was sitting on a love seat in the hall and did not have a clue as to what was going on, so Ms. Pate got her a large glass of orange juice with sugar stirred in it, to get her sugar back up. She said that helped Petitioner. She said Petitioner had clients in her building. She said Petitioner on that date did not have good balance, she could not sit up well, she appeared to be having a diabetic episode. (RX 10 p.8-11)

Ms. Pate testified that Jennifer Persuhn told her that Petitioner had fallen on September 4, 2015 because she had a diabetic episode. She said Petitioner's husband also informed her that Petitioner had a diabetic episode on September 4 when she fell at work. She said she and Petitioner had been friends for eight or nine years and she had lived with Petitioner and her husband for less than a month in November 2015. She said he did not have any ill will towards Petitioner and was not testifying to get back at her. (RX 10 p.11-13)

On cross-examination Ms. Pate said she did the same type of job Petitioner had prior to working in the office. When asked if she supervised Petitioner, Ms. Pate said she did for a few years but was not supervising her on the day after the accident when Petitioner called into the office. Ms. Pate said she had no idea why Petitioner called her the day after the accident, but it probably was because they were friends. (RX 10 p.14-16)

Ms. Pate said she also got a telephone call from Petitioner on the day after the accident and later that same day, from Petitioner's husband, Rick Taylor, called her from the emergency room, again, because they were friends. She said that Mr. Taylor advised her that Petitioner fell because of her blood sugar. When asked why Mr. Taylor would tell her the reason for Petitioner's fall Ms. Pate said, "that's what Sherri said." She said she had no other conversations with Petitioner or Mr. Taylor about Petitioner's fall. She said she lived with Petitioner and Mr. Taylor in May of 2015, because she was homeless, in a shelter for abused women and Petitionere said she would give her money and she could stay in her house. She said she moved out because Petitioner and Mr. Taylor would fight. Ms. Pate could not take it, so she found an apartment and moved out, but she remained friends with both of them. She agreed that she has not had much of a relationship with Petitioner or Mr. Taylor for a while because of the pending workers' compensation case and because of a rumor that Ms. Pate was having an affair with Mr. Taylor, which she denied had occurred. She said Petitioner was upset when she heard of the rumor of the affair. They do not speak anymore other than when they say hello at the elevator. (RX 10 p.17-22)

On re-direct examination Ms. Pate said that she was friends with Petitioner and her husband in September of 2015 and would talk to both on the phone regularly, several times a week, or would go to their house. She said she received telephone calls from Petitioner both on the day of the accident and on the day after the accident. (RX 10 p.22,23)

A transcript of a previously recorded statement of Ms. Pate, then known as Carol McLain, was introduced as Exhibit 1 to Respondent Exhibit 10. In that recorded statement Ms. Pate recounted the telephone conversation the she had with Petitioner on the day after the accident. Her rendition of the conversations she had with Petitioner and, later with Petitioner's husband, was consistent with her testimony in her deposition. The exhibit does not indicate when the statement with Ms. Pate was taken, but the transcriptionist noted that she had transcribed it on October 21, 2015. (RX 10, Exhibit 1)

Jenifer Persuhn

Jenifer Persuhn was called as a witness by Respondent and testified by deposition. She testified that in September of 2015 she was employed by Respondent as a home health aide. She said she worked with Petitioner at that time and had known her also before that as a neighbor. She said she was working for Respondent on September 4, 2015 as she had taken a client to the store and was returning to the high-rise, Friendship Manor. She said she was letting her client out of the car in front of the building and Petitioner was walking across the parking lot in front of her car. She said she waved at Petitioner and her client spoke to Petitioner, but Petitioner did not acknowledge either of them. Ms. Persuhn said she then parked her car, got out and started walking on the sidewalk. She said Petitioner was on the ground, having fallen on the sidewalk on the side of the building. Ms. Persuhn said it was a public sidewalk next to the building's parking lot. (RX 11 p.6,7)

Ms. Persuhn said that after being asked to she took photographs of the area of the accident, within a couple of days of the accident. She said there was no defect in the sidewalk or any obstructions or objects that she was which Petitioner could have tripped on. She said she got out of her car after Petitioner fell, and Petitioner at that point was trying to get back up. She asked Petitioner if she was okay and Petitioner had a blank look on her face as if she did not recognize Ms. Persuhn, who she had known since 2008, or understand what Ms. Persuhn said. She said Petitioner knew Ms. Persuhn's client as well, and did not seem to recognize the client, either. After getting up Petitioner picked up her things and started to walk toward the building. Ms. Persuhn's client had walked to the door of the building and let both Ms. Persuhn and Petitioner into the building. (PX11 p.8,9 and Deposition Exhibits A – E)

Ms. Pershun testified that after they entered the building Petitioner still seemed disoriented, not speaking, walked down the hallway, past the elevators and into another hallway. When Ms. Persuhn asked her where she was going Petitioner told her the fifth floor. When asked if she was going to take the stairs, which were at the end of that hallway, Petitioner said she was going to take the elevators, and Ms. Persuhn directed her back to the lobby. Ms. Persuhn noted that both she and Petitioner had worked in that building for years. (PX 11 p.10,11)

Ms. Persuhn said she had observed Petitioner acting in this manner in the past, and said Petitioner had told her that her acting that way in the past was because she was a severe diabetic and had low blood sugar. She said she had witnessed Petitioner have at least five or six prior low blood sugar episodes, and one or more times she had fallen during one of these episodes. On one occasion in 2010 she was helping Petitioner shovel out her truck in her driveway following a severe snowstorm and Petitioner had a blank look on her face and did not

seem to know where she was or what was going on. When asked if she was okay Petitioner shook her head no and mentioned sugar, prompting Ms. Persuhn to take her into Petitioner's house for some juice or a piece of candy. She then sat with her until Petitioner came out of it. (PX 11 p.11,12)

Ms. Persuhn testified that in her work as a caregiver she had dealt with clients who had low sugar events 10 to 15 times. She was of the opinion that Petitioner was experiencing a diabetic episode at the time of her fall on September 4, 2015. (PX 11 p.13)

On cross-examination Ms. Persuhn said she and Petitioner came to know each other as neighbors and were pretty good friends. She said she took the photographs of the area of the fall at the request of Respondent's office manager, Mary Ann. She said she had called in to report what had happenened and Mary Ann and another supervisor, Tina, asked her to take the photos. She said she took the photos with her phone a day or two after the fall. (PX 11 p.14-16)

Ms. Persuhn said she did not actually see Petitioner fall, and where she parked her car was about 20 feet from where Petitioner fell. She assumed Petitioner fell, as she was on the ground. (PX 11 p.16,17)

Ms. Persuhn said she had witnessed many episodes in the past where Petitioner's behavior was the same, disoriented, did not know where she was and could not speak. She said Friendship Manor was not a nursing home or an assisted living center, it was an apartment complex for senior citizens. She said their role was to assist the senior citizens, clean their homes, do their shopping, help with their daily needs. They do not have a role with medication or doing anything medical. As of the date of her deposition she had worked for home care agencies for nearly 30 years, including 11 years with Respondent. She said she has been a certified nurses aide for 25 years. She agreed that only physicians or physicians' assistants can place a medical diagnosis on people. (PX 11 p.17-20)

Ms. Persuhn said both she and Petitioner had clients at Friendship Manor, including some mutual clients. She said she would bump into Petitioner daily during the work week, and from 2010 onward Petitioner did have one episode in the laundry room at Friendship Manor and another at a mutual client's home where, on both occasions, Petitioner was disoriented, did not know what was going on, where she was, who anyone was, and where she had balance issues and trouble walking. On other occasions there were episodes where she saw Petitioner was coming out of or going into an episode. (PX 11 p.21-23)

Ms. Persuhn testified that she and Petitioner had not seen each other in three and a half years as Ms. Persuhn had moved to Benton, in southern Illinois, and she knew nothing about Petitioner since she had moved to Benton. She said her moving was the only reason they no longer interacted, it was nothing personal. (PX 11 p.23,24)

On re-direct examination Ms. Persuhn said that after Petitioner walked in front of her car until she again saw her, on the ground, after she had parked her car, was perhaps about three minutes. (PX 11 p.25)

MEDICAL EVIDENCE

Respondent entered a medical record of Dr. Rossi dated January 19, 2009 which noted Petitioner had been seen by Dr. Pete in the emergency room the preceding day, having had a hypoglycemic episode and falling down some stairs onto her right side, It is not noted what her glucose level was at that time. (RX 7 p.2,9)

Respondent introduced a hospital record of July 1, 2015 for treatment received when Petitioner's insulin pump malfunctioned and appears to have caused her glucose levels to vary tremendously while medical personnel were monitoring her, causing them to disconnect her pump. It was noted a new pump had been ordered, but had not arrived. Another record of May 25, 2015 noted that Petitioner had been found confused in the hospital parking lot after seeing her cardiologist. She was given orange juice and food in the emergency room. Her glucose level was found to be 46. (RX 6 p.4-9)

Petitioner was transported from her client's residence to Abraham Lincoln Memorial Hospital by ambulance. The ambulance report indicates Petitioner giving a history of being on her way into Friendship Manor and falling in the parking lot, hitting a parking block with her elbow. The ambulance crew noted a large hematoma and an abrasion with a lot of swelling at the left elbow. They also recorded her glucose level as being 66, and her being oriented with appropriate speech and obeying commands with appropriate motor responses. (PX 2 p.1,4; RX 5)

The history at Abraham Lincoln Memorial Hospital was of having tripped and landing on a concrete surface. An x-ray of the left elbow revealed an acute lightly comminuted and mildly to moderately displaced intra-articular fracture of the olecranon process of the proximal left ulna. A splint was applied. A glucose test was performed during that visit with a result of 50, noting that low was 70 and high was 105. Petitioner was given a release to return to work the next day with a restriction of no use of the left arm. (PX3 p.2,8-11)

Petitioner saw Dr. Olysav on September 9, 2015. The history given to Dr. Olysav by Petitioner was of going along the sidewalk to a patient's home when she fell onto her left elbow. Physical examination after removing the arm splint showed a deep abrasion in the area which would be projected for the incision for repair of her fracture. Dr. Olysav felt performing surgery through that portion of skin was not advised. He therefore felt that a delay of three weeks to allow the skin to heal would be advised if surgery were to occur to decrease the chance of infection. (PX 4 p.3,5; RX 1 p.2,4)

On September 14, 2015 Petitioner saw Dr. Keller on the referral of Petitioner's primary care physician, Dr. Rossi. His physical examination revealed pus along a 7 cm abrasion over the left olecranon with significant swelling in that area and down into the hand. Dr. Keller made it clear to Petitioner that they had to get rid of the infection around her elbow before surgery could be performed as the result could be a "catastrophic event." He noted she was at an increased for infection due to her diabetes. When next seen on September 22, 2015 Dr. Keller noted the abrasion was healed and there were no signs of infection present. It was decided to schedule her elbow surgery to the elbow. On September 24 Dr. Keller issued a restriction indicating Petitioner was unable to drive for work. (PX 5 p.3,4,6,8; PX 10 p.2)

Left elbow surgery was performed by Dr. Keller on September 28, 2015 to internally fix the fracture with K-wires and Synthes cable. (PX 5 p. 9,10; PX 6 p.9,10; PX 8 p.1,2)

Petitioner followed up with Dr. Keller on October 6, 2015, and was given a restriction of no use of the left arm, and October 13, 2015, when Petitioner was given return to work restrictions of no pushing of pulling

with the left arm. On November 3, 2015 Petitioner advised Dr. Keller that she was doing very well and felt she could do everything that she had been able to do prior to fracturing her elbow. She had no pain complaints other than some tenderness on the incision. She was told to discontinue physical therapy and was told to return to work without restrictions and do all of her regular work activities. Petitioner was again seen by Dr. Keller on December 17, 2015 and said she was doing extremely well and felt as good as new, noting she was ready to return to work. After an objectively normal physical examination she was again told she could work without restrictions. (PX 5 p.12-18,20-22,31,32; PX 10 p.3-6; RX 3; RX 4)

Nurse Practitioner (NP) Rexroad prepared a "To Whom It May Concern" letter dated October 27, 2015, and delivered it to Petitioner. In it she repeated Petitioner's recollection of her accident and Petitioner's belief that she was not suffering from hypoglycemia as she said she did not feel symptoms until her glucose was below 50. This letter did not state the opinion of the author, just repeated the personal opinions of Petitioner. Petitioner saw NP Rexroad on November 23, 2015 about her diabetes. She noted that "(Petitioner) does have a history of hypoglycemia unawareness. Her husband is back home helping her identify low blood sugars." NP Rexroad wrote a letter to Dr. Rossi noting that Respondent believed Petitioner's fall was due to hypoglycemia, an opinion she did not share, based upon a glucose level of 68 at the time of the fall and Petitioner's not becoming symptomatic until it was 50 or less. NP Rexroad did, however, note that it was recommended that Petitioner assess her blood glucose reading prior to driving a car. (PX 4 p.11,12,16)

NP Rexroad on December 11, 2015 responded to a question from Respondent about Petitioner's glucose level at the actual time of her accident stated, "We do not know what her blood sugar level was at the time of the fall." PX 4 p.34)

Dr. Hazard also wrote a "To Whom It May Concern" letter dated January 22, 2016, and noted he had been asked to comment on Petitioner's ability to perform her work. He noted that she should assess her glucose level prior to driving an automobile. (PX 4 p.19)

Petitioner was seen by Dr. Keller on March 3, 2016 complaining of left upper arm pain which had begun two to three months earlier. She said she had a palpable lump in the mid humerus since her elbow surgery in September. Physical examination of the left arm revealed tenderness in the shoulder area, in the proximal biceps tendon, with tenderness in the belly of the biceps muscle as well. There was no swelling or redness in the area of the previously operated elbow. She had a mildly positive drop arm sign for shoulder weakness. No diagnosis was made in regard to the left elbow, but Dr. Keller felt she had early adhesive capsulitis of the left shoulder, biceps tendinitis and he was concerned about a rotator cuff tear. He therefore ordered a left shoulder and humerus MRI. (PX 5 p.35-37)

An MRI of the left shoulder was performed on March 10, 2016 and was interpreted as showing mild AC joint osteoarthritis and subacromial subdeltoid bursitis, labral tears and extensive supraspinatus and less prominent infraspinatus and subscapularis intrasubstance contusion and edema. An MRI of the left elbow on that same date showed fixation devices, a small cyst and tendinopathy with small effusions. (PX 3 p.15,17)

Petitioner again saw Dr. Keller on March 17, 2016 She was rating her left upper arm pain as 8/10. Her physical examination was unchanged, and Dr. Keller diagnosed adhesive capsulitis. He injected her subacromial space on that visit. (PX 5 p.39-41)

Petitioner received physical therapy at Abraham Lincoln Memorial Hospital for left shoulder adhesive capsulitis from March 24, 2016 through April 21, 2016. A history of the fall on September 4, 2015 and subsequent surgery and left arm immobilization was given. By the end of this series of physical therapy Petitioner was reporting that she could do everything with her left arm and only had pain with reaching behind her back. She told the therapist that she was ready to be done with physical therapy as she had no functional limitations. (PX 3 p.20-35)

Dr. Keller examined Petitioner on May 26, 2016. She said she had some decreasing range of motion and that the injection had helped for a while but she now felt significantly worse. She said she had not improved with physical therapy. Physical examination showed her range of motion in the left shoulder had gotten worse, though she continued to have full range of motion of the left elbow. He diagnosed recurrent left shoulder adhesive capsulitis, injected her shoulder with corticosteroids and again ordered physical therapy. (PX 5 p.43-45)

Petitioner was seen for a second series of physical therapy from June 13, 2016 through July 14, 2016. Petitioner had lost some of the range of motion she had regained in the first series of physical therapy, with difficulty reaching overhead. During this series of therapy Petitioner actually appeared to regress, either from a flare-up from prior sessions or because an injection she had received had worn off. (PX 3 p.36-55)

Petitioner saw Dr. Keller again after completing physical therapy. She said she had increased pain with movements above her shoulder. Physical examination on this date showed a positive impingement sign and reduced range of motion. A shoulder arthroscopy was recommended. (PX 5 p.48,49)

Dr. Keller performed surgery on August 24, 2016, performing a distal clavicle excision due to prominent arthritis, lysis of adhesions, a subacromial decompression, and debrided the undersurface of the supraspinatus. (PX 5 p.51-53; PX 9 p.1-3)

Petitioner was seen post-operatively by Dr. Keller on September 1, 2016 and she advised him that while reaching across her body with the left arm the preceding Tuesday she heard and felt a pop in the superior shoulder, and told him her pain was in the superior shoulder. Physical examination found tenderness over the acromion. Dr. Keller said an x-ray of that date showed a small non-displaced anterior acromion fracture. He continued her in physical therapy. (PX 5 p.54-56)

On October 4, 2016 Petitioner again saw Dr. Keller and said she still had discomfort, but it was tolerable. She had undergone an open reduction and internal fixation of a right wrist fracture on September 27, 2016, just a week before this visit. Her right wrist was placed in a splint on that date and restrictions were given to her for that right wrist injury. (PX 5 p. 58-61)

Petitioner received additional physical therapy for the right wrist fracture she suffered in a fall at home from November 22, 2016 through December 20, 2016. (PX 5 p.105-115)

Petitioner saw Dr. Keller again on January 24, 2017 because of continued left shoulder and elbow pain and restrictions which were keeping her from working. She said she was unable to reach high or out due to pain. It was noted she had in the past had right shoulder surgery and she at this time was unable to rest her right elbow on hard surfaces due to pain. The only abnormality noted in regard to the left elbow was some residual tenderness, likely due to hardware irritation. (PX 5 p.62-64)

A functional capacity evaluation was performed by Azer Clinic on February 16, 2017. Their history included the accident of September 4, 2015 involving Petitioner's left elbow as well as her return to work in December of 2015 and later onset of left shoulder complaints and subsequent surgery. It also noted her falling at home and fracturing her right wrist, and the resulting surgery in September of 2016. She noted continued complaints of left shoulder pain with limited range of motion and, at times, pain in the elbow. Based upon Petitioner's left shoulder condition and limitations she was placed in the Light Workload Category for Occupational Classification. (PX 5 p.76,77; PX7 p.26,27)

Dr. Keller saw Petitioner on March 14, 2017 with continued complaints in regard to her left shoulder. A functional capacity evaluation had shown she was only able to lift up to 10 pounds from waist to shoulder and 20 pounds from floor to waist, placing her at a light duty level of work ability. Dr. Keller placed her on permanent light duty restrictions consistent with the FCE and declared her to be at maximum medical improvement. (PX 5 p.69,71; PX 10 p.7)

Respondent introduced the records of the Logan County Paramedics Association showing they had made numerous runs to Petitioner's residence between November 2, 2015 and August 25, 2017 as Petitioner was in need of medical assistance due to low blood sugar. Her symptoms, as recorded by the paramedics included being unconscious and unresponsive (glucose level 21), standing and shouting at a dog which was outdoors (glucose level 20), slurry speech (glucose level 27, combative, not normal level of alertness (glucose level 45), had fallen and was combative (glucose level 39), in bed and unresponsive (glucose level 26), angry, as spouse had taken away her car keys as he felt her blood sugar was low (glucose level 61), and two syncope episodes when her diabetes accucheck monitor read low, it had an alarm and she could not hear the alarm. (RX 2 p.2,12,21,26,31,36,41,43,47)

An Abraham Lincoln Memorial Hospital medical record of August 25, 2017 was introduced by Respondent. It indicated visits for syncope related to low blood pressure, not low blood sugar, as her glucose was 88, in the normal range. She was again seen on September 25, 2016, and her glucose was high, at 200. (RX 9 p.3-9)

Respondent also introduced a employee status report slip of Dr. Keller dated September 26, 2017 which indicates she was being treated for a patella fracture but was released to work without restrictions. (RX 8)

CONCLUSIONS OF LAW:

In support of the Arbitrator's decision relating to whether an accident occurred which arose out of and in the course of Petitioner's employment by Respondent on September 4, 2015, the Arbitrator makes the following findings:

The findings of fact, above, are incorporated herein.

The summaries of medical evidence and deposition testimony, above, are incorporated herein.

Petitioner testified that on September 4, 2015 she tripped over a speed bump in the parking lot outside a client's apartment while walking in to work with the client. She said the speed bump was removeable, and it had been removed, but she tripped over a portion that had not been removed. She said she fell, landing on her left elbow, got up, picked up her grapes, soda and ink pen which she had been carrying and walked into the building. She said she was in shock, heard a person say she was bleeding, she went to the elevator, and took it to the client's apartment on the fifth floor. The client subsequently called 911, an ambulance crew came and took her glucose, found it to be 66, she was transported to the emergency room at Abraham Lincoln Memorial Hospital where her glucose level was found to be 50. Petitioner described the effects of low blood sugar for her as gazing off into space, getting sweaty, slurring her words as if she were drunk, and an inability to speak, while also noting that she would still be able to walk and carry on.

Jenifer Persuhn, a co-worker of Petitioner who performed the same home health aide duties as Petitioner with other clients of Respondent in the same building, testified on behalf of Respondent. She said while letting a client out of her car in front of the apartment building after taking the client to the store, she saw Petitioner walking across the parking lot in front of her car. She testified that she waved at Petitioner and her client spoke to Petitioner, but that Petitioner did not acknowledge either of them. After her client exited the car, Ms. Persuhn parked her car, got out, and started walking to the apartment building on the sidewalk. She said she saw Petitioner, who was on the ground, having fallen on the sidewalk on the side of the building. That would have been approximately three minutes after she had waved to her. She said she had not seen Petitioner fall. She said Petitioner was trying to get up and she asked Petitioner if she was okay, but Petitioner had a blank look on her face as if she did not recognize Ms. Persuhn, or understood what Ms. Persuhn had said. Ms. Persuhn said she and Petitioner had known each other since 2008. She said Petitioner also knew the client who had earlier spoken to her, and did not seem to recognize her, either. Both Ms. Persuhn and Petitioner walked to the building and Ms. Persuhn's client let both of them in. Ms. Persuhn said Petitioner still seemed disoriented upon entry to the building and walked down the same two corridors Ms. Persuhn and her client did. Ms. Persuhn said she asked Petitioner where she was going, and Petitioner said the fifth floor. Ms. Persuhn asked if she was going to take the stairs, and Petitioner said she was going to take the elevator. Ms. Persuhn said they had all walked right past the elevator and she reminded Petitioner where the elevator was and Petitioner walked off in that direction.

Petitioner introduced a photo of the area where she said she fell. That photo, Petitioner's Exhibit 11, shows a raised asphalt area commonly referred to as a speed bump. It appears to be permanent, and no part of it appears to have been removed. Petitioner placed an "X" on the photo where she said she tripped. That area does not appear to have been removed, nor does any area around that mark appear to be removed or any different from the rest of the pavement and speed bump in the vicinity of the "X."

In her testimony Ms. Persuhn testified that she had reported Petitioner's fall to Respondent and that, at their request, she took photographs of the area of the accident a couple of days later. Those photographs were introduced at arbitration as Respondent Exhibit 12. Those five photographs depict a sidewalk, not the parking lot, and there does not appear to be any defect in the sidewalk or its environs.

Another co-worker, Carol Pate, testified that she spoke to Petitioner on the day of the accident and to Petitioner and her husband on the day after the accident. All of the calls had been initiated by Petitioner or her

husband. She said that Petitioner told her on September 5, 2015 that her sugar had been low and she hit the concrete thing you pull a car up to, causing her to fall. Ms. Pate said it was her understanding that Petitioner had experiences a diabetic episode. Ms. Pate said she was aware Petitioner was diabetic and had observed Petitioner have a diabetic episode in the hallway of the building where Ms. Pate lived, that Petitioner was sitting on a loveseat in the hallway and did not have a clue what was going on. Ms. Pate got her a glass of orange juice to which she had added sugar to get Petitioner's sugar back up. She said Petitioner did not have good balance at that time. Ms. Pate said that on the day after this incident Petitioner's husband also told her that Petitioner had a diabetic episode when she fell at work. Ms. Pate had given a recorded statement in the months immediately following this 2015 incident, Respondent Exhibit 1, which was totally consistent with her testimony at arbitration.

Respondent introduced medical records which showed Petitioner needing to be treated by paramedics on numerous occasions in the two years following this incident. Respondent Exhibit 2 evidences Petitioner being in need of medical assistance due to low blood sugar, and her symptoms, as described by the paramedics in those records include Petitioner being unconscious and unresponsive (glucose level 21), standing and shouting at a dog which was outdoors (glucose level 20), slurry speech (glucose level 27, combative, not normal level of alertness (glucose level 45), having fallen and being combative (glucose level 39), being in bed and unresponsive (glucose level 26), being angry as her spouse had taken away her car keys as he felt her blood sugar was low (glucose level 61), and two syncope episodes when her diabetes accucheck monitor read "low." They noted the accucheck monitor had an alarm on it and Petitioner could not hear the alarm.

The medical records introduced repeatedly note the low end of normal for glucose is 70, so Petitioner's glucose level of 50, as found by Abraham Lincoln Memorial Hospital is quite low. The description of Petitioner by Ms. Persuhn and the description of Petitioner by paramedics during her other low blood sugar incidents do not describe a person who would necessarily have a clear recollection of what level glucose might have been when having a diabetic episode, as she could not even hear an alarm going off on her glucose monitor. Ms. Persuhn's description of Petitioner's behavior on September 4 is very similar to what the paramedics had described for other dates, and, in fact, Ms. Persuhn's description is very much like Petitioner's description in her testimony of how low blood sugar affects her.

The Arbitrator believes Ms. Persuhn and Ms. Pate to have been credible in their testimony of what Ms. Persuhn saw on the date of the incident, and the telephone conversations Ms. Pate had the day of and the day after the incident. Petitioner's description of the events of September 4 have been contradicted by the testimony of two witnesses and even the photograph she introduced into evidence. The testimony about subsequent rancor and the vulgar text messages between Petitioner and Ms. Persuhn have not played a part in judging credibility as they were some time after the incident, in the case of the text messages about four months after the incident, and the actions of Ms. Persuhn and the recorded statement of Ms. Pate were in the days following the incident, or, in the case of the recorded statement, approximately six weeks after the incident, giving them greater importance.

An injury is compensable under the Illinois Workers' Compensation Act only if it arises out of and in the course of employment. Panagos v. Industrial Commission, 177 Ill. App.3d 12, 524 N.E.2d 1018 (1988). The burden is upon the party seeking an award to prove by the preponderance of the credible evidence the elements

of his claim. Peoria County Nursing Home v. Industrial Commission, 115 Ill.2d 524, 505 N.E.2d 1026 (1987). The burden is also upon the employee to prove that his or her injuries are causally related to the employment. New Guard v. Industrial Commission, 58 Ill.2d 164, 317 N.E.2d 524 (1974). Critical to that determination is Petitioner's credibility. When an Arbitrator finds that a Petitioner has lied on a particular issue the Arbitrator may then find that Petitioner is not credible as to other issues. Parro v. Industrial Commission, 167 Ill.2d 385, 657 N.E.2d 882 (1995).

Idiopathic falls at work, which occur from a personal risk, are not compensable. "Personal risks include exposure to elements that cause nonoccupational diseases, personal defects or weakness, and confrontations with personal enemies. Examples of personal risks include falls due to a bad knee or an episode of dizziness. Because such a fall is due to a personal defect or weakness, such falls, commonly known as idiopathic falls, usually do not arise out of employment." Illinois Consolidated. Telephone. Co. v. Industrial. Commission, 314 Ill. App. 3d 347, 352, 732 N.E.2d 49, 53–54 (5th Dist. 2000).

The Arbitrator finds that Petitioner has failed to prove that she suffered an accident on September 4, 2015 which arose out of and in the course of her employment by Respondent. This finding is based upon the testimony of Ms. Persuhn and Ms. Pate, the contemporaneous recorded statement of Ms. Pate, Petitioner long history of similar diabetic episodes as testified to by Ms. Persuhn and Ms. Pate, the similarity of what Petitioner described her low blood sugar reactions generally were, the medical and ambulance records which show numerous diabetic low blood sugar incidents similar in many ways to those described by Ms. Persuhn as having occurred on September 4, 2015, and the blood glucose finding of Abraham Lincoln Memorial Hospital of 50, which even NP Rexroad said could make Petitioner suffer a diabetic episode.

Petitioner's claim for benefits is therefore denied.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC025717
Case Name	Alejandro Izquierdo v. Midwest Fireproofing
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remand Arbitration
Decision Type	Commission Decision
Commission Decision Number	22IWCC0240
Number of Pages of Decision	24
Decision Issued By	Maria Portela, Commissioner

Petitioner Attorney	Sean Stec
Respondent Attorney	Peter Puchalski

DATE FILED: 6/29/2022

/s/Maria Portela, Commissioner

Signature

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

ALEJANDRO IZQUIERDO,

Petitioner,

vs. NO: 19 WC 25717

MIDWEST FIREPROOFING, INC.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation, medical expenses 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, but makes the modifications 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).

In the first sentence of the first full paragraph on page 11, we change the pronoun "her" to "his." We note that, at other places in the decision, the Arbitrator referred to Petitioner as a male, which is supported by numerous references in the medical records.

In the second paragraph on page 14, we strike the sentence beginning with "On January 8, 2020…" in its entirety.

In the fourth full paragraph on page 18, we change the date "January 27, 2019" to "January 27, 2020" in both places.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 29, 2021, is hereby affirmed and adopted with the modifications 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.

No bond is required for the removal of this cause to the Circuit Court by Respondent since no benefits are currently owed. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

June 29, 2022

/s/ *Maria E. Portela*

SE/
O: 5/24/22
49

/s/ *Thomas J. Tyrrell*

/s/ *Kathryn A. Doerries*

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

22IWCC0240

IZQUIERDO, ALEJANDRO Case# **19WC025717**

Employee/Petitioner

MIDWEST FIREPROOFING

Employer/Respondent

On 3/29/2021, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.04% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0700 GREGORIO & MARCO
SEAN C STEC
TWO N LASALLE ST SUITE 1650
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
PETER J PUCHALSKI
140 S DEARBORN ST SUITE 700
CHICAGO, IL 60603

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

ALEJANDRO IZQUIERDO
Employee/Petitioner

v.

MIDWEST FIREPROOFING
Employer/Respondent

Case # **19** WC **25717**

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 **CHARLES WATTS**, Arbitrator of the Commission, in the city of **CHICAGO**, on **MARCH 1, 2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the 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 15, 2019**, Respondent ***was*** operating under and subject 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 $**87,126.52**; the average weekly wage was $**1,675.51**.

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

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

Respondent shall be given a credit of $**23,457.21** for TTD, $**0** for TPD, $**0** for maintenance, and $**11,638.70** for other benefits, for a total credit of $**35,095.91**.

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 **$1,117.00**/week for **25 6/7** weeks, commencing **August 15, 2019** through **February 10, 2020**, as provided in Section 8(b) of the Act.

Petitioner's request for medical bills in the charged amount of $34,766.96 (PX 2) is denied.

Petitioner's request for prospective medical treatment in the form of an L4-L5 and L5-S1 lumbar discectomy and decompression surgery, as prescribed by Dr. Kevin Koutsky, is denied.

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

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

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

Signature of Arbitrator

March 25, 2021
Date

ICArbDec19(b)

MAR 29 2021

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

BEFORE THE STATE OF ILLINOIS WORKERS' COMPENSATION COMMISSION

Alejandro Izquierdo	)	
	)	
Petitioner,	)	
	)	
v.	)	No. 19 WC 25717
	)	
Midwest Fireproofing	)	
	)	
Respondent.	)	

FINDINGS OF FACT

TESTIMONY OF PETITIONER, ALEJANDRO IZQUIERDO

On May 15, 2019, Petitioner was employed by Midwest Fireproofing as a construction Laborer. (TR P 7). Petitioner was working at the CNA building pushing a plasterer on a scaffold. (TR P 10). Petitioner tripped over an air hose, fell backwards, and landed on his left elbow. (TR P 12). Petitioner finished working but noticed pain in the left shoulder and left lower back. (TR P 15). Petitioner reported his injury to his boss later in the evening. (TR P 16). Petitioner's testimony was consistent with the First Report of Injury that was completed on May 16, 2019. (PX 1). The parties stipulated that Petitioner suffered accidental injuries that arose out of and occurred in the course of his employment with Respondent. (ARBX 1).

Petitioner did not require any emergency care on his date of injury and did not seek any medical treatment for five days. (TR P 29).

Petitioner first treated at Concentra on May 20, 2019. Petitioner was then seen by Dr. Garelick for his left shoulder injuries and Dr. Murtaza for his lumbar spine. (TR P 19). Dr. Murtaza recommended that Petitioner complete lumbar steroid injections. (TR P 19-20).

Dr. Garelick completed left shoulder surgery on August 15, 2019. (TR P 19). Prior to the shoulder surgery, Petitioner testified that he was working light duty for Midwest Fireproofing. (TR P 30). Petitioner began completing post-operative physical therapy through Concentra. (TR P 45). Petitioner testified that he put forth full effort in physical therapy and that he never showed up for a physical therapy visit intoxicated or under the influence of alcohol. (TR P 46).

Petitioner testified that he completed a second opinion orthopaedic evaluation with Dr. Koutsky on November 1, 2019. (TR P 20). Petitioner was referred to Dr. Lipov for

injections and completed an EMG. (TR P 20). Petitioner testified that he was also directed by Dr. Koutsky to complete physical therapy with a chiropractor at Mid-City Rehabilitation. (TR P 33).

Petitioner completed multiple injections with Dr. Lipov but only experienced short term relief. (TR P 20-22). Dr. Lipov prescribed multiple prescription medications. (TR P 46). Petitioner testified that he discussed with Dr. Lipov the risks and potential complications of injections and signed a consent form prior to completion. (TR P 47). Petitioner testified that he provided urine samples while treating with Dr. Lipov. (TR P 47). Petitioner denied any knowledge of urine test results documenting the presence of cocaine and THC. (TR P 48).

Petitioner testified that he returned to Dr. Koutsky on February 21, 2020 and lumbar spine surgery was recommended. (TR P 22). Petitioner received a written light duty job offer in February 2020 and refused the position. (TR P 43-44). The light duty offer was entered into evidence. (RX 7).

In March of 2020, Petitioner completed an FCE at Concentra. (TR P 40-41). Petitioner testified that the FCE was ordered by Dr. Garelick at end of his shoulder treatment. (TR P 41). At the time that he completed his FCE, Petitioner testified that he was instructed to remain off work by Dr. Koutksy and that he wanted to complete lumbar spine surgery. (TR P 42). Petitioner testified that his low back pain limited the tasks and tests that he performed at his FCE. (TR P 42).

Petitioner testified that his final, pre-hearing visit with Dr. Koutsky was on July 15, 2020 and surgery was again recommended. (TR P 23). Petitioner testified that he wanted to "get fixed" and have the procedure recommended by Dr. Koutsky. (TR P 23).

Petitioner testified that he had no physical therapy after February 2020. (TR P 39). Petitioner did not return to Dr. Lipov after the initial three injections. (TR P 39). Petitioner last saw Dr. Koutsky in July 2020 and for 7 ½ months prior to the hearing date had not used any prescription medications. (TR P 40).

Petitioner testified that he continues to experience low back pain with prolonged sitting and walking and that difficulty with bending and climbing into his truck. (TR P 27). Petitioner takes over-the-counter Ibuprofen to help with his symptoms. (TR P 27).

MEDICAL RECORDS

Petitioner first treated through Concentra/Occupational Health Centers of Illinois. Petitioner was seen on May 20, 2019 and reported that he was inured t work when he tripped over an air hose. (PX 2). Petitioner presented with complaints of low back, left shoulder and elbow pain. Petitioner denied any radiating pain and had a negative straight leg raise. (PX 2). Petitioner was diagnosed with a lumbar strain, left elbow contusion and left shoulder strain. (PX 2). Petitioner was referred for physical therapy. Petitioner was placed under a five-pound lifting restriction with no overhead work and no use of

power/impacts/vibratory tools. (PX 2). Petitioner began performing physical therapy through Concentra and continued to present for regular office evaluations.

Petitioner returned for evaluation on May 23, 2019 and reported improvement. Petitioner was maintained under a five-pound restriction and was instructed to continue physical therapy. (PX 2).

Petitioner reported improvement when he was seen on June 20, 2019. Additional therapy was ordered and Petitioner was advanced to a 15 pound lifting restriction.

Petitioner was seen on June 27, 2019 and was referred for an orthopedic evaluation to address his left shoulder complaints and to a physiatrist for his lumbar spine injuries. (PX 2).

Petitioner was seen by Dr. Garelick for an orthopedic evaluation on July 10, 2019. Dr. Garileck ordered an MRI study. (PX 4).

Petitioner presented for a physiatry consultation with Dr. Sajjad Murtaza on July 12, 2019. The examination was two months after Petitioner's work accident. Petitioner presented with complaints of left-sided low back pain without radiation into his lower extremity. (PX 4). Petitioner had full and symmetrical strength in the bilateral lower extremities with no motor or sensory loss. Dr. Murtaza diagnosed left lumbar pain/spondylosis. (PX 4). Dr. Murtaza ordered physical therapy and a lumbar spine MRI.

Petitioner returned for evaluation with Dr. Garelick on July 31, 2019. Dr. Garelick reviewed the MRI films and read the study to demonstrate a small, full thickness rotator cuff tear involving the supraspinatus tendon. (PX 4). Petitioner was diagnosed with an isolated supraspinatus tendon tear and surgery was recommended. (PX 4).

Dr. Murtaza next examined Petitioner for his lumbar spine injuries on August 9, 2019. Petitioner again denied any radicular symptoms or numbness into the lower extremities. (PX 4). Dr. Murtaza diagnosed lumbar spondylosis and again recommended an MRI. (PX 4).

On August 15, 2019, Petitioner underwent left shoulder surgery at AMITA Health Saint Joseph Hospital. Dr. Garelick performed a left shoulder arthroscopy with extensive intra-articular debridement, mini open rotator cuff repair and biceps tenodesis. (PX 5).

Petitioner was seen by Dr. Garelick in an office setting on August 28, 2019. Petitioner was instructed to begin post-operative therapy. (PX 4). A physical therapy program was initiated through Concentra/Occupational Health Centers of Illinois on September 4, 2019. (PX 3).

Petitioner was seen by Dr. Murtaza on September 13, 2019. On examination Petitioner again had full and symmetrical strength in the bilateral lower extremities, a

negative straight leg raise test bilaterally and no evidence of sensory loss. Dr. Murtaza ordered a lumbar spine MRI. (PX 4).

Dr. Garelick examined Petitioner on September 25, 2019 and Petitioner reported that he was "doing pretty well." Dr. Garelick ordered additional physical therapy and released Petitioner to return to work on a light duty basis. (PX 4).

Petitioner's lumbar spine MRI study was completed through AMIC on October 14, 2019. The study demonstrated multi-level spondylosis. (PX 6). At L3-4, L4-5 and L5-S1 there was a disc osteophyte complex and moderate stenosis. At L2-3 there was minimal disc bulging and mild foraminal and central canal stenosis. The interpreting radiologist did not identify any nerve root impingement. (PX 6).

Petitioner continued performing therapy through Occupational Health Centers of Illinois. A daily therapy note from October 18, 2019 indicated that Petitioner had a very bad attitude during therapy. Petitioner was argumentative and "had a scent of alcohol on his breath" and "very red eyes." (PX 3). A therapy note from October 23, 2019 also references the smell of alcohol on Petitioner. (PX 3). There was a third mention of Petitioner presenting with scents of alcohol on his breath and red eyes in the therapy note of October 25, 2019. (PX 3).

Dr. Garelick examined Petitioner on October 23, 2019. Petitioner presented with a different complaint of right shoulder pain which he attributed to overuse. Petitioner was placed under a five-pound lifting restriction. (PX 4).

Petitioner was seen by Dr. Murtaza on October 25, 2019. Petitioner complained of low back pain radiating into the posterior left leg with occasional shooting sciatic type pains all the way down the left lower extremity. (PX 4). Dr. Murtaza diagnosed lumbar pain with left lower extremity radiculopathy. Dr. Murtaza recommended L4-5 and L5-S1 epidural steroid injections. (PX 4).

In November 2019, Petitioner transferred treatment of his lumbar spine condition to different providers. Petitioner presented for an initial orthopedic evaluation with Dr. Kevin Koutsky on November 1, 2019. (PX 6). Petitioner presented with complaints of low back pain radiating into the left lower extremity down to the foot with numbness and tingling. On examination, Dr. Koutsky found good strength in the lower extremities, a positive straight leg raise on the left side and decreased sensation along the dorsum and lateral border of the left foot. (PX 6). Dr. Koutsky reviewed Petitioner's MRI films and read the study to demonstrate, "age related" degenerative changes with mild-to-moderate multi-factorial stenosis at L3-4 and L4-5 and a generalized, left paracentral protrusion at L5-S1. (PX 6). Dr. Koutsy diagnosed left L4-5 and L5-S1 radiculopathy. Dr. Koutsky ordered an EMG study of the left lower extremity and referred Petitioner for pain management treatment in the form of an epidural steroid injection. (PX 6). Petitioner was placed under a complete work restriction. (PX 6).

An EMG was completed on November 13, 2019. There was no evidence of left-sided lumbar spine radiculopathy. There was evidence of a left sural nerve injury. (PX 6).

Petitioner began treating with a pain management physician, Dr. Eugene Lipov. On November 20, 2019, Dr. Lipov completed medial branch injections on the left side at L3-L4, L4-L5 and L5-S1. (PX 6).

As part of the injection completed on November 20, 2019, Petitioner signed a Consent for Anesthesia form. Petitioner agreed to following, "I understand that it is necessary to inform my doctor about the nature of any medications or drug I am taking, including aspirin, narcotics, PCP, cocaine, marijuana, other illicit drugs, and diet drugs such as Phen/Fen or ephedra." (RX 8). Petitioner submitted to urine testing with Illinois Orthopaedic Network and a sample from November 20, 2019 was positive for cocaine and THC. (RX 8). Subsequent urine testing from December 18, 2019 was positive for THC. (RX 8). Dr. Lipov continued prescribing medications and completing injections after the urine test results.

Also in November 2019, Petitioner transferred his therapy from Concentra to Mid-City Rehabilitation. A therapy program was completed with a chiropractor, Dr. Manal Elmusa. Petitioner completed an initial therapy program with Mid-City Rehabilitation between November 7, 2019 and December 9, 2019 involving 14 therapy sessions. (PX 10). Petitioner completed a second therapy program between December 10, 2019 and January 7, 2020 involving 12 therapy sessions. (PX 10).

Petitioner returned for evaluation with Dr. Garelick on December 4, 2019. Additional physical therapy was ordered and the office note indicates that Petitioner would then transition into a work conditioning program; Dr. Garelick noted complications with Petitioner's low back conditioning. (PX 4). Dr. Garelick opined that "if his shoulder was an isolated condition, I would anticipate return to work full duty at around 02/01/2020." (PX 4). The office note indicates that Petitioner had transferred his physical therapy venue outside of Concentra. Petitioner was maintained under a five-pound lifting restriction. (PX 4).

Dr. Lipov completed an epidural steroid injection at the L5-S1 level on December 18, 2019. (PX 6).

On January 8, 2020, Dr. Garelick recommended work conditioning but did express some concerns with Petitioner's ability to complete the program due to significant low back issues. There was a curious notation that "his affect also seems to be somewhat affected." Dr. Garelick was not certain Petitioner would be able to complete work conditioning due to low back issues but indicated that Petitioner would be released to regular duty as it relates to the left shoulder if work conditioning was completed. (PX 4).

Petitioner then completed 15 work conditioning sessions with Mid City Rehabilitation from January 13, 2020 through February 4, 2020. (PX 10). Upon review

of the work conditioning records there was no difference between those sessions and Petitioner's prior physical therapy visits. (PX 10).

Dr. Lipov saw Petitioner in an office setting on January 8, 2020. Petitioner reported temporary relief following the medial branch injection of November 20, 2019. Dr. Lipov found a negative straight leg raise bilaterally. (PX 6). Dr. Lipov diagnosed lumbar facet pain and recommended medial branch injections. (PX 6)

On January 22, 2020, Dr. Lipov completed medial branch injections from L3-S1. (PX 6).

Petitioner was examined pursuant to Section 12 of the Act by Dr. Kern Singh on January 27, 2020. This IME addressed Petitioner's lumbar spine injuries. On examination Dr. Singh found no evidence of sensory loss, full range of motion, full and symmetrical strength in the bilateral lower extremities and normal reflexes. (RX 2). Dr. Singh reviewed Petitioner's MRI films and noted diffuse spondylosis with mild central stenosis at L4-5. (RX 2). Dr. Singh reviewed Petitioner's EMG report and found no evidence of radiculopathy.

Dr. Singh diagnosed a lumbar muscular strain with degenerative spondylosis. Petitioner was placed at maximum medical improvement and was released to return to work on a full duty basis. (RX 2). Dr. Singh noted that Petitioner had mild radiographic degenerative findings, a normal neurological examination and a normal EMG. (RX 2).

Petitioner was seen by Dr. Garelick on February 5, 2020. Petitioner had completed his work conditioning program and reported ongoing pain with overhead activities. (PX 4). Dr. Garelick also ordered an FCE for the left shoulder. (PX 4).

Petitioner was seen by Dr. Lipov on February 7, 2020 and reported 70% pain relief following the medial branch blocks that wore off after approximately four days. (PX 6). Petitioner again had a negative straight leg raise bilaterally. (PX 6). Dr. Lipov recommended a radiofrequency ablation. (PX 6).

Petitioner returned for evaluation with Dr. Koutsky on February 21, 2020. Dr. Koutsky diagnosed left L4-5 and L5-S1 radiculopathy. (PX 6). Dr. Koutsky recommended a lumbar decompression and discectomy on the left at L4-5 and L5-S1. (PX 6). Dr. Koutsky argued that Petitioner suffers from lumbar radiculopathy and nerve root impingement despite EMG results to the contrary. (PX 6).

Petitioner completed an FCE on March 2, 2020 through Concentra. Petitioner demonstrated the ability to perform 52.3% of the physical demands of his job in production. (PX 11). Petitioner was functioning at a sedentary physical demand level and fell short of the medium level required by his employment position. Petitioner was found to report unreliable pain ratings. (PX 11). The overall results of the FCE were found to represent a minimal level of functioning for Petitioner. (PX 11). The FCE was deemed "unreliable." (PX 11). During material handling activities Petitioner was found to

have given sub-maximal effort with self-limiting behaviors. (PX 11). The therapist noted that there were minimal to no heart rate changes to support pain reports. (PX 11). The therapist noted that many tasks were limited by Petitioner's back pain. (PX 11).

Petitioner's final office visit with Dr. Garelick took place on March 4, 2020. Dr. Garelick reviewed Petitioner's FCE and found that the functional abilities demonstrated did not represent a true and accurate representation of Petitioner's physical capabilities. (PX 4). Dr. Garelick placed Petitioner at maximum medical improvement and released Petitioner to return to work with permanent restrictions of no lifting over 15 pounds and no pushing/pulling over 20 pounds. (PX 4).

Dr. Koutsky examined Petitioner on March 11, 2020. Petitioner's physical examination was unchanged and Dr. Koutsky recommended the same surgical procedure. (PX 6).

On May 11, 2020, Petitioner was seen by Dr. Koutsky via phone consultation. Petitioner was instructed to continue with prescription medications. (PX 7). Dr. Koutsky again recommended an L4-5, L5-S1 discectomy and decompression. (PX 7).

The final office visit with Dr. Koutsky was on June 26, 2020. Petitioner was prescribed Gabapentin and Dr. Koutsky recommended surgery. (PX 7).

Petitioner completed a phone consultation with Dr. Lipov on July 15, 2020. Dr. Lipov prescribed Gabapentin and Meloxicam. (PX 7).

Petitioner was examined by Dr. Nikhil Verma, pursuant to Section 12 of the Act, on January 13, 2021. The examination addressed Petitioner's left shoulder injuries. On examination, Dr. Verma found full range of motion with good strength and diffuse pain with palpation disproportionate to objective findings. (RX 6). Dr. Verma found evidence of effort-related weakness and symptom magnification including grip test weakness that was not associated with any rotator cuff injury. (RX 6). Dr. Verma diagnosed Petitioner as status post left shoulder rotator cuff repair with good functional recovery. (RX 6).

Dr. Verma opined that Petitioner could return to work without restrictions relative to his left shoulder injuries. (RX 6). Dr. Verma reviewed records from MidCity Rehabilitation and found no evidence to suggest that Petitioner completed a formal work conditioning program; Petitioner's treatment was a combination of physical therapy and chiropractic care. (RX 6). Dr. Verma reviewed Petitioner's FCE and found significant pain magnification and inappropriate illness behaviors. Dr. Verma opined that the FCE represented a minimal level of functioning as Petitioner self-terminated many activities.

Petitioner entered into evidence a group exhibit of medical bills from three medical providers: Illinois Orthopaedic Network ($24,542.27), Midwest Specialty Pharmacy ($7,503.25) and Metro Anesthesia Consultants ($2,721.44). (PX 2).

Respondent offered a utilization review report from UniMed Direct dated 12/26/2019. The report non-certified a recommendation from Dr. Eugene Lipov for Lidocaine injection, Bulvacaine injection, Lidothol Pad and Ondansetron Tab. (RX 4). A second report from UniMed, dated 2/13/2020, denied the same recommendation from Dr. Lipov on appeal. (RX 5).

EVIDENCE DEPOSITION TESTIMONY

Dr. Kevin Koutsky

The evidence deposition of Petitioner's treating physician, Dr. Kevin Koutsky, was completed by the parties on September 21, 20120. (PX 9). Dr. Koutsky was identified as a board certified orthopaedic surgeon. (PX 9, P 6).

Dr. Koutsky testified that he first examined Petitioner on November 1, 2019 and diagnosed a left L4-5, L5-S1 radiculopathy. Dr. Koutsky instructed Petitioner to complete physical therapy, ordered an EMG study and referred Petitioner for a pain clinic evaluation. (PX 9, P 13). Dr. Koutsky admitted that Petitioner's pain diagram completed at the time of the first visit did not denote the presence of any numbness and did not identify any symptoms into the left lower extremity. (PX 9, P 48-49).

Dr. Koutsky testified that Petitioner's left L4-5, L5-S1 radiculopathy was causally and directly related to Petitioner's work accident. (PX 9, P 22). Dr. Koutsky testified that Petitioner had preexisting degenerative changes that were aggravated and made symptomatic by the work injury. (PX 9, P 22).

Petitioner's lumbar spine MRI films were reviewed by Dr. Koutsky and his impression was age-related degenerative changes. (PX 9, P 30).

Dr. Koutsky testified that the EMG "wasn't really helpful" and admitted there was no clear evidence of lumbar radiculopathy. (PX 9, P 15). Dr. Koutsky testified that the study included a finding of sural nerve injury and that a sural nerve injury would not be caused by anything in the lumbar spine. (PX 9, P 35). Dr. Koutsky admitted that the area of Petitioner's left foot that demonstrated decreased sensation to pinprick was the same part of the foot that the left sural nerve innervates. (PX 9, P 36). Dr. Koutsky admitted that he could not delineate whether or not Petitioner's deceased sensation would be attributed to a lower lumbar level or a left sural nerve injury. (PX 9, P 37).

Dr. Koutsky discussed the injections completed by Dr. Lipov. Dr. Koutsky testified that medial branch blocks are not intended to address radicular symptoms and focus on facet-mediated pain. (PX 9, P 38-39).

Dr. Koutsky testified that on February 21, 2020 he recommended a lumbar decompression at L4-5 and L5-S1 to reduce nerve irritation. (PX 9, P 18). Dr. Koutsky testified that he disagreed with any diagnosis of a lumbar strain as Petitioner presented

with numbness and tingling in the left leg and that his symptoms were refractory to conservative treatment. (PX 9, P 19-20).

Dr. Koutsky testified that Petitioner was not capable of returning to his construction position. (PX 9, P 23).

Dr. Koutsky testified that it was a common practice to have patients sign a narcotic pain agreement and submit to periodic lab work when prescribing narcotic pain medication. (PX 9, P 42-43). Dr. Koutsky testified that lab work can detect the presence of illegal drugs and that it would be alarming to have a patient using prescription medication and illicit or illegal drugs. (PX 9, P 44).

Dr. Kern Singh

The evidence deposition of Respondent's examining physician, Dr. Kern Singh, was completed on October 21, 2020. Dr. Singh is a board certified orthopaedic surgeon and a professor in the Department of Orthopaedic Surgery at Rush University Medical Center. (RX 1). Dr. Singh completed an independent medical examination of Petitioner on January 27, 2020. (RX 3, P 6). Dr. Singh testified that on physical examination he found no sensory loss, normal range of motion, full and symmetrical strength in the bilateral lower extremities and normal reflexes. (RX 3, P 9-10). Dr. Singh testified that his findings did not suggest an active and ongoing radiculopathy or a discogenic pain source. (RX 3, P 10). Dr. Singh testified that Petitioner's MRI study and EMG results were consistent with his own physical examination of Petitioner. (RX 3, P 11).

Dr. Singh testified that Petitioner was not a candidate for an L4-5, L5-S1 diskectomy and decompression as Petitioner has no radiographic evidence of neural compression, a normal examination with no neurological deficits and no evidence of radiculopathy of EMG. (RX 3, P 15-16). Dr. Singh testified that he diagnosed Petitioner with a lumbar muscular strain and degenerative spondylosis. (RX 3, P12). Dr. Singh testified that Petitioner was capable of returning to work on a full duty basis. (RX 3, P 15).

Dr. Singh testified that a subject complaint of radicular type symptoms, alone, would not serve as an adequate basis to offer a patient epidural steroid injections or a decompressive type procedure. (RX 3, P 33-34). Dr. Singh testified that subjective complaints should be correlated with a sensory, motor or reflex change on physical examination. Dr. Singh testified that Petitioner had no decreased sensation, no reduction in motor strength and no sensory or reflex loss. (RX 3, P 34-35).

CONCLUSIONS OF LAW

The Arbitrator adopts the Statement of Facts in support of the Conclusions of Law.

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).

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 (Horvath 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, I29 Ill. 2d 52, 63 (1998). 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 employment, unexpectedly and without affirmative act or design of the employee. Mathiessen & Hegeler Zinc. Co. V. Industrial Board, 284 Ill. 378 (1918).

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).

Credibility is the quality of a witness which renders his evidence worthy of belief. The arbitrator, whose province it is to evaluate witness credibility, evaluates the demeanor of the witness and any external inconsistencies with his testimony. It is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical evidence and assign weight to witness testimony. O'Dette v. Industrial Commission, 79 Ill.2d 249, 253, 403 N.E.2d 221, 223 (1980); Hosteny v. Workers' Compensation Commission, 397 Ill. App. 3d 665, 674 (2009). Where a claimant's testimony is inconsistent with his actual behavior and conduct, the Commission has held that an award cannot stand. McDonald v. Industrial Commission, 39 Ill. 2d 396 (1968); Swift v. Industrial Commission, 52 Ill. 2d 490 (1972). While it is true that an employee's uncorroborated testimony will not bar a recovery under the Act, it does not mean that the employee's testimony will always support an award of benefits when considering all the testimony and circumstances shown by the totality of the evidence. Caterpillar Tractor Co. v. Industrial Commission, 83 Ill. 2d 213 (1980). The mere existence of testimony does not require its acceptance. Smith v. Industrial Commission, 98 Ill.2d 20, 455 N.E.2d 86 (1983). To argue to the contrary would require

that an award be entered or affirmed whenever a claimant testified to an injury no matter how much his testimony might be contradicted by the evidence, or how evidence it might be that his story is a fabricated afterthought. U.S. Steel v. Industrial Commission, 44 Ill2d 207, 214, 254 N.E.2d 522 (1969); see also Hansel & Gretel Day Care Center v. Industrial Commission, 215 Ill. App. 3d 284, 574 N.E.2d 1244 (1991). Internal inconsistencies in a claimant's testimony, as well as conflicts between the claimant's testimony and medical records, may be taken to indicate unreliability. Gilbert v. Martin & Bayley/Hucks, 08 ILWC 004187 (2010).

Petitioner testified in open hearing before the Arbitrator who viewed her demeanor under direct examination and under cross-examination. Petitioner's manner of speech, body language, and flow of answers to questions was, in totality, gave the Arbitrator pause and unease. During a short direct exam, Petitioner seemed to pause a few times as if recalling a script rather than spontaneously answering questions. Petitioner's entire demeanor changed during cross examination when confronted with questions about whether he gave full effort at examinations or whether he had been inebriated or taken illicit drugs. These observations made during trial were later validated through a review of the medical records so much so that the Arbitrator does not find Petitioner to be credible. This is particularly important when subjective complaints and findings are the basis of any medical opinion because the Arbitrator simply give no weight to what Petitioner said to various providers. If a provider reports a lack of effort during an examination, the Arbitrator believes the provider over Petitioner. More of the specific issues of Petitioner's credibility are discussed below as is the credibility of other witnesses.

In support of the Arbitrator's decision relating to F (Is Petitioner's current condition of ill-being causally related to the injury):

There is no dispute that Petitioner suffered a compensable work accident on May 15, 2019. There is no dispute that Petitioner's accident resulted in injuries to the left shoulder and the lumbar spine.

The Arbitrator finds that Petitioner's left shoulder rotator cuff tear was causally related to Petitioner's work accident of May 15, 2019. There is a consensus in the medical opinions of both Dr. Garelick and Dr. Verma on the issue on causal connection. The left shoulder injury was treated surgically by Dr. Garelick. The Arbitrator finds that Petitioner reached maximum medical improvement for his left shoulder injuries on March 4, 2020.

The Arbitrator finds that Petitioner suffered a lumbar muscular strain with degenerative spondylosis as a result of his work accident on May 15, 2019. The Arbitrator finds that Petitioner reached maximum medical improvement for his related lumbar spine injuries by January 27, 2020. The Arbitrator finds that Petitioner's condition of ill-being in the lumbar spine after January 27, 2020 is not causally related to a work accident of May 15, 2019.

The Arbitrator's Decision is based on a propensity of the credible medical evidence including the findings and opinions of Dr. Kern Singh, the results of Petitioner's diagnostic studies, inconsistencies in Petitioner's subjective presentation and physical examination findings and significant credibility issues throughout Petitioner's course of treatment.

On the issue of causation, the Arbitrator was presented with conflicting medical opinions.

Petitioner's treating orthopaedic surgeon, Dr. Kevin Koutsky, diagnosed Petitioner with left L4-5, L5-S1 radiculopathy and opined that the condition was causally related to Petitioner's work accident. (PX 9, P 22). Dr. Koutsky interpreted Petitioner's MRI to document age-related degenerative changes, mild-to-moderate multifactorial stenosis at L3-4 and L4-5 and a generalized left disc protrusion at L5-S1. (PX 7). Dr. Koutsky testified that Petitioner had pre-existing degenerative changes that were aggravated and made symptomatic by the work injury. (PX 9, P 22). Dr. Koutsky based his opinions on Petitioner's subjective complaints, physical examination findings including a positive straight leg raise and decreased sensation, along with the results of Petitioner's MRI study.

Dr. Kern Singh examined Petitioner pursuant to Section 12 of the Act on January 27, 2020. Dr. Singh found no evidence of sensory loss, full range of motion, full and symmetrical strength in the bilateral lower extremities and normal reflexes. (RX 2). Dr. Singh reviewed Petitioner's MRI films and noted diffuse spondylosis with mild central stenosis at L4-5. (RX 2). Dr. Singh reviewed Petitioner's EMG report and found no evidence of radiculopathy. (RX 2). Dr. Singh testified that Petitioner has no radiographic evidence of neural compression, a normal examination with no neurological deficits and no evidence of radiculopathy of EMG. (RX 3, P 15-16). Dr. Singh found that Petitioner had reached maximum medical improvement. (RX 2). Dr. Singh relied upon his physical examination findings, the MRI results and the EMG findings, or lack thereof, to support his opinions.

In resolving this conflict in the medical evidence, the Arbitrator first places emphasis on the objective results of Petitioner's diagnostic studies.

Petitioner completed an MRI study through Advanced Medical Imaging Center on October 14, 2019. The interpreting radiologist did not identify any nerve root effacement or impingement. (PX 6). Dr. Singh consistently found no radiographic evidence of neural compression. (RX 3, P 15-16).

Petitioner's EMG study was performed by Dr. Rizwan Arayan on November 13, 2019. There was no electrodiagnostic evidence of any lumbar radiculopathy. (PX 6). There was evidence of a left sural nerve injury. Dr. Koutsky admitted that the EMG "wasn't really helpful" and that he was hoping that the EMG would identify which disc was irritating a nerve root. (PX 9, P 15). Dr. Koutsky testified that the finding of a sural nerve injury was not caused by any condition in the lumbar spine and admitted that the sural nerve innervates the exact area that Petitioner was found to have a decreased pinprick

sensation. (PX 9, P 35-36). Dr. Koutsky admitted that he could not delineate whether any decreased response to a pinprick was being caused by a lumbar radiculopathy versus a sural nerve injury. (PX 9, P 36-37). Dr. Singh testified that the normal EMG was entirely consistent with his findings on physical examination and his impression of Petitioner's MRI study and testified that there was no objective evidence of an active and ongoing radiculopathy or a discogenic pain source. (RX 3, P 10 - 11).

In assigning weight to the conflicting medical opinions, the Arbitrator also places emphasis on inconsistencies in Petitioner's subjective presentation and the physical examination findings of Petitioner's various physicians throughout his course of treatment.

Petitioner's lumbar spine injuries were first treated through an occupational health clinic, Concentra. When Petitioner was seen on May 20, 2019 he reported bilateral lower back pain and denied any radiating symptoms. (PX 3). Petitioner had a negative straight leg raise. (PX 3).

Petitioner was subsequently referred to Dr. Murtaza and on July 12, 2019 Petitioner presented with complaints of left-sided low back pain without radiation into his lower extremity. (PX 4). Petitioner had full and symmetrical strength in the bilateral lower extremities with no motor or sensory loss. (PX 4). Petitioner was seen on August 9, 2019 and Dr. Murtaza again recorded lower back pain only; Petitioner denied any radicular symptoms or numbness into the lower extremities. (PX 4).

On September 13, 2019, Dr. Murtaza recorded, "same left-sided lower back pain, which will rarely radiate into the left leg, mainly when driving for a long period of time." (PX 4). This was the first recorded complaint vaguely suggesting a radicular component and it was four months after the subject occurrence. Dr. Murtaza still found full and symmetrical strength in the bilateral lower extremities, a negative straight leg raise test bilaterally and no evidence of sensory loss. (PX 4). The physical examination findings from Dr. Murtaza are identical to those of Dr. Kern Singh who also found full strength, a negative straight leg raise and no evidence of reflex or sensory loss.

Dr. Koutsky's initial evaluation was November 1, 2020 and it represents a change in Petitioner's subjective presentation and physical examination findings. Petitioner alleged numbness into his foot a complaint not previously recorded and actually denied throughout treatment with Dr. Murtaza. Dr. Koutsky found a positive straight leg raise on examination, contrary to Dr. Murtaza's normal findings. Dr. Koutsky found evidence of decreased sensation on physical examination, contrary to Dr. Murtaza's findings. Dr. Koutsky's finding of decreased sensation is further complicated by his admission that the sensory loss could not be definitively attributed to the lumbar spine and may be due to a sural nerve injury. Dr. Koutsky did not causally relate any sural nerve injury to Petitioner's work accident, "Sural nerve injuries usually occur to some kind of blunt trauma or penetrating injury in the sural nerve distribution. You know, he didn't have any history like that." (PX 9, P 51).

In addition to completing an orthopaedic evaluation with Dr. Koutsky in November 2020 (11/2/2019), Petitioner was also seen by Dr. Rizwan Arayan for an EMG (11/13/2019) and Dr. Lipov for injections (11/20/2019). Dr. Rizwan Arayan examined Petitioner within two weeks of the initial orthopaedic evaluation and found "sensation equal to light touch bilateral lower extremities." (PX 6). Dr. Lipov examined Petitioner on November 21, 2019 and found Petitioner to be neurovascularly intact in the lower extremities. (PX 6). On November 20, 2019, Dr. Lipov completed medial branch injections which Dr. Koutsky conceded were not intended to address radicular symptoms and were focused on facet-mediated pain. (PX 9, P 38-39). Dr. Koutsky testified that the pain diagram completed personally by Petitioner on November 1, 2019 did not indicate the presence of any symptoms into the left lower extremity. (PX 9, P 48-49). Dr. Koutsky testified that the pain diagram completed by Petitioner on March 11, 2020 did not identify any symptoms into the left lower extremity. (PX 9, P 50). Dr. Koutsky testified that Petitioner's pain diagram was consistent with facet-mediated pain that would not manifest into a lower extremity. (PX 9, P 50-51). Dr. Koutsky's findings in November 2019 are not consistent with the findings of Dr. Arayan, are not consistent with the EMG results and are not consistent with the treatment focus of Dr. Lipov.

The Arbitrator finds that Petitioner's credibility was undermined by the medical evidence in the trial record. The records from Concentra indicate that Petitioner appeared for several physical therapy visits with overt signs of intoxication including the smell of alcohol on his breath and red eyes. (PX 3). Petitioner also was documented to have had angry outbursts on a few occasions at physical therapy. (PX 3). On January 8, 2020, Dr. Garelick found that "his [Petitioner's] affect also seems to be somewhat affected." The Arbitrator reasonably infers this would suggest that Petitioner displayed signs of intoxication or inebriation. Petitioner's urine tests from November 20, 2019 documented the presence of both cocaine and THC. Throughout his FCE, Petitioner was found to have given sub-maximal effort with self-limiting behaviors; Petitioner self-terminated virtually every material handling test and the therapist noted that there were minimal to no heart rate changes to support pain reports. Dr. Verma found that Petitioner's pain with palpation was disproportionate to objective findings. Dr. Verma found evidence of effort-related weakness and symptom magnification including grip test weakness that was not associated with any rotator cuff injury. Petitioner's pain diagrams from November 2019 and March 2020 did not match the subjective complaints recorded by Dr. Koutsky. Based on the foregoing, the Arbitrator does not find Petitioner to be credible and any subjective complaints recorded in the treatment records and Petitioner's trial testimony about ongoing symptoms and complaints is given very little evidentiary weight.

Expert opinions must be supported by facts and are only as valid as the facts underlying them. *In re Joseph S.*, 339 Ill.App.3d 599, 607, 274 Ill.Dec. 284, 791 N.E.2d 80, 87 (2003). An expert opinion is only as valid as the reasons for the opinion. *Kleiss v. Cassida*, 297 Ill.App.3d 165, 174, 231 Ill.Dec. 700, 696 N.E.2d 1271, 1277 (1998). The proponent of expert testimony must lay a foundation sufficient to establish the reliability

of the bases for the expert's opinion. *Torres v. Midwest Development Co.*, 383 Ill.App.3d 20, 28, 321 Ill.Dec. 389, 889 N.E.2d 654, 662 (2008).

The Arbitrator finds that Dr. Koutsky's reliance on Petitioner's subjective complaints to be unfounded in light of various credibility issues. The Arbitrator finds that Dr. Koutsky's physical examination findings including a positive straight leg raise and decreased sensation were not consistent with the findings of Concentra, Dr. Murtaza, Dr. Singh, Dr. Arayan and Dr. Lipov. Petitioner's EMG result does not support a diagnosis of radiculopathy.

On the issue of causal connection, the Arbitrator finds the opinions of Dr. Kern Singh to be the most persuasive. Dr. Singh's physical examination findings were consistent with Dr. Murtaza. Dr. Singh's physical examination and diagnosis were consistent with the objective results of Petitioner's diagnostic studies including a normal EMG.

Based on the foregoing, the Arbitrator finds that Petitioner suffered a lumbar muscular strain with degenerative spondylosis as a result of his work accident on May 15, 2019. The Arbitrator finds that Petitioner reached maximum medical improvement for his related lumbar spine injuries by January 27, 2020. The Arbitrator finds that Petitioner's condition of ill-being in the lumbar spine after January 27, 2020 is not causally related to a work accident of May 15, 2019.

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?):

Petitioner entered into evidence a group exhibit of medical bills from three medical providers: Illinois Orthopaedic Network ($24,542.27), Midwest Specialty Pharmacy ($7,503.25) and Metro Anesthesia Consultants ($2,721.44). (PX 2). The medical bills relate solely to treatment involving Petitioner's lumbar spine injuries.

For reasons previously enumerated in Section F, the Arbitrator found that Petitioner reached maximum medical improvement for his lumbar spine injuries on January 27, 2020 and that any condition in the lumbar spine thereafter was not causally related.

The Arbitrator's denial is further supported by Respondent's Exhibits 4 and 5, utilization review reports that non-certified a recommendation from Dr. Eugene Lipov for Lidocaine injection, Bulvacaine injection, Lidothol Pad and Ondansetron Tab.

The Arbitrator denies all medical expenses after January 27, 2020 as there is no causal connection. The Arbitrator denies the injection and medications non-certified in the utilization review of December 26, 2019 and February 13, 2020 as unreasonable and unnecessary.

The Arbitrator denies any medical bill from Dr. Lipov and any ancillary provider for injections completed after November 20, 2019 based on the results of Petitioner's urine tests which documented the presence of cocaine and THC, based on the utilization review reports from UniMed and based on the opinions of Dr. Kern Singh. Dr. Singh testified that Petitioner's prior treatment was prolonged and excessive in nature and that Petitioner only required four weeks of physical therapy. (RX 2). Dr. Singh found no evidence of facet arthropathy to support medial branch blocks (RX 3, P 14).

In support of the Arbitrator's decision relating to K (Is Petitioner entitled to any prospective medical care?):

The Arbitrator denies Petitioner's request for prospective medical treatment in the form of an L4-L5 and L5-S1 lumbar discectomy and decompression surgery as recommended by Dr. Koutsky.

For reasons previously enumerated in Section F, Petitioner was found to have reached maximum medical improvement for his lumbar spine injuries on January 27, 2020 and any condition of ill-being in the lumbar spine thereafter was found to be unrelated to Petitioner's work accident. On the basis of causal connection, Petitioner's request for prospective medical treatment is denied.

The Arbitrator additionally places emphasis on the opinions offered by Dr. Kern Singh who testified that Petitioner was not a candidate for a two level decompression based on the following factors, "He has no radiographic evidence of neural compression that would correlate with any lower extremity radiculopathy. His examination is normal with no neurological deficits, and he has electromyographic evidence of no active radiculopathy. In essence, he has back pain with mild degenerative changes, no nerve root compression on his exam. No nerve root compression of his EMG." (RX 3, P 15-16).

In support of the Arbitrator's decision relating to L (Disputed TTD benefits):

The Arbitrator finds that Petitioner was temporarily and totally disabled from August 15, 2019 through February 10, 2020. The Arbitrator awards Petitioner 25 6/7 weeks of TTD benefits, at a weekly rate of $1,117.00.

The Arbitrator's Decision is supported by the findings and opinions of Dr. Kern Singh and Dr. Nikhil Verma.

For reasons previously enumerated in Section F, the Arbitrator found that Petitioner suffered a lumbar muscular strain with degenerative spondylosis as a result of his work accident on May 15, 2019. The Arbitrator found that Petitioner reached maximum medical improvement for his related lumbar spine injuries by January 27, 2020.

The finding of maximum medical improvement would terminate any entitlement to temporary total disability benefits relative to Petitioner's lumbar spine injuries.

The Arbitrator further finds that Petitioner was capable of performing work on a full duty effective January 27, 2020. This finding is supported by the opinion offered by Dr. Kern Singh.

The Arbitrator previously found that Petitioner suffered a left shoulder rotator cuff tear was causally related to Petitioner's work accident of May 15, 2019. The Arbitrator found that Petitioner reached maximum medical improvement on March 4, 2020. The finding of maximum medical improvement would terminate any entitlement to temporary total disability benefits relative to Petitioner's left shoulder injuries. Petitioner was offered, and refused, a light duty position within the restrictions imposed by Dr. Garelick on February 10, 2020. (RX 7, TR P 43-44).

The Arbitrator specifically finds that Petitioner is capable of performing work on a full duty basis relative to his left shoulder injuries, consistent with the opinion offered by Dr. Nikhil Verma.

Petitioner was examined by Dr. Nikhil Verma, pursuant to Section 12 of the Act, on January 13, 2021. Dr. Verma found full range of motion with good strength and diffuse pain with palpation disproportionate to objective findings. (RX 6). Dr. Verma found evidence of effort-related weakness and symptom magnification including grip test weakness that was not associated with any rotator cuff injury. (RX 6). Dr. Verma diagnosed Petitioner as status post left shoulder rotator cuff repair with good functional recovery and opined that Petitioner could return to work without restrictions relative to his left shoulder injuries. (RX 6).

The Arbitrator places little evidentiary value in the results of Petitioner's FCE from March 3, 2020. This is consistent with the attending therapy who summarized the FCE as follows:

> Mr. Izquierdo had a consistent, but unreliable FCE. Note many tasks were limited by Mr. Izquierdo's back pain versus his shoulder pain, or at times his right shoulder was more painful that his left. He self-terminated most material handling activities, as well as some no material handling activities prior to maximum effort. Overall, Mr. Izquierdo is most likely capable of more than what was exhibited during his FCE, but the other areas of pain (back and right shoulder) could have impacted some of the results/effort in the FCE. That being said, there were minimal to no heart rate changes to support pain reports, even when it was related to the back or other shoulder, thus indicating a lack of reliability. (PX 11).

The Arbitrator does not consider Petitioner's FCE a competent source of evidence based on reliability issues and finds that it would be nothing more than conjecture to

assign any activity restriction or alleged physical demand deficit to a left shoulder condition versus the lumbar spine.

Finally, the Arbitrator notes that the full duty release from Dr. Verma does not materially differ from the work capacity opinions offered by Dr. Garelick prior to the FCE.

Petitioner was seen by Dr. Garelick on September 25, 2019 who noted the following, "I explained to him that I will anticipate return to work regular duty on or around 01/15/2020." (PX 4). Petitioner returned for evaluation on December 4, 2019 and Dr. Garelick noted complications with Petitioner's low back conditioning. (PX 4). Dr. Garelick opined that "if his shoulder was an isolated condition, I would anticipate return to work full duty at around 02/01/2020." (PX 4). On January 8, 2020, Dr. Garelick recommended work conditioning but did express some concerns with Petitioner's ability to complete the program due to significant low back issues. Dr. Garelick was not certain Petitioner would be able to complete work conditioning due to low back issues but indicated that Petitioner would be released to regular duty as it relates to the left shoulder if work conditioning was completed. (PX 4). Dr. Garelick consistently anticipated a full duty release for Petitioner's left shoulder condition, in isolation from his lower back condition.

Prior to August 15, 2019 Petitioner worked on a light duty basis for Respondent.

Based on the foregoing, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits from August 15, 2019 through January 27, 2019 relative to his lumbar spine injuries. On January 27, 2019 Petitioner reached maximum medical improvement.

The Arbitrator finds that Petitioner is entitled to temporary total disability benefits from August 15, 2019 through February 10, 2020 relative to his left shoulder injuries. On February 10, 2020 Petitioner was offered a light duty position within the restrictions imposed by Dr. Garelick. The position was refused by Petitioner. Petitioner reached maximum medical improvement for his left shoulder injuries on March 4, 2020 which would serve as a separate basis to terminate any TTD entitlement.

Per the stipulation of the parties, Respondent is entitled to a credit in the amount of $23,457.21 for prior TTD benefits paid to Petitioner. (RX 1). Respondent is entitled to a further credit of $11,638.70 for two prior PPD advancements issued to Petitioner.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC017331
Case Name	MCGUIRE, ROBERT v. ADM
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0241
Number of Pages of Decision	16
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	Kevin Morrisson
Respondent Attorney	Jessica Bell

DATE FILED: 6/30/2022

/s/ Deborah Baker, Commissioner
Signature

DISSENT: /s/ Deborah Baker, Commissioner
Signature

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

ROBERT MCGUIRE,

Petitioner,

vs. NO: 18 WC 17331

ADM,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of whether Petitioner sustained an accidental injury arising out of and occurring in the course of his employment with Respondent, whether his current condition of ill-being is causally related to the accident, whether Petitioner is entitled to medical expenses, and the nature and extent of Petitioner's permanent disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 14, 2021 is hereby affirmed and adopted.

The bond requirement in Section 19(f)(2) is applicable only when "the Commission shall have entered an award for the payment of money." *820 ILCS 305/19(f)(2)*. Based upon the denial of compensation 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.

June 30, 2022

DJB/lyc

O: 5/11/22

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/s/ *Stephen J. Mathis*

/s/ *Deborah L. Simpson*

DISSENT (IN PART)

I disagree with the majority's decision to affirm the Decision of the Arbitrator with respect to the "arising out of" element of accident. However, I agree that the Arbitrator correctly found Petitioner's injuries occurred "in the course of" his employment with Respondent. I would find that Petitioner proved by a preponderance of the evidence that his accidental injury arose out of and occurred in the course of his employment with Respondent.

It is well known that the Petitioner must prove he sustained an accident that arose out of his employment, *inter alia*, to prove a claim is compensable before the Illinois Workers' Compensation Commission. 820 ILCS 305 (1)(d); *see also Board of Trustees of the University of Illinois v. Industrial Commission*, 44 Ill. 2d 207, 214 (1969). The words "arising out of" refer to the origin or cause of the accident and presuppose a causal connection between the employment and the accidental injury. *Illinois Bell Telephone Co. v. Industrial Commission*, 131 Ill. 2d 478, 483 (1989). To arise out of employment, an injury must be connected to some risk that is related to employment. *Sisbro v. Industrial Commission*, 207 Ill. 2d 193, 203 (2003). "Risks that an employee may be exposed to are categorized into three groups: (1) risks distinctly associated with employment, (2) risks personal to the employee, and (3) neutral risks that have no particular employment or personal characteristics." *Illinois Consolidated Telephone Co. v. Industrial Commission*, 314 Ill. App. 3d 347, 352 (2000).

At the outset, I find that Petitioner has proven his injury arose out of his employment with Respondent under a hazardous condition analysis. The presence of a "hazardous condition" on the employer's premises renders the risk of injury a risk incidental to employment; accordingly, a claimant who is injured by such a hazardous condition may recover benefits without having to prove that she was exposed to the risk of that hazard to a greater extent than are members of the general public. *Archer Daniels Midland*, 91 Ill. 2d at 216; *Mores-Harvey*, 345 Ill. App. 3d at 1040; *Suter*, 2013 IL App (4th) 130049WC, ¶ 40. In other words, such injuries are not analyzed under "neutral risk" principles; rather, injuries resulting from a hazardous condition or defect on the employer's premises are deemed "risks distinctly associated with the employment." *Dukich v. Illinois Workers' Compensation Commission*, 2017 IL App (2d) 160351WC, ¶ 40, 86 N.E.3d 1161.

Based on Petitioner's credible and persuasive testimony, and the testimony of his co-worker, Mr. Traurig, I would find that Petitioner's injury is the direct result of a hazardous condition on Respondent's premises, and thus arose out of Petitioner's employment. In reaching this conclusion, I note that Respondent acknowledged providing the break room where Petitioner was injured (T. 12, 27, 48), and acknowledged that it was not unusual for employees to show up for work early and hang out in the break room (T. 48). I also find it unrebutted that the picnic tables therein were provided by Respondent. Petitioner also testified that it was typical for employees to use the break room (T. 12), and respondent never instructed him not to use the break room to wait until his shift began. (T. 27.)

Regarding the condition of the picnic table involved in Petitioner's injury, Petitioner and Mr. Traurig testified that the table in the break room that flipped up at the time of his injury, was 1-1/2 to 2 feet longer than the other picnic tables in the break room even though the metal bracketing of the attached bench was the same size as the bracketing on the smaller tables. (T.36-38, 52-53.) Thus, the bracketing of the picnic table involved in the injury in question did not offer an adequate amount of support, making it more susceptible to flipping up when weight was applied to the attached bench. While the Arbitrator opined that she was unable to see any difference in the length of the picnic table or its metal housing in relation to other tables in the photo of the break room submitted into evidence by Respondent (Resp.'s Ex. 3), I find the photograph to be inconclusive as to whether there was a defect in the metal bracketing, as it does not show the proper angle needed to decipher such things. The photograph was not taken from an angle that would show all of the tables in the breakroom or show any size differences in the tables. (T.52-54.) Mr. Traurig testified that the lunchbox on the picnic table in the photograph made it difficult to see the actual length of the table. (T. 52-53.) However, I find the testimonies of Petitioner and Mr. Traurig, a coworker and an uninterested party, to be credible and persuasive with respect to the picnic table having a defect. Both provided consistent, detailed, and specific testimony as to the defective condition of the picnic table involved in the injury. Moreover, both Petitioner and Mr. Traurig provided unrebutted testimony that after Petitioner's injury, Respondent removed the picnic table in question from the break room. (T. 13, 36.)

I note that even if the personal risk doctrine applied to this case, which I do not believe it does, Petitioner has proven his claim is compensable under an exception. A personal risk is a risk unconnected to employment. *Rodin v. Industrial Commission*, 316 Ill. App. 3d 1224, 1229. Generally, injuries resulting from personal risks are not compensable. *Id.* However, an exception to this rule exists when the workplace conditions significantly contribute to the injury or expose the employee to an added or increased risk of injury. *Id.* As detailed above, Petitioner and Mr. Traurig credibly testified that the picnic table involved in Petitioner's injury was defective; in other words, it was larger than the other picnic tables in the break room, yet the metal bracketing underneath the table and bench was the same size as the bracketing on the shorter tables, making it prone to flipping up when someone sat on the bench.

Of further note, the majority's affirmation of the Arbitrator's conclusion that Petitioner's body weight was the cause of his injury, is contrary to both the evidence and the law. The Decision of the Arbitrator states:

> Given that there is no credible evidence of any defect with the picnic bench, the arbitrator reasonably infers from the credible evidence that the 360 pounds Petitioner placed on the end of that picnic bench is what caused the other end of the

picnic table to flip up like a see-saw, causing him to slide off of the bench and onto the ground.

It is well known that employers take their employees as they find them. *See Tower Automotive v. Illinois Workers' Compensation Commission*, 407 Ill. App. 3d 427, 434 (1st Dist. 2011). There is no legal authority to support a finding that a claimant's body weight constitutes a personal risk. A "personal risk" is determined by "whether he was exposed to a risk greater than that to which the general public is exposed." *See Rodin*, 316 Ill. App. 3d at 1229; *see* also *McAllister v. Illinois Workers' Compensation Commission*, 2020 IL 124848, ¶ 42 (finding that "personal risks include nonoccupational diseases, injuries caused by personal infirmities such as a trick knee, and injuries caused by personal enemies and are generally noncompensable.") Further, there is no evidence to support a finding that Petitioner's body weight *alone* caused the picnic table to flip up. *See Sisbro Inc. v. Industrial Commission*, 207 Ill. 2d 193, 205 (2003).

Having found credible evidence that Petitioner's injury was causally related to a hazardous condition and/or defect on Respondent's premises, I disagree with the majority, and would have found that Petitioner proved his accidental injury not only occurred in the course of his employment with Respondent, but also arose out of the same.

For the reasons set forth above, I respectfully dissent.

/s/ *Deborah J. Baker*

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC017331
Case Name	MCGUIRE, ROBERT v. ADM
Consolidated Cases	
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	11
Decision Issued By	Maureen Pulia, Arbitrator

Petitioner Attorney	Kevin Morrisson
Respondent Attorney	Jessica Bell

DATE FILED: 9/14/2021

THE INTEREST RATE FOR THE WEEK OF SEPTEMBER 14, 2021 0.05%

/s/Maureen Pulia, Arbitrator

Signature

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ROBERT MCGUIRE,
Employee/Petitioner

v.

ADM,
Employer/Respondent

Case # **18** WC **17331**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Springfield**, on **8/27/21**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **3/3/18**, Respondent ***was*** operating under and subject 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 $**50,336.00**; the average weekly wage was $**968.00**.

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.

Respondent shall be given a credit of $**00.00** for TTD, $**00.00** for TPD, $**00.00** for maintenance, and $**00.00** for other benefits, for a total credit of $**00.00**.

Respondent is entitled to a credit of $**00.00** under Section 8(j) of the Act.

ORDER

The petitioner has failed to prove by a preponderance of the credible evidence, that he sustained an accidental injury that arose out of and in the course of his employment be respondent on 3/2/18. The petitioner's claim for compensation is denied.

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

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

Maureen H Pulia

Signature of Arbitrator

SEPTEMBER 14, 2021

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 52 year old operator, alleges he sustained an accidental injury to his right arm that arose out of and in the course of his employment by respondent on 3/2/18. Petitioner has worked 20 years for respondent. Petitioner denied any problems with his right shoulder prior to the incident on 3/2/18.

Petitioner's shift was scheduled to start at 12:00 am on 3/3/21. Petitioner testified that he arrived at work approximately 30 minutes or so before his shift and would go to the breakroom where other employees were, and would remain there until he was scheduled to clock in for his shift, which was three minutes before to three minutes after his shift was scheduled to start. The location where employees clock in is located in the control room, which is in a different building than the breakroom. It is located near the supervisors' office.

Petitioner testified that before his shift, he and other employees, congregate in the breakroom and hang out there until they have to clock in. Petitioner testified that the breakroom and picnic tables are provided for the employees by respondent, and petitioner and other employees were allowed to congregate in the break area prior to their shift.

Gered Traurig, a machine operator for respondent, and co-worker of petitioner, testified that the picnic tables in the break room were all the same size, except for one which was 1.5 to 2 feet longer than the rest of them. Traurig testified that the saddle bars under each picnic table were the same size, and as a result, the bench on the longer picnic table did not have as much of the bench seat over the iron saddle bars. He also testified that he and petitioner usually got to the breakroom around 30 minutes prior to their shift, and an additional 5-6 employees arrived in the breakroom prior to the shift starting at midnight. Traurig testified that he had seen petitioner sit on the other picnic tables the same way, and the tables never flipped.

At approximately 11:30 pm, when petitioner went to sit down on the longest picnic table, he straddled the bench at the end of the bench. As he sat down on the bench, the other end of the table flipped up. As the other end of the table flipped up petitioner's lunch box left his left hand, and as he began to slide off the bench he put his right hand behind him to catch himself. Petitioner testified that he then slid off the bench onto the ground with his right arm stretched out. He noticed immediate burning and stuff. Petitioner testified that as the other end of the picnic table began lifting, Traurig, who was sitting on an adjacent table, tried to prevent the table from flipping up, but it had already started flipping up. Petitioner testified that the opposite end of the picnic table went up about four feet, and that it would have flipped up even higher if Traurig had not grabbed it to prevent it from going all the way up. Petitioner testified that over time he has sat on all the picnic tables in the breakroom and none of them flipped up.

Petitioner testified that he stops in the break room before every shift that he works. He agreed that his job does not take place in the breakroom.

Following the incident, petitioner reported the incident to his supervisor Greg Pratt. Petitioner and Pratt returned to the breakroom and looked at the table he fell off of. Petitioner testified that there were about ten people from his upcoming shift in the breakroom when this happened. Petitioner testified that the respondent provided the breakroom for the employees and never told them they could not congregate in the breakroom before their shift started. Traurig testified that before his next break that day the table that petitioner was flipped off of was taped with caution tape, and when he arrived for his next shift, it was gone.

Gregory Pratt, petitioner's Shift Supervisor, testified that petitioner came to his office at about 11:30 pm on 3/2/21 following the incident in the breakroom. He testified that petitioner told him that he injured his right arm. Petitioner reported that he sat on the bench in the breakroom and it flipped up on him, and fell off onto an outstretched arm. Pratt testified that he and petitioner walked back to the breakroom and petitioner showed him where he sat on the bench of the picnic table. Pratt testified that he did not see anything wrong with the table. He believed it was similar to the other tables in the breakroom. Pratt testified that although the job duties of an operator do not take place in the breakroom before or during the operator's shift, it is usual for the employees to show up prior to the shift and hang out in the breakroom until their shift starts. He stated that the breakroom is made available to employees by ADM.

On 3/2/18 the ADM Incident Investigation Guide, Part 1 – Notification Form was completed and signed by petitioner and Pratt. The time of the incident was identified as 11:30 pm on 3/2/18, and involved an injury to his right arm/shoulder. The type of incident was identified as "struck against". The extent of the injuries was identified as "pain and stiffness in the upper right arm/shoulder". The report noted that Pratt inspected the area and pictures were taken. The description of where and how the incident occurred was as follows:

> "Employee was getting ready to sit down at the table in the employees' breakroom prior to the start of his shift. He sat on the northwest corner of one of the benches. As he sat, the table lifted causing him to lose his balance and fall backwards. He reached behind him with his right arm to stop his fall. He then experienced some pain and stiffness in his upper right arm and shoulder, which he reported. "

Petitioner also completed a Voluntary Statement Form that read as follows:

> "Came to work as usual. I stopped in the breakroom to talk to the guys, sat down at the table and it flipped up, after getting up walk to the Control RM (office) and told my supervisor (Greg Pratt) what had happened."

Petitioner was taken to Decatur Memorial Hospital emergency room by ambulance, accompanied by his supervisor. In triage he reported pain in his right shoulder when "a bench flipped and caught over his arm". He also reported to the doctor a fall at work where he injured his right shoulder when he fell from a sitting position and caught himself with his right arm. X-rays of the right shoulder and humerus were taken and were normal. Petitioner had decreased range of motion and focal tenderness to palpation. He was assessed with a strain of the AC joint of the right shoulder, and instructed to follow-up with his healthcare provider.

On 3/5/18 petitioner presented to Decatur Memorial Hospital Corporate Health. He reported that he injured his right arm falling back. It was noted that he fell from a lunch table when it suddenly tilted up as he sat down at one end and "kinda" fell backwards. Petitioner reported the pain as burning and constant since the injury on 3/2/18, accompanied by tingling. He reported that lifting his arm, and making certain movements with the right arm and shoulder made it worse. He noted slight improvement and rated the pain at a 3/10. He stated that Aleve helps the symptoms. Petitioner was examined and was only able to lift 3 pounds. He was assessed with a sprain of the supraspinatus-infraspinatus parts of the right shoulder girdle. It was further noted that an MRI of the right shoulder should be considered at the next visit. Petitioner was instructed to follow up on 3/12/18. He indicated that he would like to keep working in the operator position.

On 3/12/18 petitioner returned to Decatur Memorial Hospital Corporate Health. His physical complaint was identified as "jammed R. arm Saturday (3-3-18) falling back to catch himself. He was examined and assessed with a right shoulder strain, and rotator cuff tendons. An MRI of the right shoulder was ordered, and petitioner was instructed to return the day after the MRI was performed. He was released to full duty work.

On 3/15/18 Shawn Rogers at Decatur Memorial Corporate Health sent an email to Tracey Parker at CORVEL asking her why the MRI had not been approved. Parker wrote back that it was not approved because petitioner's injury was not a work related injury. She told Rogers that petitioner must use his group insurance for coverage.

On 4/23/18 petitioner was examined by Audra Trump, APRN at SIU. Petitioner gave a history of sitting on a picnic table at work when it flipped up and he fell off. He reported that he used his right arm to catch

himself. He gave a history of his treatment to date. He reported that the pain had not resolved, but the burning had. He reported pain in the right shoulder when reaching and picking things up. He noted pain, popping and weakness. Following an examination, petitioner was assessed with right shoulder pain. An MRI was ordered. It was noted that if it was denied he would need physical therapy first.

On 6/6/18 petitioner underwent an MRI of his right shoulder. The impression was full-thickness, full width supraspinatus and infraspinatus tendon tears with tendinous retraction and supraspinatus muscle edema without atrophy; at least a partial-thickness tearing of the subscapularis and long head of the biceps tendons; and motion artifacts.

On 6/15/18 petitioner presented to Dr. John Kefalas. It was noted that petitioner weighed 360 pounds and his height was 5'11". He reported an injury at work on 3/3/18 (sic) when he went to sit down a picnic bench which then flipped backwards causing him to injure his right shoulder. He denied any prior right shoulder symptoms. He stated that his right arm symptoms had persisted since the incident. Dr. Kefalas reviewed the MRI. He also examined petitioner. Dr. Kefalas' impression was acute on chronic right shoulder rotator cuff tear with possible long head of the biceps injury. He recommended an intra-articular injection into the right shoulder, and physical therapy. He told petitioner he could continue his regular work. Dr. Kefalas was of the opinion that the rotator cuff may not be repairable given the size and retraction.

On 7/20/18 petitioner followed-up with Dr. Kefalas. He stated that his right shoulder was slowly improving with physical therapy. He still reported difficulty performing overhead activities with the right arm, but reported that his right shoulder was a little better, and that the therapy and the injection helped. Following an examination petitioner was instructed to continue his self directed rehabilitation program. Dr. Kefalas prescribed Celebrex. On 10/3/18 petitioner reported no change in his right shoulder condition. He reported difficulty with overhead activity. Dr. Kefalas noted an acute on chronic right shoulder rotator cuff tear. Dr. Kefalas did not think petitioner was a candidate for a right shoulder arthroscopy. He noted that petitioner was functioning, and encouraged him to continue strengthening exercises. On examination, his right shoulder external rotation was 45 degrees, abduction was 150 degrees and his internal rotation was to L4. His BMI was 50.

All treatment after 10/3/18 with Dr. Kefalas was unrelated to his right shoulder. Petitioner underwent physical therapy for his right shoulder through 7/13/18.

The respondent offered into evidence a picture of picnic tables in the breakroom. (RX3) The edge of the bench where petitioner fell from had a blue circle around it. The picture showed three rows of picnic tables. Each picnic table had 3 boards for the table; a board for each bench seat; a metal base that had a metal rod from

under the top of the table to each bench, and, a metal rod at each end that connected the metal rod of one bench seat to the metal rod of the other bench seat. That connecting metal rod was below the halfway point between the picnic table top and the floor. There also appeared to be metal rods that connect at the top of the middle of the picnic table under the picnic table top. These metal rods went in a "V' shape from that point to the middle of the metal rod that connected the metal rod of one bench seat to the other bench seat. All picnic tables in the break room appeared to be built the same way. In the row where the picnic bench petitioner fell off is located, there were three picnic benches pushed together with no space between them. In the other two rows of picnic benches visible in the picture, there appeared to be only two picnic benches in each row with space between them to walk through the benches.

Petitioner was shown the picture of the breakroom tables (RX3) and testified that he attempted to sit where the blue circle was when the table flipped and he fell off. He testified that the other tables in the room were 1-2 feet shorter than that table. He also testified that there were three tables in the row where his table was, and only two tables in the other rows.

The parties stipulated on the record that respondent would be entitled to a credit for any BCBS payments that were made by respondent with respect to this incident.

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?

Petitioner alleges he sustained an accidental injury that arose out of and in the course of his employment by respondent on 3/2/18. Respondent disputes this claim. The arbitrator finds it unrebutted that 1) on 3/2/18 petitioner arrived about 30 minutes early for his shift and went to the break room, where he went every day before his shift started, to sit and visit with fellow employees until his shift started; 2) that the break room, and the picnic tables in the break room, are provided by respondent for use by the employees; that respondent never told the employees that they were forbidden from congregating in the break room prior to their shift; and, that on 3/2/18, petitioner sat on the edge of one of the picnic table benches and the picnic table flipped up and he slid off onto to floor landing on his outstretched right arm and his buttock.

The threshold issue her is whether or not petitioner's injury arose out of and in the course of his employment by respondent on 3/2/18. In order to establish a claim for compensation under the Workers' Compensation Act, the injury must "arise out of" and occur "in the course of" the claimant's employment. Both elements must be present for a claimant to receive compensation. The "in the course of" component refers to the time, place, and circumstances under which the accident occurred. Case law has also held that injuries that occur

on the employer's premises by an employee going to or from his employment within a reasonable time before or after work can occur "in the course of" the employment. *Indian Hill Club v. Industrial Comm'n,* 309 Ill. 271. p

Given that Illinois recognizes the personal comfort doctrine and has found injuries sustained by an employee while in the performance of reasonably necessary acts of personal comfort may be found to have occurred "in the course of his employment, since they are incidental to the employment." *Chicago Extruded Metals v. Industrial Commission,* 77 Ill. 2d 81, 32 Ill. Dec 339, 395 N.E.2d 569 (1979).

In the case at bar, there was no credible evidence offered to support a finding that respondent discouraged employees from arriving as early as 30 minutes prior to their shift, or that the respondent prohibited employees from congregating in the respondent's provided break room during this period prior to the start of their shift. The arbitrator finds it not unreasonable that there is some benefit to the employer when employees are not stressed and rushing to clock in to work. The arbitrator definitely sees a benefit to the respondent of an employee arriving early for a shift and being able to take a few moments to relax and unwind, in a respondent provided area, before they are required to begin their shift, over an employer that provides no area for workers to convene before clocking in and those employees are rushing at the last minute to clock in and start their shift in a possible stressed out mode. The arbitrator finds the fact that the respondent provided this break area for the personal comfort of its employees and did not object to them arriving early and hanging out until their shift started significant in finding that this injury sustained by petitioner while in the break area 30 minutes prior to the beginning of his shift occurred "in the course of" his employment by respondent.

That said, the petitioner must also prove by a preponderance of the credible evidence that his injury "arise out of" the employment by respondent. The "arising out of" element that the petitioner must prove is primarily concerned with causal connection. The causal connection claimant must prove is between his employment and the accidental injury. The claimant must show that his injury had its origin in some risk connected with, or incidental to, the employment so as to create that causal connection. Sisbro, Inc, v. Industrial Comm'n, 207 Ill. 2d 193, 203. The analysis begins by categorizing the risk to which the claimant was exposed at the time of the accidental injury. Case law has established three categories of risks: (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.

The first category of risk is risks distinctly associated with the employment. In the case at bar, when petitioner was waiting in the break room for his shift to start, he was not performing any work related task that contributed to an act he had a common law or statutory duty to perform, nor was he performing an act incidental

to his assigned duties, especially given that petitioner himself stated that all he was doing in the break room before his shift was talking with the other employees, while waiting for his shift to start There was also no credible evidence offered to support a finding that any of these discussions were related to, or incidental to his work for respondent.

Nothwitstanding the above, the petitioner also claims the risk associated with his injury was an employment risk because the picnic bench he flipped off of was provided by respondent and was defective. Petitioner and Traurig testified that of all the picnic benches in the break room, the one petitioner flipped off was 1-2 feet longer, but the metal housing of that picnic bench was the same size as the metal housing on the smaller picnic benches, causing the benches of the picnic table he sat on not to have the same metal housing support for the benches the other picnic benches had, which made the picnic table he was flipped off more susceptible to flip.

Having had a chance to review a picture of the break room and the picnic table and bench petitioner was flipped off of, as well as the other picnic tables and benches in the break room (RX3), the arbitrator finds petitioner's claim that the size of the picnic table he fell off of was larger, and the metal housing did not fit the benches of that picnic table the same as the other picnic tables, is not persuasive. Looking at RX3, the picture of the picnic tables in the break room when petitioner was injured, the arbitrator is unable to see any difference in where the metal housing on the picnic table and bench petitioner fell off of is located, versus where the metal housing was on the other picnic tables and benches in the break room. The arbitrator sees no credible evidence in the photo to support a finding that the metal housing under the bench petitioner flipped off of was attached in a different spot than it was on all the other benches of the picnic tables in the picture. For this reason, the arbitrator finds the testimony of petitioner and Traurig that the picnic bench petitioner fell off of had a different bench to metal housing ratio not very persuasive. For these reasons the arbitrator finds the risks associated with petitioner's injury was not an employment risk.

The second category of risk is risks personal to the employee, with an exception that injuries resulting from personal risks do not arise out of employment exists when the work place conditions significantly contribute to the injury or exposed the employee to an added or increased risk of injury. *Rodin v. Industrial Comm'n*, 316 Ill, App. 3d 1224, 1229. In the case at bar, the arbitrator finds there exists no credible evidence to support a finding that the picnic table petitioner sat on was defective in any manner, or that he was performing any activity associated with his work at the time of the accident. However, there is credible evidence to support a finding that there existed a risk personal to petitioner. The arbitrator notes that at the time of injury petitioner weighed over 360 pounds. Petitioner himself testified that when he went to sit down on the bench he straddled, he sat at

the very end of the bench. Given that the there is no credible evidence of any defect with the picnic bench, the arbitrator reasonably infers from the credible evidence that the 360 pounds petitioner placed on the end of that picnic bench is what caused the other end of the picnic table to flip up like a see-saw, causing him to slide off of the bench and onto the ground. Even after petitioner fell, and Pratt and him returned to the break room to inspect the picnic bench he flipped off of, no defects were identified that were associated with that specific picnic bench. The picnic bench petitioner fell off of was exactly the same as all the other picnic benches in the break room. The arbitrator also found it significant that petitioner testified that he had previously sat on all the picnic benches in the past and never experienced any problems. For these reasons, the arbitrator finds petitioner's injury occurred solely as a result of a risk personal to him.

With respect to neutral risks, a neutral risk is compensable only when the employee can establish he was exposed to the risk to a greater degree than the general public. *Springfield Urban League,* 2013 IL App (4th) 120219WC. In the case at bar, the arbitrator finds the credible evidence supports a finding that the picnic bench petitioner flipped off of in the break room was not defective in any way. Additionally, the arbitrator finds the petitioner was at no greater risk of injury when he sat down on the bench of the picnic table in the break room, than any other person in the general public would be exposed to when they sit down on the bench of a picnic table.

Based on the above, as well as the credible evidence, although a credible argument can be made that petitioner's injury occurred in the course of his employment by respondent on 3/2/18, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that his injury arose out of his employment by respondent on 3/2/18.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?
J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?
L. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

Having found the petitioner failed to prove by a preponderance of the credible evidence, that he sustained an accidental injury that arose out of and in the course of his employment be respondent on 3/2/18, the arbitrator finds these remaining issues moot.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC000055
Case Name	BARNES, KIMBERLY v. STATE OF ILLINOIS – CHESTER MENTAL HEALTH CENTER
Consolidated Cases	17WC000060; 19WC010795;
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0242
Number of Pages of Decision	25
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	Thomas Rich
Respondent Attorney	Nicole Werner

DATE FILED: 6/30/2022

/s/ Deborah Baker, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KIMBERLY BARNES,

Petitioner,

vs. NO: 17 WC 00055

STATE OF ILLINOIS,
CHESTER MENTAL HEALTH CENTER,

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 whether Petitioner's current right shoulder condition of ill-being is causally related to the undisputed September 11, 2015 work accident, entitlement to temporary total disability benefits and the date of maximum medical improvement, entitlement to maintenance benefits, entitlement to incurred medical expenses as well as vocational rehabilitation expenses, and the nature and extent of Petitioner's permanent disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as set forth below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. This case was consolidated for hearing with case numbers 17 WC 00060 and 19 WC 10795.

Vocational Rehabilitation Expenses

The Arbitrator ordered Respondent to pay the vocational rehabilitation charges contained in Petitioner's Exhibit 18. The Commission agrees that Petitioner was engaged in a good faith job placement effort. However, we view the evidence regarding the vocational rehabilitation expenses differently.

Initially, the Commission observes the vocational rehabilitation records are incomplete. Mr. Kaver testified he performed an initial vocational assessment on August 14, 2018 and thereafter prepared regular status reports documenting his job placement efforts from November

19, 2018 through his December 29, 2020 deposition. Pet.'s Ex. 22, p. 6, 15. The Commission emphasizes, however, that the first vocational report received into evidence is dated May 15, 2019. As such, the initial assessment and the first six months of vocational status reports are absent from the record. Moreover, the vocational rehabilitation bills themselves are similarly incomplete. The first invoice in evidence is from May 28, 2019, and the service dates on the itemized list begin on March 31, 2019. Notably, that May 28, 2019 bill includes a previous balance of $7,906.00 for which there are neither corresponding vocational status reports nor itemized billing statements.

Additionally, the Commission notes Petitioner's Exhibit 18 includes a $1,393.00 invoice dated August 18, 2020, which sets forth itemized charges for testimony preparation on August 13, 2020, and waiting to testify and travel on August 14, 2020. Mr. Kaver confirmed the August 18, 2020 bill is for his services as an expert witness. Pet.'s Ex. 22, p. 39. The Commission finds this is a litigation expense to be borne by Petitioner.

Our analysis of Petitioner's Exhibit 18 reveals the total charges incurred for vocational rehabilitation services rendered through July 23, 2020 was $17,781.60. This includes the $7,906.00 balance for which there are neither reports nor bills; the Commission declines to award these unsupported charges. The Commission finds Petitioner proved entitlement to the England & Company Rehab Services charges incurred from March 31, 2019 through July 23, 2020. As such, the Commission finds Respondent is liable for vocational rehabilitation expenses in the amount of $9,875.60 ($17,781.60 - $7,906.00 = $9,875.60).

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 3, 2021, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner maintenance benefits in the amount of $575.40 per week for a period of 60 6/7 weeks, representing January 25, 2020 through March 25, 2021, as provided in §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the reasonable, necessary and causally related medical expenses detailed in Petitioner's Exhibit 1, as provided in §8(a), subject to §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 §8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the sum of $9,875.60 for vocational rehabilitation expenses, as provided in §8(a).

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $517.86 per week for a period of 250 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused a combined 50% loss of use of the person as a whole, consisting of a 20% loss of use of the person as a whole related to the cervical spine and a 30%

loss of use of the person as a whole related to the right shoulder. Respondent shall be given a credit of $5,178.60 for the stipulated PPD advance previously paid.

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.

Pursuant to Section 19(f)(1), this decision is not subject to judicial review.

June 30, 2022

/s/ *Deborah J. Baker*

DJB/mck

O: 5/11/22

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/s/ *Stephen J. Mathis*

/s/ *Deborah L. Simpson*

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC000055
Case Name	BARNES, KIMBERLY v. ST OF IL/CHESTER MENTAL HEALTH CENTER
Consolidated Cases	
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	21
Decision Issued By	Linda Cantrell, Arbitrator

Petitioner Attorney	Thomas Rich
Respondent Attorney	Nicole Werner

DATE FILED: 6/3/2021

INTEREST RATE FOR THE WEEK OF JUNE 1, 2021 0.03%

/s/ *Linda Cantrell, Arbitrator*
Signature

CERTIFIED as a true and correct copy

pursuant to 820 ILCS 305/14

JUNE 3, 2021

/s/ *Brendon O'Rourke*

Brendan O'Rourke, Assistant Secretary

Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

KIMBERLY BARNES
Employee/Petitioner
v.
STATE OF ILLINOIS/CHESTER MENTAL HEALTH CENTER
Employer/Respondent

Case # **17-WC-000055**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Linda J. Cantrell**, Arbitrator of the Commission, in the city of **Collinsville**, on **March 25, 2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury **(after March 30, 2016)**?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the 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 **Maximum medical improvement date with respect to Petitioner's right shoulder.**

FINDINGS

On **September 11, 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 $**44,881.10**; the average weekly wage was $**863.10.**

On the date of accident, Petitioner was **42** years of age, ***single*** with **4** 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 $**5,178.60** for other benefits, for a total credit of $**5,178.60 (2% body as a whole PPD advance)**.

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

ORDER

Respondent shall pay the reasonable and necessary medical services outlined in Petitioner's Group Exhibit 1, pursuant to the medical fee schedule or a PPO agreement (whichever is less), as provided in §8(a) and §8.2 of the Act. 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 §8(j) of the Act.

Respondent shall pay the reasonable and necessary charges from England and Company Rehab Services related to Petitioner's vocational rehabilitation contained in Petitioner's Group Exhibit 18. Mr. Kaver testified Petitioner's physical restrictions limit her to sedentary work. Mr. Kaver has worked consistently with Petitioner to find employment within her restrictions from approximately April 2019 through at least the date of his deposition on 12/29/20. Mr. Kaver testified that his charges were reasonable and customary for the services he rendered in the community, which was not rebutted by Respondent.

Respondent shall pay Petitioner maintenance benefits of $**575.40**/week for **60-6/7th** weeks, commencing **January 25, 2020 through March 25, 2021**, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner the sum of $**517.86**/week for a period of **250 weeks**, as provided in Section 8(d)2 of the Act, because the injuries sustained caused a combined **50% loss of the body as a whole, representing 20% loss of the body as a whole related to Petitioner's cervical spine, and 30% loss of the body as a whole related to Petitioner's right shoulder.** Pursuant to the parties stipulation and as noted above, Respondent shall receive credit of 2% loss of the body as a whole paid as an advance on permanent partial disability benefits.

The Arbitrator finds Petitioner reached maximum medical improvement with respect to her right shoulder on 7/13/18 when Dr. Mall released her with permanent restrictions. Although Petitioner sustained an aggravation of her right shoulder condition on 2/15/19 that required additional diagnostic tests, an injection, and physical therapy, Dr. Mall testified the previously placed restrictions were adequate to address her condition and did not recommend further treatment after 5/14/19.

With respect to the right shoulder, Respondent shall pay Petitioner compensation from 7/13/18 when Dr. Mall released Petitioner at maximum medical improvement with permanent restrictions, through March 25, 2021, and shall pay the remainder of the award, if any, in weekly payments. With respect to the cervical spine, Respondent shall pay Petitioner compensation from 7/16/18 when Dr. Gornet released Petitioner at maximum medical improvement, through March 25, 2021, 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.

JUNE 3, 2021

Arbitrator Linda J. Cantrell

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

KIMBERLY BARNES,	)	
	)	
Employee/Petitioner,	)	
	)	
v.	)	Case No.: 17-WC-000055
	)	
STATE OF ILLINOIS/CHESTER MENTAL HEALTH CENTER,	)	Consolidated: 17-WC-000060 19-WC-010795
	)	
Employer/Respondent.	)	

FINDINGS OF FACT

These claims came before Arbitrator Linda J. Cantrell for trial in Collinsville on March 25, 2021 on all issues. On April 18, 2017, Petitioner filed an Amended Application for Adjustment of Claim alleging injuries to her right shoulder, right arm, neck, and body as a whole as a result of an altercation with a resident on September 11, 2015. (Case No. 17-WC-000055). On April 18, 2017, Petitioner filed an Amended Application for Adjustment of Claim alleging injuries to her right shoulder, neck, and body as a whole as a result of an altercation with a resident on September 17, 2015. (Case No. 17-WC-000060). On June 26, 2019, Petitioner filed an Amended Application for Adjustment of Claim alleging injuries to her right shoulder, right arm, neck, and body as a whole as a result of performing CPR on February 15, 2019. (Case No. 19-WC-010795). The cases were consolidated for the purpose of trial.

The parties stipulate that Petitioner sustained accidental injuries that arose out of and in the course of her employment with Respondent on September 11, 2015. The issues in dispute in Case No. 17-WC-000055 are causal connection with regard to Petitioner's right shoulder after March 30, 2016, medical bills, temporary total disability benefits or maintenance benefits, vocational rehabilitation, intervening accident, maximum medical improvement date related to the right shoulder only, and the nature and extent of Petitioner's injuries. The parties stipulate that Respondent is entitled to a credit of 2% loss of the body as a whole paid as an advance for permanent partial disability benefits. All other issues have been stipulated. The Arbitrator has simultaneously issued separate Decisions in Case Nos. 17-WC-000060 and 19-WC-010795.

TESTIMONY

Petitioner was 42 years old, single, with four dependent children at the time of accident. She was employed by Respondent as a Security Therapy Aide I. Petitioner testified that on September 11, 2015 she was struggling with an agitated patient to keep him from going to the floor and heard a loud pop in her neck and right shoulder. Petitioner testified she presented to the

convenient care clinic where x-rays were taken, she was prescribed Ibuprofen, ordered to rest, and return to work on her next scheduled workday.

Petitioner returned to work on 9/17/15 and suffered another accident while assisting a nurse that was being attacked by a combative patient while administering medication. Petitioner testified the patient bit at her leg, kicked her several times, and she struck her head on the concrete wall. She sustained injuries to her neck, right shoulder, and leg. Petitioner testified she is not claiming compensation for the injuries to her leg. Petitioner underwent physical therapy that did not improve her symptoms and she was referred to Dr. Wood at the Orthopedic Institute of Southern Illinois. Dr. Wood prescribed additional physical therapy that alleviated some pain. She began treating with Dr. Nathan Mall and underwent two right shoulder surgeries that provided some relief. Petitioner underwent a third right shoulder surgery that provided more lasting relief of her symptoms.

Petitioner testified that after her second accident on 9/17/15 she was involved in an automobile accident. She testified she broke her right forearm and did not sustain injuries to her neck or right shoulder. She did not received treatment from Dr. Mall or Dr. Gornet for injuries related to the automobile accident.

Petitioner underwent a two-level cervical disc replacement by Dr. Gornet on 7/12/17. Prior to her surgery she had burning in her right shoulder that radiated up her right neck causing migraines. Petitioner testified the cervical surgery greatly improved her symptoms. She can hold her head up and her range of motion, headaches, and vertigo have improved. Petitioner returned to work after being released at MMI by Dr. Gornet and Dr. Mall. Petitioner testified Dr. Mall had her on work restrictions. She was examined by Dr. Nogalski pursuant to Section 12 of the Act who opined she could return to work without restrictions. Petitioner testified she attempted to return to work full duty and sustained a third accident.

Petitioner testified that on 2/15/19 she was performing CPR on a mannequin as part of a training class and injured her right shoulder and neck. She stated she was not able to provide the force needed to attain a passing score and performed CPR for 30 to 45 minutes. She testified her right arm was burning and hurting and an hour into the procedure her neck and head felt inflamed. Petitioner testified she feels like she is “back to square one before the surgery”. She can only drive short distances and has decreased range of motion in her neck. Dr. Mall has placed permanent restrictions on Petitioner’s right shoulder. Following her 2/15/19 accident, Petitioner treated with Dr. Mall and Dr. Gornet and was examined by Dr. Robson pursuant to Section 12 of the Act.

Petitioner testified she is currently looking for work and just submitted an application with Menard Correctional Center. She wants to continue employment with the State of Illinois as she has a vested retirement. She has applied for various state positions in surrounding counties, including a child welfare specialist, child support specialist, social service career trainee, office administrator, public aid eligibility assistant, rehab counselor trainee, child protection investigator, telecommunicator trainee, daycare licensing representative, office coordinator, and support service coordinator. Petitioner testified these positions are within her restrictions but she has not been offered employment. Petitioner is working with a vocational rehabilitation specialist

and is now applying for public sector positions. She attempts to find employment every day and has nine newspapers downloaded on her phone. After researching wages, driving distance, and benefits, she spends approximately 10 to 15 hours per week job searching. She is a mother of four children and is humiliated to lose her health insurance and apply for public aid.

Petitioner testified she is not currently treating for her neck or right shoulder. She takes Meloxicam, Zanaflex, and Fioricet. She does not wear a brace or protective devise for her shoulder. Her boyfriend drove her to the hearing site today.

MEDICAL HISTORY

On 9/14/15, Petitioner reported to Quality Healthcare Clinic Convenient Care with right shoulder pain. She reported a history of accident and x-rays were ordered that showed no bony injury. Petitioner was released with instructions to use ice and heat and work as tolerated.

On 9/23/15, Petitioner presented to Harrisburg Medical Center where new x-rays of her right shoulder were obtained and were negative for fracture. Dr. Ewell noted both work assaults along with her complaints of decreased range of motion and right shoulder pain with weakness, which made it difficult for her to dress, open doors, and write. Physical examination was positive for tenderness over the anterolateral border of the acromion and the supraspinatus with limited range of motion secondary to pain, and the assessment was contused right shoulder. Petitioner was given a Toradol injection, prescribed pain medication, taken off work, and instructed to follow-up in one week. On 10/7/15, Petitioner was referred to physical therapy which she underwent through March 2016. Follow-up visits showed some improvement in symptoms with conservative care by way of therapy and medication but remained symptomatic.

On 3/30/16, Petitioner was involved in a motor vehicle accident where she swerved to avoid hitting a farm tractor. She was a restrained driver and the airbags deployed. She presented to Memorial Hospital with complaints of right upper extremity pain. It was noted the majority of the damage to her vehicle was on the passenger side and she did not recall the accident. She denied back pain. Petitioner was diagnosed with a right mildly displaced angulated comminuted facture of the proximal ulnar shaft.

On 6/10/16, it was noted Petitioner's therapy had been interrupted by a motor vehicle accident. Physical examination remained relatively unchanged and the assessment remained strain of the right shoulder. She was referred to Dr. John Wood for orthopedic consultation.

On 7/20/16, Petitioner presented to Dr. Wood at the Orthopedic Institute of Southern Illinois with pain and stiffness in her right shoulder. Dr. Wood noted Petitioner's symptoms began on 9/11/15 following an acute trauma accident at work where she caught a 320-pound patient. Petitioner also reported her second work injury and the subsequent motor vehicle accident resulting in a forearm injury. Dr. Wood noted that an injection and physical therapy only temporarily improved her symptoms and Petitioner has been off work since September 2015. Physical examination revealed painful motion with reduction in range secondary to pain, positive apprehension test, and tenderness over the biceps region. Dr. Wood performed joint injection/aspiration with lidocaine and recommended more physical therapy. He ordered an MRI

and placed Petitioner on modified light duty with no lifting more than 2 pounds with her right arm. The MRI revealed findings consistent with long head biceps tendinopathy through the rotator interval, supraspinatus and infraspinatus tendinopathy, and trace fluid in the subacromial/subdeltoid bursa suggesting bursitis in the absence of full-thickness rotator cuff edema.

On 9/28/16, Dr. Wood noted Petitioner's condition was unchanged. He recommended surgical intervention as Petitioner had received two injections and physical therapy with no significant benefit. Petitioner received another lidocaine injection to ameliorate her symptoms pending surgery approval.

On 12/1/16, Petitioner was examined by Dr. Nathan Mall. He noted Petitioner's symptoms persisted despite conservative care and Dr. Wood recommended a right shoulder arthroscopy. Physical examination showed a markedly positive O'Brien's test with pain to palpation over the AC joint and biceps tendon within the bicipital groove. He believed the MRI was of marginal diagnostic quality and assessed a superior labral tear of the right shoulder, AC joint arthrosis and inflammation, and right biceps tendonitis. He recommended biceps tenodesis to address the superior labral tear along with AC joint resection, subacromial decompression, and evaluation of the rotator cuff.

On 12/8/16, Dr. Mall performed a right shoulder arthroscopy and partial synovectomy, subacromial decompression and acromioplasty, debridement of the superior labrum, distal clavicle excision, and open biceps tenodesis. Objective intraoperative findings included a clear superior labral tear, AC joint inflammation, and an acromial spur. Petitioner reported improvement during her initial post-operative follow-up and was referred for physical therapy which improved her range of motion and strength. However, on 2/15/17, Petitioner reported soreness on the posterolateral and top aspect of her shoulder. Dr. Mall believed Petitioner may have overworked her shoulder in physical therapy and recommended a cortisone injection in the AC joint and subacromial space to overcome inflammation.

On 3/8/17, Petitioner remained symptomatic with posterolateral shoulder pain that travelled into her neck, which notably had been present since the injury. The injection provided a few hours of relief and physical examination remained positive for discomfort over the AC joint, reduced rotator cuff strength, and pain to palpation along the cervical spine with periscapular muscle pain. Dr. Mall recommended MRIs of Petitioner's neck and shoulder to evaluate for inflammation and ensure complete resection of the distal clavicle. Dr. Mall did not suspect AC joint instability. The shoulder MRI demonstrated an intact rotator cuff and some edema at the AC joint with bone contusion of the distal clavicle without separation or tearing. The cervical MRI demonstrated a moderate-sized right disc herniation with a probable annular fissure at C5-6 extending to the right C6 root creating right foraminal narrowing, and a smaller broad-based left herniation at C4-5 extending towards the foramen. Dr. Mall referred Petitioner to Dr. Gornet. Dr. Mall also noted that the narrowing of the posterior aspect of the AC joint represented residual symptomatic impingement which was responsible for some of Petitioner's symptoms. Dr. Mall recommended additional right shoulder surgery.

On 4/19/17, Petitioner was examined by Dr. Gornet who noted she had no problems of significance with regard to her neck or shoulder prior to her accident. Petitioner reported her symptoms were constant and made worse with reaching, pulling, and fixed head positions. Physical examination demonstrated pain in the right trapezius, right shoulder, and upper arm, accompanied by headaches and trace deep tendon reflexes, though she had full range of motion of the cervical spine. Dr. Gornet reviewed the significant findings of herniation at C5-6 and central protrusion at C4-5. He believed these findings were causally connected to her work injury and explained there was often overlap between shoulder and cervical spine symptoms that resulted in manifestation of symptoms in the other area. Dr. Gornet noted Petitioner's continued headaches, despite shoulder surgery, correlated with such a conclusion, in addition to the fact that the MRI findings correlated with Petitioner's complaints. He kept Petitioner under restrictions and referred Petitioner for injections at C4-5 and C5-6.

On 6/15/17, Dr. Mall performed a right AC joint open resection, during which an additional section of the distal clavicle was resected to create additional space in the posterior aspect of the AC joint. Petitioner reported improvement post-operatively and she was referred to physical therapy. On 7/6/17, Petitioner followed up with Dr. Gornet and he noted no sustained relief from the injections. Dr. Gornet recommended a CT myelogram followed by surgery and prescribed pain medication. The myelogram confirmed symptomatic disc injuries at C4-5 and C5-6 and on 7/12/17 Dr. Gornet performed a disc replacement at both levels. Intraoperative findings revealed foraminal stenosis and right-sided herniation at C5-6 and a right-sided foraminal herniation at C4-5 that was much larger than that seen on MRI and was consistent with part of Petitioner's shoulder pain.

On 7/27/17, Petitioner returned to Dr. Mall and reported improvement following her cervical spine surgery. Good range of motion was noted in her shoulder, but she reported additional right shoulder soreness. Dr. Mall recommended physical therapy.

On 8/3/17, Petitioner reported resolution of her headaches and improvement in her shoulder and arm symptoms to Dr. Gornet, with persistent burning in her upper shoulder. Dr. Gornet believed her symptoms were consistent with the decompression and prescribed additional pain medication. On 10/6/17, Dr. Mall administered an AC joint injection due to persistent pain. On 10/19/17, Petitioner reported growing discomfort in her neck as she participated in physical therapy. Dr. Gornet reviewed Dr. Robson's Section 12 report dated 7/19/17 wherein he noted the objective MRI findings and opined there was a causal relationship between the findings and Petitioner's accidents. Dr. Robson believed Petitioner's care and treatment, particularly the cervical disc replacements, was reasonable and necessary and that Petitioner required further care to reach maximum medical improvement. Dr. Gornet prescribed additional medication and recommended Petitioner complete therapy.

On 11/10/17, Dr. Mall noted the injection did not resolve the discomfort over Petitioner's AC joint. Physical examination remained positive for point tenderness over the AC joint with residual instability present on anterior-posterior testing and weakness with rotator cuff testing manifesting as 4+/5 strength in the supraspinatus. X-rays showed formation of a calcium deposit within the AC joint possibly related to scar tissue with mild superior migration of the clavicle with respect to the coracoid. Dr. Mall recommended physical therapy and an MRI that revealed

insertional cuff tendinitis and shallow subinsertional enthesopathic changes beneath the subscapularis and infraspinatus insertions. Dr. Mall recommended a right shoulder open AC joint exploration with an internal brace of the AC joint, exploration for bony abutment that could be causing inflammation, and excision of any scar tissue. Dr. Mall believed the AC joint capsule did not heal following the resection which would cause Petitioner's symptoms. He believed this produced an anterior-posterior joint instability within the AC joint. The coracoclavicular ligaments appeared to be intact so he did not recommend a coracoclavicular ligament reconstruction.

Dr. Mall performed the third surgery on 12/28/17. He noted intraoperatively the superior AC joint ligamentous structures did not heal very well from the prior surgery. He also noted there was minimal tissue present in terms of structural tissue to provide stability to the AC joint, and the distal clavicle was notably unstable with over a centimeter of anterior to posterior translation. Dr. Mall performed an AC joint ligament repair using internal brace technique, which stabilized the clavicle and restored anterior to posterior stability to the distal clavicle and acromion. On 1/11/18, Dr. Mall noted Petitioner was doing well and referred her for physical therapy.

On 1/29/18, Petitioner returned to Dr. Gornet and reported that although she was doing well, she experienced increased tenderness in her neck and a return of her headaches approximately two months prior. Dr. Gornet advised that some of the issues in her shoulder may make her neck on guard, and since no problems manifested on current films, he assured her that no restrictions were required for her neck. Follow-up visits with Dr. Mall show that although her right shoulder AC joint was stable, she continued to have some symptoms for which he recommended continued therapy.

On 4/20/18, Dr. Mall noted Petitioner continued to have headaches and pain in her shoulder. Dr. Mall noted Dr. Gornet did not believe her symptoms were coming from her neck. Dr. Mall continued to recommend therapy and ordered scar cream to assist with pain and inflammation over her AC joint. Petitioner returned the following month with complaints of continued right shoulder pain with numbness and tingling down to her right hand. Examination showed no pain over the biceps tendon and the AC joint was stable; however, Petitioner remained tender to palpation over the AC joint along the incision. Dr. Mall recommended a functional capacity evaluation as he believed the combination of Petitioner's right shoulder and neck injuries may require permanent restrictions. Based on the FCE results, Dr. Mall placed Petitioner at maximum medical improvement with permanent restrictions of no lifting greater than 10 pounds overhead, no lifting greater than 20 pounds from floor to waist or waist level, and no lifting greater than 15 pounds from waist to chest.

On 7/16/18, Dr. Gornet noted Petitioner was doing well with respect to her cervical spine, but she continued to have aches and pains, which he attributed to her right shoulder, and noted Petitioner was under permanent restrictions placed by Dr. Mall. He ordered a CT scan that showed good positioning of the devices with excellent motion and he placed Petitioner at maximum medical improvement.

On 12/5/18, Petitioner was examined by Dr. Michael Nogalski pursuant to Section 12 of the Act. Dr. Nogalski noted Petitioner appeared to be generally deconditioned with complaints of pain in her neck and trapezial area on extension. He noted generalized tenderness over the anterior glenohumeral joint and AC joint resection region and diffuse pain over the anterior and posterior shoulder with crossover maneuver. His impression was status post right shoulder arthroscopy, debridement, and biceps tenodesis with subsequent revision open distal clavicle resection and AC joint stabilization; and status post cervical disc replacements at C4-5 and C5-6. Dr. Nogalski stated Petitioner was somewhat evasive and nonspecific in her history and characterized her description of events as being somewhat rambling. He strongly believed Petitioner sustained a strain to her shoulder which precipitated adhesive capsulitis. However, he believed the strain improved with physical therapy until Petitioner's motor vehicle accident in March 2016 where she sustained injuries to her forearm. He opined Petitioner's current objective findings were not causally related to her work injuries. He believed these were the direct result of the three subsequent operations in her right shoulder that were without clinical benefit. Dr. Nogalski opined Petitioner's treatment through 3/30/16 was causally related to her work accidents, but not subsequent care and treatment provided by either Dr. Mall or Dr. Gornet.

On 2/17/19, Petitioner presented to Memorial Hospital and reported right shoulder pain that had an onset of two days ago when she performed CPR at work. Abduction of her right arm caused severe pain. X-rays of her right shoulder revealed post-surgical and mild degenerative changes. She was released and ordered to follow up with her physician.

On 2/20/19, Petitioner returned to Dr. Mall and reported her accident of 2/15/19. Physical examination revealed pain to palpation over the AC joint and subacromial space, pain with rotator cuff testing, weakness in the supraspinatus distribution, and significant inflammation around the shoulder. Dr. Mall administered a cortisone injection which failed to provide substantial relief. Petitioner returned to Dr. Mall the following month with continued complaints and manifest pain to palpation over the AC joint and pain and weakness with rotator cuff testing. He recommended an MRI that revealed mild infraspinatus insertional tendinopathy without tearing, evidence of Petitioner's prior surgery, and no discrete labral tearing. Dr. Mall noted the MRI showed no specific pathology that would require additional care or surgical treatment. He believed Petitioner's existing permanent restrictions were sufficient to address her current shoulder condition, placed Petitioner at maximum medical improvement, and advised her to follow up with Dr. Gornet to examine her cervical spine.

Dr. Gornet examined Petitioner on 6/17/19 and noted Petitioner's new injury as result of CPR training. He noted Petitioner had been in class for over an hour and had to repeat chest compressions approximately four times as they were not registering which produced increased burning pain in Petitioner's right shoulder and neck. Petitioner presented with pain localized in her neck into both trapezii, right greater than left, with tingling into her right arm and middle finger. Dr. Gornet found the mechanism of injury could aggravate an underlying condition or produce new injury and ordered an MRI with a plain CT of her neck. Dr. Gornet linked Petitioner's current complaints in their level of severity and her need for evaluation and treatment to her recent work injury on 2/15/19.

The CT scan showed no significant facet arthropathy on the right or evidence of lucency or major heterotopic issues, though a touch of foraminal narrowing at C5-6 on the right side was noted. On 7/15/19, Dr. Gornet recommended physical therapy and potentially an injection if Petitioner remained symptomatic. He stated Petitioner could continue to work full duty from the standpoint of her cervical spine. Petitioner returned in September 2019 and reported continued symptoms of neck and shoulder pain with headaches. Dr. Gornet suggested Petitioner may have suffered small disc protrusions at C3-4 and C6-7 but these were obscured by artifact on the scans. Dr. Gornet recommended another injection at C5-6 which did not provide significant relief. Though there were small protrusions that may have represented new disc injuries at C3-4 and C6-7, Dr. Gornet recommended against further treatment as he did not believe surgery would alleviate Petitioner's symptoms. Dr. Gornet placed Petitioner at maximum medical improvement.

Petitioner returned to Dr. Gornet twice following release for routine follow-ups and continued to report symptoms. On 4/27/20, Dr. Gornet noted Petitioner continued to have increased symptoms in her neck following the training episode on 2/15/19 but he did not believe she required restrictions for her neck, particularly given the permanent restrictions placed by Dr. Mall. On 7/13/20, Dr. Gornet noted Petitioner was doing well for the most part with continued headaches.

Dr. Michael Nogalski testified by way of evidence deposition on 7/22/19. Dr. Nogalski testified that approximately 40% of his practice is composed of treatment of the shoulder and 5% is composed of medical-legal work. He testified consistently with the findings and opinions contained in his report. He noted Petitioner reported experiencing "the loudest pop" in her right shoulder while restraining the aggressive patient during her first accident, and that she "hit the wall hard" during the second accident, which resulted in the development of severe pain and inability to breathe. Dr. Nogalski testified his review of the MRI films did not demonstrate evidence of a labral tear. He found it significant that Petitioner allegedly did not report the motor vehicle accident that occurred on 3/30/16. He noted that Petitioner sustained a right forearm fracture for which she underwent outpatient open reduction and subluxation and denied any injury to her shoulder as a result of the accident. He believed that Petitioner's motor vehicle accident involving her forearm aggravated Petitioner's right shoulder condition from which she recovered prior to the collision.

Dr. Nogalski disagreed with the permanent restrictions imposed by Dr. Mall. He testified that Petitioner's full duty release for her cervical spine indicated her neck did not influence her shoulder, and he felt that Petitioner's right shoulder physical examination exhibited sufficient functional capacity to allow her to reasonably perform her work activities.

On cross-examination, Dr. Nogalski acknowledged that Dr. Robson found a causal connection between Petitioner's work accidents and her current condition of ill-being in her cervical spine. Though he was asked to evaluate Petitioner's right shoulder, he espoused his opinion that Petitioner's cervical spine condition was also unrelated to her work accidents. He admitted, however, that he does not operate on cervical spine injuries and he refers surgical patients to Dr. Robson for care and treatment. Dr. Nogalski admitted that Petitioner contemporaneously voiced complaints in her shoulder immediately following both accidents. He admitted he did not have Petitioner's treatment records from her motor vehicle accident and did

not request same after learning of her accident. He admitted he did not know if any shoulder complaints were documented following Petitioner's motor vehicle accident.

Dr. Nathan Mall testified by way of evidence deposition on 4/29/19. Dr. Mall testified that shoulder treatment and sports medicine is a subspecialty of his practice, which was the focus of his fellowship after his residency training. Approximately 60% of the surgeries he performs are for shoulder injuries. He also performs approximately one to two independent medical evaluations per week. Dr. Mall testified that in addition to his medical records, he reviewed Dr. Nogalski's independent medical evaluation and the records from Memorial Hospital which document the treatment from Petitioner's motor vehicle accident. He summarized the history of Petitioner's accidents and the medical history of her care and treatment as outlined in his records. He testified that Petitioner's MRI did demonstrate a superior labral tear, along with fluid around the biceps tendon and inflammation at the AC joint. He testified that these findings were consistent with Petitioner's symptoms and mechanism of injury of reaching out to grab a patient. She sustained a traction-type injury to her shoulder which is a classic mechanism for a superior labral tear. He testified that an altercation could certainly produce some trauma to the AC joint. He explained that the biceps tendon is essentially attached to the superior labrum, so anything that causes trauma to the superior labrum would also cause trauma to the biceps tendon. Dr. Mall opined that both of Petitioner's work accidents suffered in September 2015 were a causative or contributory factor in her right shoulder condition.

Dr. Mall testified that the intraoperative findings during Petitioner's first surgery on 12/8/16 confirmed his diagnosis. Though he addressed the objective interoperative findings, Petitioner continued to have significant symptoms for which he referred her for evaluation of her cervical spine. Though she was treated by a spine specialist, she continued to have trouble referable to her right shoulder. He ordered an MRI which showed impingement in the posterior region of the AC joint, which correlated with Petitioner's difficulty reaching behind her back. Because Petitioner's complaints did not resolve with conservative care including injection, she required a second surgery, during which the operative findings again confirmed the MRI findings and his diagnosis. With regard to the etiology of the complaints Petitioner is experiencing, Dr. Mall testified he did not feel the complaints were from Petitioner's cervical spine because the AC joint is typically pretty specific in that you push on that spot and it hurts.

Dr. Mall testified that Petitioner continued to have specific right shoulder symptoms after the second surgery, and reasonably so, because AC joint resection carries the risk of destabilization. He testified that the coracoclavicular ligaments come in and attach at a certain distance from the AC joint along the collarbone. A resection can render AC joint instability because you are cutting through the superior AC joint capsule. Dr. Mall explained that resecting a centimeter in one patient could produce a different result than the same resection in another patient. When he examined Petitioner's right shoulder AC joint it felt looser than the other side which led him to perform the third surgical procedure, AC joint stabilization, on 2/28/17. He noted that the inflammation visualized was likely brought about by some of the instability in the joint that came from the trauma, which was not a rare phenomenon. Dr. Mall testified that Petitioner's symptoms had been very consistent throughout her care and treatment with both him and Dr. Gornet, and he again related Petitioner's shoulder care and treatment to her work injuries in September 2015.

Dr. Mall testified that Petitioner's continued complaints in tandem with the injuries suffered to her shoulder and neck necessitated a functional capacity evaluation. He opined that the need for permanent restrictions is attributed to the September 2015 work accidents.

With regard to Petitioner's accident on 2/15/19, Dr. Mall testified it was not surprising Petitioner had an increase in symptoms while pushing hard on the CPR dummy to "get a green light," which was a sensor that indicated whether she was pushing hard enough to pump blood and perform successful CPR. He noted there was also some rotator cuff weakness, which was previously nonexistent, suggestive of a rotator cuff strain in addition to the ongoing problems in her AC joint. Since Petitioner's condition was obviously inflamed, he recommended imaging studies, a cortisone shots to calm the inflammation, physical therapy, and evaluation by Dr. Gornet. Dr. Mall testified that Petitioner had worsening of her symptoms, including radiculopathy, following the February 2019 accident that caused her to seek treatment. However, he stated that previously placed restrictions were adequate to address her condition and placed Petitioner at maximum medical improvement.

Dr. Mall testified he disagreed with Dr. Nogalski's opinion the medical records were conflicting as to whether Petitioner suffered a right shoulder injury or neck injury. Dr. Mall testified it is possible to suffer injuries to both and the symptoms from both make it difficult to determine the source of the complaints. He testified that a cervical spine injury does not produce a positive O'Brien's test, point pain with compression over the AC joint, or pain with compression of the biceps tendon. Although there was certainly some overlap, because the C4 and C5 nerve roots stop at the shoulder and C3 can go down into the shoulder blade area and trapezius, Petitioner clearly had a persistent shoulder problem.

Dr. Mall stated that over the 26 times he evaluated Petitioner, she was pleasant and at no point evasive or nonspecific. He testified that Dr. Nogalski's diagnosis of strain causing adhesive capsulitis from which Petitioner had reached maximum medical improvement in March 2016 was not consistent with the objective medical evidence showing Petitioner suffered a superior labral tear following a capable mechanism of injury. He also disagreed with Dr. Nogalski's opinion that Petitioner was capable of returning to full-duty work, as he just tried that and it did not work so well for her.

On cross-examination, Dr. Mall testified he possessed and reviewed records from Chester Hospital, the Orthopedic Institute of Southern Illinois, and Apex physical therapy. Dr. Mall testified that Petitioner fractured her right forearm in the March 2016 automobile accident which required immobilization for a period of time. It was not surprising her arm would we weaker and affect her physical therapy for her shoulder. He testified he did not believe the automobile accident made Petitioner's shoulder condition worse based on Petitioner's statement she did not have any worsening shoulder complaints following the accident, and the treatment records from the collision did not demonstrate a shoulder problem or complaints.

Dr. Mall testified he placed permanent restrictions on Petitioner in part due to her reports of pain, which he acknowledged was subjective, and based on recommendations of the physical

therapist performing the evaluation, who took body mechanics into consideration to prevent further or future injury.

Petitioner's vocational rehabilitation specialist, Mr. Timothy Kaver, testified by way of deposition on 12/29/20. Mr. Kaver has been performing vocational rehabilitation counseling since 1985, after he earned his master's degree in sociology with an emphasis on occupations and professions. He testified that his practice involves providing on-the-job or off-site training, job placement, and job search assistance. His practice includes referrals from the U.S. Department of Labor to return injured federal employees to the work force and providing his opinion in cases for plaintiffs and insurance companies.

Mr. Kaver testified that Petitioner's physical restrictions limited her to sedentary work, and her educational background rested in sociology, with an associate's degree in human services and a bachelor's of science degree in rehabilitation. He noted Petitioner's job duties included overseeing movement of patients, keeping accurate count reports, performing housekeeping duties from mopping to trash and laundry, processing new facility admissions, assisting with activities of daily living, providing educational support, and engaging in physical interventions with restraints, for which she annually earned $44,000. Mr. Kaver testified that handling physical altercations fell within the heavy strength level category.

Mr. Kaver testified he explored several career alternatives that Petitioner could safely use her skills within her restrictions, but she required additional computer skills. He testified that Petitioner practiced her keyboarding at home and completed additional training in PowerPoint9 through a class but was unable to attend the Excel training because she did not have funds for gas. Though he attempted to secure funding the help her take the course online, it had not yet been allocated for her at the time of the deposition.

Mr. Kaver testified that he first attempted to help Petitioner obtain employment through the State's alternative employment program (AEP), which allows injured workers to be placed in new positions within the employ of the State for which they are qualified within their physical limitations. He stated that Petitioner embarked on the arduous qualification process and completed all of the requisite paperwork, including providing physician documentation and signatures. Petitioner bid on 22 different positions with the State of Illinois and had some interviews but was not offered employment. Mr. Kaver testified the litigation dispute and COVID-19 made the process more difficult. He explained that the AEP program caused a problem in that on three different dates the State of Illinois told Petitioner to report back to work, which causes the AEP program that you are trying to become certified to cease and you have to start all over again. The first time Petitioner returned to work she became reinjured performing CPR training. The other two times Petitioner returned to work she was told by Respondent they had no work within her physical restrictions. During COVID, Petitioner's AEP paperwork was lost when the state employees did not have access to their offices for five months. Attempts to locate her paperwork were unsuccessful and she had to start all over again. She completed the AEP paperwork for the fourth time as of August 2020 and is awaiting a response.

Mr. Kaver testified that Petitioner is also qualified to staff a variety of sedentary-level professional and paraprofessional occupations outside of the State's employ based on her

transferrable skills and her degree in social service. He agreed that Petitioner's starting salary range would be higher if she could find employment with the State. Her current salary of $44,000 per year would be reduced to $27,000 to $32,000 per year starting in a private sector position, as she would most likely end up working for a not-for-profit agency. He testified that some of the roles Petitioner could serve included social human service worker, customer service representative, intake reviewer, and other general office positions that will allow her to sit or stand alternatively. He cautioned, however, the pandemic makes it more difficult for Petitioner to find a job in the field in which she was job seeking. Mr. Kaver testified that the reports he generated were kept in the normal, everyday course of business and were customary in his line of work. He further testified that his charges were reasonable and customary for the services that he rendered in the community.

CONCLUSIONS OF LAW

Issue (F): Is Petitioner's current condition of ill-being causally related to the injury (after March 30, 2016)?

Illinois law holds that "[e]very natural consequence that flows from an injury that arose out of and in the course of the claimant's employment unless caused by an independent intervening accident that breaks the chain of causation between a work-related injury and an ensuing disability or injury" is compensable. *Vogel v. Indus. Comm'n*, 354 Ill. App. 3d 780, 786, 821 N.E.2d 807, 812 (2d Dist. 2005); *Nat'l Freight Indus. v. Illinois Workers' Comp. Comm'n*, 993 N.E.2d 473, 481, 2013 IL App (5th) 120043WC, ¶ 26. Courts have consistently held that for an employer to be relieved of liability by virtue of an intervening cause, the intervening cause must completely break the causal chain between the original work-related injury and the ensuing condition; as the Court *in Lasley Const. Co.*, aptly stated: "The fact that other incidents, whether work related or not, may have aggravated claimant's condition is irrelevant." *Lasley Const. Co., Inc. v. Indus. Comm'n*, 274 Ill.App.3d 890, 893, 655 N.E.2d 5, 8, (5th Dist. 1995). See also *Vogel v. Indus. Comm'n*, 354 Ill. App. 3d 780, 786, 821 N.E.2d 807, 812, (2d Dist. 2005).

In determining what is sufficient to cause a complete break in the chain of causality, the Arbitrator finds the Appellate Court's direction in *Vogel* probative. In *Vogel v. Indus. Comm'n*, the Appellate Court stated: "This court has recognized repeatedly that, when a claimant's condition is weakened by a work-related accident, a subsequent accident that aggravates the condition does not break the causal chain." *Vogel v. Indus. Comm'n*, 354 Ill. App. 3d 780, 787, 821 N.E.2d 807, 813, 290 Ill.Dec. 495, 501 (2d Dist. 2005). In *Vogel*, the Court highlighted precedent such as *Teska v. Industrial Comm'n*, 266 Ill.App.3d 740, 742, 203 Ill.Dec. 574, 640 N.E.2d 1 (1st Dist. 1994) and *International Harvester Co. v. Industrial Comm'n*, 46 Ill.2d 238, 245, 263 N.E.2d 49, 53 (Ill. 1970). Additionally, where the second injury occurs due to treatment for the first, there is likewise no break in the causal chain. *International Harvester supra.* In *Teska*, the claimant injured his back in a workplace accident and underwent surgery on his spine. *Teska v. Indus. Comm'n,* 266 Ill.App.3d 740, 640 N.E.2d 1 (1994). After the surgery, his condition improved but he still continued to experience numbness and pain in his neck, shoulder, and left arm. While bowling, he experienced a sharp pain in his neck that radiated into his left arm. He subsequently underwent a second surgery. The Commission denied the claimant benefits for the second surgery, finding that his condition of ill-being was the result of an intervening

accident (bowling). On appeal, the *Teska* court reversed the Commission's decision as being contrary to the manifest weight of the evidence. *Id.* N.E.2d at 2. The court noted that "[e]very natural consequence that flows from the injury which arose out of and in the course of the claimant's employment is compensable under the Act, unless caused by an independent intervening accident." *Id.* N.E.2d at 3. In overturning the Commission's decision, the court noted that the claimant's condition "would not have progressed to the point it did but for his original work-related accident." The court stated: "Merely because claimant experienced an upsurge of neck pains while bowling * * * does not mean the causal connection was broken." *Id.* N.E.2d at 4.

In *International Harvester*, the Court determined that the claimant, who suffered from a continuing condition of traumatic neurosis that resulted from his work accident where he was struck on the head by a tractor, was entitled to workers' compensation benefits four years later when claimant was struck by his wife. *International Harvester Co. v. Indus. Comm'n*, 263 N.E.2d 49 (Ill. 1970). In awarding benefits, the Supreme Court found that the reason the claimant's condition existed was the work injury, and that as a natural consequence, his work injury continued and was a causative factor in total and permanent disability following the injury he sustained from his wife. *Id.*

Respondent denies that Petitioner's condition of ill-being is causally connected to her work-related accident as of the date of her automobile accident that occurred on March 30, 2016. The Arbitrator finds that Petitioner's automobile accident was not an independent intervening accident that broke the chain of causation and holds Petitioner's current condition of ill-being in her right shoulder remains causally connected to her accidental work injuries in September 2015.

In so holding, the Arbitrator finds the opinion of Dr. Mall more credible than that of Dr. Nogalski. The Arbitrator finds it highly significant that Respondent did not obtain and provide Dr. Nogalski with the treatment records from the motor vehicle accident for his review, and he admitted he was unaware if said records made any reference to Petitioner's right shoulder. The Arbitrator also notes that Dr. Nogalski did not acknowledged the presence of a labral tear, which was confirmed by the objective intraoperative findings.

In contrast, Dr. Mall had the benefit of reviewing the records documenting Petitioner's treatment following the automobile accident. The records admitted into evidence show Petitioner complained of right upper extremity pain with movement. However, Petitioner was diagnosed with a fractured forearm and no right shoulder complaints or injuries were noted. X-rays of Petitioner's right humerus, including a portion of the shoulder, revealed no fractures. Petitioner did not treat with her surgeons, Dr. Mall and Dr. Gornet, for any injuries resulting from the automobile accident. Dr. Mall credibly explained why he believed Petitioner's motor vehicle collision did not injure her right shoulder. The Arbitrator finds it significant that the absence of any right shoulder pain corroborates Petitioner's testimony that she did not suffer any injury to her shoulder in the collision. In addition, the work injury records reflect that Petitioner's physical examination remained relatively unchanged and the assessment remained the same following the collision.

As such, the medical records and testimony do not support a finding that Petitioner suffered an intervening accident, as there was no complete break in the chain of causal connection. The Arbitrator therefore finds that Petitioner sustained her burden of proof on the issue of causal connection.

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

Upon establishing causal connection and the reasonableness and the necessity of recommended medical treatment, employers are responsible for necessary prospective medical care required by their employees. *Plantation Mfg. Co. v. Indus. Comm'n*, 294 Ill.App.3d 705, 691 N.E.2d. 13 (1997). This includes treatment required to diagnose, relieve, or cure the effects of claimant's injury. *F & B Mfg. Co. v. Indus. Comm'n*, 325 Ill. App. 3d 527, 758 N.E.2d 18 (2001).

Based upon the above findings as to causal connection, the Arbitrator finds the medical care administered to Petitioner was reasonable and necessary to treat her work-related injuries. Dr. Mall and Dr. Gornet testified that all of Petitioner's care and treatment and diagnostic testing was administered to diagnose and/or relieve the effects of Petitioner's work-related injuries. Though Petitioner attempted to resolve her complaints conservatively, the evidence shows that Petitioner required multiple surgeries.

Respondent shall therefore pay the reasonable and necessary medical services outlined in Petitioner's Group Exhibit 1, pursuant to the medical fee schedule or a PPO agreement (whichever is less), as provided in §8(a) and §8.2 of the Act. 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 §8(j) of the Act.

The Arbitrator further orders Respondent to pay the reasonable and necessary charges from England and Company Rehab Services related to Petitioner's vocational rehabilitation contained in Petitioner's Group Exhibit 18. Mr. Kaver testified Petitioner's physical restrictions limit her to sedentary work. Mr. Kaver has worked consistently with Petitioner to find employment within her restrictions from approximately April 2019 through at least the date of his deposition on 12/29/20. Mr. Kaver testified that his charges were reasonable and customary for the services he rendered in the community, which was not rebutted by Respondent.

Issue (K): What temporary benefits are in dispute?

The law in Illinois holds that "[a]n employee is temporarily totally incapacitated from the time an injury incapacitates him for work until such time as he is as far recovered or restored as the permanent character of his injury will permit." *Archer Daniels Midland Co. v. Indus. Comm'n*, 138 Ill.2d 107, 561 N.E.2d 623 (Ill. 1990). The ability to do light or restricted work does not preclude a finding of temporary total disability. *Archer Daniels Midland Co. v. Indus. Comm'n*, 138 Ill.2d 107, 561 N.E.2d 623 (Ill., 1990) citing *Ford Motor Co. v. Indus. Comm'n*, 126 Ill. App. 3d 739, 743, 467 N.E.2d 1018, 1021 (1984). When an employee reaches maximum

medical improvement and is unable to resume his or her employment, the Act provides that the employer "shall also pay for treatment, instruction and training necessary for the physical, mental and vocational rehabilitation of the employee, including all maintenance costs and expenses incidental thereto." 820 ILCS 305/8(a). When vocational rehabilitation is required, it is the Petitioner who "retains the right to choose their vocational counselor." *Scoville v. D.C. Elec. of Benton*, 11 I.W.C.C. 0331, citing *Passas v. Kirby School Dist. # 140,* 94 WC 5553; 01 IIC 0178; *Hollins v. Aurora East School Dist. 131,* 07 IWCC 0382*; Hir v. City of Joliet,* 04 IIC 0614.

Dr. Mall credibly testified Petitioner required permanent restrictions with regard to her right shoulder. Dr. Mall released Petitioner at maximum medical improvement on 7/13/18 following a functional capacity evaluation resulting in permanent restrictions of no lifting greater than 10 pounds overhead, 20 pounds from floor to waist and waist level, and 15 pounds from waist to chest. Mr. Kaver testified that Petitioner's job duties of intervening and restraining patients alone exceeded her permanent restrictions.

The parties stipulated on the record that the only issue in dispute with regard to temporary benefits is the unpaid period from 1/25/20 through 3/25/21. Though the parties placed both temporary total disability and maintenance benefits in dispute, the Arbitrator notes that Petitioner had been placed at MMI by Dr. Gornet on 7/16/18 related to her cervical injury, and Dr. Mall placed Petitioner at MMI on 7/13/18 with permanent restrictions with regard to her right shoulder injury. Following both MMI releases, Petitioner was involved in a third accident on 2/15/19 that resulted in an aggravation of her cervical spine and right shoulder. Additional diagnostic tests were performed and Petitioner underwent cervical and right shoulder injections and physical therapy. At no time did Dr. Gornet place Petitioner off work or on restrictions from 2/15/19 through his second MMI release on 12/2/19. Dr. Mall again placed Petitioner at MMI on 5/14/19 following her third accident, with the same permanent restrictions related to her right shoulder.

The Arbitrator finds Petitioner is entitled to maintenance benefits for the disputed period **1/25/20 through 3/25/21**, representing a period of **60-6/7th** weeks.

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 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).

(i) Level of Impairment: Neither party submitted an AMA rating. Therefore, the Arbitrator places no weight on this factor.

(ii) Occupation: Petitioner is unable to return to her former employment for Respondent as a Security Therapy Aide. Petitioner has been placed under permanent restrictions related to her right shoulder condition that limit her to the sedentary demand category. The Arbitrator places significant weight on this factor.

(iii) Age: Petitioner was 42 years old at the time of her accident. She is young and has to live and work with substantial permanent restrictions that limit her to the sedentary functional demand category. Given the substantial number of years over which Petitioner must live and work with her disability, the Arbitrator places significant weight on this factor.

(iv) Earning Capacity: Petitioner is unable to return to her former employment as a Security Therapy Aide as a result of permanent restrictions. Mr. Kaver, a vocational rehabilitation expert, testified Petitioner would suffer a drastic reduction in earning capacity if she were not able to find a job with the State of Illinois, as her background and education would likely lead to private sector employment in a not-for-profit agency. Petitioner earned $44,000 per year working for Respondent. Dr. Kaver anticipates Petitioner will find employment earning $27,000 to $32,000 per year in the private sector. Dr. Kaver testified Petitioner applied for at least 22 positions within the State without success. The Arbitrator places substantial weight on this factor.

(v) Disability: As a result of her injuries, Petitioner underwent a right shoulder arthroscopy and partial synovectomy, subacromial decompression and acromioplasty, debridement of the superior labrum, distal clavicle excision, and open biceps tenodesis. Objective intraoperative findings included a clear superior labral tear, AC joint inflammation, and an acromial spur. Despite surgery and significant post-operative conservative care, Petitioner's right shoulder symptoms persisted resulting in a second surgery. Dr. Mall noted narrowing of the posterior aspect of the AC joint represented residual symptomatic impingement. Dr. Mall performed a right AC joint open resection, during which an additional section of the distal clavicle was resected to create additional space in the posterior aspect of the AC joint. Petitioner again failed to improve with post-operative care resulting in a third surgery. Dr. Mall recommended a right shoulder open AC joint exploration with an internal brace of the AC joint, exploration for bony abutment that could be causing inflammation, and excision of any scar tissue. Dr. Mall suspected anterior-posterior joint instability within the AC joint. Dr. Mall noted intraoperatively that the superior AC joint ligamentous structures did not heal well, there was minimal tissue present to provide stability to the AC joint, and the distal clavicle was notably unstable with over a centimeter of anterior to posterior translation. Dr. Mall performed an AC joint ligament repair using internal brace technique, which stabilized the clavicle and restored anterior to posterior stability to the distal clavicle and acromion. Despite three shoulder surgeries, Petitioner was released at maximum medical improve with permanent restrictions of no lifting greater than 10 pounds overhead, no lifting greater than 20 pounds from floor to waist or waist level, and no lifting greater than 15 pounds from waist to chest.

Petitioner underwent a two-level disc replacement surgery at C4-5 and C5-6. One year post-operative, Dr. Gornet ordered a CT scan that showed good positioning of the devices with excellent motion and he placed Petitioner at maximum medical improvement. However, Petitioner continued to complain of neck discomfort and headaches. Two years following

surgery and four months following Petitioner's third work-related accident of 2/15/19, Dr. Gornet noted pain localized in Petitioner's neck into both trapezii, right greater than left, with tingling into her right arm and middle finger. Dr. Gornet ordered an MRI with a plain CT of Petitioner's neck that showed no significant facet arthropathy on the right or evidence of lucency or major heterotopic issues, though a touch of foraminal narrowing at C5-6 on the right side was noted. Petitioner underwent physical therapy and an injection at C5-6 which did not provide significant relief. Though there were small protrusions that may have represented new disc injuries at C3-4 and C6-7, Dr. Gornet recommended against further treatment and placed Petitioner at maximum medical improvement a final time on 12/2/19.

Petitioner testified the cervical surgery initially greatly improved her symptoms. She can hold her head up and her range of motion, headaches, and vertigo had improved. She testified she currently can drive only short distances and continues to have decreased range of motion in her neck and headaches. She takes medication, including Meloxicam, Zanaflex, and generic Fioricet for her symptoms. The Arbitrator places substantial weight on this factor.

Based upon the foregoing evidence and factors, the Arbitrator orders Respondent to pay Petitioner the sum of $**517.86**/week for a period of **250 weeks**, as provided in Section 8(d)2 of the Act, because the injuries sustained caused a combined **50% loss of the body as a whole, representing 20% loss of the body as a whole as a result of injuries to her cervical spine, and 30% loss of the body as a whole as a result of injuries to her right shoulder.** Pursuant to the parties stipulation, Respondent shall receive credit of 2% loss of the body as a whole paid as an advance on permanent partial disability benefits.

With respect to the right shoulder, Respondent shall pay Petitioner compensation from 7/13/18 when Dr. Mall released Petitioner at maximum medical improvement with permanent restrictions, through March 25, 2021, and shall pay the remainder of the award, if any, in weekly payments. With respect to the cervical spine, Respondent shall pay Petitioner compensation from 7/16/18 when Dr. Gornet released Petitioner at maximum medical improvement, through March 25, 2021, and shall pay the remainder of the award, if any, in weekly payments.

Issue (O): Other: Maximum Medical Improvement date with respect to Petitioner's right shoulder?

Based upon the above evidence, the Arbitrator finds Petitioner reached maximum medical improvement with respect to her right shoulder on 7/13/18 when Dr. Mall released her with permanent restrictions. Although Petitioner sustained an aggravation of her right shoulder condition on 2/15/19 that required additional diagnostic tests, an injection, and physical therapy, Dr. Mall testified the previously placed restrictions were adequate to address her condition and did not recommend further treatment after 5/14/19.

Arbitrator Linda J. Cantrell DATED:

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC000060
Case Name	BARNES, KIMBERLY v. STATE OF ILLINOIS – CHESTER MENTAL HEALTH CENTER
Consolidated Cases	17WC000055; 19WC010795;
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0243
Number of Pages of Decision	27
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	Thomas Rich
Respondent Attorney	Nicole Werner

DATE FILED: 6/30/2022

/s/ Deborah Baker, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KIMBERLY BARNES,

Petitioner,

vs. NO: 17 WC 00060

STATE OF ILLINOIS,
CHESTER MENTAL HEALTH CENTER,

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 whether Petitioner's current condition of ill-being is causally related to the undisputed September 17, 2015 work accident, entitlement to maintenance benefits, entitlement to incurred medical expenses as well as vocational rehabilitation expenses, and the nature and extent of Petitioner's permanent disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. This case was consolidated for hearing with case numbers 17 WC 00055 and 19 WC 10795.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 3, 2021 is hereby affirmed and adopted.

Pursuant to Section 19(f)(1), this decision is not subject to judicial review.

June 30, 2022

DJB/lyc

O: 5/11/22

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/s/ *Deborah J. Baker*

/s/ *Stephen J. Mathis*

/s/ *Deborah L. Simpson*

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC000055
Case Name	BARNES, KIMBERLY v. STATE OF ILLINOIS – CHESTER MENTAL HEALTH CENTER
Consolidated Cases	17WC000060; 19WC010795;
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0242
Number of Pages of Decision	25
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	Thomas Rich
Respondent Attorney	Nicole Werner

DATE FILED: 6/30/2022

/s/ Deborah Baker, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KIMBERLY BARNES,

Petitioner,

vs. NO: 17 WC 00055

STATE OF ILLINOIS,
CHESTER MENTAL HEALTH CENTER,

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 whether Petitioner's current right shoulder condition of ill-being is causally related to the undisputed September 11, 2015 work accident, entitlement to temporary total disability benefits and the date of maximum medical improvement, entitlement to maintenance benefits, entitlement to incurred medical expenses as well as vocational rehabilitation expenses, and the nature and extent of Petitioner's permanent disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as set forth below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. This case was consolidated for hearing with case numbers 17 WC 00060 and 19 WC 10795.

Vocational Rehabilitation Expenses

The Arbitrator ordered Respondent to pay the vocational rehabilitation charges contained in Petitioner's Exhibit 18. The Commission agrees that Petitioner was engaged in a good faith job placement effort. However, we view the evidence regarding the vocational rehabilitation expenses differently.

Initially, the Commission observes the vocational rehabilitation records are incomplete. Mr. Kaver testified he performed an initial vocational assessment on August 14, 2018 and thereafter prepared regular status reports documenting his job placement efforts from November

19, 2018 through his December 29, 2020 deposition. Pet.'s Ex. 22, p. 6, 15. The Commission emphasizes, however, that the first vocational report received into evidence is dated May 15, 2019. As such, the initial assessment and the first six months of vocational status reports are absent from the record. Moreover, the vocational rehabilitation bills themselves are similarly incomplete. The first invoice in evidence is from May 28, 2019, and the service dates on the itemized list begin on March 31, 2019. Notably, that May 28, 2019 bill includes a previous balance of $7,906.00 for which there are neither corresponding vocational status reports nor itemized billing statements.

Additionally, the Commission notes Petitioner's Exhibit 18 includes a $1,393.00 invoice dated August 18, 2020, which sets forth itemized charges for testimony preparation on August 13, 2020, and waiting to testify and travel on August 14, 2020. Mr. Kaver confirmed the August 18, 2020 bill is for his services as an expert witness. Pet.'s Ex. 22, p. 39. The Commission finds this is a litigation expense to be borne by Petitioner.

Our analysis of Petitioner's Exhibit 18 reveals the total charges incurred for vocational rehabilitation services rendered through July 23, 2020 was $17,781.60. This includes the $7,906.00 balance for which there are neither reports nor bills; the Commission declines to award these unsupported charges. The Commission finds Petitioner proved entitlement to the England & Company Rehab Services charges incurred from March 31, 2019 through July 23, 2020. As such, the Commission finds Respondent is liable for vocational rehabilitation expenses in the amount of $9,875.60 ($17,781.60 - $7,906.00 = $9,875.60).

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 3, 2021, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner maintenance benefits in the amount of $575.40 per week for a period of 60 6/7 weeks, representing January 25, 2020 through March 25, 2021, as provided in §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the reasonable, necessary and causally related medical expenses detailed in Petitioner's Exhibit 1, as provided in §8(a), subject to §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 §8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the sum of $9,875.60 for vocational rehabilitation expenses, as provided in §8(a).

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $517.86 per week for a period of 250 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused a combined 50% loss of use of the person as a whole, consisting of a 20% loss of use of the person as a whole related to the cervical spine and a 30%

loss of use of the person as a whole related to the right shoulder. Respondent shall be given a credit of $5,178.60 for the stipulated PPD advance previously paid.

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.

Pursuant to Section 19(f)(1), this decision is not subject to judicial review.

June 30, 2022

/s/ *Deborah J. Baker*

DJB/mck

O: 5/11/22

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/s/ *Stephen J. Mathis*

/s/ *Deborah L. Simpson*

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC000055
Case Name	BARNES, KIMBERLY v. ST OF IL/CHESTER MENTAL HEALTH CENTER
Consolidated Cases	
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	21
Decision Issued By	Linda Cantrell, Arbitrator

Petitioner Attorney	Thomas Rich
Respondent Attorney	Nicole Werner

DATE FILED: 6/3/2021

INTEREST RATE FOR THE WEEK OF JUNE 1, 2021 0.03%

/s/ Linda Cantrell, Arbitrator
Signature

CERTIFIED as a true and correct copy

pursuant to 820 ILCS 305/14

JUNE 3, 2021

/s/ Brendon O'Rourke

Brendan O'Rourke, Assistant Secretary

Illinois Workers' Compensation Commission

22IWCC0243

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

KIMBERLY BARNES
Employee/Petitioner
v.
STATE OF ILLINOIS/CHESTER MENTAL HEALTH CENTER
Employer/Respondent

Case # **17-WC-000055**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Linda J. Cantrell**, Arbitrator of the Commission, in the city of **Collinsville**, on **March 25, 2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury **(after March 30, 2016)**?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the 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 **Maximum medical improvement date with respect to Petitioner's right shoulder.**

FINDINGS

On **September 11, 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 $**44,881.10**; the average weekly wage was $**863.10.**

On the date of accident, Petitioner was **42** years of age, ***single*** with **4** 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 $**5,178.60** for other benefits, for a total credit of $**5,178.60 (2% body as a whole PPD advance)**.

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

ORDER

Respondent shall pay the reasonable and necessary medical services outlined in Petitioner's Group Exhibit 1, pursuant to the medical fee schedule or a PPO agreement (whichever is less), as provided in §8(a) and §8.2 of the Act. 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 §8(j) of the Act.

Respondent shall pay the reasonable and necessary charges from England and Company Rehab Services related to Petitioner's vocational rehabilitation contained in Petitioner's Group Exhibit 18. Mr. Kaver testified Petitioner's physical restrictions limit her to sedentary work. Mr. Kaver has worked consistently with Petitioner to find employment within her restrictions from approximately April 2019 through at least the date of his deposition on 12/29/20. Mr. Kaver testified that his charges were reasonable and customary for the services he rendered in the community, which was not rebutted by Respondent.

Respondent shall pay Petitioner maintenance benefits of $**575.40**/week for **60-6/7th** weeks, commencing **January 25, 2020 through March 25, 2021**, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner the sum of $**517.86**/week for a period of **250 weeks**, as provided in Section 8(d)2 of the Act, because the injuries sustained caused a combined **50% loss of the body as a whole, representing 20% loss of the body as a whole related to Petitioner's cervical spine, and 30% loss of the body as a whole related to Petitioner's right shoulder.** Pursuant to the parties stipulation and as noted above, Respondent shall receive credit of 2% loss of the body as a whole paid as an advance on permanent partial disability benefits.

The Arbitrator finds Petitioner reached maximum medical improvement with respect to her right shoulder on 7/13/18 when Dr. Mall released her with permanent restrictions. Although Petitioner sustained an aggravation of her right shoulder condition on 2/15/19 that required additional diagnostic tests, an injection, and physical therapy, Dr. Mall testified the previously placed restrictions were adequate to address her condition and did not recommend further treatment after 5/14/19.

With respect to the right shoulder, Respondent shall pay Petitioner compensation from 7/13/18 when Dr. Mall released Petitioner at maximum medical improvement with permanent restrictions, through March 25, 2021, and shall pay the remainder of the award, if any, in weekly payments. With respect to the cervical spine, Respondent shall pay Petitioner compensation from 7/16/18 when Dr. Gornet released Petitioner at maximum medical improvement, through March 25, 2021, 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.

Linda J. Cantrell

JUNE 3, 2021

Arbitrator Linda J. Cantrell

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

KIMBERLY BARNES,	)	
	)	
Employee/Petitioner,	)	
	)	
v.	)	Case No.: 17-WC-000055
	)	
STATE OF ILLINOIS/CHESTER MENTAL HEALTH CENTER,	)	Consolidated: 17-WC-000060 19-WC-010795
	)	
Employer/Respondent.	)	

FINDINGS OF FACT

These claims came before Arbitrator Linda J. Cantrell for trial in Collinsville on March 25, 2021 on all issues. On April 18, 2017, Petitioner filed an Amended Application for Adjustment of Claim alleging injuries to her right shoulder, right arm, neck, and body as a whole as a result of an altercation with a resident on September 11, 2015. (Case No. 17-WC-000055). On April 18, 2017, Petitioner filed an Amended Application for Adjustment of Claim alleging injuries to her right shoulder, neck, and body as a whole as a result of an altercation with a resident on September 17, 2015. (Case No. 17-WC-000060). On June 26, 2019, Petitioner filed an Amended Application for Adjustment of Claim alleging injuries to her right shoulder, right arm, neck, and body as a whole as a result of performing CPR on February 15, 2019. (Case No. 19-WC-010795). The cases were consolidated for the purpose of trial.

The parties stipulate that Petitioner sustained accidental injuries that arose out of and in the course of her employment with Respondent on September 11, 2015. The issues in dispute in Case No. 17-WC-000055 are causal connection with regard to Petitioner's right shoulder after March 30, 2016, medical bills, temporary total disability benefits or maintenance benefits, vocational rehabilitation, intervening accident, maximum medical improvement date related to the right shoulder only, and the nature and extent of Petitioner's injuries. The parties stipulate that Respondent is entitled to a credit of 2% loss of the body as a whole paid as an advance for permanent partial disability benefits. All other issues have been stipulated. The Arbitrator has simultaneously issued separate Decisions in Case Nos. 17-WC-000060 and 19-WC-010795.

TESTIMONY

Petitioner was 42 years old, single, with four dependent children at the time of accident. She was employed by Respondent as a Security Therapy Aide I. Petitioner testified that on September 11, 2015 she was struggling with an agitated patient to keep him from going to the floor and heard a loud pop in her neck and right shoulder. Petitioner testified she presented to the

convenient care clinic where x-rays were taken, she was prescribed Ibuprofen, ordered to rest, and return to work on her next scheduled workday.

Petitioner returned to work on 9/17/15 and suffered another accident while assisting a nurse that was being attacked by a combative patient while administering medication. Petitioner testified the patient bit at her leg, kicked her several times, and she struck her head on the concrete wall. She sustained injuries to her neck, right shoulder, and leg. Petitioner testified she is not claiming compensation for the injuries to her leg. Petitioner underwent physical therapy that did not improve her symptoms and she was referred to Dr. Wood at the Orthopedic Institute of Southern Illinois. Dr. Wood prescribed additional physical therapy that alleviated some pain. She began treating with Dr. Nathan Mall and underwent two right shoulder surgeries that provided some relief. Petitioner underwent a third right shoulder surgery that provided more lasting relief of her symptoms.

Petitioner testified that after her second accident on 9/17/15 she was involved in an automobile accident. She testified she broke her right forearm and did not sustain injuries to her neck or right shoulder. She did not received treatment from Dr. Mall or Dr. Gornet for injuries related to the automobile accident.

Petitioner underwent a two-level cervical disc replacement by Dr. Gornet on 7/12/17. Prior to her surgery she had burning in her right shoulder that radiated up her right neck causing migraines. Petitioner testified the cervical surgery greatly improved her symptoms. She can hold her head up and her range of motion, headaches, and vertigo have improved. Petitioner returned to work after being released at MMI by Dr. Gornet and Dr. Mall. Petitioner testified Dr. Mall had her on work restrictions. She was examined by Dr. Nogalski pursuant to Section 12 of the Act who opined she could return to work without restrictions. Petitioner testified she attempted to return to work full duty and sustained a third accident.

Petitioner testified that on 2/15/19 she was performing CPR on a mannequin as part of a training class and injured her right shoulder and neck. She stated she was not able to provide the force needed to attain a passing score and performed CPR for 30 to 45 minutes. She testified her right arm was burning and hurting and an hour into the procedure her neck and head felt inflamed. Petitioner testified she feels like she is “back to square one before the surgery”. She can only drive short distances and has decreased range of motion in her neck. Dr. Mall has placed permanent restrictions on Petitioner’s right shoulder. Following her 2/15/19 accident, Petitioner treated with Dr. Mall and Dr. Gornet and was examined by Dr. Robson pursuant to Section 12 of the Act.

Petitioner testified she is currently looking for work and just submitted an application with Menard Correctional Center. She wants to continue employment with the State of Illinois as she has a vested retirement. She has applied for various state positions in surrounding counties, including a child welfare specialist, child support specialist, social service career trainee, office administrator, public aid eligibility assistant, rehab counselor trainee, child protection investigator, telecommunicator trainee, daycare licensing representative, office coordinator, and support service coordinator. Petitioner testified these positions are within her restrictions but she has not been offered employment. Petitioner is working with a vocational rehabilitation specialist

and is now applying for public sector positions. She attempts to find employment every day and has nine newspapers downloaded on her phone. After researching wages, driving distance, and benefits, she spends approximately 10 to 15 hours per week job searching. She is a mother of four children and is humiliated to lose her health insurance and apply for public aid.

Petitioner testified she is not currently treating for her neck or right shoulder. She takes Meloxicam, Zanaflex, and Fioricet. She does not wear a brace or protective devise for her shoulder. Her boyfriend drove her to the hearing site today.

MEDICAL HISTORY

On 9/14/15, Petitioner reported to Quality Healthcare Clinic Convenient Care with right shoulder pain. She reported a history of accident and x-rays were ordered that showed no bony injury. Petitioner was released with instructions to use ice and heat and work as tolerated.

On 9/23/15, Petitioner presented to Harrisburg Medical Center where new x-rays of her right shoulder were obtained and were negative for fracture. Dr. Ewell noted both work assaults along with her complaints of decreased range of motion and right shoulder pain with weakness, which made it difficult for her to dress, open doors, and write. Physical examination was positive for tenderness over the anterolateral border of the acromion and the supraspinatus with limited range of motion secondary to pain, and the assessment was contused right shoulder. Petitioner was given a Toradol injection, prescribed pain medication, taken off work, and instructed to follow-up in one week. On 10/7/15, Petitioner was referred to physical therapy which she underwent through March 2016. Follow-up visits showed some improvement in symptoms with conservative care by way of therapy and medication but remained symptomatic.

On 3/30/16, Petitioner was involved in a motor vehicle accident where she swerved to avoid hitting a farm tractor. She was a restrained driver and the airbags deployed. She presented to Memorial Hospital with complaints of right upper extremity pain. It was noted the majority of the damage to her vehicle was on the passenger side and she did not recall the accident. She denied back pain. Petitioner was diagnosed with a right mildly displaced angulated comminuted facture of the proximal ulnar shaft.

On 6/10/16, it was noted Petitioner's therapy had been interrupted by a motor vehicle accident. Physical examination remained relatively unchanged and the assessment remained strain of the right shoulder. She was referred to Dr. John Wood for orthopedic consultation.

On 7/20/16, Petitioner presented to Dr. Wood at the Orthopedic Institute of Southern Illinois with pain and stiffness in her right shoulder. Dr. Wood noted Petitioner's symptoms began on 9/11/15 following an acute trauma accident at work where she caught a 320-pound patient. Petitioner also reported her second work injury and the subsequent motor vehicle accident resulting in a forearm injury. Dr. Wood noted that an injection and physical therapy only temporarily improved her symptoms and Petitioner has been off work since September 2015. Physical examination revealed painful motion with reduction in range secondary to pain, positive apprehension test, and tenderness over the biceps region. Dr. Wood performed joint injection/aspiration with lidocaine and recommended more physical therapy. He ordered an MRI

and placed Petitioner on modified light duty with no lifting more than 2 pounds with her right arm. The MRI revealed findings consistent with long head biceps tendinopathy through the rotator interval, supraspinatus and infraspinatus tendinopathy, and trace fluid in the subacromial/subdeltoid bursa suggesting bursitis in the absence of full-thickness rotator cuff edema.

On 9/28/16, Dr. Wood noted Petitioner's condition was unchanged. He recommended surgical intervention as Petitioner had received two injections and physical therapy with no significant benefit. Petitioner received another lidocaine injection to ameliorate her symptoms pending surgery approval.

On 12/1/16, Petitioner was examined by Dr. Nathan Mall. He noted Petitioner's symptoms persisted despite conservative care and Dr. Wood recommended a right shoulder arthroscopy. Physical examination showed a markedly positive O'Brien's test with pain to palpation over the AC joint and biceps tendon within the bicipital groove. He believed the MRI was of marginal diagnostic quality and assessed a superior labral tear of the right shoulder, AC joint arthrosis and inflammation, and right biceps tendonitis. He recommended biceps tenodesis to address the superior labral tear along with AC joint resection, subacromial decompression, and evaluation of the rotator cuff.

On 12/8/16, Dr. Mall performed a right shoulder arthroscopy and partial synovectomy, subacromial decompression and acromioplasty, debridement of the superior labrum, distal clavicle excision, and open biceps tenodesis. Objective intraoperative findings included a clear superior labral tear, AC joint inflammation, and an acromial spur. Petitioner reported improvement during her initial post-operative follow-up and was referred for physical therapy which improved her range of motion and strength. However, on 2/15/17, Petitioner reported soreness on the posterolateral and top aspect of her shoulder. Dr. Mall believed Petitioner may have overworked her shoulder in physical therapy and recommended a cortisone injection in the AC joint and subacromial space to overcome inflammation.

On 3/8/17, Petitioner remained symptomatic with posterolateral shoulder pain that travelled into her neck, which notably had been present since the injury. The injection provided a few hours of relief and physical examination remained positive for discomfort over the AC joint, reduced rotator cuff strength, and pain to palpation along the cervical spine with periscapular muscle pain. Dr. Mall recommended MRIs of Petitioner's neck and shoulder to evaluate for inflammation and ensure complete resection of the distal clavicle. Dr. Mall did not suspect AC joint instability. The shoulder MRI demonstrated an intact rotator cuff and some edema at the AC joint with bone contusion of the distal clavicle without separation or tearing. The cervical MRI demonstrated a moderate-sized right disc herniation with a probable annular fissure at C5-6 extending to the right C6 root creating right foraminal narrowing, and a smaller broad-based left herniation at C4-5 extending towards the foramen. Dr. Mall referred Petitioner to Dr. Gornet. Dr. Mall also noted that the narrowing of the posterior aspect of the AC joint represented residual symptomatic impingement which was responsible for some of Petitioner's symptoms. Dr. Mall recommended additional right shoulder surgery.

On 4/19/17, Petitioner was examined by Dr. Gornet who noted she had no problems of significance with regard to her neck or shoulder prior to her accident. Petitioner reported her symptoms were constant and made worse with reaching, pulling, and fixed head positions. Physical examination demonstrated pain in the right trapezius, right shoulder, and upper arm, accompanied by headaches and trace deep tendon reflexes, though she had full range of motion of the cervical spine. Dr. Gornet reviewed the significant findings of herniation at C5-6 and central protrusion at C4-5. He believed these findings were causally connected to her work injury and explained there was often overlap between shoulder and cervical spine symptoms that resulted in manifestation of symptoms in the other area. Dr. Gornet noted Petitioner's continued headaches, despite shoulder surgery, correlated with such a conclusion, in addition to the fact that the MRI findings correlated with Petitioner's complaints. He kept Petitioner under restrictions and referred Petitioner for injections at C4-5 and C5-6.

On 6/15/17, Dr. Mall performed a right AC joint open resection, during which an additional section of the distal clavicle was resected to create additional space in the posterior aspect of the AC joint. Petitioner reported improvement post-operatively and she was referred to physical therapy. On 7/6/17, Petitioner followed up with Dr. Gornet and he noted no sustained relief from the injections. Dr. Gornet recommended a CT myelogram followed by surgery and prescribed pain medication. The myelogram confirmed symptomatic disc injuries at C4-5 and C5-6 and on 7/12/17 Dr. Gornet performed a disc replacement at both levels. Intraoperative findings revealed foraminal stenosis and right-sided herniation at C5-6 and a right-sided foraminal herniation at C4-5 that was much larger than that seen on MRI and was consistent with part of Petitioner's shoulder pain.

On 7/27/17, Petitioner returned to Dr. Mall and reported improvement following her cervical spine surgery. Good range of motion was noted in her shoulder, but she reported additional right shoulder soreness. Dr. Mall recommended physical therapy.

On 8/3/17, Petitioner reported resolution of her headaches and improvement in her shoulder and arm symptoms to Dr. Gornet, with persistent burning in her upper shoulder. Dr. Gornet believed her symptoms were consistent with the decompression and prescribed additional pain medication. On 10/6/17, Dr. Mall administered an AC joint injection due to persistent pain. On 10/19/17, Petitioner reported growing discomfort in her neck as she participated in physical therapy. Dr. Gornet reviewed Dr. Robson's Section 12 report dated 7/19/17 wherein he noted the objective MRI findings and opined there was a causal relationship between the findings and Petitioner's accidents. Dr. Robson believed Petitioner's care and treatment, particularly the cervical disc replacements, was reasonable and necessary and that Petitioner required further care to reach maximum medical improvement. Dr. Gornet prescribed additional medication and recommended Petitioner complete therapy.

On 11/10/17, Dr. Mall noted the injection did not resolve the discomfort over Petitioner's AC joint. Physical examination remained positive for point tenderness over the AC joint with residual instability present on anterior-posterior testing and weakness with rotator cuff testing manifesting as 4+/5 strength in the supraspinatus. X-rays showed formation of a calcium deposit within the AC joint possibly related to scar tissue with mild superior migration of the clavicle with respect to the coracoid. Dr. Mall recommended physical therapy and an MRI that revealed

insertional cuff tendinitis and shallow subinsertional enthesopathic changes beneath the subscapularis and infraspinatus insertions. Dr. Mall recommended a right shoulder open AC joint exploration with an internal brace of the AC joint, exploration for bony abutment that could be causing inflammation, and excision of any scar tissue. Dr. Mall believed the AC joint capsule did not heal following the resection which would cause Petitioner's symptoms. He believed this produced an anterior-posterior joint instability within the AC joint. The coracoclavicular ligaments appeared to be intact so he did not recommend a coracoclavicular ligament reconstruction.

Dr. Mall performed the third surgery on 12/28/17. He noted intraoperatively the superior AC joint ligamentous structures did not heal very well from the prior surgery. He also noted there was minimal tissue present in terms of structural tissue to provide stability to the AC joint, and the distal clavicle was notably unstable with over a centimeter of anterior to posterior translation. Dr. Mall performed an AC joint ligament repair using internal brace technique, which stabilized the clavicle and restored anterior to posterior stability to the distal clavicle and acromion. On 1/11/18, Dr. Mall noted Petitioner was doing well and referred her for physical therapy.

On 1/29/18, Petitioner returned to Dr. Gornet and reported that although she was doing well, she experienced increased tenderness in her neck and a return of her headaches approximately two months prior. Dr. Gornet advised that some of the issues in her shoulder may make her neck on guard, and since no problems manifested on current films, he assured her that no restrictions were required for her neck. Follow-up visits with Dr. Mall show that although her right shoulder AC joint was stable, she continued to have some symptoms for which he recommended continued therapy.

On 4/20/18, Dr. Mall noted Petitioner continued to have headaches and pain in her shoulder. Dr. Mall noted Dr. Gornet did not believe her symptoms were coming from her neck. Dr. Mall continued to recommend therapy and ordered scar cream to assist with pain and inflammation over her AC joint. Petitioner returned the following month with complaints of continued right shoulder pain with numbness and tingling down to her right hand. Examination showed no pain over the biceps tendon and the AC joint was stable; however, Petitioner remained tender to palpation over the AC joint along the incision. Dr. Mall recommended a functional capacity evaluation as he believed the combination of Petitioner's right shoulder and neck injuries may require permanent restrictions. Based on the FCE results, Dr. Mall placed Petitioner at maximum medical improvement with permanent restrictions of no lifting greater than 10 pounds overhead, no lifting greater than 20 pounds from floor to waist or waist level, and no lifting greater than 15 pounds from waist to chest.

On 7/16/18, Dr. Gornet noted Petitioner was doing well with respect to her cervical spine, but she continued to have aches and pains, which he attributed to her right shoulder, and noted Petitioner was under permanent restrictions placed by Dr. Mall. He ordered a CT scan that showed good positioning of the devices with excellent motion and he placed Petitioner at maximum medical improvement.

On 12/5/18, Petitioner was examined by Dr. Michael Nogalski pursuant to Section 12 of the Act. Dr. Nogalski noted Petitioner appeared to be generally deconditioned with complaints of pain in her neck and trapezial area on extension. He noted generalized tenderness over the anterior glenohumeral joint and AC joint resection region and diffuse pain over the anterior and posterior shoulder with crossover maneuver. His impression was status post right shoulder arthroscopy, debridement, and biceps tenodesis with subsequent revision open distal clavicle resection and AC joint stabilization; and status post cervical disc replacements at C4-5 and C5-6. Dr. Nogalski stated Petitioner was somewhat evasive and nonspecific in her history and characterized her description of events as being somewhat rambling. He strongly believed Petitioner sustained a strain to her shoulder which precipitated adhesive capsulitis. However, he believed the strain improved with physical therapy until Petitioner's motor vehicle accident in March 2016 where she sustained injuries to her forearm. He opined Petitioner's current objective findings were not causally related to her work injuries. He believed these were the direct result of the three subsequent operations in her right shoulder that were without clinical benefit. Dr. Nogalski opined Petitioner's treatment through 3/30/16 was causally related to her work accidents, but not subsequent care and treatment provided by either Dr. Mall or Dr. Gornet.

On 2/17/19, Petitioner presented to Memorial Hospital and reported right shoulder pain that had an onset of two days ago when she performed CPR at work. Abduction of her right arm caused severe pain. X-rays of her right shoulder revealed post-surgical and mild degenerative changes. She was released and ordered to follow up with her physician.

On 2/20/19, Petitioner returned to Dr. Mall and reported her accident of 2/15/19. Physical examination revealed pain to palpation over the AC joint and subacromial space, pain with rotator cuff testing, weakness in the supraspinatus distribution, and significant inflammation around the shoulder. Dr. Mall administered a cortisone injection which failed to provide substantial relief. Petitioner returned to Dr. Mall the following month with continued complaints and manifest pain to palpation over the AC joint and pain and weakness with rotator cuff testing. He recommended an MRI that revealed mild infraspinatus insertional tendinopathy without tearing, evidence of Petitioner's prior surgery, and no discrete labral tearing. Dr. Mall noted the MRI showed no specific pathology that would require additional care or surgical treatment. He believed Petitioner's existing permanent restrictions were sufficient to address her current shoulder condition, placed Petitioner at maximum medical improvement, and advised her to follow up with Dr. Gornet to examine her cervical spine.

Dr. Gornet examined Petitioner on 6/17/19 and noted Petitioner's new injury as result of CPR training. He noted Petitioner had been in class for over an hour and had to repeat chest compressions approximately four times as they were not registering which produced increased burning pain in Petitioner's right shoulder and neck. Petitioner presented with pain localized in her neck into both trapezii, right greater than left, with tingling into her right arm and middle finger. Dr. Gornet found the mechanism of injury could aggravate an underlying condition or produce new injury and ordered an MRI with a plain CT of her neck. Dr. Gornet linked Petitioner's current complaints in their level of severity and her need for evaluation and treatment to her recent work injury on 2/15/19.

The CT scan showed no significant facet arthropathy on the right or evidence of lucency or major heterotopic issues, though a touch of foraminal narrowing at C5-6 on the right side was noted. On 7/15/19, Dr. Gornet recommended physical therapy and potentially an injection if Petitioner remained symptomatic. He stated Petitioner could continue to work full duty from the standpoint of her cervical spine. Petitioner returned in September 2019 and reported continued symptoms of neck and shoulder pain with headaches. Dr. Gornet suggested Petitioner may have suffered small disc protrusions at C3-4 and C6-7 but these were obscured by artifact on the scans. Dr. Gornet recommended another injection at C5-6 which did not provide significant relief. Though there were small protrusions that may have represented new disc injuries at C3-4 and C6-7, Dr. Gornet recommended against further treatment as he did not believe surgery would alleviate Petitioner's symptoms. Dr. Gornet placed Petitioner at maximum medical improvement.

Petitioner returned to Dr. Gornet twice following release for routine follow-ups and continued to report symptoms. On 4/27/20, Dr. Gornet noted Petitioner continued to have increased symptoms in her neck following the training episode on 2/15/19 but he did not believe she required restrictions for her neck, particularly given the permanent restrictions placed by Dr. Mall. On 7/13/20, Dr. Gornet noted Petitioner was doing well for the most part with continued headaches.

Dr. Michael Nogalski testified by way of evidence deposition on 7/22/19. Dr. Nogalski testified that approximately 40% of his practice is composed of treatment of the shoulder and 5% is composed of medical-legal work. He testified consistently with the findings and opinions contained in his report. He noted Petitioner reported experiencing "the loudest pop" in her right shoulder while restraining the aggressive patient during her first accident, and that she "hit the wall hard" during the second accident, which resulted in the development of severe pain and inability to breathe. Dr. Nogalski testified his review of the MRI films did not demonstrate evidence of a labral tear. He found it significant that Petitioner allegedly did not report the motor vehicle accident that occurred on 3/30/16. He noted that Petitioner sustained a right forearm fracture for which she underwent outpatient open reduction and subluxation and denied any injury to her shoulder as a result of the accident. He believed that Petitioner's motor vehicle accident involving her forearm aggravated Petitioner's right shoulder condition from which she recovered prior to the collision.

Dr. Nogalski disagreed with the permanent restrictions imposed by Dr. Mall. He testified that Petitioner's full duty release for her cervical spine indicated her neck did not influence her shoulder, and he felt that Petitioner's right shoulder physical examination exhibited sufficient functional capacity to allow her to reasonably perform her work activities.

On cross-examination, Dr. Nogalski acknowledged that Dr. Robson found a causal connection between Petitioner's work accidents and her current condition of ill-being in her cervical spine. Though he was asked to evaluate Petitioner's right shoulder, he espoused his opinion that Petitioner's cervical spine condition was also unrelated to her work accidents. He admitted, however, that he does not operate on cervical spine injuries and he refers surgical patients to Dr. Robson for care and treatment. Dr. Nogalski admitted that Petitioner contemporaneously voiced complaints in her shoulder immediately following both accidents. He admitted he did not have Petitioner's treatment records from her motor vehicle accident and did

not request same after learning of her accident. He admitted he did not know if any shoulder complaints were documented following Petitioner's motor vehicle accident.

Dr. Nathan Mall testified by way of evidence deposition on 4/29/19. Dr. Mall testified that shoulder treatment and sports medicine is a subspecialty of his practice, which was the focus of his fellowship after his residency training. Approximately 60% of the surgeries he performs are for shoulder injuries. He also performs approximately one to two independent medical evaluations per week. Dr. Mall testified that in addition to his medical records, he reviewed Dr. Nogalski's independent medical evaluation and the records from Memorial Hospital which document the treatment from Petitioner's motor vehicle accident. He summarized the history of Petitioner's accidents and the medical history of her care and treatment as outlined in his records. He testified that Petitioner's MRI did demonstrate a superior labral tear, along with fluid around the biceps tendon and inflammation at the AC joint. He testified that these findings were consistent with Petitioner's symptoms and mechanism of injury of reaching out to grab a patient. She sustained a traction-type injury to her shoulder which is a classic mechanism for a superior labral tear. He testified that an altercation could certainly produce some trauma to the AC joint. He explained that the biceps tendon is essentially attached to the superior labrum, so anything that causes trauma to the superior labrum would also cause trauma to the biceps tendon. Dr. Mall opined that both of Petitioner's work accidents suffered in September 2015 were a causative or contributory factor in her right shoulder condition.

Dr. Mall testified that the intraoperative findings during Petitioner's first surgery on 12/8/16 confirmed his diagnosis. Though he addressed the objective interoperative findings, Petitioner continued to have significant symptoms for which he referred her for evaluation of her cervical spine. Though she was treated by a spine specialist, she continued to have trouble referable to her right shoulder. He ordered an MRI which showed impingement in the posterior region of the AC joint, which correlated with Petitioner's difficulty reaching behind her back. Because Petitioner's complaints did not resolve with conservative care including injection, she required a second surgery, during which the operative findings again confirmed the MRI findings and his diagnosis. With regard to the etiology of the complaints Petitioner is experiencing, Dr. Mall testified he did not feel the complaints were from Petitioner's cervical spine because the AC joint is typically pretty specific in that you push on that spot and it hurts.

Dr. Mall testified that Petitioner continued to have specific right shoulder symptoms after the second surgery, and reasonably so, because AC joint resection carries the risk of destabilization. He testified that the coracoclavicular ligaments come in and attach at a certain distance from the AC joint along the collarbone. A resection can render AC joint instability because you are cutting through the superior AC joint capsule. Dr. Mall explained that resecting a centimeter in one patient could produce a different result than the same resection in another patient. When he examined Petitioner's right shoulder AC joint it felt looser than the other side which led him to perform the third surgical procedure, AC joint stabilization, on 2/28/17. He noted that the inflammation visualized was likely brought about by some of the instability in the joint that came from the trauma, which was not a rare phenomenon. Dr. Mall testified that Petitioner's symptoms had been very consistent throughout her care and treatment with both him and Dr. Gornet, and he again related Petitioner's shoulder care and treatment to her work injuries in September 2015.

Dr. Mall testified that Petitioner's continued complaints in tandem with the injuries suffered to her shoulder and neck necessitated a functional capacity evaluation. He opined that the need for permanent restrictions is attributed to the September 2015 work accidents.

With regard to Petitioner's accident on 2/15/19, Dr. Mall testified it was not surprising Petitioner had an increase in symptoms while pushing hard on the CPR dummy to "get a green light," which was a sensor that indicated whether she was pushing hard enough to pump blood and perform successful CPR. He noted there was also some rotator cuff weakness, which was previously nonexistent, suggestive of a rotator cuff strain in addition to the ongoing problems in her AC joint. Since Petitioner's condition was obviously inflamed, he recommended imaging studies, a cortisone shots to calm the inflammation, physical therapy, and evaluation by Dr. Gornet. Dr. Mall testified that Petitioner had worsening of her symptoms, including radiculopathy, following the February 2019 accident that caused her to seek treatment. However, he stated that previously placed restrictions were adequate to address her condition and placed Petitioner at maximum medical improvement.

Dr. Mall testified he disagreed with Dr. Nogalski's opinion the medical records were conflicting as to whether Petitioner suffered a right shoulder injury or neck injury. Dr. Mall testified it is possible to suffer injuries to both and the symptoms from both make it difficult to determine the source of the complaints. He testified that a cervical spine injury does not produce a positive O'Brien's test, point pain with compression over the AC joint, or pain with compression of the biceps tendon. Although there was certainly some overlap, because the C4 and C5 nerve roots stop at the shoulder and C3 can go down into the shoulder blade area and trapezius, Petitioner clearly had a persistent shoulder problem.

Dr. Mall stated that over the 26 times he evaluated Petitioner, she was pleasant and at no point evasive or nonspecific. He testified that Dr. Nogalski's diagnosis of strain causing adhesive capsulitis from which Petitioner had reached maximum medical improvement in March 2016 was not consistent with the objective medical evidence showing Petitioner suffered a superior labral tear following a capable mechanism of injury. He also disagreed with Dr. Nogalski's opinion that Petitioner was capable of returning to full-duty work, as he just tried that and it did not work so well for her.

On cross-examination, Dr. Mall testified he possessed and reviewed records from Chester Hospital, the Orthopedic Institute of Southern Illinois, and Apex physical therapy. Dr. Mall testified that Petitioner fractured her right forearm in the March 2016 automobile accident which required immobilization for a period of time. It was not surprising her arm would we weaker and affect her physical therapy for her shoulder. He testified he did not believe the automobile accident made Petitioner's shoulder condition worse based on Petitioner's statement she did not have any worsening shoulder complaints following the accident, and the treatment records from the collision did not demonstrate a shoulder problem or complaints.

Dr. Mall testified he placed permanent restrictions on Petitioner in part due to her reports of pain, which he acknowledged was subjective, and based on recommendations of the physical

therapist performing the evaluation, who took body mechanics into consideration to prevent further or future injury.

Petitioner's vocational rehabilitation specialist, Mr. Timothy Kaver, testified by way of deposition on 12/29/20. Mr. Kaver has been performing vocational rehabilitation counseling since 1985, after he earned his master's degree in sociology with an emphasis on occupations and professions. He testified that his practice involves providing on-the-job or off-site training, job placement, and job search assistance. His practice includes referrals from the U.S. Department of Labor to return injured federal employees to the work force and providing his opinion in cases for plaintiffs and insurance companies.

Mr. Kaver testified that Petitioner's physical restrictions limited her to sedentary work, and her educational background rested in sociology, with an associate's degree in human services and a bachelor's of science degree in rehabilitation. He noted Petitioner's job duties included overseeing movement of patients, keeping accurate count reports, performing housekeeping duties from mopping to trash and laundry, processing new facility admissions, assisting with activities of daily living, providing educational support, and engaging in physical interventions with restraints, for which she annually earned $44,000. Mr. Kaver testified that handling physical altercations fell within the heavy strength level category.

Mr. Kaver testified he explored several career alternatives that Petitioner could safely use her skills within her restrictions, but she required additional computer skills. He testified that Petitioner practiced her keyboarding at home and completed additional training in PowerPoint9 through a class but was unable to attend the Excel training because she did not have funds for gas. Though he attempted to secure funding the help her take the course online, it had not yet been allocated for her at the time of the deposition.

Mr. Kaver testified that he first attempted to help Petitioner obtain employment through the State's alternative employment program (AEP), which allows injured workers to be placed in new positions within the employ of the State for which they are qualified within their physical limitations. He stated that Petitioner embarked on the arduous qualification process and completed all of the requisite paperwork, including providing physician documentation and signatures. Petitioner bid on 22 different positions with the State of Illinois and had some interviews but was not offered employment. Mr. Kaver testified the litigation dispute and COVID-19 made the process more difficult. He explained that the AEP program caused a problem in that on three different dates the State of Illinois told Petitioner to report back to work, which causes the AEP program that you are trying to become certified to cease and you have to start all over again. The first time Petitioner returned to work she became reinjured performing CPR training. The other two times Petitioner returned to work she was told by Respondent they had no work within her physical restrictions. During COVID, Petitioner's AEP paperwork was lost when the state employees did not have access to their offices for five months. Attempts to locate her paperwork were unsuccessful and she had to start all over again. She completed the AEP paperwork for the fourth time as of August 2020 and is awaiting a response.

Mr. Kaver testified that Petitioner is also qualified to staff a variety of sedentary-level professional and paraprofessional occupations outside of the State's employ based on her

transferrable skills and her degree in social service. He agreed that Petitioner's starting salary range would be higher if she could find employment with the State. Her current salary of $44,000 per year would be reduced to $27,000 to $32,000 per year starting in a private sector position, as she would most likely end up working for a not-for-profit agency. He testified that some of the roles Petitioner could serve included social human service worker, customer service representative, intake reviewer, and other general office positions that will allow her to sit or stand alternatively. He cautioned, however, the pandemic makes it more difficult for Petitioner to find a job in the field in which she was job seeking. Mr. Kaver testified that the reports he generated were kept in the normal, everyday course of business and were customary in his line of work. He further testified that his charges were reasonable and customary for the services that he rendered in the community.

CONCLUSIONS OF LAW

Issue (F): Is Petitioner's current condition of ill-being causally related to the injury (after March 30, 2016)?

Illinois law holds that "[e]very natural consequence that flows from an injury that arose out of and in the course of the claimant's employment unless caused by an independent intervening accident that breaks the chain of causation between a work-related injury and an ensuing disability or injury" is compensable. *Vogel v. Indus. Comm'n*, 354 Ill. App. 3d 780, 786, 821 N.E.2d 807, 812 (2d Dist. 2005); *Nat'l Freight Indus. v. Illinois Workers' Comp. Comm'n*, 993 N.E.2d 473, 481, 2013 IL App (5th) 120043WC, ¶ 26. Courts have consistently held that for an employer to be relieved of liability by virtue of an intervening cause, the intervening cause must completely break the causal chain between the original work-related injury and the ensuing condition; as the Court *in Lasley Const. Co.*, aptly stated: "The fact that other incidents, whether work related or not, may have aggravated claimant's condition is irrelevant." *Lasley Const. Co., Inc. v. Indus. Comm'n*, 274 Ill.App.3d 890, 893, 655 N.E.2d 5, 8, (5th Dist. 1995). See also *Vogel v. Indus. Comm'n*, 354 Ill. App. 3d 780, 786, 821 N.E.2d 807, 812, (2d Dist. 2005).

In determining what is sufficient to cause a complete break in the chain of causality, the Arbitrator finds the Appellate Court's direction in *Vogel* probative. In *Vogel v. Indus. Comm'n*, the Appellate Court stated: "This court has recognized repeatedly that, when a claimant's condition is weakened by a work-related accident, a subsequent accident that aggravates the condition does not break the causal chain." *Vogel v. Indus. Comm'n*, 354 Ill. App. 3d 780, 787, 821 N.E.2d 807, 813, 290 Ill.Dec. 495, 501 (2d Dist. 2005). In *Vogel*, the Court highlighted precedent such as *Teska v. Industrial Comm'n*, 266 Ill.App.3d 740, 742, 203 Ill.Dec. 574, 640 N.E.2d 1 (1st Dist. 1994) and *International Harvester Co. v. Industrial Comm'n*, 46 Ill.2d 238, 245, 263 N.E.2d 49, 53 (Ill. 1970). Additionally, where the second injury occurs due to treatment for the first, there is likewise no break in the causal chain. *International Harvester supra.* In *Teska*, the claimant injured his back in a workplace accident and underwent surgery on his spine. *Teska v. Indus. Comm'n,* 266 Ill.App.3d 740, 640 N.E.2d 1 (1994). After the surgery, his condition improved but he still continued to experience numbness and pain in his neck, shoulder, and left arm. While bowling, he experienced a sharp pain in his neck that radiated into his left arm. He subsequently underwent a second surgery. The Commission denied the claimant benefits for the second surgery, finding that his condition of ill-being was the result of an intervening

accident (bowling). On appeal, the *Teska* court reversed the Commission's decision as being contrary to the manifest weight of the evidence. *Id.* N.E.2d at 2. The court noted that "[e]very natural consequence that flows from the injury which arose out of and in the course of the claimant's employment is compensable under the Act, unless caused by an independent intervening accident." *Id.* N.E.2d at 3. In overturning the Commission's decision, the court noted that the claimant's condition "would not have progressed to the point it did but for his original work-related accident." The court stated: "Merely because claimant experienced an upsurge of neck pains while bowling * * * does not mean the causal connection was broken." *Id.* N.E.2d at 4.

In *International Harvester*, the Court determined that the claimant, who suffered from a continuing condition of traumatic neurosis that resulted from his work accident where he was struck on the head by a tractor, was entitled to workers' compensation benefits four years later when claimant was struck by his wife. *International Harvester Co. v. Indus. Comm'n*, 263 N.E.2d 49 (Ill. 1970). In awarding benefits, the Supreme Court found that the reason the claimant's condition existed was the work injury, and that as a natural consequence, his work injury continued and was a causative factor in total and permanent disability following the injury he sustained from his wife. *Id.*

Respondent denies that Petitioner's condition of ill-being is causally connected to her work-related accident as of the date of her automobile accident that occurred on March 30, 2016. The Arbitrator finds that Petitioner's automobile accident was not an independent intervening accident that broke the chain of causation and holds Petitioner's current condition of ill-being in her right shoulder remains causally connected to her accidental work injuries in September 2015.

In so holding, the Arbitrator finds the opinion of Dr. Mall more credible than that of Dr. Nogalski. The Arbitrator finds it highly significant that Respondent did not obtain and provide Dr. Nogalski with the treatment records from the motor vehicle accident for his review, and he admitted he was unaware if said records made any reference to Petitioner's right shoulder. The Arbitrator also notes that Dr. Nogalski did not acknowledged the presence of a labral tear, which was confirmed by the objective intraoperative findings.

In contrast, Dr. Mall had the benefit of reviewing the records documenting Petitioner's treatment following the automobile accident. The records admitted into evidence show Petitioner complained of right upper extremity pain with movement. However, Petitioner was diagnosed with a fractured forearm and no right shoulder complaints or injuries were noted. X-rays of Petitioner's right humerus, including a portion of the shoulder, revealed no fractures. Petitioner did not treat with her surgeons, Dr. Mall and Dr. Gornet, for any injuries resulting from the automobile accident. Dr. Mall credibly explained why he believed Petitioner's motor vehicle collision did not injure her right shoulder. The Arbitrator finds it significant that the absence of any right shoulder pain corroborates Petitioner's testimony that she did not suffer any injury to her shoulder in the collision. In addition, the work injury records reflect that Petitioner's physical examination remained relatively unchanged and the assessment remained the same following the collision.

As such, the medical records and testimony do not support a finding that Petitioner suffered an intervening accident, as there was no complete break in the chain of causal connection. The Arbitrator therefore finds that Petitioner sustained her burden of proof on the issue of causal connection.

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

Upon establishing causal connection and the reasonableness and the necessity of recommended medical treatment, employers are responsible for necessary prospective medical care required by their employees. *Plantation Mfg. Co. v. Indus. Comm'n*, 294 Ill.App.3d 705, 691 N.E.2d. 13 (1997). This includes treatment required to diagnose, relieve, or cure the effects of claimant's injury. *F & B Mfg. Co. v. Indus. Comm'n*, 325 Ill. App. 3d 527, 758 N.E.2d 18 (2001).

Based upon the above findings as to causal connection, the Arbitrator finds the medical care administered to Petitioner was reasonable and necessary to treat her work-related injuries. Dr. Mall and Dr. Gornet testified that all of Petitioner's care and treatment and diagnostic testing was administered to diagnose and/or relieve the effects of Petitioner's work-related injuries. Though Petitioner attempted to resolve her complaints conservatively, the evidence shows that Petitioner required multiple surgeries.

Respondent shall therefore pay the reasonable and necessary medical services outlined in Petitioner's Group Exhibit 1, pursuant to the medical fee schedule or a PPO agreement (whichever is less), as provided in §8(a) and §8.2 of the Act. 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 §8(j) of the Act.

The Arbitrator further orders Respondent to pay the reasonable and necessary charges from England and Company Rehab Services related to Petitioner's vocational rehabilitation contained in Petitioner's Group Exhibit 18. Mr. Kaver testified Petitioner's physical restrictions limit her to sedentary work. Mr. Kaver has worked consistently with Petitioner to find employment within her restrictions from approximately April 2019 through at least the date of his deposition on 12/29/20. Mr. Kaver testified that his charges were reasonable and customary for the services he rendered in the community, which was not rebutted by Respondent.

Issue (K): What temporary benefits are in dispute?

The law in Illinois holds that "[a]n employee is temporarily totally incapacitated from the time an injury incapacitates him for work until such time as he is as far recovered or restored as the permanent character of his injury will permit." *Archer Daniels Midland Co. v. Indus. Comm'n*, 138 Ill.2d 107, 561 N.E.2d 623 (Ill. 1990). The ability to do light or restricted work does not preclude a finding of temporary total disability. *Archer Daniels Midland Co. v. Indus. Comm'n*, 138 Ill.2d 107, 561 N.E.2d 623 (Ill., 1990) citing *Ford Motor Co. v. Indus. Comm'n*, 126 Ill. App. 3d 739, 743, 467 N.E.2d 1018, 1021 (1984). When an employee reaches maximum

medical improvement and is unable to resume his or her employment, the Act provides that the employer "shall also pay for treatment, instruction and training necessary for the physical, mental and vocational rehabilitation of the employee, including all maintenance costs and expenses incidental thereto." 820 ILCS 305/8(a). When vocational rehabilitation is required, it is the Petitioner who "retains the right to choose their vocational counselor." *Scoville v. D.C. Elec. of Benton*, 11 I.W.C.C. 0331, citing *Passas v. Kirby School Dist. # 140,* 94 WC 5553; 01 IIC 0178; *Hollins v. Aurora East School Dist. 131,* 07 IWCC 0382*; Hir v. City of Joliet,* 04 IIC 0614.

Dr. Mall credibly testified Petitioner required permanent restrictions with regard to her right shoulder. Dr. Mall released Petitioner at maximum medical improvement on 7/13/18 following a functional capacity evaluation resulting in permanent restrictions of no lifting greater than 10 pounds overhead, 20 pounds from floor to waist and waist level, and 15 pounds from waist to chest. Mr. Kaver testified that Petitioner's job duties of intervening and restraining patients alone exceeded her permanent restrictions.

The parties stipulated on the record that the only issue in dispute with regard to temporary benefits is the unpaid period from 1/25/20 through 3/25/21. Though the parties placed both temporary total disability and maintenance benefits in dispute, the Arbitrator notes that Petitioner had been placed at MMI by Dr. Gornet on 7/16/18 related to her cervical injury, and Dr. Mall placed Petitioner at MMI on 7/13/18 with permanent restrictions with regard to her right shoulder injury. Following both MMI releases, Petitioner was involved in a third accident on 2/15/19 that resulted in an aggravation of her cervical spine and right shoulder. Additional diagnostic tests were performed and Petitioner underwent cervical and right shoulder injections and physical therapy. At no time did Dr. Gornet place Petitioner off work or on restrictions from 2/15/19 through his second MMI release on 12/2/19. Dr. Mall again placed Petitioner at MMI on 5/14/19 following her third accident, with the same permanent restrictions related to her right shoulder.

The Arbitrator finds Petitioner is entitled to maintenance benefits for the disputed period **1/25/20 through 3/25/21**, representing a period of **60-6/7th** weeks.

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 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).

(i) Level of Impairment: Neither party submitted an AMA rating. Therefore, the Arbitrator places no weight on this factor.

(ii) Occupation: Petitioner is unable to return to her former employment for Respondent as a Security Therapy Aide. Petitioner has been placed under permanent restrictions related to her right shoulder condition that limit her to the sedentary demand category. The Arbitrator places significant weight on this factor.

(iii) Age: Petitioner was 42 years old at the time of her accident. She is young and has to live and work with substantial permanent restrictions that limit her to the sedentary functional demand category. Given the substantial number of years over which Petitioner must live and work with her disability, the Arbitrator places significant weight on this factor.

(iv) Earning Capacity: Petitioner is unable to return to her former employment as a Security Therapy Aide as a result of permanent restrictions. Mr. Kaver, a vocational rehabilitation expert, testified Petitioner would suffer a drastic reduction in earning capacity if she were not able to find a job with the State of Illinois, as her background and education would likely lead to private sector employment in a not-for-profit agency. Petitioner earned $44,000 per year working for Respondent. Dr. Kaver anticipates Petitioner will find employment earning $27,000 to $32,000 per year in the private sector. Dr. Kaver testified Petitioner applied for at least 22 positions within the State without success. The Arbitrator places substantial weight on this factor.

(v) Disability: As a result of her injuries, Petitioner underwent a right shoulder arthroscopy and partial synovectomy, subacromial decompression and acromioplasty, debridement of the superior labrum, distal clavicle excision, and open biceps tenodesis. Objective intraoperative findings included a clear superior labral tear, AC joint inflammation, and an acromial spur. Despite surgery and significant post-operative conservative care, Petitioner's right shoulder symptoms persisted resulting in a second surgery. Dr. Mall noted narrowing of the posterior aspect of the AC joint represented residual symptomatic impingement. Dr. Mall performed a right AC joint open resection, during which an additional section of the distal clavicle was resected to create additional space in the posterior aspect of the AC joint. Petitioner again failed to improve with post-operative care resulting in a third surgery. Dr. Mall recommended a right shoulder open AC joint exploration with an internal brace of the AC joint, exploration for bony abutment that could be causing inflammation, and excision of any scar tissue. Dr. Mall suspected anterior-posterior joint instability within the AC joint. Dr. Mall noted intraoperatively that the superior AC joint ligamentous structures did not heal well, there was minimal tissue present to provide stability to the AC joint, and the distal clavicle was notably unstable with over a centimeter of anterior to posterior translation. Dr. Mall performed an AC joint ligament repair using internal brace technique, which stabilized the clavicle and restored anterior to posterior stability to the distal clavicle and acromion. Despite three shoulder surgeries, Petitioner was released at maximum medical improve with permanent restrictions of no lifting greater than 10 pounds overhead, no lifting greater than 20 pounds from floor to waist or waist level, and no lifting greater than 15 pounds from waist to chest.

Petitioner underwent a two-level disc replacement surgery at C4-5 and C5-6. One year post-operative, Dr. Gornet ordered a CT scan that showed good positioning of the devices with excellent motion and he placed Petitioner at maximum medical improvement. However, Petitioner continued to complain of neck discomfort and headaches. Two years following

surgery and four months following Petitioner's third work-related accident of 2/15/19, Dr. Gornet noted pain localized in Petitioner's neck into both trapezii, right greater than left, with tingling into her right arm and middle finger. Dr. Gornet ordered an MRI with a plain CT of Petitioner's neck that showed no significant facet arthropathy on the right or evidence of lucency or major heterotopic issues, though a touch of foraminal narrowing at C5-6 on the right side was noted. Petitioner underwent physical therapy and an injection at C5-6 which did not provide significant relief. Though there were small protrusions that may have represented new disc injuries at C3-4 and C6-7, Dr. Gornet recommended against further treatment and placed Petitioner at maximum medical improvement a final time on 12/2/19.

Petitioner testified the cervical surgery initially greatly improved her symptoms. She can hold her head up and her range of motion, headaches, and vertigo had improved. She testified she currently can drive only short distances and continues to have decreased range of motion in her neck and headaches. She takes medication, including Meloxicam, Zanaflex, and generic Fioricet for her symptoms. The Arbitrator places substantial weight on this factor.

Based upon the foregoing evidence and factors, the Arbitrator orders Respondent to pay Petitioner the sum of $**517.86**/week for a period of **250 weeks**, as provided in Section 8(d)2 of the Act, because the injuries sustained caused a combined **50% loss of the body as a whole, representing 20% loss of the body as a whole as a result of injuries to her cervical spine, and 30% loss of the body as a whole as a result of injuries to her right shoulder.** Pursuant to the parties stipulation, Respondent shall receive credit of 2% loss of the body as a whole paid as an advance on permanent partial disability benefits.

With respect to the right shoulder, Respondent shall pay Petitioner compensation from 7/13/18 when Dr. Mall released Petitioner at maximum medical improvement with permanent restrictions, through March 25, 2021, and shall pay the remainder of the award, if any, in weekly payments. With respect to the cervical spine, Respondent shall pay Petitioner compensation from 7/16/18 when Dr. Gornet released Petitioner at maximum medical improvement, through March 25, 2021, and shall pay the remainder of the award, if any, in weekly payments.

Issue (O): Other: Maximum Medical Improvement date with respect to Petitioner's right shoulder?

Based upon the above evidence, the Arbitrator finds Petitioner reached maximum medical improvement with respect to her right shoulder on 7/13/18 when Dr. Mall released her with permanent restrictions. Although Petitioner sustained an aggravation of her right shoulder condition on 2/15/19 that required additional diagnostic tests, an injection, and physical therapy, Dr. Mall testified the previously placed restrictions were adequate to address her condition and did not recommend further treatment after 5/14/19.

Arbitrator Linda J. Cantrell DATED:

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC010795
Case Name	BARNES, KIMBERLY v. STATE OF ILLINOIS – CHESTER MENTAL HEALTH CENTER
Consolidated Cases	17WC000055; 17WC000060;
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	22IWCC0244
Number of Pages of Decision	20
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	Thomas Rich
Respondent Attorney	Nicole Werner

DATE FILED: 6/30/2022

/s/ Deborah Baker, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KIMBERLY BARNES,

Petitioner,

vs. NO: 19 WC 10795

STATE OF ILLINOIS,
CHESTER MENTAL HEALTH CENTER,

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 whether Petitioner's current condition of ill-being is causally related to the undisputed February 15, 2019 work accident, entitlement to maintenance benefits, entitlement to incurred medical expenses as well as vocational rehabilitation expenses, and the nature and extent of Petitioner's permanent disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. This case was consolidated for hearing with case numbers 17 WC 00055 and 17 WC 00060.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 3, 2021 is hereby affirmed and adopted.

Pursuant to Section 19(f)(1), this decision is not subject to judicial review.

June 30, 2022

DJB/lyc
O: 5/11/22
43

/s/ *Deborah J. Baker*

/s/ *Stephen J. Mathis*

/s/ *Deborah L. Simpson*

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC010795
Case Name	BARNES, KIMBERLY v. ST OF IL/CHESTER MENTAL HEALTH CENTER
Consolidated Cases	
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	17
Decision Issued By	Linda Cantrell, Arbitrator

Petitioner Attorney	Thomas Rich
Respondent Attorney	Nicole Werner

DATE FILED: 6/3/2021

INTEREST RATE FOR THE WEEK OF JUNE 1, 2021 0.03%

/s/ Linda Cantrell, Arbitrator
Signature

CERTIFIED as a true and correct copy

pursuant to 820 ILCS 305/14

JUNE 3, 2021

/s/ Brendon O'Rourke

Brendan O'Rourke, Assistant Secretary

Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

KIMBERLY BARNES
Employee/Petitioner

v.

STATE OF ILLINOIS/CHESTER MENTAL HEALTH CENTER
Employer/Respondent

Case # **19-WC-010795**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Linda J. Cantrell**, Arbitrator of the Commission, in the city of **Collinsville**, on **March 25, 2021**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the 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 **Maximum medical improvement date with respect to Petitioner's right shoulder.**

FINDINGS

On **February 15, 2019**, Respondent ***was*** operating under and subject 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 $**44,881.10**; the average weekly wage was $**863.10.**

On the date of accident, Petitioner was **45** years of age, ***single*** with **4** dependent children.

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

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

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

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

ORDER

Based on the Arbitrator's finding that Petitioner's current condition of ill-being is not causally related to her subsequent accident that occurred on 2/15/19 but remains related to her accidents on 9/11/15 and 9/17/15, and the Arbitrator having awarded Petitioner medical expenses, maintenance benefits, and permanent partial disability benefits in Case No. 17-WC-000055, the Arbitrator does not award further benefits 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.

Linda J. Cantrell

JUNE 3, 2021

Arbitrator Linda J. Cantrell

STATE OF ILLINOIS)
) SS
COUNTY OF MADISON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

KIMBERLY BARNES,	)	
	)	
Employee/Petitioner,	)	
	)	
v.	)	Case No.: 19-WC-010795
	)	
STATE OF ILLINOIS/CHESTER MENTAL HEALTH CENTER,	)	Consolidated: 17-WC-000055
	)	17-WC-000060
	)	
Employer/Respondent.	)	

FINDINGS OF FACT

These claims came before Arbitrator Linda J. Cantrell for trial in Collinsville on March 25, 2021 on all issues. On April 18, 2017, Petitioner filed an Amended Application for Adjustment of Claim alleging injuries to her right shoulder, right arm, neck, and body as a whole as a result of an altercation with a resident on September 11, 2015. (Case No. 17-WC-000055). On April 18, 2017, Petitioner filed an Amended Application for Adjustment of Claim alleging injuries to her right shoulder, neck, and body as a whole as a result of an altercation with a resident on September 17, 2015. (Case No. 17-WC-000060). On June 26, 2019, Petitioner filed an Amended Application for Adjustment of Claim alleging injuries to her right shoulder, right arm, neck, and body as a whole as a result of performing CPR on February 15, 2019. (Case No. 19-WC-010795). The cases were consolidated for the purpose of trial.

The parties stipulate that Petitioner sustained accidental injuries that arose out of and in the course of her employment with Respondent on February 15, 2019. The issues in dispute in Case No. 19-WC-010795 are causal connection, medical bills, temporary total disability benefits or maintenance benefits, vocational rehabilitation, intervening accident, maximum medical improvement date related to the right shoulder only, and the nature and extent of Petitioner's injuries. The parties stipulate that Respondent is entitled to a credit of 2% loss of the body as a whole paid as an advance for permanent partial disability benefits. All other issues have been stipulated. The Arbitrator has simultaneously issued separate Decisions in Case Nos. 17-WC-000055 and 17-WC-000060.

TESTIMONY

Petitioner was 45 years old, single, with four dependent children at the time of accident. She was employed by Respondent as a Security Therapy Aide I. Petitioner testified that on September 11, 2015 she was struggling with an agitated patient to keep him from going to the floor and heard a loud pop in her neck and right shoulder. Petitioner testified she presented to the

convenient care clinic where x-rays were taken, she was prescribed Ibuprofen, ordered to rest, and return to work on her next scheduled workday.

Petitioner returned to work on 9/17/15 and suffered another accident while assisting a nurse that was being attacked by a combative patient while administering medication. Petitioner testified the patient bit at her leg, kicked her several times, and she struck her head on the concrete wall. She sustained injuries to her neck, right shoulder, and leg. Petitioner testified she is not claiming compensation for the injuries to her leg. Petitioner underwent physical therapy that did not improve her symptoms and she was referred to Dr. Wood at the Orthopedic Institute of Southern Illinois. Dr. Wood prescribed additional physical therapy that alleviated some pain. She began treating with Dr. Nathan Mall and underwent two right shoulder surgeries that provided some relief. Petitioner underwent a third right shoulder surgery that provided more lasting relief of her symptoms.

Petitioner testified that after her second accident on 9/17/15 she was involved in an automobile accident. She testified she broke her right forearm and did not sustain injuries to her neck or right shoulder. She did not received treatment from Dr. Mall or Dr. Gornet for injuries related to the automobile accident.

Petitioner underwent a two-level cervical disc replacement by Dr. Gornet on 7/12/17. Prior to her surgery she had burning in her right shoulder that radiated up her right neck causing migraines. Petitioner testified the cervical surgery greatly improved her symptoms. She can hold her head up and her range of motion, headaches, and vertigo have improved. Petitioner returned to work after being released at MMI by Dr. Gornet and Dr. Mall. Petitioner testified Dr. Mall had her on work restrictions. She was examined by Dr. Nogalski pursuant to Section 12 of the Act who opined she could return to work without restrictions. Petitioner testified she attempted to return to work full duty and sustained a third accident.

Petitioner testified that on 2/15/19 she was performing CPR on a mannequin as part of a training class and injured her right shoulder and neck. She stated she was not able to provide the force needed to attain a passing score and performed CPR for 30 to 45 minutes. She testified her right arm was burning and hurting and an hour into the procedure her neck and head felt inflamed. Petitioner testified she feels like she is “back to square one before the surgery”. She can only drive short distances and has decreased range of motion in her neck. Dr. Mall has placed permanent restrictions on Petitioner’s right shoulder. Following her 2/15/19 accident, Petitioner treated with Dr. Mall and Dr. Gornet and was examined by Dr. Robson pursuant to Section 12 of the Act.

Petitioner testified she is currently looking for work and just submitted an application with Menard Correctional Center. She wants to continue employment with the State of Illinois as she has a vested retirement. She has applied for various state positions in surrounding counties, including a child welfare specialist, child support specialist, social service career trainee, office administrator, public aid eligibility assistant, rehab counselor trainee, child protection investigator, telecommunicator trainee, daycare licensing representative, office coordinator, and support service coordinator. Petitioner testified these positions are within her restrictions but she has not been offered employment. Petitioner is working with a vocational rehabilitation specialist

and is now applying for public sector positions. She attempts to find employment every day and has nine newspapers downloaded on her phone. After researching wages, driving distance, and benefits, she spends approximately 10 to 15 hours per week job searching. She is a mother of four children and is humiliated to lose her health insurance and apply for public aid.

Petitioner testified she is not currently treating for her neck or right shoulder. She takes Meloxicam, Zanaflex, and Fioricet. She does not wear a brace or protective devise for her shoulder. Her boyfriend drove her to the hearing site today.

MEDICAL HISTORY

On 9/14/15, Petitioner reported to Quality Healthcare Clinic Convenient Care with right shoulder pain. She reported a history of accident and x-rays were ordered that showed no bony injury. Petitioner was released with instructions to use ice and heat and work as tolerated.

On 9/23/15, Petitioner presented to Harrisburg Medical Center where new x-rays of her right shoulder were obtained and were negative for fracture. Dr. Ewell noted both work assaults along with her complaints of decreased range of motion and right shoulder pain with weakness, which made it difficult for her to dress, open doors, and write. Physical examination was positive for tenderness over the anterolateral border of the acromion and the supraspinatus with limited range of motion secondary to pain, and the assessment was contused right shoulder. Petitioner was given a Toradol injection, prescribed pain medication, taken off work, and instructed to follow-up in one week. On 10/7/15, Petitioner was referred to physical therapy which she underwent through March 2016. Follow-up visits showed some improvement in symptoms with conservative care by way of therapy and medication but remained symptomatic.

On 3/30/16, Petitioner was involved in a motor vehicle accident where she swerved to avoid hitting a farm tractor. She was a restrained driver and the airbags deployed. She presented to Memorial Hospital with complaints of right upper extremity pain. It was noted the majority of the damage to her vehicle was on the passenger side and she did not recall the accident. She denied back pain. Petitioner was diagnosed with a right mildly displaced angulated comminuted facture of the proximal ulnar shaft.

On 6/10/16, it was noted Petitioner's therapy had been interrupted by a motor vehicle accident. Physical examination remained relatively unchanged and the assessment remained strain of the right shoulder. She was referred to Dr. John Wood for orthopedic consultation.

On 7/20/16, Petitioner presented to Dr. Wood at the Orthopedic Institute of Southern Illinois with pain and stiffness in her right shoulder. Dr. Wood noted Petitioner's symptoms began on 9/11/15 following an acute trauma accident at work where she caught a 320-pound patient. Petitioner also reported her second work injury and the subsequent motor vehicle accident resulting in a forearm injury. Dr. Wood noted that an injection and physical therapy only temporarily improved her symptoms and Petitioner has been off work since September 2015. Physical examination revealed painful motion with reduction in range secondary to pain, positive apprehension test, and tenderness over the biceps region. Dr. Wood performed joint injection/aspiration with lidocaine and recommended more physical therapy. He ordered an MRI

and placed Petitioner on modified light duty with no lifting more than 2 pounds with her right arm. The MRI revealed findings consistent with long head biceps tendinopathy through the rotator interval, supraspinatus and infraspinatus tendinopathy, and trace fluid in the subacromial/subdeltoid bursa suggesting bursitis in the absence of full-thickness rotator cuff edema.

On 9/28/16, Dr. Wood noted Petitioner's condition was unchanged. He recommended surgical intervention as Petitioner had received two injections and physical therapy with no significant benefit. Petitioner received another lidocaine injection to ameliorate her symptoms pending surgery approval.

On 12/1/16, Petitioner was examined by Dr. Nathan Mall. He noted Petitioner's symptoms persisted despite conservative care and Dr. Wood recommended a right shoulder arthroscopy. Physical examination showed a markedly positive O'Brien's test with pain to palpation over the AC joint and biceps tendon within the bicipital groove. He believed the MRI was of marginal diagnostic quality and assessed a superior labral tear of the right shoulder, AC joint arthrosis and inflammation, and right biceps tendonitis. He recommended biceps tenodesis to address the superior labral tear along with AC joint resection, subacromial decompression, and evaluation of the rotator cuff.

On 12/8/16, Dr. Mall performed a right shoulder arthroscopy and partial synovectomy, subacromial decompression and acromioplasty, debridement of the superior labrum, distal clavicle excision, and open biceps tenodesis. Objective intraoperative findings included a clear superior labral tear, AC joint inflammation, and an acromial spur. Petitioner reported improvement during her initial post-operative follow-up and was referred for physical therapy which improved her range of motion and strength. However, on 2/15/17, Petitioner reported soreness on the posterolateral and top aspect of her shoulder. Dr. Mall believed Petitioner may have overworked her shoulder in physical therapy and recommended a cortisone injection in the AC joint and subacromial space to overcome inflammation.

On 3/8/17, Petitioner remained symptomatic with posterolateral shoulder pain that travelled into her neck, which notably had been present since the injury. The injection provided a few hours of relief and physical examination remained positive for discomfort over the AC joint, reduced rotator cuff strength, and pain to palpation along the cervical spine with periscapular muscle pain. Dr. Mall recommended MRIs of Petitioner's neck and shoulder to evaluate for inflammation and ensure complete resection of the distal clavicle. Dr. Mall did not suspect AC joint instability. The shoulder MRI demonstrated an intact rotator cuff and some edema at the AC joint with bone contusion of the distal clavicle without separation or tearing. The cervical MRI demonstrated a moderate-sized right disc herniation with a probable annular fissure at C5-6 extending to the right C6 root creating right foraminal narrowing, and a smaller broad-based left herniation at C4-5 extending towards the foramen. Dr. Mall referred Petitioner to Dr. Gornet. Dr. Mall also noted that the narrowing of the posterior aspect of the AC joint represented residual symptomatic impingement which was responsible for some of Petitioner's symptoms. Dr. Mall recommended additional right shoulder surgery.

On 4/19/17, Petitioner was examined by Dr. Gornet who noted she had no problems of significance with regard to her neck or shoulder prior to her accident. Petitioner reported her symptoms were constant and made worse with reaching, pulling, and fixed head positions. Physical examination demonstrated pain in the right trapezius, right shoulder, and upper arm, accompanied by headaches and trace deep tendon reflexes, though she had full range of motion of the cervical spine. Dr. Gornet reviewed the significant findings of herniation at C5-6 and central protrusion at C4-5. He believed these findings were causally connected to her work injury and explained there was often overlap between shoulder and cervical spine symptoms that resulted in manifestation of symptoms in the other area. Dr. Gornet noted Petitioner's continued headaches, despite shoulder surgery, correlated with such a conclusion, in addition to the fact that the MRI findings correlated with Petitioner's complaints. He kept Petitioner under restrictions and referred Petitioner for injections at C4-5 and C5-6.

On 6/15/17, Dr. Mall performed a right AC joint open resection, during which an additional section of the distal clavicle was resected to create additional space in the posterior aspect of the AC joint. Petitioner reported improvement post-operatively and she was referred to physical therapy. On 7/6/17, Petitioner followed up with Dr. Gornet and he noted no sustained relief from the injections. Dr. Gornet recommended a CT myelogram followed by surgery and prescribed pain medication. The myelogram confirmed symptomatic disc injuries at C4-5 and C5-6 and on 7/12/17 Dr. Gornet performed a disc replacement at both levels. Intraoperative findings revealed foraminal stenosis and right-sided herniation at C5-6 and a right-sided foraminal herniation at C4-5 that was much larger than that seen on MRI and was consistent with part of Petitioner's shoulder pain.

On 7/27/17, Petitioner returned to Dr. Mall and reported improvement following her cervical spine surgery. Good range of motion was noted in her shoulder, but she reported additional right shoulder soreness. Dr. Mall recommended physical therapy.

On 8/3/17, Petitioner reported resolution of her headaches and improvement in her shoulder and arm symptoms to Dr. Gornet, with persistent burning in her upper shoulder. Dr. Gornet believed her symptoms were consistent with the decompression and prescribed additional pain medication. On 10/6/17, Dr. Mall administered an AC joint injection due to persistent pain. On 10/19/17, Petitioner reported growing discomfort in her neck as she participated in physical therapy. Dr. Gornet reviewed Dr. Robson's Section 12 report dated 7/19/17 wherein he noted the objective MRI findings and opined there was a causal relationship between the findings and Petitioner's accidents. Dr. Robson believed Petitioner's care and treatment, particularly the cervical disc replacements, was reasonable and necessary and that Petitioner required further care to reach maximum medical improvement. Dr. Gornet prescribed additional medication and recommended Petitioner complete therapy.

On 11/10/17, Dr. Mall noted the injection did not resolve the discomfort over Petitioner's AC joint. Physical examination remained positive for point tenderness over the AC joint with residual instability present on anterior-posterior testing and weakness with rotator cuff testing manifesting as 4+/5 strength in the supraspinatus. X-rays showed formation of a calcium deposit within the AC joint possibly related to scar tissue with mild superior migration of the clavicle with respect to the coracoid. Dr. Mall recommended physical therapy and an MRI that revealed

insertional cuff tendinitis and shallow subinsertional enthesopathic changes beneath the subscapularis and infraspinatus insertions. Dr. Mall recommended a right shoulder open AC joint exploration with an internal brace of the AC joint, exploration for bony abutment that could be causing inflammation, and excision of any scar tissue. Dr. Mall believed the AC joint capsule did not heal following the resection which would cause Petitioner's symptoms. He believed this produced an anterior-posterior joint instability within the AC joint. The coracoclavicular ligaments appeared to be intact so he did not recommend a coracoclavicular ligament reconstruction.

Dr. Mall performed the third surgery on 12/28/17. He noted intraoperatively the superior AC joint ligamentous structures did not heal very well from the prior surgery. He also noted there was minimal tissue present in terms of structural tissue to provide stability to the AC joint, and the distal clavicle was notably unstable with over a centimeter of anterior to posterior translation. Dr. Mall performed an AC joint ligament repair using internal brace technique, which stabilized the clavicle and restored anterior to posterior stability to the distal clavicle and acromion. On 1/11/18, Dr. Mall noted Petitioner was doing well and referred her for physical therapy.

On 1/29/18, Petitioner returned to Dr. Gornet and reported that although she was doing well, she experienced increased tenderness in her neck and a return of her headaches approximately two months prior. Dr. Gornet advised that some of the issues in her shoulder may make her neck on guard, and since no problems manifested on current films, he assured her that no restrictions were required for her neck. Follow-up visits with Dr. Mall show that although her right shoulder AC joint was stable, she continued to have some symptoms for which he recommended continued therapy.

On 4/20/18, Dr. Mall noted Petitioner continued to have headaches and pain in her shoulder. Dr. Mall noted Dr. Gornet did not believe her symptoms were coming from her neck. Dr. Mall continued to recommend therapy and ordered scar cream to assist with pain and inflammation over her AC joint. Petitioner returned the following month with complaints of continued right shoulder pain with numbness and tingling down to her right hand. Examination showed no pain over the biceps tendon and the AC joint was stable; however, Petitioner remained tender to palpation over the AC joint along the incision. Dr. Mall recommended a functional capacity evaluation as he believed the combination of Petitioner's right shoulder and neck injuries may require permanent restrictions. Based on the FCE results, Dr. Mall placed Petitioner at maximum medical improvement with permanent restrictions of no lifting greater than 10 pounds overhead, no lifting greater than 20 pounds from floor to waist or waist level, and no lifting greater than 15 pounds from waist to chest.

On 7/16/18, Dr. Gornet noted Petitioner was doing well with respect to her cervical spine, but she continued to have aches and pains, which he attributed to her right shoulder, and noted Petitioner was under permanent restrictions placed by Dr. Mall. He ordered a CT scan that showed good positioning of the devices with excellent motion and he placed Petitioner at maximum medical improvement.

On 12/5/18, Petitioner was examined by Dr. Michael Nogalski pursuant to Section 12 of the Act. Dr. Nogalski noted Petitioner appeared to be generally deconditioned with complaints of pain in her neck and trapezial area on extension. He noted generalized tenderness over the anterior glenohumeral joint and AC joint resection region and diffuse pain over the anterior and posterior shoulder with crossover maneuver. His impression was status post right shoulder arthroscopy, debridement, and biceps tenodesis with subsequent revision open distal clavicle resection and AC joint stabilization; and status post cervical disc replacements at C4-5 and C5-6. Dr. Nogalski stated Petitioner was somewhat evasive and nonspecific in her history and characterized her description of events as being somewhat rambling. He strongly believed Petitioner sustained a strain to her shoulder which precipitated adhesive capsulitis. However, he believed the strain improved with physical therapy until Petitioner's motor vehicle accident in March 2016 where she sustained injuries to her forearm. He opined Petitioner's current objective findings were not causally related to her work injuries. He believed these were the direct result of the three subsequent operations in her right shoulder that were without clinical benefit. Dr. Nogalski opined Petitioner's treatment through 3/30/16 was causally related to her work accidents, but not subsequent care and treatment provided by either Dr. Mall or Dr. Gornet.

On 2/17/19, Petitioner presented to Memorial Hospital and reported right shoulder pain that had an onset of two days ago when she performed CPR at work. Abduction of her right arm caused severe pain. X-rays of her right shoulder revealed post-surgical and mild degenerative changes. She was released and ordered to follow up with her physician.

On 2/20/19, Petitioner returned to Dr. Mall and reported her accident of 2/15/19. Physical examination revealed pain to palpation over the AC joint and subacromial space, pain with rotator cuff testing, weakness in the supraspinatus distribution, and significant inflammation around the shoulder. Dr. Mall administered a cortisone injection which failed to provide substantial relief. Petitioner returned to Dr. Mall the following month with continued complaints and manifest pain to palpation over the AC joint and pain and weakness with rotator cuff testing. He recommended an MRI that revealed mild infraspinatus insertional tendinopathy without tearing, evidence of Petitioner's prior surgery, and no discrete labral tearing. Dr. Mall noted the MRI showed no specific pathology that would require additional care or surgical treatment. He believed Petitioner's existing permanent restrictions were sufficient to address her current shoulder condition, placed Petitioner at maximum medical improvement, and advised her to follow up with Dr. Gornet to examine her cervical spine.

Dr. Gornet examined Petitioner on 6/17/19 and noted Petitioner's new injury as result of CPR training. He noted Petitioner had been in class for over an hour and had to repeat chest compressions approximately four times as they were not registering which produced increased burning pain in Petitioner's right shoulder and neck. Petitioner presented with pain localized in her neck into both trapezii, right greater than left, with tingling into her right arm and middle finger. Dr. Gornet found the mechanism of injury could aggravate an underlying condition or produce new injury and ordered an MRI with a plain CT of her neck. Dr. Gornet linked Petitioner's current complaints in their level of severity and her need for evaluation and treatment to her recent work injury on 2/15/19.

The CT scan showed no significant facet arthropathy on the right or evidence of lucency or major heterotopic issues, though a touch of foraminal narrowing at C5-6 on the right side was noted. On 7/15/19, Dr. Gornet recommended physical therapy and potentially an injection if Petitioner remained symptomatic. He stated Petitioner could continue to work full duty from the standpoint of her cervical spine. Petitioner returned in September 2019 and reported continued symptoms of neck and shoulder pain with headaches. Dr. Gornet suggested Petitioner may have suffered small disc protrusions at C3-4 and C6-7 but these were obscured by artifact on the scans. Dr. Gornet recommended another injection at C5-6 which did not provide significant relief. Though there were small protrusions that may have represented new disc injuries at C3-4 and C6-7, Dr. Gornet recommended against further treatment as he did not believe surgery would alleviate Petitioner's symptoms. Dr. Gornet placed Petitioner at maximum medical improvement.

Petitioner returned to Dr. Gornet twice following release for routine follow-ups and continued to report symptoms. On 4/27/20, Dr. Gornet noted Petitioner continued to have increased symptoms in her neck following the training episode on 2/15/19 but he did not believe she required restrictions for her neck, particularly given the permanent restrictions placed by Dr. Mall. On 7/13/20, Dr. Gornet noted Petitioner was doing well for the most part with continued headaches.

Dr. Michael Nogalski testified by way of evidence deposition on 7/22/19. Dr. Nogalski testified that approximately 40% of his practice is composed of treatment of the shoulder and 5% is composed of medical-legal work. He testified consistently with the findings and opinions contained in his report. He noted Petitioner reported experiencing "the loudest pop" in her right shoulder while restraining the aggressive patient during her first accident, and that she "hit the wall hard" during the second accident, which resulted in the development of severe pain and inability to breathe. Dr. Nogalski testified his review of the MRI films did not demonstrate evidence of a labral tear. He found it significant that Petitioner allegedly did not report the motor vehicle accident that occurred on 3/30/16. He noted that Petitioner sustained a right forearm fracture for which she underwent outpatient open reduction and subluxation and denied any injury to her shoulder as a result of the accident. He believed that Petitioner's motor vehicle accident involving her forearm aggravated Petitioner's right shoulder condition from which she recovered prior to the collision.

Dr. Nogalski disagreed with the permanent restrictions imposed by Dr. Mall. He testified that Petitioner's full duty release for her cervical spine indicated her neck did not influence her shoulder, and he felt that Petitioner's right shoulder physical examination exhibited sufficient functional capacity to allow her to reasonably perform her work activities.

On cross-examination, Dr. Nogalski acknowledged that Dr. Robson found a causal connection between Petitioner's work accidents and her current condition of ill-being in her cervical spine. Though he was asked to evaluate Petitioner's right shoulder, he espoused his opinion that Petitioner's cervical spine condition was also unrelated to her work accidents. He admitted, however, that he does not operate on cervical spine injuries and he refers surgical patients to Dr. Robson for care and treatment. Dr. Nogalski admitted that Petitioner contemporaneously voiced complaints in her shoulder immediately following both accidents. He admitted he did not have Petitioner's treatment records from her motor vehicle accident and did

not request same after learning of her accident. He admitted he did not know if any shoulder complaints were documented following Petitioner's motor vehicle accident.

Dr. Nathan Mall testified by way of evidence deposition on 4/29/19. Dr. Mall testified that shoulder treatment and sports medicine is a subspecialty of his practice, which was the focus of his fellowship after his residency training. Approximately 60% of the surgeries he performs are for shoulder injuries. He also performs approximately one to two independent medical evaluations per week. Dr. Mall testified that in addition to his medical records, he reviewed Dr. Nogalski's independent medical evaluation and the records from Memorial Hospital which document the treatment from Petitioner's motor vehicle accident. He summarized the history of Petitioner's accidents and the medical history of her care and treatment as outlined in his records. He testified that Petitioner's MRI did demonstrate a superior labral tear, along with fluid around the biceps tendon and inflammation at the AC joint. He testified that these findings were consistent with Petitioner's symptoms and mechanism of injury of reaching out to grab a patient. She sustained a traction-type injury to her shoulder which is a classic mechanism for a superior labral tear. He testified that an altercation could certainly produce some trauma to the AC joint. He explained that the biceps tendon is essentially attached to the superior labrum, so anything that causes trauma to the superior labrum would also cause trauma to the biceps tendon. Dr. Mall opined that both of Petitioner's work accidents suffered in September 2015 were a causative or contributory factor in her right shoulder condition.

Dr. Mall testified that the intraoperative findings during Petitioner's first surgery on 12/8/16 confirmed his diagnosis. Though he addressed the objective interoperative findings, Petitioner continued to have significant symptoms for which he referred her for evaluation of her cervical spine. Though she was treated by a spine specialist, she continued to have trouble referable to her right shoulder. He ordered an MRI which showed impingement in the posterior region of the AC joint, which correlated with Petitioner's difficulty reaching behind her back. Because Petitioner's complaints did not resolve with conservative care including injection, she required a second surgery, during which the operative findings again confirmed the MRI findings and his diagnosis. With regard to the etiology of the complaints Petitioner is experiencing, Dr. Mall testified he did not feel the complaints were from Petitioner's cervical spine because the AC joint is typically pretty specific in that you push on that spot and it hurts.

Dr. Mall testified that Petitioner continued to have specific right shoulder symptoms after the second surgery, and reasonably so, because AC joint resection carries the risk of destabilization. He testified that the coracoclavicular ligaments come in and attach at a certain distance from the AC joint along the collarbone. A resection can render AC joint instability because you are cutting through the superior AC joint capsule. Dr. Mall explained that resecting a centimeter in one patient could produce a different result than the same resection in another patient. When he examined Petitioner's right shoulder AC joint it felt looser than the other side which led him to perform the third surgical procedure, AC joint stabilization, on 2/28/17. He noted that the inflammation visualized was likely brought about by some of the instability in the joint that came from the trauma, which was not a rare phenomenon. Dr. Mall testified that Petitioner's symptoms had been very consistent throughout her care and treatment with both him and Dr. Gornet, and he again related Petitioner's shoulder care and treatment to her work injuries in September 2015.

Dr. Mall testified that Petitioner's continued complaints in tandem with the injuries suffered to her shoulder and neck necessitated a functional capacity evaluation. He opined that the need for permanent restrictions is attributed to the September 2015 work accidents.

With regard to Petitioner's accident on 2/15/19, Dr. Mall testified it was not surprising Petitioner had an increase in symptoms while pushing hard on the CPR dummy to "get a green light," which was a sensor that indicated whether she was pushing hard enough to pump blood and perform successful CPR. He noted there was also some rotator cuff weakness, which was previously nonexistent, suggestive of a rotator cuff strain in addition to the ongoing problems in her AC joint. Since Petitioner's condition was obviously inflamed, he recommended imaging studies, a cortisone shots to calm the inflammation, physical therapy, and evaluation by Dr. Gornet. Dr. Mall testified that Petitioner had worsening of her symptoms, including radiculopathy, following the February 2019 accident that caused her to seek treatment. However, he stated that previously placed restrictions were adequate to address her condition and placed Petitioner at maximum medical improvement.

Dr. Mall testified he disagreed with Dr. Nogalski's opinion the medical records were conflicting as to whether Petitioner suffered a right shoulder injury or neck injury. Dr. Mall testified it is possible to suffer injuries to both and the symptoms from both make it difficult to determine the source of the complaints. He testified that a cervical spine injury does not produce a positive O'Brien's test, point pain with compression over the AC joint, or pain with compression of the biceps tendon. Although there was certainly some overlap, because the C4 and C5 nerve roots stop at the shoulder and C3 can go down into the shoulder blade area and trapezius, Petitioner clearly had a persistent shoulder problem.

Dr. Mall stated that over the 26 times he evaluated Petitioner, she was pleasant and at no point evasive or nonspecific. He testified that Dr. Nogalski's diagnosis of strain causing adhesive capsulitis from which Petitioner had reached maximum medical improvement in March 2016 was not consistent with the objective medical evidence showing Petitioner suffered a superior labral tear following a capable mechanism of injury. He also disagreed with Dr. Nogalski's opinion that Petitioner was capable of returning to full-duty work, as he just tried that and it did not work so well for her.

On cross-examination, Dr. Mall testified he possessed and reviewed records from Chester Hospital, the Orthopedic Institute of Southern Illinois, and Apex physical therapy. Dr. Mall testified that Petitioner fractured her right forearm in the March 2016 automobile accident which required immobilization for a period of time. It was not surprising her arm would we weaker and affect her physical therapy for her shoulder. He testified he did not believe the automobile accident made Petitioner's shoulder condition worse based on Petitioner's statement she did not have any worsening shoulder complaints following the accident, and the treatment records from the collision did not demonstrate a shoulder problem or complaints.

Dr. Mall testified he placed permanent restrictions on Petitioner in part due to her reports of pain, which he acknowledged was subjective, and based on recommendations of the physical

therapist performing the evaluation, who took body mechanics into consideration to prevent further or future injury.

Petitioner's vocational rehabilitation specialist, Mr. Timothy Kaver, testified by way of deposition on 12/29/20. Mr. Kaver has been performing vocational rehabilitation counseling since 1985, after he earned his master's degree in sociology with an emphasis on occupations and professions. He testified that his practice involves providing on-the-job or off-site training, job placement, and job search assistance. His practice includes referrals from the U.S. Department of Labor to return injured federal employees to the work force and providing his opinion in cases for plaintiffs and insurance companies.

Mr. Kaver testified that Petitioner's physical restrictions limited her to sedentary work, and her educational background rested in sociology, with an associate's degree in human services and a bachelor's of science degree in rehabilitation. He noted Petitioner's job duties included overseeing movement of patients, keeping accurate count reports, performing housekeeping duties from mopping to trash and laundry, processing new facility admissions, assisting with activities of daily living, providing educational support, and engaging in physical interventions with restraints, for which she annually earned $44,000. Mr. Kaver testified that handling physical altercations fell within the heavy strength level category.

Mr. Kaver testified he explored several career alternatives that Petitioner could safely use her skills within her restrictions, but she required additional computer skills. He testified that Petitioner practiced her keyboarding at home and completed additional training in PowerPoint9 through a class but was unable to attend the Excel training because she did not have funds for gas. Though he attempted to secure funding the help her take the course online, it had not yet been allocated for her at the time of the deposition.

Mr. Kaver testified that he first attempted to help Petitioner obtain employment through the State's alternative employment program (AEP), which allows injured workers to be placed in new positions within the employ of the State for which they are qualified within their physical limitations. He stated that Petitioner embarked on the arduous qualification process and completed all of the requisite paperwork, including providing physician documentation and signatures. Petitioner bid on 22 different positions with the State of Illinois and had some interviews but was not offered employment. Mr. Kaver testified the litigation dispute and COVID-19 made the process more difficult. He explained that the AEP program caused a problem in that on three different dates the State of Illinois told Petitioner to report back to work, which causes the AEP program that you are trying to become certified to cease and you have to start all over again. The first time Petitioner returned to work she became reinjured performing CPR training. The other two times Petitioner returned to work she was told by Respondent they had no work within her physical restrictions. During COVID, Petitioner's AEP paperwork was lost when the state employees did not have access to their offices for five months. Attempts to locate her paperwork were unsuccessful and she had to start all over again. She completed the AEP paperwork for the fourth time as of August 2020 and is awaiting a response.

Mr. Kaver testified that Petitioner is also qualified to staff a variety of sedentary-level professional and paraprofessional occupations outside of the State's employ based on her

transferrable skills and her degree in social service. He agreed that Petitioner's starting salary range would be higher if she could find employment with the State. Her current salary of $44,000 per year would be reduced to $27,000 to $32,000 per year starting in a private sector position, as she would most likely end up working for a not-for-profit agency. He testified that some of the roles Petitioner could serve included social human service worker, customer service representative, intake reviewer, and other general office positions that will allow her to sit or stand alternatively. He cautioned, however, the pandemic makes it more difficult for Petitioner to find a job in the field in which she was job seeking. Mr. Kaver testified that the reports he generated were kept in the normal, everyday course of business and were customary in his line of work. He further testified that his charges were reasonable and customary for the services that he rendered in the community.

CONCLUSIONS OF LAW

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

Illinois law holds that "[e]very natural consequence that flows from an injury that arose out of and in the course of the claimant's employment unless caused by an independent intervening accident that breaks the chain of causation between a work-related injury and an ensuing disability or injury" is compensable. *Vogel v. Indus. Comm'n*, 354 Ill. App. 3d 780, 786, 821 N.E.2d 807, 812 (2d Dist. 2005); *Nat'l Freight Indus. v. Illinois Workers' Comp. Comm'n*, 993 N.E.2d 473, 481, 2013 IL App (5th) 120043WC, ¶ 26. Courts have consistently held that for an employer to be relieved of liability by virtue of an intervening cause, the intervening cause must completely break the causal chain between the original work-related injury and the ensuing condition; as the Court *in Lasley Const. Co.*, aptly stated: "The fact that other incidents, whether work related or not, may have aggravated claimant's condition is irrelevant." *Lasley Const. Co., Inc. v. Indus. Comm'n*, 274 Ill.App.3d 890, 893, 655 N.E.2d 5, 8, (5th Dist. 1995). See also *Vogel v. Indus. Comm'n*, 354 Ill. App. 3d 780, 786, 821 N.E.2d 807, 812, (2d Dist. 2005).

In determining what is sufficient to cause a complete break in the chain of causality, the Arbitrator finds the Appellate Court's direction in *Vogel* probative. In *Vogel v. Indus. Comm'n*, the Appellate Court stated: "This court has recognized repeatedly that, when a claimant's condition is weakened by a work-related accident, a subsequent accident that aggravates the condition does not break the causal chain." *Vogel v. Indus. Comm'n*, 354 Ill. App. 3d 780, 787, 821 N.E.2d 807, 813, 290 Ill.Dec. 495, 501 (2d Dist. 2005). In *Vogel*, the Court highlighted precedent such as *Teska v. Industrial Comm'n*, 266 Ill.App.3d 740, 742, 203 Ill.Dec. 574, 640 N.E.2d 1 (1st Dist. 1994) and *International Harvester Co. v. Industrial Comm'n*, 46 Ill.2d 238, 245, 263 N.E.2d 49, 53 (Ill. 1970). Additionally, where the second injury occurs due to treatment for the first, there is likewise no break in the causal chain. *International Harvester supra.* In *Teska*, the claimant injured his back in a workplace accident and underwent surgery on his spine. *Teska v. Indus. Comm'n,* 266 Ill.App.3d 740, 640 N.E.2d 1 (1994). After the surgery, his condition improved but he still continued to experience numbness and pain in his neck, shoulder, and left arm. While bowling, he experienced a sharp pain in his neck that radiated into his left arm. He subsequently underwent a second surgery. The Commission denied the claimant benefits for the second surgery, finding that his condition of ill-being was the result of an intervening accident (bowling). On appeal, the *Teska* court reversed the Commission's decision as being

contrary to the manifest weight of the evidence. *Id.* N.E.2d at 2. The court noted that "[e]very natural consequence that flows from the injury which arose out of and in the course of the claimant's employment is compensable under the Act, unless caused by an independent intervening accident." *Id.* N.E.2d at 3. In overturning the Commission's decision, the court noted that the claimant's condition "would not have progressed to the point it did but for his original work-related accident." The court stated: "Merely because claimant experienced an upsurge of neck pains while bowling * * * does not mean the causal connection was broken." *Id.* N.E.2d at 4.

In *International Harvester*, the Court determined that the claimant, who suffered from a continuing condition of traumatic neurosis that resulted from his work accident where he was struck on the head by a tractor, was entitled to workers' compensation benefits four years later when claimant was struck by his wife. *International Harvester Co. v. Indus. Comm'n*, 263 N.E.2d 49 (Ill. 1970). In awarding benefits, the Supreme Court found that the reason the claimant's condition existed was the work injury, and that as a natural consequence, his work injury continued and was a causative factor in total and permanent disability following the injury he sustained from his wife. *Id.*

Respondent denies that Petitioner's condition of ill-being is causally connected to her work-related accident as of the date of her automobile accident that occurred on March 30, 2016. The Arbitrator finds that Petitioner's automobile accident was not an independent intervening accident that broke the chain of causation and holds Petitioner's current condition of ill-being in her right shoulder remains causally connected to her accidental work injuries in September 2015.

In so holding, the Arbitrator finds the opinion of Dr. Mall more credible than that of Dr. Nogalski. The Arbitrator finds it highly significant that Respondent did not obtain and provide Dr. Nogalski with the treatment records from the motor vehicle accident for his review, and he admitted he was unaware if said records made any reference to Petitioner's right shoulder. The Arbitrator also notes that Dr. Nogalski did not acknowledged the presence of a labral tear, which was confirmed by the objective intraoperative findings.

In contrast, Dr. Mall had the benefit of reviewing the records documenting Petitioner's treatment following the automobile accident. The records admitted into evidence show Petitioner complained of right upper extremity pain with movement. However, Petitioner was diagnosed with a fractured forearm and no right shoulder complaints or injuries were noted. X-rays of Petitioner's right humerus, including a portion of the shoulder, revealed no fractures. Petitioner did not treat with her surgeons, Dr. Mall and Dr. Gornet, for any injuries resulting from the automobile accident. Dr. Mall credibly explained why he believed Petitioner's motor vehicle collision did not injure her right shoulder. The Arbitrator finds it significant that the absence of any right shoulder pain corroborates Petitioner's testimony that she did not suffer any injury to her shoulder in the collision. In addition, the work injury records reflect that Petitioner's physical examination remained relatively unchanged and the assessment remained the same following the collision.

As such, the medical records and testimony do not support a finding that Petitioner suffered an intervening accident, as there was no complete break in the chain of causal

connection. Dr. Mall and Dr. Gornet testified credibly that Petitioner's diagnosis and symptoms are causally connected to her work accidents that occurred on 9/11/15 and 9/17/15. The subject accident that occurred on 2/15/19 caused an aggravation of Petitioner's cervical and right shoulder conditions for which she underwent limited treatment and returned to baseline. Dr. Gornet did not place Petitioner of work or restrict her work duties at any time following the 2/15/19 incident. Dr. Mall's pre-accident permanent restrictions remained the same and he released her at maximum medical improvement three months following the 2/15/19 incident.

Therefore, the Arbitrator finds that Petitioner's current conditions of ill-being with respect to her cervical spine and right shoulder are causally connected to her injuries that occurred on 9/11/15 and 9/17/15 and are not causally connected to the accident that occurred on 2/15/19.

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

Based on the Arbitrator's finding that Petitioner's current condition of ill-being is not causally related to her subsequent accident that occurred on 2/15/19 but remains related to her accidents on 9/11/15 and 9/17/15, and the Arbitrator having awarded Petitioner medical expenses, maintenance benefits, and permanent partial disability benefits in Case No. 17-WC-000055, the Arbitrator does not award further benefits herein.

Issue (K): What temporary benefits are in dispute?

Based on the Arbitrator's finding that Petitioner's current condition of ill-being is not causally related to her subsequent accident that occurred on 2/15/19 but remains related to her accidents on 9/11/15 and 9/17/15, and the Arbitrator having awarded Petitioner medical expenses, maintenance benefits, and permanent partial disability benefits in Case No. 17-WC-000055, the Arbitrator does not award further benefits herein.

Issue (L): What is the nature and extent of the injury?

Based on the Arbitrator's finding that Petitioner's current condition of ill-being is not causally related to her subsequent accident that occurred on 2/15/19 but remains related to her accidents on 9/11/15 and 9/17/15, and the Arbitrator having awarded Petitioner medical expenses, maintenance benefits, and permanent partial disability benefits in Case No. 17-WC-000055, the Arbitrator does not award further benefits herein.

Issue (O): Other: Maximum Medical Improvement date with respect to Petitioner's right shoulder?

Based upon the above evidence, the Arbitrator finds Petitioner reached maximum medical improvement with respect to her right shoulder on 7/13/18 when Dr. Mall released her with permanent restrictions. Although Petitioner sustained an aggravation of her right shoulder condition on 2/15/19 that required additional diagnostic tests, an injection, and physical therapy,

Dr. Mall testified the previously placed restrictions were adequate to address her condition and did not recommend further treatment after 5/14/19.

Arbitrator Linda J. Cantrell DATED: