STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

NICHOLAS OLIZ,

Petitioner,

No. 15 WC 30841
20IWCC0287

GWEN HUNT D/B/A PK'S,

Respondent.

ORDER

This matter comes before the Commission on Petitioner's Petition to Correct Clerical Error pursuant to Section 19(f) of the Act. The Commission having been fully advised in the premises finds the following:

The Commission finds that said Decision should be recalled for the correction of a clerical/computational error.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Commission Decision dated May 18, 2020, is hereby recalled pursuant to Section 19(f) of the Act. Respondent does not object to Petitioner's Petition. The parties should return their original decisions to Commissioner K. Doerries.

IT IS FURTHER ORDERED BY THE COMMISSION that a Corrected Decision shall be issued simultaneously with this Order.

Kathryn A. Doerries

DATED: JUN 4 - 2020
o- 3/10/20
KAD/jsf

Kathryn A. Doerries

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

NICHOLAS OLIZ,

Petitioner,

vs.

NO: 15 WC 30841
20 IWCC 0287

GWEN HUNT D/B/A PK's,

Respondent.

CORRECTED DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, wage rate/benefit rates, temporary total disability, 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.

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

- Petitioner was a 48-year-old employee of Respondent, for about six years. He described his job as a bartender in Carbondale, Illinois. Breaking up disputes at Respondent's facility was part of Petitioner's responsibilities as a bartender. Petitioner reported that he was paid $8.25 per hour, plus tips, and he worked 15 to 40 hours per week.

- Respondent presented a wage statement for the year prior to the accident reflecting wages paid of $11,451.07, (RX 2). Petitioner offered tax returns 2012 and 2013, wherein, he did not report any tips and did not pay taxes regarding tips received, (PX 2). Petitioner also presented calendar's documenting his tips for those years, (PX 3). Petitioner testified that shortly before the hearing, he had filed amended returns for those years to reflect the tips, but had not yet paid the taxes in that regard.

- Petitioner had an undisputed accident in the early hours of April 30, 2013 when he

intervened in an altercation and injured his left shoulder. Petitioner subsequently underwent treatment with Dr. Golz, an orthopedic, and Dr. Thalman, a chiropractor. Petitioner underwent MRI's on June 4, 2013 and June 24, 2013 with impressions of subacromial impingement and tendinosis. There were no tears noted; there was thinning of the tendon with mild bursal surface fraying. Petitioner was diagnosed with left shoulder pain/strain, and adhesive capsulitis. Dr. Golz, and Respondent's Section 12 examiner, Dr. Paletta agree with the radiologist interpretation that there were no rotator cuff tears on either of those MRI's.

- Petitioner saw Dr. Paletta for a Section 12 examination for Respondent on September 23, 2013 and he opined in his November 1, 2013 correspondence that Petitioner should continue the physical therapy and he recommended an injection to the glenohumeral joint and a Medrol dose pack and NSAIDS. Therapy was emphasized on restoring range of motion of the shoulder, rotator cuff and periscapular strengthening per impingement protocol. He further opined Petitioner would reach maximum medical improvement in 6-12 weeks if there was a positive response to the injection and post injection therapy. He then did not believe there was indication for ongoing or implementation of manipulative chiropractic care. (RX 1).

- Petitioner had treatment with Dr. Thalman between April 30, 2013 and February 19, 2014, for chiropractic manipulative therapy of about 88 visits. (PX 4).

- Petitioner had 12 therapy visits at NovaCare Rehabilitation between January 8, 2014 and March 19, 2014 for diagnosis of shoulder joint pain, joint stiffness, and lack of coordination and was discharged due to no approval for continued therapy. When discharged, they noted Petitioner was progressing with shoulder range of motion and advancing with scapular stabilization program. (PX 6).

- Petitioner continued to treat with Dr. Golz who administered a subacromial injection July 13, 2013 and the October 30, 2013 visit noted it had provided significant improvement. At that time ROM was better and strength and pain levels were about the same. Overhead activities were an issue and he complained of aching discomfort. Petitioner continued to work full duty with modifications, which was still uncomfortable. Dr. Golz did not think there was any significant adhesive capsulitis but still believed the biggest problem was rotator cuff tendinitis. X-rays then indicated some early AC arthritis, some slight narrowing of the acromiohumeral distance and subclavical spurring, but no significant glenohumeral arthrosis. Continued therapy and a Medrol dose pack was prescribed along with pain medication and home exercises. (PX 5).

- Dr. Golz noted December 11, 2013 that the injection had significantly helped with motion. He then believed the rotator cuff tendinitis was improving slowly with conservative care. Therapy and home exercise were continued. The Medrol was not refilled. The restrictions were continued.

- Dr. Golz saw Petitioner March 5, 2014. At that time no further therapy had been approved

and Petitioner was doing home exercises and working full duty. Home exercise was again emphasized as well as protective mechanics. Petitioner was taking over-the-counter anti-inflammatory medication and Petitioner requested another injection. Dr. Golz believed another injection was reasonable to decrease inflammation to allow better exercise and help the symptoms. Further therapy was prescribed. Employment status was not then addressed.

- On May 14, 2014, Dr. Golz noted Petitioner was working full duty and had graduated from therapy and Petitioner continued advance to home exercises. Petitioner then reported was 90% better then prior to treatment especially with ROM, though he felt strength was diminished and with occasional pain. The doctor noted near full AROM of the shoulder being more fluid with good abduction strength. He noted some patient complaints of mild tenderness over the anterolateral aspect of the shoulder but there was no significant crepitus or AC joint signs, no instability, no labral signs and the long head of the biceps appeared intact. Dr. Golz assessed that presentation was most compatible with biceps tendinitis. He planned another ultra-sound guided injection to the bicipital groove and encouraged Petitioner to be more diligent with use of Naprosyn and home exercises and continue protective mechanics. No medications were prescribed.

- The ultrasound guided injection on September 8, 2014 was to address the left shoulder pain. At the time of the injection, the ultrasound impression noted no evidence of a full-thickness tear of the bicipital tendon; a small linear tear was noted. Therapy was continued after the injection. (PX 5).

- Dr. Golz saw Petitioner October 15, 2014. He noted the small linear tear found on ultrasound and noted that the injection provided complete and lasting relief of the anterior pain. He also noted Petitioner had recently moved furniture. He discontinued use of the Naprosyn. Petitioner had noted that moving furniture and weather changes had aggravated the shoulder pain. Pain was then noted more localized laterally, per Petitioner the pain now in the 'other tendon'. Petitioner felt his shoulder was cocked forward. The doctor noted ROM still restricted slightly and overhead motion was slow and uncomfortable. Dr. Golz noted good abduction strength and negative supraspinatus test and long head of biceps was non-tender. Dr. Golz had explained the natural course of rotator cuff tendinitis. It was then too soon for another injection. He thought there may be benefit to steroids due to inflammatory exacerbation of the symptoms and Petitioner was again placed on Naprosyn. Employment status was not addressed.

- Dr. Golz's notes of December 31, 2014 noted a telephone call from Petitioner noting that the steroid injection had helped but he was then having increased pain and difficulty performing his job and Petitioner requested a high definition MRI. (PX 5).

- Dr. Golz saw Petitioner January 7, 2015 and Petitioner indicated the steroid dose pack helped while he was on it and he had been doubling up on the Naprosyn due to ongoing soreness and shoulder stiffness. Petitioner felt his condition was then worse with daily complaints and losing ROM and strength. Dr. Golz noted some loss of motion and abduction strength loss and tenderness anterolateral. The long head of the biceps was okay and there were no AC joint signs and no instability. Dr. Golz noted Petitioner slow and

guarded and uncomfortable motion into and from overhead. He then recommended an MRI to access labral pathology and recommended continued home exercises and protective mechanics. Employment status was not discussed.

- Petitioner had the left shoulder MRI January 21, 2015 for left shoulder pain, possible rotator cuff tear. The impression was a full thickness supraspinatus tendon tear, tendinopathy versus partial tear involving the infraspinatus tendon; superior labral tear; questionable mild thickening along the inferior glenohumeral ligament, possibly due to previous injury; component of adhesive capsulitis not excluded. (PX 7).

- Dr. Golz saw Petitioner February 18, 2015 and Petitioner indicated the shoulder was getting worse and he had persistent, achy discomfort and his arm was weak. Petitioner noted trouble lifting and trouble working overhead, and he had loss of range of motion and nocturnal complaints; he could not lie on his left shoulder. He was working with modifications. Dr. Golz noted overhead motion was guarded and slow and less range of motion and abduction weakness and positive supraspinatus weakness. The long head biceps appeared to be intact and there were no AC signs. An MR arthrogram of January 21, 2015 noted a full thickness tear of the rotator cuff with no retraction and no atrophy and the long head of the biceps appeared intact; some signal changes along the superior labrum. Dr. Golz then recommended a left shoulder arthroscopy due to Petitioner's failure to respond to conservative care and persistent functional limitation. Work status was not addressed.

- Petitioner underwent 19 sessions of physical therapy at the Orthopedic Institute of Southern Illinois between March 24, 2014 and February 24, 2015. The discharge summary noted Petitioner had reached maximal level and also noted anterior/lateral pain which was worse because he had to move furniture. (PX 5).

- Petitioner decided on having the surgery in the phone call of March 19, 2015. Surgery was ultimately denied by workers' compensation insurance April 7, 2015.

- Dr. Golz saw Petitioner April 12, 2015 and noted the shoulder becoming progressively worse and more bothersome with functional limitation. He was taking non-steroidal medication with some relief and he continued the home exercises. On exam, Dr. Golz noted limited ROM and overhead motion guarded and slow. Abduction strength was found weak and Petitioner with a positive supraspinatus test but no instability and no AC joint signs and the biceps was intact. Petitioner was to continue conservative care. Dr. Golz there noted the initial MRI showed some rotator cuff tendinitis and the 'second' MRI showed a full thickness rotator cuff tear and he recommended surgery given the failed conservative treatment and he recommended to continue protective mechanics and home exercise and medications pending Petitioner's decision on surgery. Work status was not addressed.
  (Of NOTE-Dr. Golz reference to the 'second' MRI showing the tear appears to be a misstatement, as Petitioner had two MRI's in June 2013 that did not reveal any tears and the January 2015 was the next MRI and that did reveal the full thickness tear.).

- Petitioner saw Dr. Paletta for a 2nd Section 12 examination April 8, 2015. Petitioner then

had subjective complaints noted of pain more laterally and posteriorly, particularly with lowering his arm. Petitioner was still taking Naprosyn daily, the amount depending on his level of discomfort. On examination, Dr. Paletta noted normal right shoulder and the left shoulder revealed no asymmetry, muscle atrophy or deformity. He noted painful arc of motion with guarding with forward motion. He noted some weakness with rotator cuff strength testing and some pain with resisting manual testing with normal rotational strength and slightly decreased supraspinatus strength with pain complaints with resisted strength testing and normal strength. Dr. Paletta noted positive impingement signs with no instability to load and shift testing. Dr. Paletta's impression was that Petitioner had a focal full thickness rotator cuff tear supraspinatus, left shoulder and possible superior labral tear. (RX 3).

- Dr. Paletta noted Petitioner's continued complaints of worsening shoulder pain and noted weakness found on examination that was not present in the prior exam. He reviewed the MRI and stated that it demonstrated a focal full thickness tear of the supraspinatus, a different finding than on prior MRI studies. He stated that the treatment had been reasonable and necessary. He noted the prior studies in 2013 did not demonstrate evidence of a full thickness tear. In 2013 he noted there was some tendinopathy and slight tendon thickening with no retraction or defect or full thickness tear of the rotator cuff. He noted the MR arthrogram clearly showed thinning of the tendon which was a dramatic change from the prior study. He stated now Petitioner had a full thickness tear previously not seen.

- Dr. Paletta opined that Petitioner's diagnosis was not causally related to the April 2013 incident. He noted Petitioner had two MRI's within two months of the injury and neither showed any evidence of a full thickness rotator cuff tear involving the supraspinatus, and multiple physicians reviewed those studies. He noted the MR arthrogram clearly showed the thinning of the tendon with a focal full thickness tear which was a dramatic change from previous study; now he has a full thickness rotator cuff tear.

- Dr. Paletta agreed with Dr. Golz's recommendation to consider surgery to repair the rotator cuff but he did not agree that it was related to the incident in 2013 as MRI's done within two months of the incident showed no evidence of a tear. Dr. Paletta did not think further diagnostic testing was needed. Dr. Paletta stated 19 months had passed between the initial MRI scan showing no tears and the MR arthrogram that then demonstrated a rotator cuff tear. He stated that while Petitioner denied any intervening trauma or injury, clearly something occurred during that timeframe that resulted in a full thickness rotator cuff tear. He again indicated that the need for surgery was not related to the work accident. Dr. Paletta reiterated his opinion from his prior examination that Petitioner was at maximum medical improvement regarding the work related shoulder injury.

- Petitioner then had an MRI July 27, 2016 that revealed a partial supraspinatus tendon tear, hypertrophy of the AC joint with inferior spurring resulting in impingement. There was indication of possible fraying within the posterior labrum posteriorly, mild thickening along the inferior glenohumeral ligament possibly associated with adhesive capsulitis. (PX 7).

- Dr. Golz again saw Petitioner July 28, 2016 with the left shoulder static and Petitioner was still considering surgery. A light duty restriction was imposed with no overhead heavy lifting. Surgery was being planned for the end of the year.

- The August 3, 2016 Dr. Golz record indicated Petitioner was unresponsive to conservative care and assessment was left shoulder rotator cuff tear and surgery was again discussed. Work status was not addressed.

- The September 9, 2016 operative report of Dr. Golz noted the left shoulder arthroscopic surgery and debridement, subacromial decompression and mini open rotator cuff repair.

- Petitioner was seen for post-operative visits December 14, 2016 and into January 2017 with Robert Deaton, CNP (at Orthopedic Institute of Southern Illinois; with Dr. Golz) who noted healing and no infection and therapy was ordered. Progression of recovery was slow but satisfactory. Employment status was not addressed.

- Petitioner requested a work release (to perform work as a stagehand) April 12, 2017 and Dr. Golz allowed Petitioner to work within pain tolerance. (PX 5). Petitioner had a follow up visit and Dr. Golz noted slow, gradual improvement with good strength.

- On September 27, 2017, Robert Deaton, CNP, noted 4/10 pain which was dull, achy, and aggravated by daily activities and the weather. An MRI was then recommended. Petitioner had an MRI at Cedar Court Imaging December 13, 2017. The impression was moderate supraspinatus tendinopathy with an insertional tear, high grade, possible full thickness tear. There was mild to moderate infraspinatus tendinopathy with no tear, and degenerative changes of the shoulder with spurs. (PX 5). On December 20, 2017, Mr. Deaton, CNP, noted the left shoulder showed normal ROM and strength and a right shoulder rotator cuff surgery was recommended to address a rotator cuff tear.

The Commission, herein, affirms and adopts the decision of the Arbitrator as to causal connection, average weekly wage/benefit rates, temporary total disability, and medical expenses.

> §8.1(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.

The Commission affirms and adopts the weight the Arbitrator gave as to factors §8.1(b) (i) through

(iv). As Petitioner reached MMI at the time of Dr. Golz October 15, 2014 exam, temporary total disability and medical expenses are denied thereafter. Petitioner suffered a left shoulder injury, strain, and resulting adhesive capsulitis April 30, 2013. The weight of the evidence shows that as a result of that injury Petitioner received conservative treatment, including physical therapy and injections, and anti-inflammatory medications. The MRI's performed shortly after the injury did not reveal any tears.

Petitioner saw Dr. Paletta for a Section 12 examination for Respondent on September 23, 2013 and he opined in his November 1, 2013 correspondence that Petitioner should continue the physical therapy and he recommended an injection to the glenohumeral joint and a Medrol dose pack and NSAIDS. Therapy was emphasized on restoring range of motion of the shoulder, rotator cuff and periscapular strengthening per impingement protocol. He further opined Petitioner would reach maximum medical improvement in 6-12 weeks if there was a positive response to the injection and post injection therapy.

The ultrasound guided injection on September 8, 2014 was to address the left shoulder pain. At the time of the injection, the ultrasound impression noted no evidence of a full-thickness tear of the bicipital tendon; a small linear tear was noted.

Dr. Golz saw Petitioner October 15, 2014. He noted the small linear tear found on ultrasound and noted that the injection provided complete and lasting relief of the anterior pain. He also noted Petitioner had recently moved furniture. He discontinued use of the Naprosyn. Petitioner had noted that moving furniture and weather changes had aggravated the shoulder pain. Pain was then noted more localized laterally, per Petitioner the pain was now in the 'other tendon'.

Petitioner had therapy at the Orthopedic Institute of Southern Illinois between March 24, 2014 and February 24, 2015. The discharge summary noted Petitioner had reached maximal level and also noted anterior/lateral pain which was worse because he had to move furniture.

Dr. Golz ordered an MRI of the left shoulder, dated January 21, 2015, for left shoulder pain, possible rotator cuff tear. The impression of the MRI then was a full thickness supraspinatus tendon tear, tendinopathy versus partial tear involving the infraspinatus tendon; superior labral tear; questionable mild thickening along the inferior glenohumeral ligament, possibly due to previous injury; component of adhesive capsulitis not excluded.

Dr. Golz April 12, 2015 visit notes indicated the 'initial' MRI showed some rotator cuff tendinitis and the 'second' MRI showed a full thickness rotator cuff tear. It appears that was clearly a misstatement as Petitioner had two MRI's June 4, 2013 and June 24, 2013 which revealed no tears. The next MRI ('second') was done January 21, 2015 and that did reveal the full thickness supraspinatus tear.

The evidence clearly shows that Petitioner had the injection that had provided complete and lasting of the anterior pain (positive response) at the October 15, 2014 visit (MMI) and Petitioner then noted the aggravation of shoulder pain after moving furniture and weather changes. The therapy discharge notes also noted Petitioner had reached maximum level of improvement until it worsened from moving furniture. While the Commission agrees Petitioner is entitled to a

loss of 7.5% loss of use of his person as a whole as result of the injury, the Commission assigns greater weight to §8.1(b) (v) given the evidence of disability corroborated by the treating medical records that there was no full thickness supraspinatus tear as result of the April 30, 2013 accident. Petitioner had recovered from the left shoulder injury, strain, and resulting adhesive capsulitis within 6-12 weeks of the successful ultrasound injection as indicated by Dr. Paletta, prior to discovery of the rotator cuff tear in January 2015. The Commission, herein, affirms the permanent partial disability award of 7.5% loss of Petitioner's person as a whole as result of the injury.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of **$220.00** per week (min. rate) 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 Petitioner's person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit of $13,132.35 for medical expenses paid under §8(a) of the Act. No medical expenses awarded after October 15, 2014.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $21,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 4 – 2020
o-3/10/20

KD/jsf

Kathryn A. Doerries

Maria E. Portela

DISSENT

I find that the evidence supports that Petitioner's current condition of ill-being is causally related to his undisputed April 30, 2013 accident, and that the alleged intervening accident did not break the chain of causal connection.

In *PAR Elec. v. Ill. Workers' Comp. Comm'n*, 2018 IL APP (3d) 170656WC, the court addressed the issue of intervening accident. The Court stated:

> To obtain compensation under the Act, an employee must establish by a preponderance of the evidence a causal connection between a work-related injury and the employee's condition of ill-being. *Vogel*, 354 Ill. App. 3d at 786. Every natural consequence that flows from a work-related injury is compensable under the Act unless the chain of causation is broken by an independent intervening accident. *National Freight Industries*, 2013 IL App (5th) 120043WC, 993 N.E.2d 473, 373 Ill. Dec. 167, *Vogel*, 354 Ill. App. 3d at 786; *Teska*, 266 Ill. App. 3d at 742. Under an independent intervening cause analysis, compensability for an ultimate injury or disability is based upon a finding that the employee's condition was caused by an event that would not have occurred "but for" the original injury. *International Harvester Co.*, 46 Ill. 2d at 245. Thus, when an employee's condition is weakened by a work-related accident, a subsequent accident, whether work related or not, that aggravates the condition does not break the causal chain. See *Lee v. Industrial Comm'n*, 167 Ill. 2d 77, 87, 656 N.E.2d 1084, 212 Ill. Dec. 250 (1995); *Vogel*, 354 Ill. App. 3d at 787; *Lasley Construction Co. v. Industrial Comm'n*, 274 Ill. App. 3d 890, 893, 655 N.E.2d 5, 211 Ill. Dec. 345 (1995). "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." *Global Products*, 392 Ill. App. 3d at 411. As long as there is a "but for" relationship between the work-related injury and subsequent condition of ill-being, the first [***39] employer remains liable. *Global Products*, 392 Ill. App. 3d at 412.

The majority found the opinion from Respondent's Section 12 examiner persuasive. Dr. Paletta opined that Petitioner's rotator cuff tear was not causally related to his April 30, 2013 accident as the original MRIs did not demonstrate any evidence of a full thickness rotator cuff tear. I disagree with the majority and would adopt Dr. Robert Golz's opinion that the tear apparent on the second MRI [January 21, 2015] was likely a progression of his initial injury and was better delineated with the arthrogram study.

The MRIs from June 2013 were performed without contrast. The June 4, 2013 MRI noted that a partial rotator cuff tear could not be excluded. The June 24, 2013 MRI revealed no tear but found thinning of the supraspinatus tending along with mild bursal surface fraying. It was not until the January 21, 2015 that an MRI with contrast was performed and a full thickness supraspinatus tendon tear was identified.

The majority finds that Petitioner sustained an intervening accident on October 15, 2014 which caused the full thickness supraspinatus tendon tear. I disagree. The October 15, 2014 record indicates that Petitioner recently "moved some furniture, went off Naprosyn and with this and the weather changes he now has aggravated his shoulder pain." His examination, however, revealed that he still had slightly restricted range of motion and overhead motion was a little uncomfortable. There is no evidence as to the severity of this event.

Leading up to the October 15, 2014 visit, Petitioner consistently treated with Dr. Golz and his shoulder complaints were well documented in the record. While some of the records note some improvement following the injections, the vast majority of the records confirm that Petitioner consistently complained of shoulder discomfort and range of motion issues. His complaints after October 15, 2014 continued and were consistent with his complaints prior to this alleged intervening accident.

Based upon the above, and pursuant to the reasoning in *Par Electric*, I would find that this alleged incident does not constitute an intervening accident sufficient to break the chain of causal connection.

As I would find causal connection, I would affirm the Arbitrator's finding of an AWW of $220.21. I would award Petitioner all reasonable and necessary medical expenses, TTD from September 23, 2015 through April 12, 2017, and award Petitioner 15% MAW.

D. Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

OLIZ, NICHOLAS
Employee/Petitioner

Case# **15WC030841**

GWEN HUNT D/B/A PK'S
Employer/Respondent

20IWCC0287

On 7/16/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.01% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5983 CARAWAY FISHER & BROOMBAUGH PC
DANIEL G BROOMBAUGH
9423 W MAIN ST
BELLEVILLE, IL 62223

0000 JELLIFFE DOERGE & PHELPS PC
KELLY PHELPS
108 E WALNUT ST PO BOX 406
HARRISBURG, IL 62946

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

NICHOLAS OLIZ
Employee/Petitioner

v.

GWEN HUNT d/b/a PK's
Employer/Respondent

Case # 15 WC 030841

Consolidated cases: _____

20IWCC0287

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Ed Lee**, Arbitrator of the Commission, in the city of **Herrin, Illinois**, on **05/14/2019**. 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 **04/30/2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**11,451.07**; the average weekly wage was $**220.21**.

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

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

Respondent *has 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 $**13,232.35** for other benefits, for a total credit of $**13,232.35**.

Respondent is entitled to a credit of any medical benefits paid under Section 8(j) of the Act.

ORDER

Respondent shall be given credit of $13,232.35 for medical benefits paid under Sections 8(a) and 8.2 of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, to the following: 1) Dr. Thalman, dates of service 04/30/2013 through 02/09/2014; 2) Dr. Golz/Orthopaedic Institute of Southern Illinois, dates of service 06/09/2013 through 10/15/2014; 3) Cedar Court Imaging, date of service 06/24/2013; and 4) Novacare Rehabilitation, dates of service 01/08/2014 through 02/14/2014, as provided in Sections 8(a) and 8.2 of the Act.
Respondent shall be given a credit for any for medical benefits that have been paid, as provided in Section 8(j) of the Act.

TTD benefits are denied.

Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 7.5% loss of use of person-as-a-whole pursuant to §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

7/13/19
Date

JUL 16 2019

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

NICHOLAS OLIZ,	)	
	)	
Petitioner,	)	
	)	
vs.	)	15-WC-030841
	)	
GWEN HUNT d/b/a PK's,	)	
	)	**20IWCC0287**
Respondent.	)	

MEMORANDUM OF DECISION OF ARBITRATOR

EVIDENCE PRESENTED AT ARBITRATION

Respondent is a bar in Carbondale, Illinois. Petitioner was a bartender for respondent. (T. 9). He was paid $8.25 per hour, plus tips, and worked 15 to 40 hours per week. (T. 9-11).

In the early morning hours of April 30, 2013, petitioner sustained an accidental injury to his left shoulder that arose of out and in the course of his employment when he attempted to break up or prevent a fight at the bar. (T. 21-23).

Petitioner first sought treatment for his left shoulder injury on April 30, 2013, at Thalman Chiropractic. (PX 4). Petitioner gave Dr. Thalman a history of his accident. He was complaining of pain in his left shoulder. Dr. Thalman performed a physical examination. Dr. Thalman's assessment was acute strain/sprain of the left shoulder, suspect biceps and supraspinatus tear. Dr. Thalman performed treatment consisting of ultrasound, cryotherapy, and interferential current. Petitioner was given work restrictions of light work.

Respondent accommodated petitioner's light work restrictions and petitioner continued to work after the accident.

Petitioner continued to receive chiropractic treatment from Dr. Thalman. Dr. Thalman ordered an MRI that was performed on June 4, 2013. (PX 4). That MRI was interpreted as showing subacromial impingement with tendonosis. (PX 4). Dr. Thalman reviewed the MRI report and felt that it was inconclusive and suboptimal. (PX 4). On June 12, 2013, Dr. Thalman referred petitioner to Dr. Robert Golz for examination. Dr. Golz is an orthopedic surgeon with the Orthopaedic Institute of Southern Illinois. After the referral to Dr. Golz, petitioner continued to treat with Dr. Thalman until February 19, 2014. (PX 4).

Petitioner was examined by Dr. Golz on June 19, 2013. (PX 5). He gave Dr. Golz a history of his work accident. He was complaining of left shoulder pain. Dr. Golz performed a physical examination. Dr. Golz's impression was left rotator cuff tendonitis versus tear. Dr. Golz was okay with petitioner continuing therapy with Dr. Thalman. Petitioner was to continue working with the same restrictions previously set by Dr. Thalman. Dr. Golz recommended a repeat MRI. Petitioner was to return for follow-up examination after the repeat MRI was completed.

The repeat MRI was performed on June 24, 2013. That MRI was interpreted as showing supraspinatus tendinopathy, no tear. (PX 7).

Petitioner returned to Dr. Golz's office on July 10, 2013. (PX 5). Dr. Golz reviewed the repeat MRI and also the MRI done on June 4, 2013. Dr. Golz's impression was supraspinatus tendinopathy with no tear. Dr. Golz injected petitioner's subacromial space. Dr. Golz recommended that petitioner continue therapy with Dr. Thalman. Petitioner was to continue to work with his previous restrictions. Petitioner was released from Dr. Golz's care to return as needed.

On September 23, 2013, petitioner was examined by Dr. George Paletta pursuant to Section 12 of the Act. (RX 1). Dr. Paletta took a history from petitioner, which included his work accident. Dr. Paletta reviewed petitioner's treatment records, performed a physical examination, and obtained and reviewed x-rays of petitioner's left shoulder. The MRI scans of June 4, 2013, and June 13, 2013, were available for Dr. Paletta's review. Dr. Paletta reviewed and compared the MRIs. He interpreted the MRI of 6-4-13 as showing some rotator cuff tendonopathy with no evidence of a tear. He interpreted the MRI of 6-13-13 as showing supraspinatus tendonopathy with no evidence of a partial thickness or full thickness tear. Dr. Paletta's impression was resolving adhesive capsulitis secondary to initial shoulder strain. Dr. Paletta opined that the adhesive capsulitis and shoulder strain were related to his work accident. He also opined that there was no evidence of a labral tear or rotator cuff tear that required surgical treatment. Dr. Paletta recommended an intraarticular injection in conjunction with a Medrol dose pack followed by some over the counter anti-inflammatories. He also recommended a focused physical therapy program emphasizing rotator cuff strengthening. Finally, Dr. Paletta said that petitioner could continue to work full duty, without restriction. He expected petitioner to achieve maximum medical improvement within 6 to 12 weeks after the intraarticular injection.

Petitioner returned to Dr. Golz's office on October 30, 2013. (PX 5). He was still complaining of aching discomfort in his shoulder and difficulty with overhead activity. Dr. Golz read Dr. Paletta's report for his examination of 9-23-14 and thought that his recommendation for an intraarticular injection was reasonable. Therefore, Dr. Golz performed that injection at this visit. Dr. Golz recommended therapy. Petitioner insisted that his therapy be done with Dr.

Thalman. Dr. Golz wrote out formal therapy orders for Dr. Thalman. Petitioner was to continue to work full duty.

Petitioner continued to treat with Dr. Golz. He was seen by Dr. Golz on December 11, 2013, and told to continue therapy for 6 weeks with a goal of home exercises. (PX 5).

Dr. Golz saw petitioner on March 5, 2014. (PX 5). Petitioner had obtained some therapy at Novacare Rehabilitation since he last saw Dr. Golz. That therapy began on January 8, 2014, and ended on March 19, 2014. (PX 6). Dr. Golz discussed the natural history of rotator cuff and bicipital tendinitis with petitioner. Dr. Golz also performed a subacromial injection.

Petitioner returned to see Dr. Golz on May 14, 2014. (PX 5). Dr. Golz thought he was progressing satisfactorily with conservative treatment for his rotator cuff tendinitis. Petitioner reported that he was experiencing similar symptoms in his right shoulder. Dr. Golz continued the treatment plan and told petitioner to return for a recheck in 3 months.

On August 20, 2014, petitioner was next seen by Dr. Golz. (PX 5). At this visit, Dr. Golz noted that petitioner had 2 MRIs of the left shoulder which both showed some rotator cuff tendinitis but no tear. Petitioner also reported that he had experienced recent exacerbations of soreness and pain following activities such as pulling a starter cord for a motor and cleaning up the bar. Dr. Golz performed a physical examination and felt that petitioner's presentation was most compatible with biceps tendinitis and suggested an ultrasound guided injection of the bicipital groove. Petitioner was to return for recheck after the injection.

The ultrasound guided injection of the bicipital tendon sheath was performed on September 8, 2014. (PX 5).

On September 17, 2014, petitioner was seen by Dr. J.T. Davis of the Orthopaedic Institute of Southern Illinois for bilateral knee pain. (PX 5). There was no treatment noted for his left shoulder.

Petitioner returned to Dr. Golz on October 15, 2014. (PX 5). This was petitioner's first visit after the ultrasound guided injection of the bicipital groove. Petitioner reported that the injection gave him complete and lasting relief of his anterior pain but he recently moved some furniture, went off his Naprosyn, and with the weather changes, he had aggravated his shoulder pain. Dr. Golz told petitioner to continue his home exercises and protective mechanics. He was to return for recheck in 6 days.

Petitioner did not return to see Dr. Golz again until January 7, 2015. (PX 5). His left shoulder pain was worse. Dr. Golz reviewed the last MRI from June

2013 and felt is showed some signal changes in the rotator cuff but no obvious tear. Dr. Golz ordered a new MRI.

On January 21, 2015, petitioner had another MRI of his left shoulder performed. (PX 5). The radiologist interpreted it as showing a full thickness supraspinatus tendon tear.

Dr. Golz next examined petitioner on February 18, 2015. (PX 5). Dr. Golz reviewed the recent MRI. He interpreted it as showing a full thickness tear of the rotator cuff. He recommended surgery to repair the tear.

On April 8, 2015, petitioner was again examined by Dr. Paletta pursuant to Section 12 of the Act. (RX 3). Another history was obtained from petitioner. Dr. Paletta also reviewed records of petitioner's treatment and performed a physical examination. Dr. Paletta obtained x-rays of petitioner's left shoulder. Dr. Paletta also reviewed the MRI scan of 1-25-15 and compared it to the prior MRIs done in June 2013. Dr. Paletta opined that both MRIs in June 2013 did not demonstrate any evidence of a full thickness rotator cuff tear. However, the 1-25-15 MRI did show evidence of a full thickness rotator cuff tear. Dr. Paletta noted in his report for this examination that several physicians, including Dr. Golz, radiologists, and him, reviewed the June 2013 MRIs and none interpreted them as showing a full thickness tear. Those MRIs were done within 2 months of petitioner's work accident. Dr. Paletta opined that the full thickness rotator cuff tear demonstrated on the 1-25-15 MRI was not related to petitioner's work accident in April 2013.

Petitioner returned to Dr. Golz on April 22, 2015. (PX 5). Dr. Golz examined petitioner but most of the visit was centered around causation of the left rotator cuff tear. Dr. Golz's office note for this visit states that petitioner denied any complaints prior to his injury on April 30, 2013. Petitioner also denied that he suffered any subsequent injury. Based on these representations by petitioner, Dr. Golz thought that the rotator cuff tear now present on the most recent MRI was a progression of his initial injury and better delineated with the recent MRI arthrogram. Dr. Golz again recommended surgery to report the rotator cuff tear.

Dr. Golz examined petitioner on July 28, 2015. (PX 5). He was still complaining of left shoulder pain.

Petitioner claims he was fired by respondent on September 23, 2015. (T. 35).

Petitioner was next seen by Dr. Golz approximately 1 year later on July 19, 2016. (PX 5). He was still experiencing left shoulder pain. Dr. Golz ordered a repeat MRI arthrogram.

On August 3, 2016, petitioner was seen by Dr. Golz. (PX 5). The repeat MRI arthrogram had been performed and it again showed the full thickness tear of the supraspinatus tendon. Dr. Golz recommended surgery and petitioner agreed.

Petitioner returned to Dr. Golz's office on August 23, 2016. (PX 5). He had questions regarding his scheduled shoulder surgery. His questions were answered by a nurse practitioner, Robert Deaton.

Dr. Golz performed surgery on petitioner on September 19, 2016. (PX 5). The procedure was left shoulder arthroscopy with debridement, subacromial decompression, and mini open rotator cuff repair. The post-operative diagnoses were left rotator cuff tear and advance AC joint arthrosis.

Petitioner began a course of physical therapy after his surgery. His therapy was performed at Memorial Hospital of Carbondale. (PX 8). He began therapy on September 21, 2016, and completed it on February 8, 2017.

Petitioner had a post-operative appointment with Dr. Golz on October 4, 2016. (PX 5). He was doing well and told to continue with physical therapy and to return in 4 weeks. This office note is silent as to any work restrictions.

Petitioner was seen at Dr. Golz's office for post-operative appointments on October 26, 2016; December 14, 2016; and January 25, 2017. (PX 5). He was progressing slowly but satisfactory. Petitioner was told to continue with therapy. These office notes are silent as to any work restrictions.

On March 29, 2017, petitioner was examined by Dr. Golz. (PX 5). Petitioner was done with therapy. Dr. Golz told petitioner to gradually start to advance his activities and return to the office in 3 months. Again, this office note is silent as to any work restrictions.

Contained in Dr. Golz's records is a nurse's note dated April 12, 2017, stating that petitioner was going to do stage hand work and requested a work release note. (PX 5). The note further states that petitioner could overhead lift and was able to go back to work. Dr. Golz advised petitioner to let pain be his guide and do activities within his pain tolerance.

Petitioner was next examined by Dr. Golz on June 28, 2017. (PX 5). His left shoulder was doing better but his right shoulder was painful. Petitioner was to return for an examination 1 year post surgery.

On September 27, 2017, petitioner was seen at Dr. Golz's office. (PX 5). He was still experiencing pain in his left shoulder. His right shoulder was also painful. There was a concern noted for possible rotator cuff tear of the right shoulder so an MRI was ordered for it.

Petitioner was seen at Dr. Golz's office on December 13, 2017, complaining of bilateral knee pain. (PX 5).

On December 20, 2017, petitioner returned to Dr. Golz's office to follow up for his knee pain. (PX 5). However, petitioner had undergone a right shoulder MRI on December 14, 2017, and he was there to discuss the findings of that test too. The right shoulder MRI demonstrated moderate supraspinatus tendinopathy with an insertional tear. Surgery for the right rotator cuff tear was discussed with petitioner but declined. He was to follow up as needed.

Petitioner returned to Dr. Golz's office on April 11, 2018, for bilateral knee osteoarthritis. (PX 5).

Petitioner testified that he has a little less strength in his left shoulder. (T. 37). He also testified he has some restricted range of motion in his left shoulder. (T. 37-38).

CONCLUSIONS OF LAW

Issue F: Is petitioner's current condition of ill-being causally related to the injury?

The weight of the evidence shows that petitioner suffered a left shoulder strain and resulting adhesive capsulitis as a result of his accident on April 30, 2013. Petitioner failed to meet his burden of proof that the left rotator cuff tear was causally related to his accident on April 30, 2013.

Petitioner had 2 MRIs of his left shoulder done in June 2013. The first MRI was on June 4, 2013. The second was on June 24, 2013. Both of these MRIs were within 2 months of petitioner's accident. These MRIs were reviewed by several doctors – Dr. Golz, Dr. Paletta, the radiologists – and none of them interpreted them as showing a rotator cuff tear. The MRI done on January 21, 2015, however, showed a rotator cuff tear. These diagnostic tests establish that the rotator cuff tear present on the January 2015 MRI was not caused by petitioner's accident on April 30, 2013.

Dr. Paletta's causation opinion set forth in his IME report of April 8, 2015, corroborates that petitioner's rotator cuff tear was not causally related to his accident on April 30, 2013.

Dr. Golz's causation opinion set forth in his office note of April 22, 2015, is not as persuasive as Dr. Paletta's causation opinion. Dr. Golz's opinion is predicated on petitioner's representation to him that he did not have any symptoms before his accident and that he did not have any subsequent injury. For reasons set forth below, the Arbitrator does not find petitioner credible.

The evidence establishes that after the ultrasound guided injection on September 8, 2014, petitioner suffered an intervening incident that caused the left rotator cuff tear. ***See* National Freight Industries v. Illinois Workers' Compensation Com'n, 2013 IL App (5th) 120043WC.** Dr. Golz' office note for October 15, 2014, states that petitioner reported complete and lasting relief of his left shoulder pain after the ultrasound guided injection of his bicipital groove. Petitioner admitted to Dr. Golz at this office visit, however, that his pain recently returned after he aggravated his left shoulder moving furniture. Petitioner reported to Dr. Golz at his next visit on January 7, 2015, that his left shoulder was worse. Shortly thereafter, the January 2015 MRI showed the rotator cuff tear that was not present on the June 2013 MRIs. Hence, by October 15, 2014, there was a change in petitioner's symptoms and a change in the pathology of his left shoulder that was confirmed by diagnostic tests, i.e., MRIs.

The Arbitrator also notes that petitioner developed right shoulder pain and a right rotator cuff tear without any noted trauma.

Based on the foregoing, the Arbitrator finds that petitioner suffered a left shoulder strain and resulting adhesive capsulitis as a result of his accident on April 30, 2013. That injury was resolved after the ultrasound guided injection of his bicipital groove on September 8, 2014. The left rotator cuff tear is not causally related to his accident on April 30, 2013.

Issue G: What were petitioner's earnings?

Petitioner claims that his earnings during the year preceding his injury were $43,913.00. He claims an average weekly wage of $844.48. Petitioner testified that respondent paid him $8.25 per hour, plus tips, and that he worked 15 to 40 hours per week.

Respondent offered into evidence a wage statement showing that during the year preceding his injury, petitioner was paid $11,451.07. (RX 4). Respondent claims an average weekly wage of $220.21.

There is a difference of $32,461.93 between petitioner's and respondent's claimed earnings during the year preceding his injury. Petitioner claims this difference is the tips he received while working for respondent. In support of his claim, petitioner offered into evidence amended U.S. tax returns for 2012 and 2013. (PX 2). Petitioner also offered into evidence calendars documenting his tips. (PX 3).

The Arbitrator finds that petitioner failed to meet his burden of proof regarding his earnings. Petitioner did not report on his tax returns the tips he received in 2012 or 2013. Therefore, he did not pay taxes on those tips. Petitioner claims he did file amended returns reporting his tips in 2012 and 2013

but he did not do this until April 17, 2019, 1 month before this arbitration. Petitioner testified, however, that he still has not paid taxes for any tips received in 2012 or 2013. (T. 16).

Based on the foregoing, the Arbitrator does not find petitioner's testimony and evidence regarding his earnings credible. The only reliable evidence regarding earnings is respondent's wage statement showing earnings of $11,451.07, and an average weekly wage of $220.21. Therefore, the Arbitrator finds that petitioner's earnings during the year preceding his injury was $11,451.07, and the average weekly wage, calculated to Section 10 of the Act, was $220.21.

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 causation finding above, petitioner is awarded the following medical expenses set forth in petitioner's exhibit 9, subject to the fee schedule and any credits due respondent:

1. Dr. Thalman, dates of service 04/30/2013 through 02/09/2014;
2. Dr. Golz/Orthopaedic Institute of Southern Illinois, dates of service 06/09/2013 through 10/15/2014;
3. Cedar Court Imaging, date of service 06/24/2013; and
4. Novacare Rehabilitation, dates of service 01/08/2014 through 02/14/2014.

All other medical expenses are denied in light of the arbitrator's causation finding.

Issue K: What temporary total disability benefits are in dispute?

Petitioner claims to be entitled to TTD benefits from 09/23/2015 through 04/12/2017. Based on the Arbitrator's causation finding above, the Arbitrator finds that petitioner is not entitled to TTD benefits for this time period. Therefore, petitioner's claim for TTD benefits is denied.

Issue L: What is the nature and extent of the injury?

Pursuant to the 5 factors set forth in Section 8.1b(b) of the Act, as for subsection (i), the Arbitrator notes that no permanent partial disability report or opinion was submitted into evidence. Therefore, the Arbitrator gives no weight to this factor.

As for subsection (ii), the Arbitrator notes that petitioner was employed as a bartender at the time of the accident and that he is able to return to work in his prior capacity. The Arbitrator gives little weight to this factor.

As for subsection (iii), petitioner was 48 years old at the time of the accident. The Arbitrator gives little weight to this factor.

As for subsection (iv), petitioner's future earnings capacity, the was no evidence that petitioner has suffered a diminishment in his future earnings capacity as a result of said accident. The Arbitrator gives little weight to this factor.

Finally, as to subsection (v), evidence of disability corroborated by the medical records, the Arbitrator finds that petitioner suffered a left shoulder strain and resulting adhesive capsulitis as a result of his accident on April 30, 2013. This injury was treated conservatively with therapy, injections, and anti-inflammatory medication. Petitioner was not restricted from working after his accident. Petitioner achieved maximum medical improvement after an ultrasound guided injection of his bicipital groove on September 8, 2014.

Based on the foregoing factors, the Arbitrator finds that petitioner has sustained permanent partial disability to the extent of 7.5% loss of use of the person-as-a-whole, or 37.5 weeks of permanent partial disability, pursuant to Section 8(d)(2) of the Act.

Issue N: Is respondent due any credit?

The parties stipulated that respondent is entitled to a credit of $13,232.35 in medical benefits paid. Therefore, the Arbitrator finds that respondent is entitled to a credit of $13,232.35 in medical benefits paid.

16 WC 29265

20IWCC0298

STATE OF ILLINOIS) BEFORE THE ILLINOIS WORKERS' COMPENSATION

)SS COMMISSION

COUNTY OF MADISON)

SANDRA KENNEDY,

Petitioner,

v. 16 WC 29265

WARREN G. MURRAY CENTER, 20 IWCC 0298

Respondent.

ORDER OF RECALL UNDER SECTION 19(F)

The Commission on its own Motion recalls the Decision and Opinion on Review of the Workers' Compensation Commission dated May 28, 2020, pursuant to Section 19(f) of the Act due to a clerical error.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision and Opinion on Review dated May 28, 2020 is hereby recalled and a Corrected Decision and Opinion on Review is hereby issued simultaneously.

Stephen J. Mathis

STEPHEN J. MATHIS

DATED: JUN 10 2020

SJM/sj

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16 WC 29265
20IWCC0298

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

Sandra Kennedy,

Petitioner,

vs.

NO: 16 WC 29265
20IWCC0298

Warren G. Murray Center,

Respondent.

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 8, 2019 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.

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.

DATED: JUN 10 2020
SJM/sj
o-5/19/2020
44

Stephen J. Mathis

Douglas D. McCarthy

Authorization- Special Concurrence/Dissent

I concur with the majority in all aspects of its decision other than its order to compel Respondent to authorize medical treatment. This issue was previously addressed by the Court in Hollywoood Casino-Aurora, Inc. v. Illinois Workers' Compensation Commission, 2012 IL App (2d) 110426WC, which is dispositive. The Court noted "Assuming for the sake of analysis that this provision of the Act [Section 8(a)] is sufficiently broad so as to include a requirement that an employer authorize medical treatment for an injured employee in advance of the services being rendered, the fact still remains that there is no provision in the Act authorizing the Commission to assess penalties against an employer that delays in giving such authorization." Id. at ¶ 19. Ordering Respondent to authorize medical treatment is meaningless where no enforcement mechanism exists under the Act. In accordance with Section 8(a) of the Act and the Court's holding in Hollywood Casino, I would order Respondent to provide and pay for the awarded medical expenses and/or treatment.

L. Elizabeth Coppoletti

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

KENNEDY, SANDRA K
Employee/Petitioner

Case# **16WC029265**

WARREN G MURRAY CENTER
Employer/Respondent

20IWCC0298

On 7/8/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.04% 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:

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SPRINGFIELD, IL 62794-9255

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

JUL - 8 2019

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

20 IWCC0298

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)

Sandra K. Kennedy
Employee/Petitioner

v.

Warren G. Murray Center
Employer/Respondent

Case # 16 WC 29265

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Collinsville, on May 29, 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. ☒ 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 _____

20IWCC0298

FINDINGS

On the date of accident, June 13, 2016, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $39,851.89; the average weekly wage was $813.30.

On the date of accident, Petitioner was 56 years of age, married with 0 dependent child(ren).

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

Respondent shall be given a credit of $19,790.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $19,790.00.

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

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 7, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Respondent shall authorize and pay for prospective medical treatment including, but not limited to, the cervical fusion surgery recommended by Dr. David Robson.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

July 2, 2019
Date

JUL 8 - 2019

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained an accidental injury arising out of and in the course of her employment by Respondent on June 13, 2016. According to the Application, "Petitioner was injured while trying to change and dress an uncooperative individual" and sustained an "Acute cervical injury, MAW & other body parts" (Arbitrator's Exhibit 2). This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of medical bills as well as prospective medical treatment. By agreement, counsel for Petitioner and Respondent reserved issues in regard to Petitioner's entitlement to temporary total disability and temporary partial disability benefits. Respondent stipulated Petitioner sustained a work-related accident, but disputed liability on the basis of causal relationship (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a mental health technician. On June 13, 2016, Petitioner was attempting to change the clothing of a patient who was uncooperative. Petitioner was next to the patient's bed and, when she attempted to raise him, she felt a "shock" in the base of her neck. The accident was reported to Respondent in a timely manner.

Petitioner initially sought medical treatment at SSM Health Express Clinic on June 13, 2016, where she was seen by Kendra Bowen, a Physician Assistant. Petitioner informed PA Bowen of the accident and complained of pain referable to the upper back. PA Bowen diagnosed Petitioner with a muscle strain and prescribed medication (Petitioner's Exhibit 1).

Petitioner was subsequently evaluated by Dr. Robert Guillemette, a physician with SSM Health Express Clinic, on June 28, 2016. At that time, Petitioner complained of upper back/neck pain. Dr. Guillemette prescribed medication and ordered physical therapy (Petitioner's Exhibit 1).

Dr. Guillemette continued to see Petitioner in July/August, 2016. When he saw Petitioner on August 12, 2016, Petitioner had complaints of neck pain with radiation into the right shoulder. Petitioner had been receiving physical therapy, but advised it was not helping. Dr. Guillemette ordered an MRI scan of Petitioner's cervical spine (Petitioner's Exhibit 1).

The MRI was performed on October 7, 2016. According to the radiologist, the MRI revealed degenerative disc disease at C5-C6 and C6-C7 as well as moderate/severe foraminal narrowing relating to disk osteophyte complex (Petitioner's Exhibit 4).

On October 18, 2016, Petitioner was seen at SSM Health Express Clinic by Michelle Harter, a Physician Assistant. PA Harter's record of that date noted the findings of the MRI scan and referred Petitioner to Dr. Robinson [Robson], a spine specialist (Petitioner's Exhibit 1).

Petitioner was evaluated by Dr. David Robson, an orthopedic surgeon, on January 11, 2017. Petitioner advised Dr. Robson of the accident and that she continued to have lower neck and right shoulder pain and physical therapy had worsened her symptoms. Dr. Robson reviewed the MRI scan and opined Petitioner had a disk osteophyte complex at C5-C6 and C6-C7. He recommended Petitioner undergo an epidural steroid injection and referred Petitioner to Dr. Kaylea Boutwell, a pain management specialist (Petitioner's Exhibit 5).

Dr. Boutwell saw Petitioner on February 13, 2017. At that time, Dr. Boutwell administered an epidural steroid injection on the right at C6-C7 (Petitioner's Exhibit 6).

When Petitioner was seen by Dr. Robson on February 23, 2017, she advised the injection had a complete resolution of her pain symptoms; however, it was temporary. Petitioner was again complaining of neck and right arm pain. Dr. Robson recommended Petitioner undergo another epidural steroid injection (Petitioner's Exhibit 5).

Dr. Boutwell again saw Petitioner on March 13, 2017. At that time, Dr. Boutwell administered an epidural steroid injection on the right at C6-C7 (Petitioner's Exhibit 6).

When Petitioner was seen by Dr. Robson on March 30, 2017, she advised the second injection was not as effective as the first. However, Dr. Robson recommended Petitioner undergo another epidural steroid injection (Petitioner's Exhibit 5).

At the direction of Respondent, Petitioner was examined by Dr. Michael Chabot, an orthopedic surgeon, on June 5, 2017. In connection with his examination of Petitioner, Dr. Chabot reviewed medical records provided to him by Respondent. Included in the medical records reviewed/abstracted by Dr. Chabot were medical records, which predated the accident, dated July 5, July 31, and August 14, 2012. According to Dr. Chabot's medical report, the records appeared to be in regard to a lumbar strain (Respondent's Exhibit 4). The actual records were not tendered into evidence at trial.

Dr. Chabot's findings on examination were benign and he noted only a slight decrease of the range of motion of the cervical spine. He reviewed the MRI and agreed it revealed disc degeneration at C5-C6 and C6-C7. Dr. Chabot opined Petitioner was at MMI, could return to work without restrictions and no further medical treatment was indicated, including epidural steroid injections (Respondent's Exhibit 4).

Petitioner was scheduled to be seen by Dr. Robson on June 12, 2017, but the appointment was canceled. At trial, Petitioner testified she was returning from the canceled appointment and was a passenger in a vehicle driven by her husband. While on the highway, the vehicle Petitioner was in was involved in a serious accident and Petitioner's husband was killed as a result thereof. The vehicle's airbag was deployed and Petitioner sustained a fracture of the sternum and two ribs. However, Petitioner testified she did not experience any new neck symptoms as a result of the accident.

Subsequent to the vehicular accident, Petitioner was treated at St. Louis University Hospital. Respondent tendered into evidence the hospital records which confirmed Petitioner sustained a fracture of the sternum as well as the left fourth and fifth ribs. Petitioner underwent CT scans of the cervical, thoracic and lumbar spine, which revealed no evidence of fractures. Petitioner did not receive any treatment for cervical/neck complaints (Respondent's Exhibit 6).

Petitioner was again seen by Dr. Robson on April 25, 2018, which was over one year since the last time she saw him on March 30, 2017. At trial, Petitioner testified that while her neck symptoms continued, her life was dominated by dealing with the tragic loss of her husband.

When Dr. Robson saw Petitioner on April 25, 2018, Petitioner continued to complain of neck pain as well as bilateral arm pain. Petitioner was willing to consider surgery. Dr. Robson reaffirmed his diagnosis of disk osteophyte complex at C5-C6 and C6-C7 which had failed conservative treatment over a significant period of time. Dr. Robson ordered an MRI scan of the cervical spine (Petitioner's Exhibit 5).

The MRI was performed on April 30, 2018. According to the radiologist, there was disc bulging at multiple levels of the cervical spine, mild central canal stenosis at C6-C7 and C7-T1 and moderate left foraminal stenosis at C5-C6 and C6-C7 (Petitioner's Exhibit 5).

Dr. Chabot was deposed on March 23, 2018, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Chabot's testimony was consistent with his medical report and he reaffirmed the opinions contained therein. Dr. Chabot stated that, based upon his review of the medical records, Petitioner had a history of neck complaints prior to the accident of June 13, 2016. He testified Petitioner sustained a lower cervical and thoracic strain as a result of the accident, Petitioner was not in need of any further medical treatment, was at MMI and could work without restrictions (Respondent's Exhibit 5; pp 9, 14-17).

Respondent's counsel then posed a hypothetical question to Dr. Chabot in which they asked him to assume Petitioner had been involved in an automobile accident in which she had sustained a fracture of the sternum and fractured ribs and whether this could affect her cervical condition. Dr. Chabot responded that such an accident could have caused Petitioner to have sustained a whiplash injury (Respondent's Exhibit 5; pp 17-18).

On cross-examination, Dr. Chabot agreed that the records he reviewed regarding the treatment Petitioner sought in July/August, 2012, made no reference to Petitioner having cervical spine or neck complaints. Dr. Chabot also agreed he had no knowledge of Petitioner's current condition or complaints (Respondent's Exhibit 5; pp 19-24).

Dr. Robson was deposed on December 20, 2018, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Robson's testimony was consistent with his medical records and he reaffirmed the opinions contained therein. In regard to his not having seen Petitioner for over one year, Dr. Robson testified it was his understanding Petitioner's husband had died and her life had been dominated with dealing with that tragedy. Dr. Robson ordered the second MRI scan because of the amount of time that had lapsed since the first MRI scan was performed and Petitioner was contemplating surgery (Petitioner's Exhibit 8; pp 12-14).

Dr. Robson testified the MRI scans were similar and consistent with his findings on examination. He recommended Petitioner undergo an anterior cervical discectomy and fusion from C5 to C7. He testified the accident of June 13, 2016, was the cause of the condition he diagnosed and for which he was recommending surgery (Petitioner's Exhibit 8; pp 14-17).

In regard to the automobile accident, Dr. Robson testified this did not cause him to change his opinion in regard to either causation or Petitioner's need for medical treatment (Petitioner's Exhibit 8; pp 18-19).

On cross-examination, Dr. Robson was interrogated about his opinion in regard to the automobile accident. He agreed it was "possible" that a fractured sternum and fractured ribs could have also affected her neck; however, he noted he had reviewed MRIs taken before and after the accident which were "unchanged" (Petitioner's Exhibit 8; pp 26-28).

At trial, Petitioner testified she still has neck and arm pain. Petitioner no longer works as a mental health technician because she obtained a job in Respondent's kitchen. At trial, Petitioner testified she was concerned about the safety of both herself and the patients because of her neck pain. Petitioner stated she does seek help from other employees on an as needed basis. She wants to proceed with whatever treatment Dr. Robson recommends.

Rebecca Spencer testified for Respondent at trial. Spencer was Petitioner's supervisor in dietary. Spencer testified Petitioner was able to perform all of her job duties. On cross-examination, she agreed Petitioner was an honest person.

Conclusions of Law

In regard to disputed issue (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner's current condition of ill-being is causally related to the accident of June 13, 2016.

In support of this conclusion the Arbitrator notes the following:

There was no dispute Petitioner sustained a work-related accident injuring her neck and right arm on June 13, 2016.

There was no evidence Petitioner had any neck or cervical spine symptoms prior to June 13, 2016. The prior medical records from July/August, 2012, referenced in Dr. Chabot's report were apparently in regard to a lumbar strain. As noted herein, the actual records were not tendered into evidence at trial.

Petitioner's primary treating physician, Dr. Robson, has opined Petitioner has a disk osteophyte complex at C5-C6 and C6-C7 which has failed conservative treatment. In that regard, Petitioner has received medication, physical therapy and undergone epidural steroid injections. According to Petitioner, the physical therapy worsened her symptoms and the injections only provided temporary relief.

Respondent's Section 12 examiner, Dr. Chabot, opined Petitioner had prior cervical spine and neck complaints, apparently basing this on the medical records from July/August, 2012. As aforestated, these records apparently referenced a lumbar strain. Further, on cross-examination, Dr. Chabot admitted there was no reference in those prior medical records regarding any neck/cervical complaints by Petitioner.

Dr. Chabot has also opined Petitioner may have sustained a whiplash injury as a result of the vehicular accident in which she sustained a fractured sternum and fractured ribs.

Dr. Robson testified the car accident did not cause him to change his opinion in regard to causality. While he agreed it was "possible," the vehicular accident may have affected Petitioner's neck, he noted that he reviewed MRIs of the cervical spine taken before and after the accident which were "unchanged."

Given the preceding, the Arbitrator finds the opinion of Dr. Robson to be more persuasive than that of Dr. Chabot in regard to causality.

In regard to disputed issue (J) the Arbitrator makes the following conclusion of law:

Based upon the Arbitrator's conclusion of law in regard to disputed issue (F) the Arbitrator concludes that all of the medical treatment provided to Petitioner was reasonable and necessary and Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services as identified Petitioner's Exhibit 7, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

In regard to disputed issue (K) the Arbitrator makes the following conclusion of law:

Based upon the Arbitrator's conclusion of law in disputed issue (F) the Arbitrator concludes Petitioner is entitled to prospective medical treatment, including, but not limited to, the cervical fusion recommended by Dr. Robson.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS
COUNTY OF JEFFERSON)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Cowger,
Petitioner,

vs.

No: 19 WC 09703,
20 IWCC 0289

CPC Logistics, Inc.,
Respondent.

ORDER

Motion to Recall pursuant to Section 19(f) of the Act was filed by the Respondent on June 2, 2020. The Commission finds that a clerical error does not exists in its Decision and Opinion on Review dated May 20, 2020.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Respondent's motion to correct a decision, pursuant to Section 19(f) dated June 2, 2020, is hereby denied.

DATED: JUN 10 2020

Marc Parker

mp/wj
68

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jacqueline Robinson,
Petitioner,

vs.

NO: 16 WC 19976
20 IWCC 317

Walmart,
Respondent.

ORDER OF RECALL UNDER SECTION 19(f)

This matter comes before the Commission on Respondent's motion to correct a clerical error in the Decision and Opinion on Review of the Commission filed June 10, 2020. After reviewing the Decision on Review, the Commission recalls the Decision for the purposes of correcting the clerical error.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision dated June 10, 2020, is hereby vacated and recalled pursuant to Section 19(f) for a clerical error contained therein.

IT IS FURTHER ORDERED BY THE COMMISSION that a Corrected Decision shall be issued simultaneously with this Order.

DATED: JUN 22 2020
DLS/rm

Deborah L. Simpson
Deborah L. Simpson

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JACQUELINE ROBINSON,

Petitioner,

vs.

NO: 16 WC 19976
20 IWCC 317

WALMART,

Respondent.

CORRECTED DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of average weekly wage, benefit rate, temporary total disability ("TTD"), and credit, 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 testified that while she was off work due to her work-related injury, she received income of $10.50 an hour for 15 hours a week from Help-at-Home working as a caregiver for her mother. Petitioner's testimony was not rebutted. The Arbitrator awarded Petitioner 25&6/7 weeks from September 7, 2016 through March 7, 2017, the date of Petitioner's termination. The Arbitrator found that normally Petitioner would be entitled to TTD from June 16, 2016 to March 7, 2017 for 39&5/7 weeks. "However, Petitioner testified that she received wages from Help-at-Home during this period." Therefore, she was not temporarily totally disabled for that period. He also noted that she did not claim temporary partial disability benefits. Therefore, the Arbitrator awarded TTD for only 25&6/7 weeks.

The Commission finds that the Arbitrator erred in denying all temporary disability benefits for the period of time Petitioner received some income from Help-at-Home. While she did receive some income for that work, that did not suggest that she was able to return to work at her prior job with Respondent. We conclude that Petitioner is entitled to temporary partial disability benefits for that period representing 2/3 of the difference in her average weekly wage and the income she received from her work for Help-at-Home. The Commission has the authority to award such benefits when the record indicates that they are warranted even though the Petitioner did not formally request temporary partial disability benefits. We do not believe it is appropriate to punish a claimant because of a failure to formally request a certain benefit when the record indicates that such benefit is due. Based on the evidence in the record, the Commission awards an additional award of $148.33 for a period of 13&6/7 weeks, representing 2/3 of the difference between her average weekly income of $380.00 and the actual income she received from Help-at-Home of $157.50 for that period.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $253.00 per week for a period of 25&6/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the additional sum of $143.33 for a period of 13&6/7 weeks, that being the period of temporary partial incapacity for work under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner permanent partial disability benefits of $253.00 per week for a period of 40 weeks, because the injuries sustained caused the loss of the use of 8% of the person-as-a-whole.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $20,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 2 2 2020

Deborah L. Simpson

Barbara N. Flores

Marc Parker

DLS/dw
O-4/16/20
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ROBINSON, JACQUELINE
Employee/Petitioner

Case# **16WC019976**

15WC027066
16WC022314

WAL-MART STORE 3601
Employer/Respondent

20IWCC0317

On 10/22/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.41% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0612 DWYER AND COOGAN
CAROLEANN GALLAGHER
140 S DEARBORN ST SUITE 1603
CHICAGO, IL 60603

5074 QUINTAIROS PRIETO WOOD & BOYER
MICHAEL J SCULLY
233 S WACKER DR 70TH FL
CHICAGO, IL 60606

20IWCC0317

20 IWCC0317

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

Jacqueline Robinson
Employee/Petitioner

v.

Wal-Mart Store 3601,
Employer/Respondent

Case # **16** WC **019976**

Consolidated cases: **15 WC 027066**
16 WC 022314

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **2/8/2018, 3/2/2018 and 4/6/2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

20IWCC0317

FINDINGS

On **May 30, 2016**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**19,760.00**; the average weekly wage was $**380.00**.

On the date of accident, Petitioner was **51** 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 $**10,868.00** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**10,868.00**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $253.00 per week for 25-67 weeks, commencing 9/7/2016 through 3/7/2017, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $253.00 per week for 40 weeks, because the injuries sustained caused the 8% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner the compensation benefits that have accrued from 5/30/2016 through 4/6/2018, 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

October 22, 2018
Date

OCT 22 2018

INTRODUCTION

This matter was tried with two companion cases, Case Nos. 15 WC 027066 and 16 WC 022314, which involved the claimed accident date of June 8, 2015 (after amendments of the Applications for Adjustment of Claim at the end of Petitioner's testimony).

FINDINGS OF FACT

Petitioner was employed by Respondent as a cashier. She began working for Respondent in May of 2014.

On May 30, 2016, Petitioner was working the self check registers. Petitioner was struck by a pole on the left side of her face as she tried to get supplies for the registers. Petitioner testified that she was struck on the left side of her head, left side of her face, her left eye, left ear, jaw and forehead. There wasn't any blood, but there was swelling. She was dazed and grabbed a cart to steady herself. A co-worker summoned help. Petitioner sat down and was attended to by the night manager. He brought a first aid kit and ice for her face. The night manager said he was getting paperwork for an incident report. He did not come back, apparently going home. Petitioner then found her supervisor, LaTasha Muse and told her that she was hit in the face. Petitioner said that she wanted to go home. Muse said that she would be assessed attendance points if she went home. Another supervisor, Clinique, had Petitioner fill out paperwork and had her sit in the self checkout area until her shift was over.

The next day, Petitioner contacted Muse and inquired about seeing a doctor, as she was dizzy, could not hear, had a black eye, her face was swollen and her head was pounding. Muse said that she would get back to Petitioner, but she did not. Petitioner called Muse the next day and was instructed to come into the store. Muse took Petitioner to Concentra on June 2, 2016. This is where Petitioner first received medical care for her injuries.

Petitioner had treatment at Concentra from June 2, 2016 to June 7, 2016. On June 2, 2016, She was seen with a history of being struck in the face with a shepherd's hook on May 30, 2016. Her complaints were of left ear pain and pressure, headache, nausea, blurred vision, swelling in the eye and neck pain. There was no loss of consciousness or fall. The physical exam showed very mild swelling of the left lower eyelid. The rest of the PE was benign. The diagnosis was: cervical strain; facial contusion and eye contusion. The recommendations were: Ibuprofen; CT of the head and orbital CT. She was taken off work for June 2 and could work modified duty thereafter. (PX 10)

Petitioner was seen for re-check on June 3, 2016. She had complaints of dizziness, blurred vision and headaches. The CT was negative for intracranial hemorrhage. She had been working her regular duties. An ophthalmology referral was made. Petitioner could return to work, sitting work only. Petitioner was seen on June 7, 2016 and was referred to a neurologist. It was recommended that she be seen that week. She was taken off work, effective June 7, 2016 and instructed to limit activities ("No activity, no work"). (PX 10, PX 11)

Petitioner was sent by Respondent to Dr. Andriani Siavelis, OD at Westchester Eye Surgeons. She was seen on June 7, 2016. The diagnosis was: 1. Cortical senile cataract; 2. Macular edema absent; 3. Type II DM; and 4. Moderate head injury (without injury to the eyeball). A neurologic exam was recommended and the patient was to be off work until the exam by a neurologist.

Apparently, there was a delay in setting up the neurologic consult. Petitioner's attorney and Respondent were able to agree that Petitioner be examined by Dr. Richard Lazar on February 21, 2017. Dr. Lazar's assessment was that Petitioner sustained a concussion at work, that she was experiencing headaches with some features due to post-concussion and some due to stress and emotional components, but that her headaches were getting better. Petitioner told Dr. Lazar that she wanted to return to work but that she also wanted some symptomatic headache treatment. Dr. Lazar recommended her primary care physician "administer something like Limbitrol or Fiorinal" on an as needed basis, that Petitioner have two more weeks off of work to get the medications and make any necessary adjustments, at which point she could return to work without restriction. (RX 9)

Petitioner's employment with respondent was terminated February 8, 2017. This was apparently due to alleged deficiencies in her FMLA paperwork. It appears that Petitioner could re-apply for a job at Respondent, but she has not done so. Petitioner has applied for perhaps 300 jobs since February of 2017, but has not been hired, apparently because of limitations regarding her shoulder.

Petitioner testified that she does not hear as well as she did before the accident. She cannot see as well as before the accident. She has headaches and ear pain. She complains of vertigo. She has problems sleeping. She copes with the headaches as best she can.

Petitioner testified that she received TTD benefits from Walmart from June 2, 2016 through March 14, 2017. Petitioner claims that she is owed TTD benefits from Respondent from March 8, 2017 through March 2, 2018.

Petitioner testified that she was employed by Help at Home, LLC as a home health care aid from September 11, 2014 through September 6, 2016 and earned $10.05 per hour. She agreed that she worked about 15 hours per week for Help at Home, LLC. Petitioner denied filing an unemployment claim against Help at Home, LLC but testified that she had filed a claim for unemployment against Respondent. No documentation of an unemployment claim against Respondent was offered at trial.

Evidence of Petitioner's unemployment claim against Help at Home, LLC was admitted. These records show that Petitioner filed a claim for unemployment benefits against Help at Home, LLC, as well as two appeals of administrative determinations regarding her claim. The claims adjudicator determined that Petitioner was not eligible for benefits. Following the claims adjudicator's determination, the claim was appealed to a Referee, then to the Board of Review, and finally to the Circuit Court of Cook County. (RX 15)

On April 23, 2017, Petitioner filed a claim for unemployment insurance against Help at Home, LLC. The employer protested Petitioner's right to benefits, and submitted allegations that Petitioner voluntarily quit and provided no reason or notice despite the availability of continuing work. On May 17, 2017, the claims adjudicator denied Petitioner benefits because the evidence showed that Petitioner was not available for work and that Petitioner conditionally narrowed her opportunities and had no reasonable prospects for securing work. Petitioner appealed the denial. (RX. 15)

A telephonic hearing was held regarding Petitioner's appeal of the claims adjudicator's determination that she was not eligible for benefits on June 8, 2017. During the telephonic hearing testimony was taken under oath by the Referee. Petitioner testified that she was released to return to work without restrictions sometime at the end of February of 2017. Petitioner also provided "pages 4 and 5 of a purported medical note releasing her to return to work" and a discharge summary from Petitioner's physical therapy provider. Petitioner further testified that she had made five job contacts each of the two weeks under review, or ten job contacts total. Petitioner also admitted that she had not contacted Help at Home, LLC following her release to return to work. The representative for Help at Home, LLC testified that Petitioner would be returned to work if she attended a three-day training session. (RX. 15)

On June 9, 2017, the Referee issued an Administrative Law Judge's Decision, which affirmed the determination of the claims adjudicator. The Referee found that "Her testimony and work search was not credible," and that Petitioner failed to meet her burden to establish her eligibility for benefits. (RX. 15)

Petitioner appealed the Administrative Law Judge's Decision to the Board of Review on July 7, 2017. The Board of Review issued a decision on August 30, 2017 finding that Petitioner did not did not meet her burden to show that she was entitled to receive unemployment benefits in light of testimony from Petitioner that was inconsistent with the medical records she provided as evidence. (RX. 15)

On October 2017, Petitioner filed a Pro Se Complaint for Administrative Review in the Circuit Court of Cook County, Law Division. On February 14, 2018, Judge Daniel Kubasiak entered an Opinion and Order in the case which includes a Procedural History, Facts, Discussion, and Order. Judge Kubasiak found that Petitioner told her employer that she was not coming back to work during a phone conversation on October 31, 2016 and that her testimony was inconsistent with the medical records she provided as evidence. The judge also found that "The manifest weight of the evidence supports the finding that Plaintiff merely made a perfunctory effort in her work search to qualify for unemployment benefits." Judge Kubasiak confirmed the decision of the Board of Review. (RX. 15)

Petitioner's testimony establishes that she worked for and collected wages from Help at Home LLC while she was collecting TTD from Respondent. She stopped working for Help at Home, LLC when she had the shoulder surgery by Dr. Sonnenberg.

Petitioner's claimed bills regarding this case were admitted as PX 19. Respondent's Medical Payment Ledger was admitted as RX 14. Respondent's TTD Ledger was admitted as RX 13.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

To obtain compensation under the Act, petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of her claim (O'Dette v. Industrial Commission, 79 Ill.2d 249, 253 (1980)),

including that there is some causal relationship between her employment and his injury. Caterpillar Tractor Company v. Industrial Commission, 129 Ill.2d 52, 63 (1989) To be compensable under the Act, an injury need only be a cause of an employee's condition of ill-being, not the sole or primary causative factor. Sisbro, Inc. v. Industrial Comm'n, 207 Ill.2d 193, 205 (2003)

Decisions of the Arbitrator shall be based exclusively on evidence in the record of proceeding and material that has been officially noticed. 820 ILCS 305/1.1 (e)

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner sustained accidental injuries which arose out of and in the course of her employment by Respondent on May 30, 2016. This finding is based upon petitioner's testimony and the medical records.

WITH RESPECT TO ISSUE (E), WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Respondent disputed Notice, but the testimony establishes that Petitioner's supervisor took her to the company clinic for medical treatment on June 2, 2016, three days after the accident. Notice was proved.

WITH RESPECT TO ISSUE (F), IS PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner's current condition of ill-being, as diagnosed by Dr. Lazar (status post concussion 5/30/2016 at work, with mixed headaches, post concussion and stress related) is causally related to the injury. This finding is based upon Petitioner's testimony, the medical records and Dr. Lazar's report.

WITH RESPECT TO ISSUE (G), WHAT WERE PETITIONER'S EARNINGS, THE ARBITRATOR FINDS AS FOLLOWS:

At the time of submission of exhibits on March 2, 2018, the Parties agreed that the TTD rate and the TTD rate would be $253.00. Therefore, the Arbitrator found Petitioner's claimed AWW of $380.00 to be correct, as is set forth above in this Decision.

WITH RESPECT TO ISSUE (I), DID PETITIONER HAVE A DEPEDENT CHILD AT THE TIME OF THE ACCIDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner's unrebutted testimony establishes that she had a 16 year-old son at the time of 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:

Petitioner claimed medical expenses from Concentra, Skan-Bedford Park and Westchester Eye Surgeons, SC as a result of the injury. (PX 19). RX 14 and PX 19 show that the bills were paid by Respondent and there are no outstanding balances. Accordingly, no bills are awarded.

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:

Given Petitioner's claimed TTD on ArbX 2, her testimony and the medical records, along with RX 13 (the TTD summary), Petitioner would be entitled to TTD from 6/2/2016 to 3/7/2017, a period of 39-5/7 weeks. However, Petitioner testified that she received wages from Help at Home during this time period, through September 6, 2016. Therefore, as she was not temporarily and totally disabled from June 2, 2016 through September 6, 2016, she is not entitled to TTD for that time period.

No wage or attendance records from Help at Home were submitted. There was no claim for TPD. Therefore, the wages from Help at Home do not impact the AWW and the Arbitrator relies on Petitioner's testimony in awarding TTD only from 9/7/2016 to 3/7/2017, a period of 25-67 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 "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors;

(i) the reported level of impairment pursuant to subsection (a);
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records.

No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. Accordingly, this factor is given no weight in determining PPD.

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 cashier at the time of the accident and that she is able to return to work in her prior capacity as a result of said injury, per Dr. Lazar. This factor is given substantial weight in determining PPD.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 51 years old at the time of the accident. This factor is given some weight in determining PPD.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner testified that her employment opportunities are limited due to her shoulder condition, which is not the subject of this case. This factor is given some weight in determining PPD.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that it took some time for an examination by a neurologist to be done, even though Respondent's clinic documented the urgency of an examination (as was documented by the eye doctor, Dr. Siavelis). The Arbitrator does give weight to Dr. Lazar's opinions that the post-concussion headaches are at least in part related to the injury. Thus, some of Petitioner's subjective complaints are corraberated by medical records and the opinion of a specialist. Moderate weight is given to this factor in determining PPD.

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 8% loss of use of the person as a whole, pursuant to §8(d)2 of the Act.

WITH RESPECT TO ISSUE (N), IS RESPONDENT DUE ANY CREDIT, THE ARBITRATOR FINDS AS FOLLOWS:

Respondent paid Petitioner $10,868.00 in TTD benefits. The TTD rate is $253.00 per week. Petitioner is awarded 25-6/7 weeks of TTD, or $6,541.82. There has been an overpayment of TTD benefits in the amount of $4,326.18, for which Respondent is entitled to a credit against the PPD award.