STATE OF ILLINOIS)
) SS
COUNTY OF MADISON)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BENJAMIN ROBINSON,)
)
Petitioner,)
) No. 18 WC 003791
vs.) 19 IWCC 0429
)
TYSON FOOD,)
)
Respondent.)

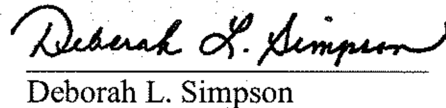
ORDER

This matter comes before the Commission pursuant to Respondent's Motion to Recall the Commission Decision and Opinion on Review to correct clerical errors 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 and Opinion on Review should be recalled for the correction of the clerical/computational errors.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Commission Decision and Opinion on Review dated August 12, 2019, is hereby recalled pursuant to Section 19(f) of the Act. The parties should return their original decisions to Commissioner Deborah L. Simpson.

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



Deborah L. Simpson

DATED: SEP 6 - 2019
DLS/mav
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STATE OF ILLINOIS)	☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF COOK)	☒ Reverse Accident	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BENJAMIN ROBINSON,

Petitioner,

vs. NO: 18 WC 03791
19 IWCC 429

TYSON FOODS,

Respondent.

CORRECTED DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, and permanent disability and being advised of the facts and law, views the evidence differently than the Arbitrator, reverses the Decision and awards compensation under the Illinois Workers' Compensation Act ("Act") as stated below.

Pursuant to the Application for Adjustment of Claim Petitioner filed with the Commission on February 6, 2018, an arbitration hearing was conducted on October 25, 2018 to decide Petitioner's claim that his employment with Respondent gave rise to him developing bilateral carpal tunnel on January 12, 2018. The arbitration hearing resulted in the presiding Arbitrator finding that Petitioner failed to prove that he sustained an accident that arose out of and in the course of his employment with Respondent as well as that his current condition of ill-being is causally related to his employment with Respondent.

Petitioner began working for Respondent on December 27, 2017 as a materials supervisor and, as such, was initially detailed to the production side of Respondent's operation for a couple days where he placed "meat logs" weighing 26- to 28-pounds a piece into wheeled buckets. He performed this activity nine or ten-hour workdays with the workdays broken up by one-hour lunches and ten to fifteen-minute breaks. After a few days working on the production side, he transferred to the packing side where he moved pallets of Respondent's products by means of pallet jacks. The pallets were said to weigh as much as 1,700 pounds and, with the aid of two

other individuals, the pallets were pushed or pulled 50 to 75 feet. Petitioner transitioned from performing this task for two to three hours a day to five hours day. After, approximately one-and-a-half weeks of performing this activity, Petitioner began experiencing symptoms of carpal tunnel syndrome in both of his hands on or about January 12, 2018.

The Arbitrator noted how soon after Petitioner began working for Respondent he sought treatment for his wrists, noting in the Decision of the Arbitrator, the "crux of the dispute between the parties herein is whether Petitioner worked for Respondent long enough to, in fact, cause or aggravate his pre-existing carpal tunnel syndrome." The Arbitrator further noted Dr. Shawn Kutnik, who examined Petitioner at Respondent's request under Section 12 of the Act, testified, "Petitioner's exposure time was not enough to cause any chronic structural changes which would result in the development of carpal tunnel syndrome." The Arbitrator adopted this portion of Dr. Kutnik's testimony as one of her rationales for finding Petitioner did not sustain a compensable accident.

The Arbitrator drew attention to Petitioner's January 24, 2018 examination by Dr. Lowell Senintaffer, an examination in which Petitioner was recorded complaining of bilateral hand and forearm pain that had been present for several months. The Arbitrator found that history inconsistent with the history Petitioner gave Dr. Kutnik. Dr. Kutnik testified to Petitioner telling him that the pain and numbness in his hands began in January 2018. The Commission, in reviewing the evidence deposition of Dr. Senintaffer, found that he testified that Petitioner told him that his symptoms had been present for "many years." Based on Dr. Senintaffer's testimony, the Commission agrees that the history Petitioner provided Dr. Kutnik was inconsistent with the one he provided Dr. Senintaffer. The Commission, in finding Petitioner had symptoms of bilateral carpal tunnel syndrome prior to his employment with Respondent and misled Dr. Kutnik about this, does not find either to necessarily preclude Petitioner from being entitled to benefits under the Act.

Petitioner's symptoms of bilateral carpal tunnel syndrome prior to beginning work with Respondent confirms Dr. Kutnik's position that Petitioner's employment with Respondent did not cause his bilateral carpal tunnel syndrome. The question before the Commission now becomes whether Petitioner's employment with Respondent aggravated or accelerated his preexisting bilateral carpal tunnel syndrome.

The Arbitrator, as quoted above, suggested that there might be a minimum amount of time that an employee must work for an employer before that work could cause or aggravate preexisting carpal tunnel syndrome. In this immediate case, the Arbitrator found Petitioner having worked for Respondent for seventeen days to be too few to have made his complaints compensable under the Act. No explanation was offered as to how that conclusion was reached.

Dr. Kutnik, while concluding that Petitioner's work activities for Respondent did not cause his bilateral carpal tunnel syndrome, testified that he did not know what caused Petitioner's symptomatology to increase and thought that it probably was not a coincidence that Petitioner's symptoms worsened after Petitioner began working at a hand-intensive job. In the report Dr. Kutnik authored following his examination of Petitioner, he wrote that the work Petitioner performed "can result in an aggravation of the symptoms of carpal tunnel syndrome

. . . ."

The Commission relies on the totality of the evidence presented in the case and concludes the evidence demonstrates Petitioner had preexisting bilateral carpal tunnel syndrome that was made worse by the work he performed for Respondent. The Commission finds, based on the evidence, that Petitioner sustained an accident to both hands that arose out of and in the course of his employment with Respondent on January 12, 2018.

Having addressed accident, the Commission turns its attention to the issue of whether Petitioner's accident was causally related to his need for the medical treatment he received and is causally related to any permanent disability Petitioner experiences. Dr. Kutnik, in his report, concluded "that the patient's bilateral carpal tunnel syndrome is not causally related to his work at Pierre [sic] Foods in that he had an exceptionally limited exposure time of only 2 weeks . . . ."

Dr. Kutnik's report and the Arbitrator speculate that, "Petitioner may have suffered a temporary increase in symptoms ... [and] the need for surgery was not causally related . . . ." This position does not deny the existence of a causal relationship between Petitioner's accident and his need for treatment, only surgical treatment. Despite this, no compensation for medical expenses were contemplated, not even the treatment provided while Petitioner was experiencing the "temporary increase in symptoms."

Petitioner's history of his condition, as recorded by Dr. Sensintaffer on January 24, 2018, indicated that he performed a very physical job that involved pushing and pulling and that the work exacerbated his symptoms. Dr. Sensinaffer noted, in the same record, that Petitioner's bilateral carpal tunnel syndrome was exacerbated by his job. Dr. Sensintaffer's note does not provide specific details as to what it was Petitioner did for Respondent, but what he recorded was not inaccurate. Furthermore, Dr. Sensitaffer concluding on January 24, 2018 that Petitioner's employment exacerbated his symptoms is more compelling than the evidence deposition testimony Dr. LeeBurton provided concerning causation.

Petitioner's treating medical records follow close enough in time to the date of his accident and his history and complaints as recorded in those records are consistent enough as to find them to be credible evidence demonstrating there to be a causal relationship between the injuries Petitioner sustained while working for Respondent and the medical treatment he received treating those injuries. Accordingly, the Commission finds Petitioner to be entitled to medical expenses as contemplated under Section 8(a) of the Act.

The Commission also finds Petitioner entitled to permanent partial disability benefits under Section 8(e) of the Act. He sustained an aggravation of his preexisting bilateral carpal tunnel syndrome that necessitated bilateral carpal tunnel releases which, by all accounts, appear to have greatly improved, if not, resolved the symptoms of which he complained.

The Act dictates, as Petitioner's accident occurred after September 1, 2011, that the criteria specified under Section 8.1(b) of the Act be used to establish permanent partial disability. Pursuant to Section 8.1(b), the Commission finds as follows:

(1) Neither party procured an impairment rating using AMA guidelines; Dr. Kutnik

opined Petitioner lost a 1% use of his right hand and a 1% use of his left hand that translated to a 1% whole person impairment rating; no evidence was offered that Dr. Kutnik's assessment comported with Section 8.1(a) of the Act; no weight is given to this factor.

(2) Petitioner was a warehouse supervisor at the time of his injury and is currently a shift manager with another employer; little weight is given to this factor.

(3) Petitioner was 43 years of age at the time of the accident and is in the middle of working career; some weight is given to this factor.

(4) No evidence was offered with respect to Petitioner's future earning capacity; no weight is given to this factor.

(5) There is some evidence of disability corroborated by the treating medical records; Petitioner's last visit to Dr. LeeBurton occurred on April 11, 2018; no refence was made to a physical examination being conducted; Petitioner was recorded as saying that a lot of his preoperative symptoms had resolved; a restriction of lifting no more than 8-pounds was to end at the beginning of May 2018; Petitioner's last visit to Dr. Sensintaffer occurred on May 8, 2018; Petitioner indicated that he had good grip strength with his right hand and less strength with the left hand and a little tightness involving his left wrist; physical examination did not appear to include Petitioner's hands or wrists; Petitioner offered a referral for occupational therapy; greater weight is placed on this factor.

No single enumerated factor is the sole determinant of Petitioner's disability. The Commission, on the bases of the factors considered under Section 8.1(b) and Petitioner's testimony of his hands being much better and his grip strength being better, concludes Petitioner sustained a 10% loss use of his right hand and a 12.5% loss use of his left hand as a result of the injuries sustained on January 12, 2018.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $519.22 per week for a period of 42.75 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 10% loss of use of Petitioner's right hand and the 12.5% loss of use of Petitioner's left hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $3,861.11for medical expenses under §8(a) of the Act.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $26,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 6 - 2019
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O: 06/11/19
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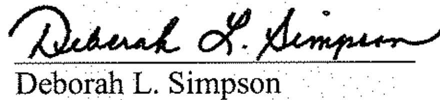
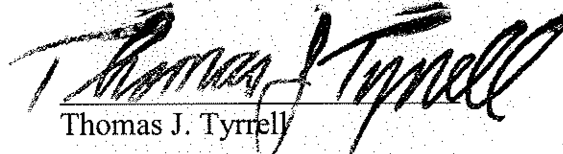

Deborah L. Simpson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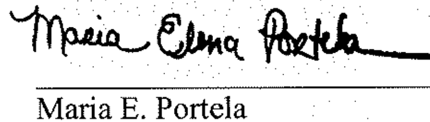
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STATE OF ILLINOIS) BEFORE THE ILLINOIS WORKERS' COMPENSATION
) SS COMMISSION
COUNTY OF COOK)

PATRICK J. KENNEDY,
Petitioner,

vs. NO. 11 WC 2121 & 11 WC 2946
19 IWCC 439

STATE OF ILLINOIS DEPARTMENT OF HUMAN SERVICES,
Respondent.

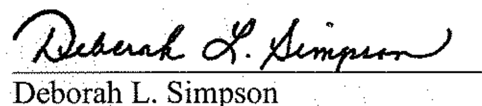
ORDER OF RECALL UNDER SECTION 19(F)

A Petition to Recall Decision pursuant to Section 19(f) of the Illinois Workers' Compensation Act to correct a clerical error in the Decision and Opinion on Review of the Commission dated August 16, 2019 having been filed by Petitioner herein, and the Commission having considered said Petition, the Commission is of the opinion that the Petition should be granted.

IT IS THEREFOR ORDERED BY THE COMMISSION that the Decision and Opinion on Review dated August 16, 2019 is hereby recalled pursuant to Section 19(f) for clerical error contained therein.

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

DATED: SEP 10 2019



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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 Accident/causation	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PATRICK KENNEDY,

Petitioner,

vs. Nos: 11 WC 2121 &
11 WC 2946
19 IWCC 439

STATE OF ILLINOIS DEPARTMENT OF HUMAN SERVICES,

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 accident, causal connection, medical expenses, temporary total disability, and permanent partial disability, and being advised of the facts and law, reverses the Decision of the Arbitrator, finds that Petitioner sustained his burden of proving he sustained a compensable accident on June 18, 2010 causing a condition of ill-being of his cervical spine, and awards benefits.

I Testimony

Petitioner testified that he worked as a carpenter for Respondent for 25 years. On June 18, 2010, he was working at Reed Mental Health Center. He was using a metal tool cart, which he estimated weighed 300 or 400 pounds. As he was pushing the cart from one job to another, his "knee started to buckle," he "was already sweating," he "felt numbness and like a light behind" his eyes, and he had a headache. When asked what part of his body bothered him, Petitioner responded his neck. He asked a housekeeper nearby if there was a doctor present, and he went and saw Dr. Carag. When he came to her, she said "what's wrong with you, you don't look good, sit down." He described some symptoms, she said something about a heart attack, put a Nitroglycerin pill in his mouth, and told somebody to call 911.

He was taken to the Resurrection Hospital Emergency Department by ambulance. Petitioner testified he was given a blood test and a doctor said "you didn't have a heart attack. He goes, but you should follow up with your doctor, and there's a doctor you should go to follow up with for your heart attack." He was released from the hospital. Petitioner followed up with Dr. Fisher and Dr. Tenzer. He was referred to Dr. Katznelson, a neurologist.

He told Dr. Katznelson that he had numbness in his left arm/hand, "had the dropsies," and felt faint occasionally. Petitioner thought it was something neurologic and wanted an MRI. He had an MRI of his neck and thoracic spine and returned to Dr. Katznelson on September 23, 2010 to discuss the MRI findings. Dr. Katznelson told him "that there was discs" in his neck. He took Petitioner off work and prescribed physical therapy. Later, he prescribed medication, which appears to have been Neurontin. The physical therapy concentrated on his neck.

Petitioner also complained about his symptoms to his primary care physician, Dr. Pitlosh. He referred Petitioner to Dr. Yapor, a neurosurgeon. Petitioner gave Dr. Yapor his MRI. He told Petitioner he needed cervical fusion surgery. He also provided Petitioner a traction machine. He still uses the machine a couple of times a day.

Petitioner returned to Dr. Pitlosh and informed him that Dr. Yapor recommended surgery. Dr. Pitlosh wanted Petitioner to get a second opinion before major surgery, and referred him to Dr. Deutsch, whom he saw on March 11, 2011. He concurred with the recommendation for surgery. Petitioner has not had the recommended surgery. At the request of his lawyer, Petitioner saw Dr. Palacci in 2016.

Petitioner testified he was off work from June 18, 2010 to July 7, 2011, when he was released to work after he declined surgery. He returned to work at full duty. He noticed that he "wasn't moving as quick," "everything seemed to be a chore," he "had to rethink things twice," and he "had to lighten" his loads. Petitioner testified he never had any problems with his neck, left shoulder, thoracic area, or numbness down the left side of his back prior to the accident. When he came to work on that day, he "was feeling really good, grateful to have a job."

Currently, Petitioner depends on the traction machine. Just holding his head up is a problem, he still had the "dropsies," more in his left hand, and sensitivity in his hands causes problems with his work as a locksmith. He is in pain every day but does not take medication. He has some difficulty with activities of daily living.

On cross examination, Petitioner testified he never weighed his tool cart. He felt neck pain but did not have chest pain when he moved the cart. He denied he asked Dr. Carag to test his blood pressure; they already were without him asking. He denied telling Dr. Carag that he had chest pain on and off that morning. Rather, they told him he had chest pains, he did not tell them.

Petitioner testified that he never told the paramedics on the ambulance about episodes of chest pain, they never asked him any questions, and did not provide any treatment. He also denied that he reported chest pain. Petitioner also denied he reported chest pains at the hospital emergency department. Petitioner just told them, "they think [he] was having a heart attack." He reported left arm numbness at the emergency department but not to the ambulance crew or Dr. Carag; as he did not have a chance to do so.

Petitioner acknowledged that he "guessed" he reported chest pain at the emergency department when presented with their records. However, he testified that he reported pain in his head, neck, and arm. The pill, presumably the Nitroglycerin, did not resolve his pain and he "still felt bad." Petitioner did not remember undergoing a stress test or that doctors wanted to admit him. Petitioner denied refusing treatment at the emergency department, but acknowledged signing a Release and Refusal of Treatment document. He was told he should see his heart doctor and testified he was never told he needed x-rays or an MRI at the emergency department, and neither was taken at that time.

Petitioner testified that he saw Dr. Katznelson two or three times. He did not recall whether he saw him on August 31, 2010.

Petitioner also saw Dr. Butler for a Section 12 examination. While he was off work he could "barely" perform activities at home and while he did do gardening he did not do "the heavy lifting part, just the harvesting." His garden is about 40 x 40 and he puts it up and takes it down every year. He uses a rototiller weighing 45 pounds.

Petitioner agreed that in March 2000 he was "crushed by a building" while serving in the Navy, but denied he had numbness in his upper body as a result. He was not diagnosed with a disc protrusion at that time. A physical therapy record indicating that he made such a statement was incorrect. A Veterans' Administration doctor told him had a trapezius problem.

Petitioner agreed that he saw Dr. McCall but denied that he told him that he had a workup for a similar condition while in the Navy and got 20% disability upon discharge. He got 10% disability for his trapezius. Petitioner also testified that the diagnosis that his condition would worsen as he got older referred to arthritis in his lower back.

The last time he saw Dr. Pitlosh for his current injury was July 6, 2011. He had a couple of off-work notes from medical providers and turned them over. Petitioner denied that he demanded that Dr. Katznelson order an MRI due to his 1999 or 2000 injury. When presented with a note from Dr. Katznelson noting as much, Petitioner responded that he thought that they were in mutual agreement that he needed an MRI. He explained that he told doctors about his prior history but did not know which he informed about that previous injury. Petitioner testified that Drs. Yapor, Deutsch, and Pitlosh all told him his condition had nothing to do with his military injuries.

Petitioner denied that he told Dr. Palacci that he had two episodes of chest pain. He did not recall whether he told Dr. Palacci that a building fell on him. Petitioner denied telling Dr. Palacci that he had a disc protrusion and told him that he never had a prior neck trauma because he did not have any.

On redirect, Petitioner testified he left the hospital because they told him he did not have a heart attack. He worked for Respondent as a carpenter without difficulty from the time he left the Navy to the date of his accident. In the Navy, he had problems with his lower back and trapezius. He was never previously diagnosed with a neck-disc problem.

On re-cross examination, Petitioner agreed that he received 10% disability from the Navy and still receives that benefit.

II Medical records

The ambulance records from June 18, 2010 indicate that Petitioner was working when he had two episodes of chest pain that lasted about 20 minutes. He was currently pain free and had no shortness of breath. He was given Nitroglycerin and Aspirin because of the chest pains.

The records from Resurrection Hospital Emergency Department indicated Petitioner presented after two episodes of "CP/pressure, SOB (presumably shortness of breath) @ work," the first at rest and the second while pushing a cart. Pain improved with rest and resolved when given Nitro by EMTs. PTSD from a "brain injury" noted. An ECG/stress test was negative for ischemia. A brain MRA showed no evidence of hemodynamic significant stenosis of the carotid arteries and showed very hyproplastic distal sight vertebral artery which is barely seen. The right distal vertebral artery was not visualized and was very hyperplastic and attenuated. There was no evidence of focal stenosis, occlusion, or aneurysmal dilation. Petitioner refused admission for to the hospital after being told he was not having a heart attack. The hospital staff recommended he be admitted to undergo a stress test.

On July 22, 2010, Dr. Tenzer performed a left heart catheterization, right femoral angiography with placement of angio-seal device for the preop diagnosis of abnormal nuclear stress test with chest pain. The postop diagnosis was "normal cardiac catheterization." On August 12, 2010, a chest CT taken at Resurrection because of chest pain showed no evidence of acute pulmonary disease and no apparent cause of Petitioner's clinical symptoms. He was restricted to no lifting or excessive bending for 48 hours.

On August 4, 2010, Petitioner presented to Dr. McCall. He noted that Petitioner's chief complaint was low back pain, and a "sensation of being crushed left chest into left scapula with numbness in bilateral upper extremities." He characterized Petitioner as a "somewhat difficult historian." Petitioner stated he felt like he was being crushed when pushing a cart at work. "His vision got blurry. His legs gave out." An Angiogram was negative.

Petitioner reported he received 20% medical disability for a similar condition upon discharge from the Navy in 1999. Petitioner reported whatever his prior condition was, he was told his prognosis was going to get "much worse as he gets older and he [was] concerned that these are manifestations of such." He also felt that this was a "work-related injury; though it was not registered as such." Dr. McCall took x-rays which showed disc spaces were fairly well preserved and "there was just a hint of spondylolisthesis at L4 and L5." Currently, Petitioner reported soreness in the low back and hips and felt like he had "weights tied to his hips."

On August 31, 2010, Petitioner presented to Dr. Katznelson "for some neurological symptoms following an episode that occurred at work." Suddenly, he developed chest pain, blurred vision, numbness in the left arm/leg, and "his left face felt like a blow torch as well." He was given Nitroglycerin and taken to an emergency department. Since, he felt "like his left arm and leg do not work right," and he has "continual numbness in the left side of his face." He was under the care of a psychologist for PTSD. "On motor exam, he exerted very poor effort with his left arm and left leg and weakness had a give way type quality to it, probably 4/5 in every muscle."

Dr. Katznelson's greatest concern was that he had a "small infarct" and that he was going to get a brain MRI. Petitioner also requested cervical and thoracic MRIs because of his pain, which Dr. Katznelson ordered. Petitioner indicated he took a lot of aspirin for his pain, and Dr. Katznelson advised him to only take a baby aspirin. He also strongly advised him to get a psychiatric consultation for non-occupationally related conditions, his PTSD and depression.

A brain MRI, taken on September 10, 2010, showed no evidence of acute intracranial process, abnormal enhancement, or enhancing mas lesions. There was mild central and cortical involutional changes. A cervical MRI was taken on September 16, 2010 for severe neck and back pain, which showed mild-to-moderate degenerative disc disease with disc bulging, probable minimal disc protrusion/spurring C4-T1, with no significant encroachment of the cord or spinal cord abnormality. On the same day, a thoracic MRI showed very mild degeneration with disc bulging at T7-8, with no significant encroachment of the cord or spinal cord abnormality. Later, Dr. Katznelson noted that the brain MRI findings were "nonacute" while the cervical MRI showed some disc bulging (C5-T8) and foraminal narrowing (C5-C7). Petitioner reported "radicular sounding symptoms shooting down his left arm." Dr. Katznelson prescribed Neurontin. He did not formally release Petitioner to work but would consider it if Petitioner felt better the next week.

On October 26, 2010, Dr. Katznelson noted that he had difficulty understanding Petitioner who was very scattered and disorganized. He could not explain all of Petitioner's symptoms based on the cervical pathology. He increased Neurontin, continued physical therapy, ordered an EMG/NCV, and took Petitioner off work "until a diagnosis is more clearly established."

On November 4, 2010, Petitioner presented to Dr. Pitlosh. In handwritten notes which are largely illegible, Dr. Pitlosh indicated that on June 18th Petitioner was lifting a lot of weight, and there became concern about cardiac problems. He mentions radicular pain, and something illegibly "severe" in the left chest/shoulder. He diagnosed cervical degenerative disc disease, referred Petitioner to Dr. Yapor, and restricted him from lifting any weight before being cleared by neurology.

Petitioner presented to Dr. Yapor. He reported being taken out from his job site in an ambulance after injuring himself lifting heavy objects on June 18, 2010. Dr. Yapor noted that Petitioner was previously in perfect health with a non-contributory past medical history. Dr. Yapor found decreased sensation in the C5 and C6 dermatomes of the left arm and decreased cervical range of motion due to pain. He had physical therapy and traction with no benefit. Petitioner indicated, "that he needs to have something done." Dr. Yapor recommended a two-level discectomy/fusion.

On February 11, 2011, Petitioner returned to Dr. Pitlosh. He reported that he continued to drop things. Dr. Pitlosh noted that Petitioner had seen Dr. Yapor at Resurrection, but now wanted a second referral now that he was at Rush. An MRI showed cervical degenerative disc disease with impingement C4-T1. Dr. Pitlosh prescribed Tramadol, recommended physical therapy, and recommended referral to neurosurgery.

On March 11, 2011, Petitioner presented to Dr. Deutsch on referral from Dr. Pitlosh, with the chief complaint of neck and left arm pain. He also complained of diffuse left arm weakness. Petitioner reported a work accident at which time he developed neck and arm pain. A cardiac condition was ruled out.

Dr. Deutsch noted the MRI showed disc herniations at C5-6 and C6-7, with effacement of the C7 nerve root. Besides diffuse neck stiffness, positive Spurling's, difficulty turning his neck, and some triceps weakness, the examination appeared to be normal. Dr. Deutsch diagnosed cervical radiculopathy and noted Petitioner reported the symptoms began with his work accident. He recommended a discectomy at C5-6 and C6-7.

Dr. Deutsch authored a narrative letter in which he noted that Petitioner reported pushing a 300-pound cart when he developed neck pain, left arm pain, and chest pain. He summarized his examination and diagnosis of cervical radiculopathy. He noted that the MRI showed small disc herniations at two levels. He recommended a two-level discectomy and opined that the cervical radiculopathy was related to his work accident based on Petitioner's report of acute onset of pain.

III Doctors' depositions

Dr. Palacci testified by deposition on November 1, 2016. He is board-certified in internal medicine. Currently, his practice involves performing disability evaluations in internal medicine,

providing Section 12 medical examinations, and doing impairment ratings. His experience included cases in which the traumatic injury has been to the neck and back.

At the request of Petitioner's lawyer, he saw Petitioner on April 20, 2016, after he had reviewed his medical records. Petitioner reported he was asymptomatic until he had a sudden onset of neck pain on June 18, 2010 after pushing a 300-pound metal cart full of tools. He had cardiac testing which was negative. It was thought he had a heart attack because he had left arm numbness and possibly chest pains. He had no symptoms prior to his accident.

Petitioner reported to Dr. Palacci current daily 8/10 chronic achy pain. He complained of pain shooting down his left arm, which Dr. Palacci agreed was radicular pain. Petitioner also reported some sharp pain radiating down his left arm several times a week, with some numbness in his fingers. He used a traction device at home. Dr. Palacci noted reduced range of motion, tenderness in the trapezius muscles, positive Spurling's, and normal reflexes/strength.

Dr. Palacci opined that Petitioner's condition was aggravated by the work accident causing it to become permanently symptomatic. He also opined that Petitioner had to be off work for about 12 months after the accident. Dr. Palacci disagreed with the opinion of Dr. Butler who opined Petitioner's condition was not caused by the accident.

On cross examination, Dr. Palacci testified he was not an orthopedic surgeon and about 10% of his practice involves performing Section 12 examinations. He did not currently treat patients, but in the past, he treated patients with neck injuries many, many times. Petitioner did not mention that he was a Navy veteran nor that he had been discharged because of a neck condition. Dr. Palacci acknowledged that he did not review any records prior to an MRA report dated July 3, 2010, or see any medical records from the day of the accident. Dr. Palacci explained that degenerative disc disease symptoms are typically slow in onset, while acute radicular symptoms, like Petitioner's are usually the result of a disc herniation.

Dr. Butler testified by deposition on March 13, 2017. He is a board-certified orthopedic surgeon and independent medical examiner. He sees about 40 patients and performs about 10 IMEs a week. He performed a Section 12 medical examination on Petitioner evaluating his cervical spine on June 29, 2016. Subsequent to the exam, he reviewed his medical records. He did not have the actual MRI films, but only the reports. Petitioner reported pushing a tool cart when he felt a sensation of passing out. Eventually, he was given surgical options from two neurosurgeons.

Regarding Petitioner's work accident, Dr. Butler testified it appeared to him that Petitioner suffered an episode of angina. Later, he was found to have cervical degenerative disc disease and stenosis. The medical records did not support a causal connection between Petitioner's cervical condition and his work accident. Petitioner was at maximum medical improvement and did not need any additional treatment.

On cross examination, Dr. Butler testified he doubted that he had all of Petitioner's medical records. He thought he had sufficient information to arrive at his conclusions on causation but agreed that more information is better. He also agreed that Petitioner reported to him that he was pushing a 300-pound cart and that pushing such a cart was part of his job responsibilities. Pain in his neck and left-arm numbness were part of his complaints he reported from the accident. He also reported some radicular symptoms. However, Dr. Butler disagreed that Petitioner's history was consistent throughout. He noted that his history at the emergency department was different from the histories he gave subsequent doctors. Dr. Butler also acknowledged that he did not see any records noting that Petitioner complained of neck/back pain or hand numbness prior to the date of accident.

Dr. Butler agreed with Dr. Yapor's diagnosis but believed the history he was provided was inaccurate. He also agreed that Dr. Deutsch opined that the accident caused Petitioner's disc herniations. Dr. Butler further agreed that his finding of decreased pin-prick sensitivity was likely due to the cervical pathology noted in the MRI. Petitioner reported working with pain daily since the accident. If he had such pain since 2010, Dr. Butler agreed his condition would be considered permanent. While pushing a 300-pound cart would be consistent with a cervical injury if there was initial complaint of neck pain, there was no such report here. He did not see any report indicating that Petitioner injured his neck.

Dr. Butler did not believe Petitioner's condition was related to his accident at any point in time. He noted that Petitioner did not complain of neck pain until six weeks after the accident, and he first complained of low back pain, for which he had an MRI. While Dr. Butler agreed the treatment Petitioner received was reasonable, he did not believe it was related to a work injury. The Commission notes that Dr. Butler, in his report, which was admitted into evidence at the hearing, stated that Petitioner's accident "is no longer related to the patient's current objective findings…the Patient had not had an MRI since 2010."

IV Conclusions of Law

The Arbitrator found that Petitioner proved neither that he sustained an accident on June 18, 2010 nor that the alleged accident caused his condition of ill-being of the cervical spine. He found Petitioner to not be credible based on his failure to report aspects of his medical history to doctors. He also noted that the initial medical records showed no neck complaints.

On the issue of causation, the Arbitrator found the opinions of Dr. Butler more persuasive that those of Dr. Palacci, noting that Petitioner told Dr. Palacci he did not have any prior problems with his neck and did not mention that he had a medical discharge from the Navy. Similarly, the Arbitrator discounted the opinions of Dr. Deutsch and Dr. Yapor because they also did not have complete information about Petitioner's medical history.

The Commission concludes that the Arbitrator erred in finding no accident and no causation. That Petitioner, a veteran and 25-year employee of Respondent, had an onset of multiple symptoms at the time of his accident does not undercut his credibility. Petitioner's testimony about the accident was not disputed. In addition, the fact that doctors initially believed he suffered a heart attack did not contradict Petitioner's testimony that he injured his neck and arm in the accident, and doctors initially concentrating on cardiac issues was understandable and led to overlooking any orthopedic issues at the time. The opinions of Respondent's Section 12 examiner, Dr. Butler, to the contrary are not persuasive. Six years after the accident, Dr. Butler saw Petitioner on one occasion and thereafter opined that Petitioner's condition was not causally related to the accident at work. However, Dr. Butler made admissions limiting the persuasiveness of his conclusions. He testified that he did not review the actual MRI films and doubted that he had all of Petitioner's medical records. Dr. Butler also admitted that pushing a 300-pound cart would be consistent with a cervical injury, that Petitioner's cervical diagnosis was correct, and that the findings of decreased pin-prick sensitivity was likely due to pathology as noted in the cervical MRI (report). The latter admissions buttress the findings and opinions of Petitioner's treating physicians that he suffers from a cervical condition with radiculopathy that requires surgery as a result of the accident at work.

The Arbitrator was very concerned that Petitioner did not report his prior military injury. However, Petitioner testified that the prior injury involved his lower back and trapezius no evidence was presented about any prior cervical or neck issues. In addition, while Petitioner's testimony was somewhat inconsistent it must be considered in overlay of psychological issues noted in the medical records which can affect memory and the ability to communicate effectively. Dr. McCall noted that Petitioner was a poor historian, and Dr. Katznelson noted that he had difficulty understanding Petitioner because he was scattered and unorganized. The ultimate consideration is that prior to the accident Petitioner was able to work as a carpenter despite any pre-existing condition and that after the accident he developed undisputed cervical pathology for which two neurosurgeons recommended two-level fusion surgery.

Regarding the issue of medical expenses, the Commission notes that Respondent's Section 12 medical examiner, Dr. Butler, acknowledged that all treatment Petitioner received was reasonable. Therefore, the Commission finds that all the treatment rendered was reasonable and necessary to treat Petitioner's work-related condition of ill-being and awards all medical expenses submitted into evidence.

Regarding the issue of temporary total disability, Petitioner testified that he was off work from the date of the accident until July 7, 2011. Based on that testimony Petitioner seeks an award of 55 weeks of temporary disability benefits. In our review of the record, the first, and only, off work note we saw was from Dr. Katznelson dated October 26, 2010. We saw no release to work note, however, Petitioner testified that he returned to work on July 7, 2011. Therefore, the Commission awards temporary disability benefits of 36&3/7 weeks.

Regarding the issue of permanent partial disability, the Commission notes that no impairment rating under AMA Guides was presented and no weight is given to that factor. The Commission gives greater weight to the fact that Petitioner was able to return to his previous physically demanding job despite his injury and also therefore did not establish any potential loss of income. The Commission gives some weight to Petitioner's age (53 at the time of accident and over 60 at arbitration) which indicates he would not have to live with the condition for a prolonged future working life. Finally, the Commission gives greater weight to the evidence of disability corroborated in the medical record. Petitioner's testified about his continuing problems and his ongoing complaints were corroborated by the fact that there was sufficient pathology that two neurosurgeons recommended a two-level fusion, though Petitioner declined to proceed with surgery. Based on these statutory factors, the Commission concludes that a permanent partial disability award of 50 weeks representing loss of 10% of the person-as-a-whole is appropriate.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated April 16, 2018 is reversed and the Commission finds that Petitioner sustained his burden of proving he sustained a compensable accident on June 18, 2010 causing a condition of ill-being of his cervical spine.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $1,130.67 per week for a period of 36&3/7 weeks, that being the period of temporary total incapacity for work under §8(b).

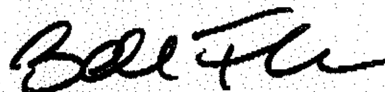
IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $664.72 per week for a period of 50 weeks, as the injuries sustained caused the permanent partial loss of the use of the person-as-a-whole to the extent of 10% thereof under §8(d)2.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay $35,334.40 in medical expenses submitted into evidence, under §8(a), subject to the applicable medical fee schedule in §8.2.

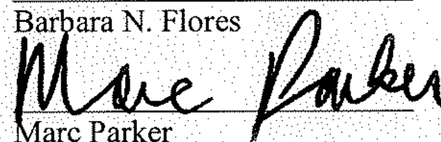
IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

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

DATED: SEP 10 2019



Barbara N. Flores



Marc Parker

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Dissent

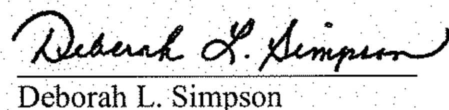
I respectfully dissent from the decision of the majority. I would have affirmed and adopted the Decision of the Arbitrator in which he found that Petitioner did not sustain his burden of proving he sustained a compensable accident on June 18, 2010 which caused a current condition of ill-being of his cervical spine and denied benefits.

I agree with the Arbitrator that Petitioner was not credible. His report of the mechanism of injury varied, he did not appear to provide complete medical history to any doctor, and he denied making statements to medical providers that were clearly in their records. In addition, the fact that he was able to work at full duty as a carpenter for seven years despite his subjective complaints of constant pain and disability, seriously undercuts credibility. I also agree with the Arbitrator and find the opinions of Dr. Butler persuasive. He is correct that the medical records do not support the allegation that he suffered any neck injury in the alleged accident.

The only treater who appears to have actually opined that Petitioner's condition was caused by his alleged work accident was Dr. Deutsch and he specifically predicated that opinion on his assumption that Petitioner experienced immediate onset of neck pain after the accident. However, that assumption is completely contradicted by the medical records. Despite Petitioner's testimony to the contrary, the emergency department records do not make any mention of cervical or neck pain whatsoever and there was no treatment or even diagnostic testing of the cervical spine. In fact, the first mention of any neck pain appears to have been six weeks after the accident.

In addition, Dr. Katznelson's evaluation indicated symptom magnification or even malingering. He observed non-organic behaviors and could not explain his symptoms from his cervical pathology alone. When he took Petitioner off work (the only off-work note that appears to be in the record) he did so because he could not explain Petitioner's symptoms or make a definitive diagnosis based on Petitioner's pathology and subjective complaints. In this regard, it is interesting, and perhaps a little concerning, that Petitioner chose to hire a semi-retired internist as a Section 12 examining doctor to evaluate Petitioner's alleged cervical condition rather than deposing one of his treaters, or at least hiring an orthopedic or neurosurgeon to provide expert testimony.

For the reasons stated above, I would have affirmed and adopted the Decision of the Arbitrator in which he found that Petitioner did not sustain his burden of proving he sustained a compensable accident on June 18, 2010 which caused a current condition of ill-being of his cervical spine and denied benefits. Therefore, I respectfully dissent from the majority decision.



Deborah L. Simpson