STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Alice M. Short,
Petitioner,

vs. No. 13 WC 3130

18IWCC0194

State Governor's Office of Management & Budget,
Respondent.

DECISION AND OPINION ON REVIEW

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

Petitioner testified she worked as an administrative assistant for the Governor's Office of Management and Budget, preparing forms, typing and filing. In an average day, which varied from 7½ hours to 16 hours, she would spend half her time at her desk, and the other half, filing.

On 10/11/12, Petitioner fell down a stairway while exiting her building after a fire alarm sounded. She hit her head on a bannister and fell head first, unconscious, onto a landing. She was taken to the emergency room of Memorial Medical Center, with complaints of head and neck pain. Her discharge diagnosis was concussion and neck sprain. The week after her accident, Petitioner began treating with her primary care physician, Dr. Vasconcelles, to whom she complained of shoulder, neck and "whole back" pain shooting down her arms and legs. Although Petitioner claimed those symptoms began after her accident, Dr. Vasconcelles' October and November 2012 records do not corroborate those complaints.

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Petitioner underwent physical therapy and chiropractic treatment with Dr. Venturini which she claimed provided little relief. She saw a neurologist, Dr. Warach, who ordered MRI's and EMG/NCV testing. She saw a pain management doctor, Dr. Salvacion, who administered two lumbar epidural steroid injections which provided no relief.

Petitioner testified her severe headaches lasted six months. In September 2013, Petitioner returned to her job at Respondent, working light duty on a part-time basis for two weeks, then returning full-time. Petitioner denied that her supervisors accommodated her restrictions. Because Petitioner asserted that she could not keep up with her work due to pain, Dr. Vasconcelles took her off work and has not released her, since.

Seven months after her accident, Petitioner returned to her psychiatrist, Dr. Tabatabai, with whom she previously treated for depression and anxiety. Prior to her accident, Petitioner claimed to have missed no work due to depression and anxiety, but asserted those conditions became unmanageable, after.

In April 2014, Petitioner began working a new part-time job answering phones as a secretary for Parkway Church, where she worked until she was terminated in March 2015. In September 2015, she began another part-time job as a switchboard operator for St. John's Hospital ("HSHS"); she quit that job in May 2016 because of the stress of directing phone calls.

At arbitration, Petitioner testified she still experiences dizziness and has balance problems. She still experiences headaches on a monthly basis, especially when the barometric pressure changes. She currently does gardening and spends time with her grandchildren.

Jennifer Cavanaugh testified on behalf of Respondent that she was Petitioner's supervisor. In October 2012, Petitioner's duties did not usually require lifting over 10 lbs.; many people were available there to help Petitioner with lifting, if needed. There was never a problem if Petitioner needed to stretch or stand. Contrary to Petitioner's testimony, Petitioner was never asked to work 60-hour weeks after her accident and she never did. When Petitioner returned to her job in October 2013, she never complained of difficulty keeping up with her workload.

Layla McLean testified on behalf of Respondent that her duties there included managing information regarding workers' compensation claims. She had knowledge of Petitioner's September 2013 work restrictions from Dr. Vasconcelles, and all were accommodated. Petitioner was also told to let Respondent know if there was anything they could do for her such as breaks to sit or stand, or altering her work schedule to accommodate appointments. Ms. McLean sent Petitioner emails informing her that Respondent was willing to take any means necessary to get her back to work and help her as required. In response, Petitioner sent off work slips and an email stating that she would not be returning to work after October 23, 2013.

Mark Gifford testified on behalf of Respondent that he was Petitioner's supervisor at the Parkway Christian Church when she worked there as a secretary for almost one year following her accident, from April 30, 2014 to March 16, 2015. She was always able to complete her work and never expressed difficulty about completing her assigned tasks. She was terminated for not advancing in her position.

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Peggy Henry testified as a rebuttal witness on behalf of Petitioner that she worked for Respondent as an administrative assistant/receptionist, and was a co-worker of Petitioner. On October 11, 2012, she witnessed Petitioner fall head first down a 14-step flight of concrete stairs, hitting her neck and the back of her head. Prior to her accident, Petitioner was working on cleaning and moving files and cabinets from an office. Although Petitioner had to lift items weighing between 17-20 lbs., Petitioner could determine how much she could lift and carry.

Petitioner's initial treating records from the emergency room of Memorial Medical Center were not offered into evidence. The first record in evidence was Dr. Vasconcelles' office note of October 19, 2012, showing Petitioner complained of severe right-sided headaches and short-term memory loss. Dr. Vasconcelles' diagnosis was concussion and acute post-traumatic headaches. Two weeks later, Petitioner's complained of dizziness and neck stiffness; Dr. Vasconcelles added "neck sprain" to her diagnoses. Although Petitioner reported no new symptoms to Dr. Vasconcelles on December 6, 2012, a week later Petitioner reported experiencing a new low back pain that was different than the low back soreness she had experienced right after her fall. By January 2013 Petitioner reported her neck was improving, but that her pain was aggravated by her 60-hour work weeks.

Neurologist Dr. Joseph Warach reported in January 2013 that Petitioner's NCV studies were fairly unremarkable and provided no electrophysiologic explanation for her cervical and upper extremity pain syndrome, which may have had a musculoskeletal basis. Following a second EMG/NCV of the lower extremities, which showed subacute bilateral L5 radiculopathies, he suggested Petitioner see a pain specialist.

As the months went by, Dr. Warach reported that Petitioner's lumbosacral pain with radiation had worsened, while her dizziness had dramatically improved. By February 2013, Dr. Warach reported her dizziness had completely resolved, and she could return to light duty work.

Dr. Salvacion's March 2013 records show Petitioner told him that her back and right lower extremity pain had been present since October 2012. Dr. Salvacion administered two lumbar injections which provided no long-lasting benefit, and diagnosed Petitioner with lumbar degenerative disk disease and lumbar radiculopathy.

On August 29, 2013, Dr. Vasconcelles wrote that Petitioner's back discomfort was the reason she could not work. In March 2014, Dr. Vasconcelles reported that Petitioner suffered from chronic pain syndrome and fatigue since her work accident from which she would never recover, and he believed she would not be able to return to her occupation.

Although Petitioner had been working part-time at Parkway Church since April 2014, she told Dr. Vasconcelles on June 5, 2014 that she had not been able to return to work and was not receiving any income. In September 2014, Petitioner told Dr. Vasconcelles she had not worked for more than 1 year, even though she had been working the prior four months at Parkway.

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Petitioner also treated with orthopedic physician, Dr. Williams. In May 2013 he reported that her pain stemmed from multilevel lumbar and cervical degenerative changes. He recommended conservative treatment and limiting her use of narcotic medications. In November 2013, he documented Petitioner's reports that: she had recently been diagnosed with fibromyalgia; her employer was demanding she work 12-15 hours per day, and she was determined she could not go back to work. Dr. Williams recommended she return to activities as tolerated, use non-steroidal anti-inflammatories and limit her use of narcotics.

Partial records of Petitioner's psychiatrist, Dr. Tabatabai, were offered into evidence. They did not include five years of Petitioner's pre-accident records or the two most recent years of her treatment. On May 8, 2013, Dr. Tabatabai diagnosed Petitioner with severe recurrent major depression and anxiety disorder, though he placed no work restrictions on her at that time. Six months later, Petitioner told him she had been working 13-hour days and was applying for disability. Dr. Tabatabai opined that Petitioner was unable to be gainfully employed and met the criteria for disability status, based on her current symptoms and her past history of severe depressive illness since 2007. Dr. Tabatabai's October 2014 note stated Petitioner remained depressed, anxious and overwhelmed; she was still disabled and might require hospital or in-patient care. Dr. Tabatabai's records did not show he was aware that Petitioner was working.

On August 26, 2013, Petitioner was examined by Respondent's Section 12 doctor, Stephen Pineda. Following his exam, Dr. Pineda gave his opinion that Petitioner's neck sprain, chronic headaches and concussion-related problems appeared resolved, though she still complained of low back pain. He opined she was at maximum medical improvement for her work accident, and could return to her regular job with no restrictions. He recommended a functional capacity evaluation, which Petitioner declined to undergo.

On June 24, 2014, Petitioner underwent a Section 12 examination by Dr. Stephen Weiss. His report documented her complaints of pain on superficial palpation, the presence of pain behavior, and an inconsistent response to straight leg raising. He found those all to be positive Waddell signs consistent with symptomatic magnification. Dr. Weiss diagnosed Petitioner with: pre-existing cervical and lumbar degenerative disc disease; soft tissue cervical and lumbar sprains and possibly a temporary exacerbation of pre-existing lumbar degenerative disc disease. He found her exam to be objectively unremarkable, and that her work injury had resolved without any permanency. He opined that she had reached MMI in June 2013 and that all treatment after that was unrelated to her work injury. He performed an AMA Impairment rating, and found her impairment to be 0% for her resolved cervical strain and 0% for her lumbar strain.

Petitioner has not undergone any surgery since her accident. The consensus of her doctors was that she was not a surgical candidate.

The Arbitrator found the following conditions to be related to Petitioner's fall down the stairs: neck and low back sprains, post-concussion headaches, fibromyalgia/chronic pain syndrome, depression and anxiety. The Arbitrator awarded Petitioner permanent and total disability benefits under §8(f) of the Act, as well payment of all of the medical expenses contained in Petitioner's Exhibit 9, under §8(a) and §8.2 of the Act. The Arbitrator further awarded Petitioner 109-3/7 weeks of temporary total disability benefits for intermittent periods

between January 10, 2013 and October 24, 2016 under §8(b) of the Act, and 84 weeks of temporary partial disability benefits for intermittent dates between April 15, 2014 and May 28, 2016 under §8(a) of the Act. The Arbitrator found Petitioner to be a credible witness, and found the opinions of Drs. Vasconcelles and Tabatabai to be more persuasive than those of Drs. Pineda and Weiss, because the latter doctors had not reviewed all of Petitioner's records.

The Commission views the evidence differently than did the Arbitrator. First, it does not find Petitioner to be a credible witness, for myriad reasons. She gave varying accounts of when her low back pain began, telling Dr. Williams that it started right after her fall, but telling Dr. Venturini that it came on gradually. Contrary to those histories, Dr. Vasconcelles reported on December 13, 2012, that Petitioner complained of "new" low back pain that was different than the soreness she had experienced at the time of her accident.

Petitioner also testified at arbitration that she still experiences dizzy spells, although Dr. Warach's April 2013 records reported that her dizziness had completely resolved. Petitioner told Dr. Vasconcelles in January 2013 that she was working 60-hour weeks, but her time records show she never worked more than 37½ hours in any week from her accident date through January 8, 2013. Petitioner told Dr. Tabatabai that she had been working up to 13-hour days, when her timesheets show she never worked more than 7½ hours on any day after her accident.

During the nine-month period when Petitioner worked for Parkway Church, she hid that fact from Dr. Vasconcelles, telling her that she was not working and had no income. Petitioner also told Dr. Weiss in April 2014 that she had not worked since October 2013, which was not true. Dr. Weiss found Petitioner had positive Waddell's signs and exhibited pain behaviors.

Petitioner's testimony that Respondent did not accommodate her restrictions when she returned to work in September 2013 was contradicted by two Respondent witnesses – Jennifer Cavanaugh and Layla McLean – who testified that all her restrictions were accommodated.

While the Arbitrator discounted the opinions of Drs. Pineda and Weiss for not having reviewed all of Petitioner's records, the Commission notes the Arbitrator's own findings were based upon incomplete records. Petitioner did not offer into evidence the initial emergency room records of Memorial Medical Center, where she was treated shortly after her accident. Dr. Tabatabai's records in evidence were incomplete; they were missing years of Petitioner's treatment with that doctor, both before and after her accident. The Commission questions the reliability of Dr. Tabatabai's two-year old opinion when, since then, he has provided two years of treatment. Portions of Dr. Vasconcelles' records were heavily redacted, including Petitioner's histories, active problems and her medications, some of which she blamed for her symptoms.

The Commission finds Petitioner provided inconsistent, incomplete and inaccurate histories to her treating physicians. The Commission finds that Petitioner's injuries from her work accident included only: a concussion, post-concussive headaches, temporary short-term memory loss, dizziness, and neck and back sprains and strains, most of which resolved in six to ten months following her accident.

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The Commission finds Petitioner has not proven she is permanently and totally disabled from work as a result of her work accident. In so finding, the Commission relies upon the August 26, 2013 opinion of Dr. Pineda that Petitioner's chronic headaches and neck pain had resolved and she was at MMI and able to work without restrictions. Those opinions were consistent with the opinion of Dr. Warach that Petitioner's dizziness had resolved, and the opinion of Dr. Williams in November 2013 that her neck pain was tolerable and controllable.

While the Arbitrator found Petitioner's low back symptoms were causally related to her accident because they materialized, "within a reasonable amount of time," the medical records in evidence do not support such conclusion. In none of Dr. Vasconcelles' October and November 2012 office notes were there any reports of low back pain or complaints. Not until December 13, 2012, did Dr. Vasconcelles report Petitioner's complaint of new back pain, which Petitioner herself described as different than the soreness she experienced after her accident. The Commission finds Petitioner's lumbar spine symptoms and complaints on and after December 13, 2012 to be a new condition, unrelated to her work accident. While Petitioner suffered lumbar strains and sprains from her work accident, the Commission finds those had resolved prior December 13, 2012.

The Commission finds that Petitioner misled Dr. Vasconcelles and Dr. Tabatabai regarding her physical ability to work, as well as her reasons for not wanting to. Because their opinions were not based upon accurate and complete information, the Commission finds them less persuasive.

The Commission finds Petitioner has not proven her depression and anxiety were causally related to or aggravated by her accident. She suffered from those conditions prior to her accident. Without reviewing Dr. Tabatabai's diagnoses and findings prior to Petitioner's accident, the Commission is unable to ascertain whether those conditions were aggravated or exacerbated by her work accident, and if so, to what extent. Without Dr. Tabatabai's more recent records, the Commission cannot state whether Petitioner's anxiety or depression still are still present, and if so, the current cause thereof.

The Commission also finds Petitioner has not proven that her chronic pain syndrome or fibromyalgia were causally related to her accident. As the record shows, Petitioner's head and cervical injuries from her accident had resolved prior to those diagnoses – which were made following Petitioner's new onset of lumbar symptoms on December 13, 2012.

The Commission finds Petitioner has proven she sustained, as a result of her accident: a concussion; post-concussion headaches; short term memory loss; dizziness; vertigo, and cervical and lumbar sprains and strains. The Commission finds Petitioner has suffered permanent partial disability of 40% loss of use of person-as-a-whole under §8(d)2, based upon the following factors enumerated in §8.1(b):

(i) *Reported Impairment:* Dr. Weiss was the only physician to provide an AMA Impairment rating: 0% for both Petitioner's cervical strain, and 0% for her lumbar strain. The Commission gives this factor moderate weight.

(ii) *Injured Employee's Occupation:* Petitioner's occupation was that of an administrative assistant. The Commission finds that Petitioner recovered from her work injuries to the point that she was able to, and did, return to work at that position. The Commission gives this factor moderate weight.

(iii) *Age of Employee at Time of Injury:* Petitioner was 53 years old at the time of her injury. The Commission gives this factor moderate weight.

(iv) *Employee's Future Earning Capacity:* Dr. Pineda found Petitioner able to work without restrictions at her prior job as of August 26, 2013. While Petitioner is not currently working, that was not proven to be the result of injuries from her October 11, 2012 work accident. The Commission gives this factor some weight.

(v) *Evidence of Disability Corroborated by Treating Medical Records:* Petitioner worked for 3 months following her accident before any physician authorized her off work. She returned to her usual position at Respondent almost one year after her accident. Though she worked at that position for only one month, she demonstrated her ability to be gainfully employed by working two part-time jobs, lasting 10 and 8 months. The Commission gives this factor moderate weight.

The Commission finds Petitioner entitled to temporary total disability benefits for a period of 36-4/7 weeks, from January 10, 2013 through September 22, 2013, pursuant to §8(b) of the Act. She returned part time to her prior position on September 23, 2013. Although Dr. Pineda released Petitioner to full duty work the month before, Dr. Vasconcelles still had her on restrictions which Respondent did not accommodate until then.

The Arbitrator awarded Petitioner all the reasonable and necessary medical expenses set forth in Petitioner's exhibit, PX9. The Commission, however, finds the treatment for all of Petitioner's lumbar spine issues on and after December 13, 2012 to be unrelated to Petitioner's work accident. The Commission also finds Petitioner's conditions of depression, anxiety, chronic pain syndrome and fibromyalgia to be unrelated to her accident. The Commission reverses the award of any medical expenses incurred for the treatment of those injuries which may have been awarded by the Arbitrator.

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

IT IS FURTHER ORDERED BY THE COMMISSION that the award of temporary total disability benefits is modified. Respondent shall pay Petitioner temporary total disability benefits of $456.92/week for 36-4/7 weeks, commencing January 10, 2013 through September 22, 2013, as provided by §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of temporary partial disability benefits is vacated.

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IT IS FURTHER ORDERED BY THE COMMISSION the award of permanent and total disability benefits of $485.80/week for life commencing October 25, 2016 as provided in §8(b) of the Act, with possible cost-of-living adjustments paid by the Rate Adjustment Fund as provided in §8(g) of the Act, is hereby vacated. Instead, Respondent shall pay to Petitioner the sum of $411.23 per week for a period of 200 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries to Petitioner's head and spine caused the 40% disability to the person-as-a-whole.

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that the clerical error in the Arbitration decision on page 1, paragraph 4, is corrected from, "October 15th, 2016," to read, "October 15, 2012."

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

DATED: MAR 30 2018

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jdl/mcp
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Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SHORT, ALICE M
Employee/Petitioner

Case# **13WC003130**

STATE GOVERNOR'S OFFICE OF MANAGEMENT BUDGET
Employer/Respondent

18IWCC0194

On 1/6/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.63% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2046 BERG & ROBESON PC
ALLEN C MUELLER
1217 S 6TH ST
SPRINGFIELD, IL 62705

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

0988 ASSISTANT ATTORNEY GENERAL
JORDAN HOMER
500 S SECOND ST
SPRINGFIELD, IL 62706

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

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62794-9255

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

JAN 6 2017

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Sangamon)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Alice M. Short
Employee/Petitioner

v.

State Governor's Office of Management Budget
Employer/Respondent

Case # 13 WC 3130

Consolidated cases: N/A

18IWCC0194

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Springfield**, on **October 24, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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FINDINGS

On **October 11, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$35,640.00**; the average weekly wage was **$685.38**.

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

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

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

Respondent shall be given a credit of **$16,320.51** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$16,320.51**.

Respondent is entitled to a general credit for any medical bills paid by its group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical expenses as set forth in PX 9, including reimbursements to Petitioner for co-pays and out-of-pocket expenses and prescriptions, subject to the Medical Fee Schedule, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive credit for all medical bills previously paid, including any paid by its group medical plan for which credit is allowed under Section 8(j) of the Act and shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner temporary partial disability benefits of **$303.33/week** for **48 weeks**, commencing **4/15/14** through **3/16/15**, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner temporary partial disability benefits of **$290.79/week** for **36 weeks**, commencing **9/20/15** through **5/28/16**, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of **$456.92/week** for **109 3/7 weeks**, commencing **January 10, 2013 through September 22, 2013 (a period of 36 4/7 weeks)**, and again from **October 25, 2013 through April 14, 2014 (a period of 24 4/7 weeks)**, from **March 17, 2015 through September 19, 2015 (a period of 27 weeks)** and from **May 29, 2016 through October 24, 2016 (a period of 21 2/7 weeks)**, as provided in Section 8(b) of the Act. Respondent shall receive credit for any TTD benefits previously paid.

Respondent shall pay Petitioner permanent and total disability benefits of **$485.80/week for life**, commencing **10-25-16**, as provided in Section 8(f) of the Act.

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

18IWCC0194

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

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

Nancy Lindsay
Signature of Arbitrator

December 22, 2016
Date

JAN 6 - 2017

Alice M. Short v. State Governors Office of Management Budget, 13 WC 3130

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

Petitioner was employed by Respondent on October 11, 2012, and had been so employed as an administrative assistant II for the preceding 5 years. On that date, Petitioner fell while exiting the building after a fire alarm had sounded. She recalled missing a step and falling, hitting her head on the hand rail. Respondent does not dispute accident. (See AX 1, RX 4, RX 5)

Petitioner testified that she did not remember the actual fall, but she did remember ending up head first on the landing with her legs above on the stairs. She recalled being helped up. She did not want to go to the hospital by ambulance, and called her husband, who transported her to Memorial Medical Center.

Records from Memorial Medical Center's emergency room are not a part of the record. Radiology records from that visit reflect a history of the fall with a loss of consciousness, followed by complaints of headaches, and neck pain. CT scans of the head and neck were performed. The CT of the head was normal, while the CT of Petitioner's neck revealed multi-level degenerative changes in the cervical spine. (PX5)

Petitioner did not work on October 12th or October 15th, 2016. She did work on October 17th and 18th, 2012. (RX 6)

Petitioner followed with her primary care physician, Dr. Vasconcelles, on October 19, 2012. At that time she complained of headaches but noted they were different from her longstanding migraines. There was no mention of neck pain or of a CT of the neck having been performed. A cursory/superficial examination of Petitioner's neck was performed and described as "normal." No examination of Petitioner's neck or back musculoskeletal structures appears to have been done. Dr. Vasconcelles' diagnosis was a concussion and acute post-traumatic headaches. Narcotic pain medication was prescribed. (PX1)

Petitioner continued working for Respondent on a full duty basis (7.5 hours/day) commencing October 24, 2012. (RX 6)

Petitioner returned to see Dr. Vasconcelles on November 5, 2012 four weeks after having "hit her head and also [straining] her neck and upper back." At that time Petitioner's chief complaint was neck and back pain, as well as continued headaches which were described as intermittent but no longer as frequent. Petitioner reported that her back and upper neck pain was getting worse, and occasional radicular tingling in the left upper extremity was reported. Dr. Vasconcelles performed a musculoskeletal inspection/palpation of Petitioner's joints, bones, and muscles which was provocative for pain and tightness to palpation in the posterior upper neck and back muscles bilaterally. Petitioner's diagnosis/assessment was: 1) concussion; 2) acute post-traumatic headaches; and 3) neck sprain. Dr. Vasconcelles added Gabapentin to Petitioner's medications, and physical therapy was ordered. (PX1)

Petitioner was seen at Memorial Industrial Rehabilitation on November 12, 2012, complaining at that time of neck, bilateral shoulder, and upper-mid back pain. Petitioner was working full duty and reporting headaches 2-3 times/week. Her complaints included intermittent left upper extremity tingling which was being experienced daily. Her pain was reported to have increased over the preceding 48 hours with activity, including prolonged sitting, neck rotation, driving, and reaching across her body. Petitioner's pain level was reported as 7 out 10 at its best. Physical examination noted decreased range of motion with pain in all planes of movement, and tenderness was noted throughout the neck and upper back (shoulder and scapula muscle groups). The therapist noted Petitioner's exam and findings were consistent with a neck sprain. (PX1, 3)

Petitioner attended physical therapy on November 29, 2012 reporting increased neck soreness/pain since the day before. She had walked to the next building at work (the capitol) and up some stairs and to several rooms all over the building noting increased soreness as she did so. A headache occurred shortly thereafter. (PX 1, 3)

Petitioner again attended therapy on December 5, 2012 reporting "2/10" pain in her neck and that she had been feeling better but still having some stiffness in her neck although it was greatly improved. (PX 1, 3)

Petitioner returned to Dr. Vasconcelles on December 6, 2012 for her "one month follow-up on neck and back pain." She made no specific low back complaints. On examination, she was noted to have palpable pain and muscle spasms in her upper back, left shoulder, and posterior back. Petitioner's diagnosis and assessment was unchanged. (PX1)

Petitioner worked 2.5 hours on December 13, 2012. (RX 6)

Petitioner again attended therapy on December 13, 2012 reporting that she had a worsening headache; however, her shoulders weren't too bad. Petitioner reported trouble sleeping and being worn out during the day. She also mentioned some low back and right hip soreness. No treatment appears to have been directed to those areas of complaints. Petitioner complained of some head pain and nausea with certain exercises. Therapy was placed on hold pending Petitioner's doctor's recommendations. (PX 1, 3)

On Petitioner's visit with Dr. Vasconcelles later that same day, Petitioner reported ongoing headaches but having trouble with physical therapy as the exercises "hurt her head." Petitioner had gone to therapy that morning but was unable to finish. Petitioner also reported a lot of pain in her low back and tailbone, as well as radiating pain down her right leg. Dr. Vasconcelles noted that "the low back pain was new," though Petitioner had reported low back soreness after the fall but "this was different." On examination, Petitioner had low back discomfort over her L5 musculature. Low back pain was added to the diagnosis. Petitioner was referred to a chiropractor. (PX1)

Petitioner cancelled her therapy appointment for December 14, 2012 advising the therapist that she had seen her doctor again and was going to try chiropractic care instead. (PX 3)

Petitioner did not work December 13, 2012 through December 26, 2012. (RX 6)

Petitioner presented to Dr. Venturini, a chiropractor, on December 17, 2012. Petitioner gave a history of going down a flight of stairs in response to a fire drill when she hit her head on the first stair which, she believed, caused her to become unconscious. Petitioner reported that, according to observers, she continued to fall down fourteen stairs hitting her head several times during the fall. She came to a stop, regained consciousness and continued out of the building. Her husband, thereafter, took her to Memorial Medical Center where CT scans were taken, "she was told she had fractures," and she was released. She then followed up with Dr. Vasconcelles who diagnosed her with a neck sprain. Petitioner further reported worsening headaches since December 1st. She had tried one trial of therapy but it had not helped her symptoms. She had tried another round this past week but had to stop when she became nauseous during the first session. Petitioner further reported missing work due to her symptoms. She was taking muscle relaxers that made her feel fired and "out of it." A secondary complaint included anterior forearm pain since the accident. She further reported the inability to work due to pain and weakness as she had been having problems with typing, standing, walking, stooping, squatting, kneeling, bending, carrying, lifting, reaching, sitting, nervousness and irritability. As a result of the accident Petitioner felt she was having difficulty going to sleep and would wake up in the middle of the night due to pain. She denied any problems with sleep prior to the accident. (PX 5) Petitioner's complaints that day included headaches, neck pain and low back pain, the latter two of which came on gradually after the accident. Petitioner's past medical history included headaches and anxiety. On examination the doctor noted tenderness in the cervical, thoracic and lumbar spine with reduced ranges of motion in the cervical and lumbar spines. Treatment to be undertaken was to include manipulation of the neck, low back, and mid-back. (PX5)

On follow-up visits with Dr. Venturini, continued complaints of headaches, low back pain, and left shoulder pain were made by Petitioner, as well as some complaints of dizziness. Petitioner completed a Neck Disability Index showing fairly severe pain with activities of daily living. Petitioner reported having felt better on Monday but after lying down for 45 minutes her pain was 3-4 times worse when she awakened. Dr. Vasconcelles wanted her off the Vicodin and changed her other medications but Petitioner couldn't "function like this" so she wasn't going into work. (PX 5)

Petitioner underwent chiropractic treatment on December 21, 2012 noting she was not as stiff when she woke up but was having problems with medication side effects. (PX 5)

As of December 26, 2012 Dr. Curtis (Dr. Venturini's office) was noting Petitioner's symptoms included left arm pain, low back pain, left shoulder blade pain, dizziness, left forearm pain, and right forearm pain. (PX 5)

Petitioner returned to work full duty on December 27, 2012. (RX 6)

As of December 28, 2012 Petitioner was reporting that nothing seemed better. She had taken the entire preceding week off and thought it would help but it didn't as she noticed stiffness when resting and headaches when up and moving. Her subjective pain complaints remained unchanged. (PX 5)

By January 3, 2013 when seen by Dr. Venturini, Petitioner was reporting no further forearm pain but that her neck, dizziness, and headaches were about the same. Dr. Venturini suggested a referral to a neurologist because her complaints were not responding to treatment. (PX5)

Petitioner signed her Application for Adjustment of Claim herein on January 3, 2013. (AX 2) Petitioner worked for Respondent on January 8, 2013. (RX 6)

On January 10, 2013, Dr. Vasconcelles re-examined Petitioner. Petitioner's complaints included head and neck pain. She reported being unable to work on a consistent basis due to pain and had not worked one full week since her accident. Dr. Vasconcelles noted "She is working at the State and is working for 60 hrs./week which seems to aggravate her pain." Petitioner reported malaise, confusion, and dizziness but denied any limb weakness or difficulty walking. Petitioner reported pain with palpation in her upper shoulders and the base of her neck. She was given a note for work limiting her to 37 hours "instead of the 60 hours she is currently working." When she examined Petitioner at that visit, the doctor noted Petitioner was taking Neurontin for her pain control and was continuing to experience headaches that could be quite severe. She had seen Dr. Venturini six times for her neck and head pain and had been unable to work on a consistent basis due to her pain, having only worked one week since October. Petitioner had continued headaches and neck pain despite medication and treatment. Dr. Vasconcelles changed medications and referred Petitioner to a neurologist. A Health Status Form (unsigned) and dated the same date indicated Petitioner was unable to work until seen by a neurologist due to post-traumatic headaches and neck pain. (PX1)

Dr. Warach, a neurologist, saw Petitioner on January 14, 2013. Petitioner gave a history of the accident and described her complaints since then: constant severe aching pain, variable in intensity, on the left side of her head where she hit it; dizziness associated with severe headaches; persistent constant aching and sharp pain in the posterior cervical region with radiation into both shoulders; neck stiffness; pain in both forearms which had resolved with chiropractic treatment but had returned over preceding two days and was now intermittent aching pain; intermittent aching pain in the low back with radiation down the entire right leg; and persistent memory difficulties. (PX 1)

Dr. Warach's neurological examination showed tenderness on percussion over the posterior cervical and lumbosacral regions. Straight-leg raising was positive of the right at 1 degree, and on the left at 5 degrees elevation. Petitioner also demonstrated an astasia-abasia gait pattern with tandem ambulation but was able to tandem ambulate. Dr. Warach's impression was that of:1) non-focal neurological examination (except for gait pattern); 2) status post concussive head injury; 3) post-concussive headaches; 4) post-traumatic memory difficulty; 5) post-traumatic dizziness and imbalance; 6) post-traumatic cervical and upper extremity pain syndrome, rule out cervical radiculopathy; 7) post-traumatic lumbosacral and lower extremity pain, rule out lumbosacral radiculopathy; and 8) bilateral forearm pain. Dr. Warach ordered MRI scans of Petitioner's brain, neck, and back, as well as EEG and EMG studies. (PX1)

Petitioner's MRI of her brain was normal. (PX 5) The MRI of the cervical spine showed minimal multi-level degenerative changes with mild neural foraminal encroachment at C3-4. A mild disc bulge at C5-6 was also noted. (PX2)

Petitioner's MRI of the lumbar spine dated January 18, 2013 revealed multilevel degenerative changes:

> At L3-4, a broad-based disc bulge and facet joint hypertrophy and thickening of the ligamentum flavum. Mild right and left neural foraminal encroachment.
>
> At L4-5, a broad-based disc bulge, facet joint hypertrophy and thickening of the ligamentum flavum. Mild to moderate right and mild left neural foraminal encroachment.
>
> At L5-S1, broad based disc bulge, with facet joint hypertrophy and thickening of the ligamentum flavum. It was noted that these findings were in the setting of congenital short pedicles. (PX2)

Petitioner's EEG studies were normal.(PX 1)

Petitioner's EMG/nerve conduction studies were considered "fairly unremarkable" and normal for the upper extremities. Studies of the lower extremities performed on January 31, 2013 were positive for bilateral L5 radiculopathies. (PX2; PX 1)

In a letter to Dr. Vasconcelles dated January 31, 2013 Dr. Warach reported on the above imaging studies and noted that Petitioner had bulging discs at L3-L5. He brought up the possibility of a referral to a pain specialist. (PX 1)

In follow-up with Petitioner on February 14, 2013, Dr. Warach noted that Petitioner's cervical complaints were improving, as was her dizziness. Petitioner was reporting persistent intermittent post-traumatic dizziness and imbalance with true vertigo consistent with a probable labyrinthine concussive injury. She seemed 50 % better. Her post-traumatic posterior cervical neck pain with radiation down both arms was characterized by aching and sharp pain, variable in intensity and with occasional tingling of her entire left arm but 40% better. Petitioner's intermittent post-traumatic lumbosacral pain with radiation down her entire right leg was not improved at all. She had also been experiencing constant posterior thoracic region pain with achiness and sharp pain in the preceding week but she did not wish to undergo any neurologic testing in that area. However, the low back pain and radiculopathy were not improved. Petitioner had undergone six chiropractic sessions with no benefit whatsoever. Petitioner was scheduled to go on vacation in Florida the next week. She was using Tramadol and Gabapentin as needed and her mental status was noted to be stable, speech fluent, and her ability to carry on conversation just fine. Dr. Warach's diagnoses were post-traumatic probable labyrinthine concussive injury; post-traumatic cervical and upper extremity pain; and post-traumatic lumbosacral and lower extremity pain; thoracic region pain; and bilateral L5 radiculopathies. He recommended additional physical therapy, and prescribed Antivert for the dizziness. Petitioner reported her therapy at memorial was of no help but she was willing to try again. Petitioner reported she wasn't working and the

doctor advised her to avoid heavy lifting, strain, and other provocative activities and to avoid ladders and other potentially dangerous activities. (PX2)

On March 11, 2013 Dr. Warach re-examined Petitioner who was reporting that she was experiencing constant lumbosacral pain with radiation down her right leg which had worsened since their last visit but was now 20 % better. She was also reporting persistent intermittent posterior cervical neck pain with radiation into both arms which had plateaued at 40% improvement. Her dizziness and vertigo was 90% better. Petitioner reported that she did not undergo the physical therapy previously ordered as workers' compensation would not approve it. She was not interested in an orthopedic or neurosurgical consultation but was interested in being referred to a regional pain clinic or specialist for consideration of appropriate injections. Motor strength testing revealed 5/5 strength in all four extremities. Her diagnoses remained unchanged. Petitioner was to speak with Dr. Vasconcelles regarding a referral. No other changes in her treatment were noted. (PX 2)

On March 21, 2013, Petitioner presented to Dr. Vasconcelles with an antalgic gait and reports of pain when lying flat. She also reported seeing Dr. Warach who found "3 slipped discs in her lumbar spine." Petitioner reported that her neck pain was manageable; however, her lower back pain was increasing and progressing since the accident. Petitioner also reported that her headaches were better and less frequent. Dr. Vasconcelles also noted a history of Petitioner's fall with her initial injury being upper neck pain and post-traumatic headaches. She wrote that Petitioner was doing much better in that regard but was now having low back pain secondary "to disc herniations" at L3-L5. Petitioner was to be undergoing a course of injections for her lower back pain and until then she was to remain off work because it entailed activity that could worsen/aggravate her back. Dr. Vasconcelles recommended evaluation and treatment by a pain clinic. (PX1)

Petitioner was seen by Dr. Salvacion for a pain consultation on March 28, 2013. Petitioner reported head, low back, and neck injuries since falling down a flight of stairs. In particular she described having a lot of pain in her back extending down her legs which she described as throbbing, pounding, crushing, and itching. His physical examination showed a painful gait and that Petitioner favored the right leg when walking. He also noted limited lumbar range of motion in flexion and extension, normal sensation to lower extremities, positive straight-leg raising bilaterally, and tenderness to palpation to lumbar spine midline. His impression was lumbar degenerative disc disease and lumbar radiculopathy. He recommended a trial of epidural steroid injections. (PX 1, 4)

Petitioner underwent an injection at L5-S1on April 9, 2013. (PX 4)

Dr. Warach re-examined Petitioner on April 22, 2013. Petitioner reported persistent constant lumbosacral pain with radiation down her right leg which was plateaued at 20% better. Her neck pain and radiating arm pain had worsened since their last visit but was now 10% better. Petitioner's right leg was occasionally giving out but her dizziness had resolved. She denied any other neurological complaints. Petitioner denied any relief from her lumbar epidural injection. Petitioner also told the doctor that Dr. Vasconcelles had referred her to Dr. Joseph Williams for an orthopedic consultation but it was canceled because workers' compensation had not approved

it. Dr. Warach recommended she proceed with it on her personal insurance. Her diagnoses were that of bilateral L5 radiculopathies and post-traumatic cervical and lumbosacral pain syndromes with upper and lower extremity pain syndromes. Dr. Warach felt Petitioner could work in a light duty capacity. (PX 2)

Petitioner followed up with Dr. Vasconcelles on April 22, 2013, reporting no improvement following the first injection. Petitioner also reported that her right lower extremity had given out several times as "she has herniated discs" in her low back and that Dr. Warach had found worsening nerve damage in her back. A surgical consultation was discussed. Petitioner was kept off work for her low back pain and radiculopathy. (PX1; PX 2)

Petitioner underwent another injection but at L4-5 on April 25, 2013. (PX 4)

Upon the referral of Dr. Vasconcelles, Petitioner saw Dr. Williams, an orthopedic surgeon, on May 7, 2013 for complaints of chronic low back pain which Petitioner represented had been present since a fall down concrete steps at work on October 12, 2012. (PX 1, PX 6) He also noted complaints of axial neck pain and bilateral upper extremity pain, with the left being worse than the right. Petitioner told the doctor that she was an executive assistant in the Governor's Office and had worked from October through January as the pain was tolerable; however, since then she had been unable to do so. Dr. Williams reviewed the films and other studies and performed a physical examination, which did not reveal any focal deficits to her upper or lower extremities. He felt Petitioner had multilevel lumbar and cervical degenerative changes, "all of which are sources of pain." He did not feel surgery would provide the relief Petitioner was looking for, and, therefore, recommended further conservative care. He further recommended limiting her use of narcotic pain medication. (PX 6)

Petitioner presented to Dr. Tabatabai, a psychiatrist, on May 8, 2013, having last been seen in June of 2012. According to his notes Petitioner had fallen down stairs at work in October of 2012 and had been on short-term disability since "Jan. 2012." Her history included diagnoses of cervical and lumbar disc disease with two pain shots and increased anxiety, racing thoughts, insomnia, "etc." Petitioner reported trying to stay active at home but being limited by pain. She was doing physical therapy at home and spending time with her mother who was now fairly healthy. She was assessed with severe recurrent major depression and non-specific anxiety disorder. Medications were adjusted. (PX 7)

As of May 20, 2013 when Petitioner again saw Dr. Vasconcelles, the doctor was noting chronic neck pain due to Petitioner's "herniated disc" after a fall at work. The injections hadn't really helped. She was on Neurontin and tramadol but the latter wasn't as effective as Ibuprofen. Petitioner reported she still wasn't back to work due to her pain and limitations. Her job would reportedly require her to file, write/type and walk long distances and due to her level of discomfort she didn't feel that would be possible. Petitioner was performing stretching exercises she had learned on the Internet. Dr. Venturini was only addressing her lower back pain and she had stopped going to him due to appointments running out. Petitioner felt her lower back pain was better but her neck pain was now the problem. Petitioner also reported that she was having right lower extremity pain that would radiate down to her ankle and, sometimes with stairs, it

would feel like her leg was going to give out. Dr. Vasconcelles continued Petitioner's leave and sent her back to Dr. Venturini for her neck pain and possible use of a TENs unit. (PX 1)

Dr. Venturini re-examined Petitioner on June 19, 2013 noting she was there for persistent, continued lower back pain bilaterally, right buttock, hip, posterior lateral to lateral calf and heel which she felt were related to her fall at work. Petitioner reported that her low back pain, right buttock pain, right hamstring pain, right calf pain, and right heel pain came on gradually after the accident but was progressively worsening. Petitioner reported her neck pain was immediate after her work accident. With regard to her neck pain she noticed it in the morning but it would be aggravated in the afternoon. Petitioner's physical exam was positive for tenderness upon palpation and muscle tension. Some trigger points were noted. A Revised Oswestry Assessment was performed regarding Petitioner's low back pain. A Neck Disability Index was also completed. The former reflected a crippling disability while the latter was described as "severe." (PX 5)

Petitioner reported some improvement in her symptoms when seen by the chiropractor on June 21, 2013. (PX 5)

Petitioner denied any improvement when seen by Dr. Venturini on June 24, 2013 noting that she had helped hang some pictures with a friend and it really aggravated her back. She also reported some "extra stress" on Saturday with work comp issues. The focus of the exam was her low back as that was her primary area of complaint. (PX 5)

On June 24, 2013 Petitioner returned to see Dr. Vasconcelles in "follow up" for her upper back and neck after a fall. She continued to complain of lower back pain going into her right leg. She was seeing Dr. Venturini and Dr. Curtis and noting some improvement. Petitioner also reported bilateral ankle swelling but no pain. That had begun two weeks earlier. A prior history of similar complaints was noted. She was noted to be in no acute distress, well appearing, and appearing normal. Petitioner was described as appearing more comfortable and less stressed. On examination she had some pain, tenderness and tightness in her neck and upper shoulders. (PX 1)

Dr. Venturini noted "some improvement" when he examined Petitioner on July 3, 2013. (PX 5)

Dr. Peter Curtis conducted a re-evaluation of Petitioner on July 12, 2013 regarding her lower back and neck complaints with Petitioner reporting an exacerbation of lower back complaints over the 4th of July Holiday weekend. Petitioner felt unable to perform physical work activities and had ongoing problems with sleep. (PX 5)

Petitioner presented to Dr. Venturini's office on July 18, 2013 reporting no improvement since her last visit. (PX 5)

When examined by Dr. Vasconcelles on July 19, 2013 Petitioner reported undergoing therapy with Dr. Curtis and chiropractic care with Dr. Venturini. Petitioner wished to go back to work in mid-August although she mentioned a flare several weeks earlier which was probably due to stress as she had received a letter about an examination in St. Louis with a doctor chosen by her

employer. Petitioner reported that her attorney needed a letter with a restriction asking her to be examined by someone in Springfield as sitting in a car for more than ½ hour hurt her back. She denied any new symptoms and was taking Gabapentin daily and also using Ibuprofen but wished to switch to something less frequent. Petitioner was using her Vicodin sparingly. The doctor began her on Mobic instead of the Ibuprofen. (PX 1)

Petitioner's final visit with the chiropractor was on July 29, 2013 when she reported no improvement although she was able to do a "deep cleaning" at her house without a flare-up. She thought stress was aggravating her low back pain. (PX 5)

Petitioner returned to see Dr. Venturini on August 5, 2013, having last seen him in June of 2013. Petitioner reported a return of symptoms or increase of complaints since her last visit. She had been very busy the past Thursday and her energy level was pretty low. She was busy over the weekend as well and in the pool which felt good; however, when she emerged from it, her low back hurt. Petitioner also reported having some neck pain recently and she had been doing her physical therapy exercises previously taught to her. Petitioner's subjective pain complaints included low back pain, right buttock pain, right shoulder blade pain, neck pain and mid-back pain. (PX 5)

Petitioner continued to follow with Dr. Vasconcelles on August 15, 2013 reporting trouble sleeping due to pain and that she had been "hurting" for the last two weeks with no known triggers. Petitioner was seeing Dr. Venturini and undergoing some therapy with improvement. She was hoping to return to work on August 16th but didn't feel she could do so due to her pain. Petitioner was taking her Vicodin sparingly and had discontinued Mobic as it didn't help. She was also on Gabapentin which had helped initially but no longer. Petitioner reported some tension headaches. Petitioner's Vicodin was increased and her Gabapentin stopped. Petitioner remained off work until her pain improved. Her diagnoses remained unchanged. She was to return in two weeks. (PX 1)

At the request of Respondent, Petitioner was examined by Dr. Stephen Pineda on August 26, 2013. In his report he noted a separate medical summary not otherwise discussed or mentioned in his report. Petitioner reported her current medications were Cymbalta, Clonazepam, Lyrica (just begun a day or two earlier), aspirin, vitamins, and, on rare occasion, Hydrocodone for pain. Petitioner described her job as involving office work with the occasional need to assist in moving an office which might require her to move boxes or packages weighing up to fifty pounds. Petitioner described her injury and further acknowledged having continued to work from the date of accident through January of 2013. In his report, Dr. Pineda noted that Petitioner's initial headaches and neck strain had seemed to resolve; however, she continued with lower back pain and right leg problems which were doing better until mid-August when she was scheduled to go back to work, had a flare-up and her pain became so severe that she could not go back to work. Dr. Pineda agreed that Petitioner was not a surgical candidate. His diagnosis was lumbar pain with a history of degenerative disc disease. On the issue of causation, he stated, "the only statements that one can make regarding causality is that she states this pain began at the time of the fall." As for further treatment, Pineda opined, "The only reasonable strategy that I would recommend right now is symptom control." He suggested that from a mechanical standpoint, Petitioner did not need any activity restrictions. However, he noted that pain would be a

restrictor of activities. He noted no neurological deficits. Her physical exam was benign. He thought an FCE might be considered if an exact measurement of her true capabilities was required. (PX 8; RX1)

Petitioner returned to Dr. Vasconcelles on August 29, 2013. Dr. Vasconcelles noted that Petitioner has had "chronic back and neck pain since an injury at work about 10 months [earlier.]" Petitioner advised the doctor that she wanted to return to work but was concerned about her ability to do so given her chronic, persistent pain. Petitioner also reported that she had cancelled her second opinion with a chiropractor per the advice of Dr. Pineda. Dr. Vasconcelles thought Petitioner should remain off work for two weeks owing to a recent "flare-up of her pain" and see how she was doing in a couple of weeks. She also wanted Petitioner to follow-up with Dr. Salvacion regarding long-term management of her pain. Petitioner was to return on September 12, 2013 to determine her ability to return to work after discussing the matter of restrictions with her attorney. (PX1)

Petitioner saw Dr. Salvacion on September 9, 2013 for her back and right leg pain. She gave an interim history of no long-standing improvement with the epidural injections, and continued pain in the low back and into the right leg. She complained that the worst pain at that time was muscular across her low back with spasms in the lumbar region going up into the thoracic region. Petitioner noted she had been back to see Dr. Pineda and he thought, Dr. Williams, neither of whom had recommended surgery. On examination, Dr. Salvacion found spasms in the lumbar and thoracic paraspinal musculature. He recommended against further injections, but did prescribe a new medication (Blaclofen) for the spasms. He referred Petitioner to the Marianjoy Rehabilitation Institute in Wheaton for evaluation of the ongoing musculoskeletal pain and lumbar radiculopathy to try to improve Petitioner's functional ability and allow her to return to work. (PX 1, 4)

Dr. Vasconcelles re-examined Petitioner on September 12, 2013 with Petitioner reporting she had seen Dr. Salvacion for her chronic pain per the suggestion of her "Workman's comp staff at work." She wasn't back to work due to her pain and was having a particularly bad day that day. Petitioner reported low back pain radiating up her back and wondering if it could be her kidneys. She was told to return in one month and that her leave would be continued for one month until she decided on her next step for treatment. Petitioner remained off work due to chronic pain syndrome and back pain.(PX 1)

Based on Dr. Pineda's report, Respondent terminated Petitioner's TTD benefits and had her return to work. She was paid temporary total disability benefits through September 22, 2013. (RX3).

Petitioner saw Dr. Vasconcelles before her return to work, on September 23, 2013. The doctor noted Petitioner was an administrative assistant but had to back up the receptionist at times. Petitioner reported some improvement with her pain control. Dr. Vasconcelles signed off on the return to work, with restrictions of no lifting over 10 lbs., no pushing or pulling over 10 lbs. with her arms, no reaching above shoulder level and no standing over 10 minutes or sitting over 30 minutes without moving/stretching. These restrictions were to remain in effect until October 15,

2013. (PX 1) The doctor also commented that Petitioner would need time off (FMLA) for severe flare-ups of her pain. (PX1)

Petitioner returned to work on September 24, 2013 initially working half days and then proceeding, as of October 5, 2013 to full days. (RX 6)

Petitioner returned to see Dr. Vasconcelles on October 15, 2013. Petitioner had been back at work for four weeks although the first two weeks were only half days. She described it as rough, with continued pain and a lot of fatigue. Petitioner reported using a massage chair at home which helped. Dr. Vasconcelles allowed her to continue with work, but added that if Petitioner's responsibilities were increased to the point of it being a problem, restrictions would be revisited. (PX1)
Petitioner stopped working for Respondent as of October 23, 2013. (RX 6)

Petitioned returned to see Dr. Vasconcelles on October 25, 2013.She reported a flare-up of her chronic pain syndrome beginning the previous day. She had transitioned to full-time work, and had experienced pain and was very uncomfortable. Dr. Vasconcelles found soft tissue pain and trigger points on examination. She increased the Lyrica being prescribed, and wanted her to see Dr. Williams again. She also noted that Petitioner was going to apply for permanent disability due to the persistent and chronic nature of her symptoms. (PX1)

In a separate note from that visit, Dr. Vasconcelles wrote:

> [Petitioner] was in my office today and is having continued pain associated with her chronic pain syndrome so I have decided she is to again stop working and apply for permanent disability. The prognosis that she will recover full function without pain is poor, especially now that she has been suffering for over 1 year. The stress of performing her job is contributing to her persistent pain issues so removing her from the work environment so she can rest and pursue alternative treatments is necessary. (PX1)

In a note dated November 5, 2013 Petitioner left forms for Dr. Vasconcelles to complete regarding disability benefits for the period of January through September of 2013. Dr. Vasconcelles completed the Occupational Disability Report on November 8, 2013 indicating Petitioner was suffering from chronic pain syndrome/fibromyalgia and degenerative disc disease in her neck and back and was unable to work from January 5, 2013 through September 23, 2013. A second form gave an onset date of November 1, 2013. When she would be able to return to work was unknown as Petitioner was applying for permanent disability. (PX 1)

Petitioner returned to see Dr. Tabatabai on November 7, 2013 reporting that she had seen the workman's compensation doctor who had released her to work and she had done so on September 23, 2013. Her primary care doctor had given her restrictions two weeks ago "woke up and unable to move, had to use hydrocodone to be able to work" which required as much as 13 hours per day. She was now applying for permanent disability. She appeared tearful, low, and frustrated and "financial stress" was noted. Petitioner's medication was adjusted. Her diagnoses remained the same as in May of 2013. (PX 7)

Petitioner returned to see Dr. Williams on November 19, 2013 in regard to her low back. At that time she was still complaining of lower back pain and radiating right leg pain. She also noted tingling in her leg and random stabbing pains all over her back. Petitioner reported having returned to work on September 23, 2013 and then developing worsening pain which required her to take excessive amounts of Norco through the day to maintain her work. Petitioner stopped working on October 25, 2013. Petitioner's current medications included 2 Norco tablets, 75 mg. of Lyrica, and Cymbalta on a daily basis. Petitioner had quit smoking six months earlier. Petitioner reported being diagnosed with fibromyalgia earlier in the month and also reported the inability to sit or stand. She was noted to be tearful and stated that her employer and supervisor at work were demanding that she work 12 – 16 hours per day. Petitioner also reported neck pain but not as bad as her back pain. Dr. Williams again noted the MRI findings which did not suggest any nerve root impingement or instability and he saw no need for surgery. He recommended activities as tolerated and limiting her use of narcotics. She was to return as needed. (PX 1, 6)

Dr. Vasconcelles re-examined Petitioner on December 3, 2013 for her ongoing chronic pain syndrome. Petitioner reported good days and bad days with and without medication. She was experiencing some lightheadness with Lyrica. Petitioner was not working. She reported sharp, shooting pains in her neck and mid-back episodic in nature. Nothing reportedly helped with the pain but it would eventually resolve on its own. She also reported radiation down into her legs and her right arm. Dr. Vasconcelles noted that Petitioner had "known disc herniations" in the neck and lower back but the surgeons were of the opinion they were not surgical in nature and probably not causing her pain. Petitioner was diagnosed with chronic pain syndrome and fatigue. Dr. Vasconcelles noted in Petitioner's Health Status form that Petitioner was unable to work due to chronic pain syndrome. (PX 1)

On December 13, 2013 Respondent's attorney advised Petitioner's attorney an FCE was being scheduled. (RX 7)

In an email dated January 9, 2014 Linda O'Neall from CMS advised Respondent's attorney that Petitioner had advised she did not wish to go through the FCE because she didn't think it would help her. Furthermore, if one did end up being scheduled Petitioner wished to speak with her attorney first. (RX 7)

Petitioner followed up with Dr. Tabatabai on January 29, 2014. Petitioner reported being three months without any income as she had been denied state retirement. Petitioner appeared very depressed and anxious, did not want any more medication, was irritable with her husband, and wanted a letter, if possible, to assist her. She further noted that her attorney wouldn't call her back, she was going to be losing her insurance which cost $1600.00 per month, and she had an appeal scheduled for the following week regarding her retirement. Petitioner's physical limitations included back pain, the inability to sit for longer than 30 minutes, back pain when sitting, the inability to stand more than 10 minutes, and pain down her right leg with bending and lifting. Petitioner's emotional limitations included the inability to concentrate, crying, irritability, and hopelessness. Her diagnoses remained unchanged with the doctor noting that Petitioner had chronic pain syndrome which was limiting her activity level and contributing to her depressive symptoms. He did not feel she was able to be gainfully employed at that time. (PX 7)

In a letter addressed "To Whom It May Concern" and dated January 30, 2014, Dr. Tabatabai wrote that he had been following Petitioner for a number of years for her major depressive disorder and anxiety disorder having first seen her in 2007 as part of a partial hospital program at Memorial Medical Center. At that time Petitioner had fairly significant depressive symptoms but she improved with aggressive treatment and had always been compliant with care and treatment. With regard to her injury, Dr. Tabatabai noted that Petitioner had been off and on from work for a period of time after the accident but unable to return after October 23, 2013. Since then "she has had a pain syndrome as well as exacerbation of depressive illness." She was last seen in his office the day before and had fairly significant depressive symptoms at that time. He wrote, "Obviously this is a pre-existing diagnosis but exacerbated by chronic pain, financial stress, and the lengthy disability process." Dr. Tabatabai noted that Petitioner was continuing to have physical limitations with difficulty sitting or standing longer than ten to thirty minutes and was experiencing fairly constant low back pain with some radiation down the right leg. Additionally, she was quite emotionally labile/tearful with difficulty concentrating and retaining information. Her self-care had reportedly declined, she felt helpless and hopeless, and was experiencing a very restricted activity level at home. Dr. Tabatabai felt Petitioner, from a mental health perspective, was completely unable to manage a part-time or full-time job of any kind. He felt her pain syndrome had contributed to both her physical and emotional limitations. He felt she fit the criteria for disability status. His plan was to continue monitoring Petitioner in an effort to stabilize her depression and improve her quality of life and ability to function. (PX 7)

Petitioner returned to see Dr. Vasconcelles on March 4, 2014 for a three month follow up visit after "having had an accident at work one year earlier that had triggered a chronic pain syndrome." Petitioner also reported losing her health insurance, not currently receiving any compensation and having been turned down for FMLA. Petitioner reported ongoing pain for which she used Lyrica and tried stretching exercises. She had been seen in therapy and instructed in exercises for management. Petitioner reported persistent lower back pain and intermittent pain in her neck, left flank and mid-back. Petitioner reported strains in her marriage due to her health issues and she wasn't seeing a therapist. The need for a therapist to assist with Petitioner's chronic pain management was noted with the understanding that they would follow up on a referral when Petitioner had health insurance. The doctor authored a note stating that she had seen Petitioner that day for her chronic pain syndrome and fatigue post injury two years earlier. Dr. Vasconcelles described Petitioner's symptoms and daily pain as unchanged and she felt Petitioner was unable to work and was going to pursue her permanent disability status as it is "my opinion that she will never recover from this medical diagnosis and will not be able to return to her occupation." (PX 1)

Petitioner began working at Parkway Christian Church in April of 2014 as a secretary/office administrator. She was to perform general secretarial services at $11.50 an hour up to 20 hours per week. Under the terms of the agreement it was to end on December 31, 2014. (PX 11; RX 9)

Petitioner was examined by Dr. Vasconcelles on June 5, 2014 regarding her chronic pain syndrome and inability to return to work. Petitioner reported she was working with her disability attorney to get full disability but she wasn't receiving any income currently which was very stressful. Petitioner had cashed in her retirement for income and had been without any payments

for approximately 8 months. Petitioner reported flares of her pain due to stress and she was using her Vicodin sparingly for pain management but only when it was bad. Petitioner was trying to stay as active as possible doing her exercises at home noting that if she stayed active she felt better but sometimes she was so fatigued that she couldn't do her exercises. Petitioner was not seeing a therapist for her stress and her chronic pain because it would not be covered as she had lost her health insurance and all current care was with workers' compensation. In a note dated June 5, 2014 Dr. Vasconcelles stated she was Petitioner's primary care doctor and had seen her that day for her continued leave from work due to her chronic pain syndrome. Petitioner was noted to be having ongoing pain and fatigue and was unable to return to work. She was to be re-evaluated in three months. (PX 1)

At the request of Respondent, Petitioner was examined by Dr. Stephen Weiss on June 24, 2014. A written report followed. As part of the history noted by the doctor, Petitioner denied any prior problems with her neck or lower back. They reviewed her treatment after the accident and with Dr. Vasconcelles including her referrals to Dr. Warach, physical therapy and injections. Petitioner further reported being diagnosed with fibromyalgia in October of 2013 and being prescribed Lyrica for it. Dr. Weiss' report reflects no review of any medical records after March 4, 2014. He reviewed no records of Dr. Tabatabai or Dr. Williams. Dr. Weiss did review an October 11, 2012 emergency room note indicated Petitioner had a headache and right knee pain after falling down a flight of steps. X-rays of her right knee were negative. Additionally, according to the October 17, 2012 Employer's First Report of Injury, Petitioner was exiting the fire drill and slipped injuring her head, back, elbow, and right hip. (RX 2, p. 4)

At the time of her exam with Dr. Weiss, Petitioner's complaints included constant neck pain with intermittent radiation down both upper extremities to her wrists as well as constant low back pain with intermittent pain running down to her right foot. She had not worked since October of 2013. Dr. Weiss further noted in his report that Petitioner told him he was missing a referral from Dr. Pineda to a pain clinic which, in turn, referred her for physical therapy; however, she never underwent the therapy as workers' compensation would not approve it. Dr. Weiss noted some limitations in motion on examination of Petitioner's neck and low back, but his examination was otherwise unremarkable. Dr. Weiss noted Petitioner's Waddell's signs were positive, a suggestion to him of symptom magnification. He felt Petitioner was at maximum medical improvement (MMI) 6 weeks after her second epidural steroid injection, and that she could work on an unrestricted basis. (RX 2)

Dr. Vasconcelles re-examined Petitioner on September 5, 2014 noting Petitioner had been off work for more than one year due to chronic pain syndrome induced by an accident at work. Petitioner was currently waiting to find out from the DSS about her disability status and also from her employer's disability program. Petitioner reported that her inability to work had resulted in financial strains that have forced her into Medicaid for her health care and leading her to be on the verge of a divorce and bankruptcy due to her issues. Dr. Vasconcelles' diagnosis was noted as lower back pain and chronic pain syndrome. The doctor referred Petitioner to another attorney for a second opinion regarding her workers' compensation case and she was to return in three months. (PX 1)

Dr. Tabatabai issued another note after examining Petitioner on October 16, 2014. He noted Petitioner remained depressed, anxious, and overwhelmed and might require partial hospital care or inpatient care in the near future. In the meantime, he felt she met the criteria to be considered disabled. Her progress remained guarded. (PX7)

Petitioner followed up with Dr. Vasconcelles on January 29, 2015 regarding her history of "fibromyalgia that was post traumatic due to an injury at work." Petitioner reported muscle tension headaches that appeared with weather changes and trigger point pain. She was maintaining on Lyrica, Vicodin, heat rest and stretching exercises. Petitioner also reported the past winter having been bad for her due to pain and the inability to exercise due to weather. Petitioner's complaints also include more forgetfulness and "fogginess" so that she frequently would forget to take her medication. Petitioner was noted to be separated and working part-time performing administrative work at a local church.

Petitioner stopped working at Parkway Christian Church as of March 8, 2015. According to church records, the Church was having "several problems with her work." While there she earned $11,058.00. (PX 11; RX 9)

On June 15, 2015 Petitioner presented to Dr. Vasconcelles in follow-up after a motor vehicle accident. Dr. Vasconcelles noted that Petitioner was a restrained driver in a car and her gas pedal stuck causing her to strike a brick building. Petitioner was removed from the car by emergency personnel and seen at the emergency room where a CT scan was taken of her head and neck as well as a chest x-ray and echocardiogram. Petitioner was diagnosed with a fractured sternum. Petitioner's history of chronic pain was also noted with Petitioner reportedly having to use her Vicodin regularly. (PX 1)

Petitioner saw Dr. Vasconcelles on July 6, 2015 reporting she had fractured her sternum in a motor vehicle accident on June 9, 2015. Petitioner reported doing better and being able to be active in her yard again with no new symptoms of concern. Petitioner reported radiating pain into her left upper extremity one evening but it had resolved. The motor vehicle accident was due to a defect in her car. Dr. Vasconcelles noted Petitioner had an ongoing workers' compensation case with her previous employer and would be due for a visit for reassessment of her issues regarding that injury in September. (PX 1)

Petitioner presented for a recheck on her chronic pain syndrome/fibromyalgia on September 11, 2015 telling Dr. Vasconcelles she was having a bad day and denying any recent injury or activity to cause her worsening pain. Petitioner was using Vicodin for days when the pain was really bad. She reported new symptoms of burning pain in her upper back as though it was in her skin. Petitioner also reported occasional knee pain. Petitioner was taking Lyrica, exercising by walking, and had DVDs for Pilates and Yoga. Petitioner was working a part-time job and noting Medicare was saying she might be making too much (money) and might be dropped. Petitioner also told the doctor she had been reading on the Mayo web site about a new blood test for diagnosing fibromyalgia. Petitioner was to call with the name of the blood test and the doctor would order it. (PX 1)

Petitioner began working for Hospital Sisters Health System (HSHS) on September 20, 2015 on a part-time basis as she averaged about twenty hours per week. She was paid $11.10 per hour. (PX 10)

Dr. Vasconcelles performed a quarterly disability check-up of Petitioner on December 11, 2015. The doctor noted that Petitioner had post-traumatic induced soft tissue pain and had been on medical leave for three years from her previous job. Petitioner was working part-time in the afternoons at HSHS answering phones in its IT office. Petitioner reported pain flare-ups with weather changes and facial swelling. Petitioner was engaged in stretching, hot showers, heating pads, and medication to help with the pain. She was also trying yoga as that had helped in the past. Petitioner's recent bone density scan showed osteoporosis for which she was started on Fosomax. Petitioner's Lyrica dosage was increased. Work ability was not addressed. (PX 1)

Petitioner was examined by Dr. Vasconcelles on January 14, 2016 regarding dental issues as she had upcoming dental work scheduled. Dr. Vasconcelles' notes indicate that she also refilled Petitioner's Hydrocodone for her back pain as it was time to do so. (PX 1)

On March 11, 2016, Petitioner again presented to Dr. Vasconcelles in follow-up for her chronic pain syndrome/fibromyalgia which "was felt to be caused by an accident several years ago." Petitioner reported a recent flare of her pain "perhaps due to the weather" and noted it was different from her normal upper and lower back pain in that it radiated into her right proximal lateral thigh. Petitioner reported compliance with her use of Lyrica, Vicodin, and stretching exercise and denied any recent injury or illness. Petitioner reported that she was working, but felt "the stress of work may be factoring into her pain flare." Dr. Vasconcelles further noted a history of degenerative disc disease in Petitioner's spine with mild disc herniations that could case flare-ups of pain also. Petitioner was reportedly going into arbitration with her attorney for payment of disability from her first employer and then with SRS. Dr. Vasconcelles referred Petitioner to a therapist, Kay Gottrich, for help dealing with the chronic pain and depression. She was given an off work slip for that visit and Monday due to chronic pain and fatigue. (PX1)

On April 29, 2016, Petitioner returned to see Dr. Vasconcelles in follow-up to "continue disability leave due to a work injury." Dr. Vasconcelles noted Petitioner had a chronic pain syndrome "felt to be generated by this injury" and which was being managed with "tonic medication" including Lyrica and Vicodin. Petitioner was reporting worsening pain and increased use of Vicodin. Dr. Vasconcelles further noted that she "was really there that day" for "documentation of fibromyalgia which has not been officially documented in her chart as it is under her diagnosis of chronic pain syndrome." Petitioner was noted to have pain at her left thoracic and lumbar musculature that has been bothering her for a few days. Petitioner told Dr. Vasconcelles that she was working at a part-time job but having issues with continued pain and fatigue which made it very difficult to do the job and, indeed, expressed uncertainty as to whether she could continue the job. Dr. Vasconcelles further noted that Petitioner was in the process of getting permanent disability from her prior employer. She was also seeing a therapist as she was having a lot of depressive symptoms aggravating her pain. Petitioner was taking medication to help with the pain and psychological factors going with it. Dr. Vasconcelles gave Petitioner a note for her to leave her current job due to her chronic pain syndrome and fatigue and a copy of the office visit note was given to her for forwarding to her attorney. (PX1)

In a Health Status Form dated May 5, 2016 (and unsigned) Petitioner was noted to be unable to work due to "current medical issues." Her diagnosis was listed as chronic pain syndrome with fatigue.

Petitioner's last day of work with HSHS was May 28, 2016. (PX 10)

Summary of the Arbitration Hearing

Petitioner's case proceeded to arbitration on October 24, 2016. The issues in dispute were causal connection, medical bills, temporary total disability, maintenance, and the nature and extent of Petitioner's injury. The witnesses included: Petitioner; Jennifer Cavanaugh, Layla McLean, Mark Gifford, and Peggy Henry.

Petitioner testified that prior to going to work for Respondent, she spent five years as the residency coordinator at SIU School of Medicine. Prior to that job Petitioner spent ten years at Hanson Professional Services as an administrative assistant. Petitioner testified to being a high school graduate and receiving a certificate from Jacksonville Business & Careers.

Petitioner was employed by Respondent on October 11, 2012, and had been so employed as an administrative assistant II for the preceding 5 years.

Petitioner further testified that she worked in the Debt Department as well as for the agency's Director when he was in Springfield. Petitioner testified that her job required her to process "capital release forms" (requests for money) and run errands to various other state agencies. She also did filing and was the back-up receptionist. When the Director was in town, she would set up meetings and run errands for him, including getting his lunch. When the directors changed, she had to help with the office move. Petitioner testified that she was responsible for a great deal of filing which required her to move throughout the office handling both big stacks of paper and bankers boxes weighing fifty to one hundred pounds. Petitioner believed she filed on a daily basis and moved banker's boxes on a monthly basis. She felt she spent 40% of her time on her feet and the remainder was spent sitting.

Petitioner testified that the fire alarm went off on October 11, 2012 and as she and other co-workers descended the stairs from the sixth floor of the building she fell ten to twelve steps hitting her head on the hand rail. Petitioner fell down an entire flight of concrete steps onto the landing below, striking her head as she fell.

Petitioner testified that she did not remember the actual fall, but she did remember ending up head first on the landing with her legs above on the stairs. She recalled being helped up by a co-worker Peggy Henry. She did not want to go to the hospital by ambulance, and called her husband, who transported her to Memorial Medical Center.

Petitioner testified that she did not remember a lot about her visit to Memorial Medical Center that "it was like I was in a smoke filled room." She recalled having x-rays of her knee and a CT scan of her head and neck. Her primary complaints at that time were in her head and neck. In

describing the location of the pain in her head at that time, Petitioner indicated the back of her head on the left side. Petitioner testified that she was diagnosed with a concussion and neck sprain.

Petitioner further testified that she was instructed to follow-up with her family physician, and did so, seeing Dr. Vasconcelles a week after the fall. When Petitioner saw Dr. Vasconcelles initially, her areas of complaint were her head, neck, and whole back, including pain down both her arms and legs as well as headaches. Initially, she was treated with medication and physical therapy. Petitioner testified that the therapy was of temporary benefit. Petitioner was next referred to a chiropractor, Dr. Venturini. Petitioner saw Dr. Venturini for six visits, and Petitioner testified to no relief from the chiropractic relief.

Petitioner denied ever having any problems or treatment for her neck, upper back, low back, or shoulders prior to this accident, and the arbitrator notes that no evidence was introduced to the contrary. Petitioner admitted that she had experienced migraine headaches periodically over the years prior to her injury. She described her migraines as affecting the front of her head, forehead area, and behind her eyes, as opposed to her post-injury headaches, which were more localized around the area where she struck her head.

Petitioner continued to work for the first few months after her injury. She testified that she had to call in often because of the pain, but that she did not ask for nor did her doctors authorize her to be off work. Instead, she used sick time and comp time when she was absent. Petitioner testified that in December she was allowed to take/use vacation days.

Petitioner further testified that as of January 16, 2013 she was off work and under the care of Dr. Vasconcelles. During the time, she was still experiencing neck and low back pain, as well as the headaches. In January, she was referred to Dr. Warach, who ordered various diagnostic testing, and then recommended a pain clinic for her neck and back. She saw Dr. Salvacion, who did two epidural injections for her low back. She testified that she did not get any relief from those. Petitioner next saw Dr. Pineda, and recalled that he had referred her back to the pain clinic. She returned to Dr. Salvacion and he referred her Marian Rehabilitation Institute in Wheaton. Petitioner testified that she was never evaluated there because it was not approved.

In late September 2013, Petitioner returned to work for Respondent, part-time for two weeks, and then full-time. She continued working until October 23, 2013. She understood that she was under restrictions on her return. Petitioner testified that she returned to her same job; however, her restrictions were not accommodated. She was doing a lot of running for the Director, and had to deliver bounded books for bond sales. She noticed that she could not keep up with the work because of the pain in her neck, shoulders, and back. The walking aggravated her back pain. Over the few weeks back, her symptoms got a lot worse, prompting her return to Dr. Vasconcelles. At that point, Dr. Vasconcelles took her off work. She testified that Dr. Vasconcelles's opinion on her work ability has not changed since that time.

Petitioner further testified that during this time period she was also seeing Dr. Tabatabai, a psychiatrist. Petitioner acknowledged a prior history of treatment with him for depression and anxiety but she had been able to work steadily without any lost time on account of either

condition. Petitioner described her anxiety and depression as being well managed up until her work accident but unmanageable thereafter. According to Petitioner, Dr. Tabatabai prescribed various medications and dosages to manage her symptoms and she recalled that the doctor suggested to her that it would be difficult for her to return to work.

Petitioner testified that Dr. Vasconcelles told her in October of 2013 that she needed to be on permanent disability and that her opinion on that hasn't changed since then.

Petitioner found part-time employment on her own with Parkway Church as a part-time secretary/receptionist. Petitioner worked for the Church until March 2015, when she was dismissed. She testified that the senior interim pastor told her she was being let go because of a "failure to improve." Asked whether she was able to complete the tasks of that job, Petitioner said she would get it done, but her work was not satisfactory, she would make frequent mistakes. She attributed that to her pain medications, which made her "foggy." She noted that she was taking ever more pain medications during the time she worked there because she was experiencing increased pain.

Petitioner testified that after losing her job at the church she didn't start looking for work right away because she wasn't physically or mentally able to do so.

Petitioner testified that she was in a car accident in June of 2015 and broke her sternum. For a short period of time she felt an increase in her neck and back problems but it subsided after about a week.

Petitioner also testified that in the fall of 2015, she found another part-time job working for HSHS as a switchboard operator four hours per day. Petitioner indicated that the job was not physically demanding. That job required more constant sitting, which increased her dependence on her pain medications. She said her concentration was not up to par. She testified that the work was also mentally stressful, as she was handling multiple calls from multiple systems, and having to re-route the calls around multiple facilities. Petitioner testified that she quit her job in May of 2016 as she "gave up."

At this point in the hearing, Petitioner stood up for a few minutes and then sat down again.

Petitioner testified that prior to her work accident she spent a lot of time with her two grandchildren attending activities they were involved in; however, as a result of the accident she finds traveling the sixty miles to visit them hard on her as it is difficult to handle the walking and sitting. On a day to day basis, Petitioner tries to set a daily goal to reach. She has difficulty doing multiple loads of laundry or cleaning her floor.

Petitioner testified that she has been taking Hydrocodone since the accident with the need to periodically increase the dosage. She further testified that she still experiences dizzy spells and, at times, her balance isn't good. She feels some of these problems may be related to the medications she takes as a result of her accident. Petitioner also, on a monthly basis, experiences headaches especially when the barometric pressure changes.

Petitioner testified that she continues to treat with Dr. Vasconcelles and Dr. Tabatabai.

On cross-examination Petitioner added that her job with Respondent occasionally required her to use a step ladder for filing. She estimated that she spent half her time at her desk and half her time filing although the amount of time spent at her desk could increase towards the end of the fiscal year. Petitioner confirmed that she worked 7.5 to 16 hours per day.

Petitioner also testified that she no longer gardens as she once did and that her grandchildren come and visit her rather than her going to them.

On redirect examination Petitioner testified that she returned to work in October of 2013 per Dr. Pineda who felt she could do so. Petitioner tried and couldn't keep up as her work duties would increase her back, neck, and shoulder pain and cause right leg pain and limping. Petitioner testified that on her last day at work her supervisor asked if she had checked with the director to see if he needed her beyond 5:00 p.m.

Petitioner's witness, Peggy Henry, testified to observing Petitioner falling down 14 concrete steps onto the landing below. She also testified regarding Petitioner's job duties. At the time of Petitioner's injury, her job involved typing, moving offices and files, moving furniture. She would have had to sort files, throwing old files into a dumpster. The files had to be retrieved from shelves in boxes, and pulled down to sort through them. She described these as bankers boxes. She estimated that the boxes would weigh between 17 and 20 pounds. She said Petitioner returned to the same job, but missed a lot of work because she would get light-headed and dizzy.

Ms. Henry also testified regarding Petitioner's efforts to return to work in late September 2013. According to her, Petitioner was trying to get Phil's office moved and her office moved. They had to separate those offices, move furniture, move chairs, move files into separate offices which required them to move everything, including telephones.

Jennifer Cavanaugh testified on behalf of Respondent. Ms. Cavanaugh was employed in the same agency/office as Petitioner as assistant technology fiscal operations manager. She was Petitioner's supervisor at the time of the accident. Ms. Cavanaugh testified generally as to what Petitioner's job duties would have entailed, and said that after her accident she would not have asked Petitioner to lift or move anything greater than 10 pounds. Ms. Cavanaugh also admitted that Petitioner also worked as a part of the debt management group, which was not under her supervision, and it would have also been assigning tasks for Petitioner to perform. She did not recall whether Petitioner had been asked to move the director's office in October of 2012 but it was likely. She further testified that there were people available to help with heavy lifting but she would have needed to ask. She also acknowledged that Petitioner would get work instructions from numerous people. Ms. Cavanaugh acknowledged that Petitioner took some time off in the fall of 2013 after returning to work for health reasons. She also acknowledged that Petitioner took time off between October of 2012 and January of 2013 for health reasons which she presumed stemmed from her accident. She acknowledged that Petitioner returned to work on September 24, 2013 after last working in January. When Petitioner returned to work in 2013 she voiced no complaints to Ms. Cavanaugh.

Layla McLean also testified for Respondent. She was/is the fiscal manager for Respondent and, as such, managed its workers' compensation claims. She testified regarding the general practices of the agency with respect to workers' compensation claims, and its efforts to accommodate restrictions. She also suggested that she had communicated to Petitioner to let it be known if she needed anything, whether she needed to walk around, take off for treatment, etc.

On cross-examination Ms. McLean admitted that when Petitioner returned to work in 2013, initially half-time hours, she was charged vacation days for the missed hours because she was no longer on workers' compensation at that time having been released her to come back per the independent medical exam with no restrictions. Ms. McLean was unsure if she was aware of any restrictions when Petitioner returned to work in September of 2013. She further testified that through e-mails back and forth with Petitioner, she advised Petitioner that they would be willing to take any means necessary to get her back to work and help her with anything she needed. Ms. McLean also testified to sending an e-mail to Petitioner asking her for clarification as to whether a previously sent e-mail was a resignation as she needed to clarify Petitioner's status. Ms. McLean also testified that she received Dr. Vasconcelles' note taking Petitioner off work completely in October of 2013.

Ms. McLean was unaware of any time between the accident and January 8, 2013 when Petitioner was working more than sixty hours per week. She further testified that Petitioner was placed on temporary total disability as of January 9, 2013.

Mark Gifford also testified. Mr. Gifford was formerly pastor at the church Petitioner worked at for a short time. He testified that he supervised her during her tenure at the church. Mr. Gifford testified that Petitioner was never unable to complete her work nor did she ever approach him advising that she was having difficulty completing her job duties. He agreed that she was ultimately fired from her position but that it wasn't because she couldn't complete her assigned tasks; rather, she was unable to advance in the position.

Respondent's Exhibit 5 contains a list of medical bills paid by Respondent.

The Arbitrator concludes:

Issue (F) Causal Connection:

Petitioner's current condition of ill-being is causally connected to her accident of October 11, 2012. This conclusion is based upon a chain of events and the medical records of Drs. Vasconcelles and Tabatabai. The Arbitrator further finds Petitioner to have been a credible witness.

Petitioner has been diagnosed with a neck sprain, low back sprain, post-concussion headaches, chronic pain syndrome/fibromyalgia, depression and anxiety. Petitioner's medical history did not include anything to suggest previous complaints to her neck, upper extremities, low back, or lower extremities. While Petitioner did have pre-existing migraine headaches, her post-injury headaches were of a different nature. She also had pre-existing depression, but her testimony and records would suggest that was well-controlled by medication, and that Petitioner had never

missed any time from work related to that issue. Prior to October 11, 2012 it appears that Petitioner was able to work full duty in a job that often involved long days and a great deal of activity. While her primary occupation required her to mainly sit or file, Petitioner was also an assistant to the agency director when he was in town which required a great deal of activity and running around on errands. Her testimony regarding her job duties was essentially unrebutted. Everything changed after October 11, 2012.

While the emergency room records weren't admitted into evidence they were readily available to both parties and it appears from Dr. Weiss' Section 12 exam report that he reviewed them. According to his report, Petitioner had complaints of a head and right knee pain at the E.R. Respondent's First Report of Injury mentioned head, back, elbow and right hip complaints. (RX 2, p. 4) After the accident Petitioner was treated for headaches, a neck strain and low back pain. While the latter did not materialize immediately it did so within a reasonable amount of time. While Dr. Vasconcelles noted Petitioner's low back complaints in March of 2013 were new and different she never stated they weren't unrelated. Furthermore, neither Dr. Weiss nor Dr. Pineda took issue with Petitioner's low back complaints. They both agreed she had sustained, at a minimum, a strain and/or temporary exacerbation. Respondent also stipulated to TTD benefits through June 5, 2013.

The Arbitrator has given consideration to the varied histories Petitioner provided to doctors regarding the onset of her complaints (gradual v. immediate). She finds no significant disparity in these histories as the bottom line is that Petitioner consistently associated them with her fall and, again, Respondent's examining doctors connected the low back strain, neck strain, and headaches to the fall.

The Arbitrator is aware that the records of Petitioner's treating doctors, especially Dr. Vasconcelles and Dr. Tabatabai, don't clearly indicate the doctors were aware of Petitioner's jobs with Parkway Church and HSHS; however, Petitioner testified that they were and her testimony was unrebutted. The Arbitrator is also aware that, at times, Petitioner's histories and representations to the doctors (such as in October and November of 2013 when she reported having demands put upon her to work 12-16 hours days and having to increase her Hydrocodone to get through a day which could require working up to thirteen hours) were not in accord with the realities of her return to work (work records showed working 7.5 hours per day) but, again, Petitioner testified to being asked to check with her director about staying late and Ms. McLean, while a supervisor for Petitioner, wasn't her only supervisor. Thus, the Arbitrator is unable to conclude that Petitioner's histories were so false as to render her not credible. The overwhelming weight of the medical evidence from the fall of 2013 suggests that Petitioner was struggling to return to work in her full capacity and while subsequent medical records might suggest additional factors (financial issues, marital problems, job performance stress, and workers' compensation issues/stresses) were playing a role in Petitioner's pain complaints, the accident remained "a factor" in her ongoing condition and difficulties. Petitioner has never returned to the physical and emotional condition she was in prior to her work accident.

The Arbitrator also notes that the medical records suggest Petitioner has some memory difficulties. It is not entirely clear if these relate directly to her physical trauma or the medications she takes to address the injuries sustained in her fall. Either way, the difficulties

relate to the accident and they, too, have been factored in addressing pertinent issues herein. Petitioner's memory difficulties/concentration issues were apparent during the hearing. That she may have been incorrect about a referral from Dr. Pineda to a pain clinic is not known. Perhaps, she was confused or misunderstood. Perhaps Dr. Pineda told her that but did not put it in his report. Dr. Pineda was not deposed.

In the end, Petitioner was a credible witness.

The Arbitrator is also aware that, for the most part, all of Petitioner's tests have been relatively benign with MRI scans showing degenerative changes but nothing acute. Petitioner's lower extremity studies were "fairly unremarkable" but did reflect a bilateral L5 radiculopathy. Petitioner's lower leg complaints have been limited to her right side and she injured her right knee during the fall, according to ER notes reviewed by Dr. Weiss. The Arbitrator is also cognizant that Dr. Vasconcelles' records occasionally referenced herniated discs when no other doctor ever described Petitioner's discs as herniated; rather, they were described as bulging. Nevertheless, Dr. Vasconcelles used the terms inter-changeably and she also had very thorough records on Petitioner as noted by the size of PX 1 and the inclusion of so many outside records initialed by her. As such, her opinions were well informed.

The Arbitrator has considered the role of the June 2015 motor vehicle accident and does not feel it broke the causation chain. Petitioner may have had a brief period of increased pain after the accident but records show she returned to her base-line (pre-car accident) within a short period of time.

Respondent has placed significant reliance on the opinions of its examining physicians – Dr. Pineda and Dr. Weiss. The Arbitrator is not persuaded by either, primarily because neither doctor reviewed all of Petitioner's treating records post-accident nor was either doctor was aware of Petitioner's treatment with her psychiatrist, the first visit of which occurred prior to her examination with Dr. Pineda. As such, neither doctor considered the impact of Petitioner's recurrent depression and anxiety in her symptoms of pain. While Dr. Weiss felt Petitioner was magnifying her symptoms, he was the only doctor to suggest it but, again, his report was not based upon a review of all her records. Indeed, Respondent never had Petitioner examined by a psychiatrist whatsoever. Furthermore, Dr. Weiss did not address the diagnosis of chronic pain, the recommendations of several of the treating physicians of a need for ongoing pain management for that pain, or the suggestion of a referral to an inpatient pain program to further evaluate and treat that pain. Dr. Pineda did not have a complete understanding of Petitioner's job duties for Respondent and, therefore, wasn't fully informed to assess her ability to return to work.

Issue (K) Temporary Total (TTD) and Temporary Partial (TPD) Benefits:

Petitioner was initially taken off work by Dr. Vasconcelles on January 10, 2013. Petitioner testified she began receiving TTD benefits on January 16, 2013. Ms. McLean testified it was January 9, 2013. Petitioner's time sheets show she last worked on January 8, 2013. The Arbitrator places the greatest reliance on Dr. Vasconcelles' note and finds Petitioner was entitled to temporary total disability benefits as of January 10, 2013. Thereafter Petitioner was released

to return to work with restrictions as of September 23, 2013 and Petitioner did, in fact, return to work on the 23rd. Petitioner is entitled to TTD benefits from January 10, 2013 through September 22, 2013, a period of 36 4/7 weeks. While Respondent maintains Petitioner is only entitled to TTD benefits until June 5, 2013, based upon the opinion of Dr. Weiss, the Arbitrator has found Dr. Weiss' opinion unpersuasive and she adopts her causation discussion above in support of her findings herein.

Petitioner was again taken off work by Dr. Vasconcelles as of October 25, 2013 and Dr. Vasconcelles has not released her to return to work for Respondent since then. Dr. Tabatabai has also kept Petitioner off work. As of March 4, 2014 Dr. Vasconcelles did not feel Petitioner would ever be able to return to her occupation. Dr. Tabatabai felt Petitioner, from a mental health perspective, was completely unable to manage a part-time or full-time job of any kind and that her chronic pain syndrome had contributed to both her physical and mental limitations. He felt she fit the criteria for disability status. As of October of 2014 Dr. Tabatabai's opinion remained unchanged and he even noted the possibility of partial hospital care.

Since October 25, 2013 Petitioner has been employed at two part-time jobs. She has been unable to succeed at either, having been terminated by the Church and having to quit with HSHS. Her earnings while working were minimal. Her testimony regarding her ability to handle the jobs was credible and unrebutted.

That Petitioner was able to briefly work at these jobs does not undermine Dr. Tabatabai's opinions. He did not feel she would be able to manage part-time or full-time work and, in actually, she was unable to do so. Petitioner is entitled to temporary partial for the two periods she was able to work part-time. Her earnings for Parkway Church totaled $11,058.00, which were her earnings over 48 weeks (4/15/14 – 3/16/15), or $230.38 per week. Based on her AWW with Respondent of $685.38, she is entitled to TPD of $303.33 per week for 48 weeks, or $14,559.84. Petitioner worked for HSHS for 36 weeks (9/20/15 – 5/23/16), and earned $8971.28, or $249.20 per week. She is entitled to TPD of $290.79 per week for 36 weeks, or $10,468.44.

Setting aside the periods for which Petitioner has been awarded temporary partial disability, Petitioner would be further entitled to TTD benefits for the following periods of time: October 25, 2013 through April 14, 2014 (24 4/7weeks); March 17, 2015 through September 19, 2015 (27 weeks); and May 29, 2016 through October 24, 2016 (21 2/7weeks).

Issue (J) Medical Bills:

Petitioner is awarded the medical bills contained in Petitioner's Exhibit 9. The medical bills contained in Petitioner's Exhibit 9 are all for treatment related to treatment for Petitioner's work-related injuries, and are awarded, subject to the fee schedule and any credit Respondent may have for payment of those bills either through workers' compensation or Petitioner's group insurance through Respondent. Respondent shall further reimburse Petitioner for her co-pays and out-of-pocket expenses as set forth in PX 9. All bills awarded are subject to the Medical Fee Schedule. Respondent shall hold Petitioner harmless from any claims for which Respondent is receiving its 8(j) credit.

Issue (L) Nature and Extent:

Petitioner is permanently and totally disabled as a result of her work accident of October 11, 2012 pursuant to Section 8(f) of the Act.

Dr. Vasconcelles has indicated that Petitioner cannot return to work. Dr. Tabatabai has offered the same opinion with respect to Petitioner's depression and anxiety, which he opined were aggravated by her injuries and resulting chronic pain. Notwithstanding those recommendations, Petitioner sought and obtained employment on her own and attempted to work on two separate occasions. From her description of both jobs, they were less physically demanding than her work with Respondent. However, in both jobs, Petitioner was unable to continue performing her duties. In the first job, she was terminated because she could not keep up with the work demands, which she attributed to her pain and her pain medications. In the second, her increased pain forced Dr. Vasconcelles to take her back off work. Since being taken off work on October 25, 2013 by Dr. Vasconcelles, Petitioner has never been released to return to work for Respondent by her or Dr. Tabatabai.

These efforts to work show that Petitioner was motivated to work, and motivated to try to continue to work even in the face of increased symptoms, but was unable to continue to do so. Both jobs were essentially sedentary in nature, but Petitioner could not perform them even 20 hours per week.

The Arbitrator therefore concludes that Petitioner is medically wholly and permanently disabled within the meaning of Section 8(f).

****

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Marcus Shane Walker,
Petitioner,

vs. NO: 15 WC 11478

Southern Illinois University-Carbondale,
Respondent.

18IWCC0195

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 15, 2016 is hereby affirmed and adopted.

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

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

DATED: MAR 30 2018

o-01/31/18
jdl/wj
68

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WALKER, MARCUS SHANE
Employee/Petitioner

Case# **15WC011478**

SOUTHERN ILLINOIS UNIVERSITY CARBONDALE
Employer/Respondent

18IWCC0195

On 8/15/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.44% 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:

5236 CULLEY FEIST KUPPART & TAYLOR
KREIG TAYLOR
3 S MAIN ST SUITE 2
HARRISBURG, IL 62946

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

0904 STATE UNIVERSITY RETIREMT SYS
PO BOX 2710 STATION A
CHAMPAIGN, IL 61825

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

AUG 15 2016

RUTH A. HASSIA, Acting Secretary
Illinois Workers' Compensation Commission

18IWCC0195

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

MARCUS SHANE WALKER
Employee/Petitioner

v.

SOUTHERN ILLINOIS UNIVERSITY CARBONDALE
Employer/Respondent

Case # **15** WC **11478**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Herrin**, on **April 15, 2016.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **December 23, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**N/A**; the average weekly wage was $**N/A**.

On the date of accident, Petitioner was **44** years of age, *single* with **0** dependent children.

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

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

Respondent shall be given a credit of $**12,561.58** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**12,561.58**.

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

ORDER

As explained in the Arbitration Decision, Petitioner failed to prove by a preponderance of the evidence that he sustained an accident that arose out of and in the course of his employment on December 23, 2011. All benefits are denied. The Arbitrator makes no findings regarding the remaining issues.

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

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

Signature of Arbitrator

August 11, 2016
Date

AUG 15 2016

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MARCUS SHANE WALKER
Employee/Petitioner

18IWCC0195

v.

Case #: 15 WC 11478

SOUTHERN ILLINOIS UNIVERSITY CARBONDALE
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On his date of accident, December 23, 2014, Petitioner was 44 years old, single, with no dependent children. He was employed by Respondent as a temporary lamper at Southern Illinois University Carbondale and had been so employed since December 2, 2014. Previous to this position, he worked for Respondent as a temporary building service/maintenance worker from December 15, 2013, through May 31, 2014. At the time of trial Petitioner was not working for Respondent or any other employer. He testified his education consisted of a couple of years at a junior college, studying law enforcement, as well as some hours at John A. Logan College. He did not obtain an associate's degree. He previously worked as a correctional officer for the Department of Corrections for about four years, as an installer for Dish Network, as an underground coal miner, and a position in tactical security. Petitioner testified his work history consisted of jobs that required a lot of lifting, climbing, and dealing with conflict situations.

Petitioner testified that his job as a lamper required him to set and change the lights around campus. He consistently had to get up and down ladders and sometimes had to lift heavy things like boxes or ladders. In his previous position with Respondent, he was a building service worker, which involved doing janitorial work and a little bit of maintenance work. He testified it was a six-month job. He did not work for Respondent between the end of that job in May 2014 and the beginning of the lamper job in December 2014. Petitioner testified that his rate of pay as a lamper was $28.21 per hour, that he was hired to work forty hours a week, and that he worked second shift Monday through Friday.

On the date of accident, Petitioner was changing lights in Morris Library and was called by his co-worker Don to help him take a "Little Giant" ladder up the stairs to the engineering room in the library to change some lights. Petitioner estimated the ladder weighed about 100 pounds and took two individuals to carry. He testified that the stairs he and Don were walking up were steep and narrow, unlike regular stairs. As he was walking up the stairs carrying the

ladder with Don, he felt a shift and a pop in his left knee and then got a sharp pain and burning sensation on the inside of his knee. He did not think it was serious at the time, and he did not say anything to anyone and did not want to put his job in jeopardy. He finished out his shift and testified he had pain in his knee that was increasing. When he got home he iced and wrapped it. He testified he woke up about 1:30 or 2:00 a.m. and when he got up to use the restroom he could not put any weight on his knee. He called his supervisor Duane and told him what happened. Duane gave him the number for work comp and told him to call them. Petitioner testified he filled out a claim the next day and also spoke to Duane, Brad Dillard, and Phil Catton.

The day after the accident Petitioner's mother took him to the emergency room. He testified the doctor observed the swelling and instructed him to stay off his left leg until he was seen by his own doctor. He followed up with his primary doctor, who took him off work and started him in physical therapy. He testified he was paid by worker's comp for the time he was off work. He was ultimately referred by his primary doctor to an orthopedist, Dr. Wood, and was seen on March 25, 2015. Dr. Wood continued to keep him off work and he continued to be paid benefits while he was off. Dr. Wood referred him for additional therapy, which he attended, but which did not help. He ultimately had surgery on his left knee on May 12, 2015. He testified that he was paid for his time off work and that to his knowledge his bills were paid by worker's comp. Following surgery he continued to have pain and swelling in his left knee and continued to attend physical therapy. He testified he made minimal progress with therapy and eventually it was terminated by worker's comp, which he believed hurt his progress.

Petitioner testified that Dr. Wood eventually released him at maximum medical improvement on September 24, 2015. He placed permanent restrictions on his activities at that point, which included avoiding climbing and no lifting over 40 pounds. Petitioner testified his job with Respondent required him to consistently climb and to lift over 40 pounds, and he was not able to return to his position with those restrictions. Petitioner testified he has not been paid worker's compensation benefits since they were terminated on September 26, 2015. He testified he had been looking for work but had not found anything, and kept track of his efforts on the job log admitted as Petitioner's Exhibit 9. He believed he had a job with the sheriff's department in Harrisburg, but at the end of the hiring process he was told he could not be hired due to his lifting restrictions. The job would have paid $9-10 per hour. Petitioner testified he is in need of vocational assistance in helping him look for a job. The Arbitrator notes that the job log admitted (PX9) is four pages long and contains a total of 28 prospective employers contacted. The Arbitrator further notes that none of the pages contain any dates, either on the individual Employer lines or at the top of each page, to indicate date of contact.

With regard to his current symptoms and complaints, Petitioner testified he has trouble trying to walk and he gets fatigued, which leads to the burning sensation returning in the left side of his knee. He has weakness with no strength in the left knee, and walking up stairs gives him problems. He currently takes Norco for the pain, which is prescribed by Penny Smith in his primary physician's office. He testified if he stays off his knee the pain is not nearly as bad. Prior to the accident he did not have any complaints of pain in his left leg, nor did he have any difficulties performing his job duties. Prior to the accident he played basketball and lifted weights, and is no longer able to do either.

On cross-examination, Petitioner acknowledged that both jobs he held at SIU had been temporary positions. He testified he was told by Phil Catton that the lamper position was going to be permanent, but he was not given specifics on it. He was unaware of any kind of examination he would need to take to be permanent full time at SIU, and testified he had not taken a state exam. Petitioner acknowledged he does not have a college degree and also acknowledged that he had several jobs in many different fields. He testified he worked second shift, which was 3:00 to 11:00 p.m., and admitted he did not work a complete shift most of the time he was employed as a lamper, as he had to leave to catch the bus home at 10:30 or 11:00. He did not have a driver's license at that time, so relied on public transportation, but testified he did have a license at the time of trial.

Petitioner acknowledged he had a full thickness cartilage defect in his right knee previously and had undergone two surgeries on his right knee. He testified he had not applied for Social Security Disability, and has been looking for work since he was released at MMI on September 24, 2015. Petitioner reviewed the job log (PX9) and testified it listed 28 jobs he had applied for between September 2015 and April 2016. He admitted, however, there was a period of time after November 23, 2015, that he did not look for a job, due to a death in the family.

Respondent presented witness Donald Morehead, who is a sub-foreman with building services for Respondent. Mr. Morehead testified he was working on December 23, 2014, and he recalled carrying a ladder with Petitioner on that date. The ladder was big and bulky and weighed around 100 pounds. It can be carried by one person for a short distance, but not up a flight of stairs, which required two people. He testified the ladder was on the top floor of the library and had to be carried to the mechanical room above that in order to replace some lamps. The ladder had to be carried up a flight of stairs, followed by a turn, and then up a shorter flight of stairs. The lamps were changed in the mechanical room and then he and Petitioner carried the ladder back down to the top floor of the library and put it on a cart to be wheeled out to the truck. Mr. Morehead testified both he and Petitioner were carrying the ladder and that he was behind Petitioner on the way up the stairs. He did not see Petitioner stumble, fall, or misstep.

After that job was completed Mr. Morehead went to another job, but about 10:00 p.m. he went back to the library to pick up Petitioner, as he had been asked to take him to the bus stop. He testified he did not see anything out of the ordinary with Petitioner at that time, and Petitioner did not indicate he had experienced any kind of injury. He testified that someone who worked that shift would take Petitioner to the bus at around the same time. Mr. Morehead identified the Witness Report he filled out, marked as Respondent's Exhibit 6, and testified it accurately reflected what he recalled from the events of that day. He testified that filling out this report was standard procedure when an accident occurred.

Mr. Morehead testified Petitioner was hired on an "extra help contract" for the lamper position, and that it was a temporary position. It was temporary because the person who held the lamper position had been in a motorcycle accident, and Petitioner was filling in while she was recuperating. He testified there is only one lamper position on campus for the academic side, and that he was needed back in his position as a sub-foreman, so Respondent hired a temporary lamper until the other person returned from her recuperation. He testified there is a state exam that must be taken in order to become a permanent full time employee.

On cross-examination, Mr. Morehead testified his position at the time of Petitioner's accident was fill-in lamper. He had been in that position for about six weeks prior to the accident, returned to his sub-foreman position for about six weeks, and went back to the lamper position to fill in again in August 2015. He testified he sometimes worked with Petitioner, depending on the job requirements of what the foreman needed, and that he helped train Petitioner. He was not involved in the hiring and firing of individuals, but based on his personal knowledge, Petitioner's position was not going to be permanent. Mr. Morehead testified that a temporary employee's hourly rate depends on the job title and the union they are affiliated with. His understanding was that Petitioner's rate of pay was $28.21 an hour, and that he was to work approximately 40 hours a week. He testified Petitioner was in a training phase, that there was a learning curve, and that he did not have any problems with Petitioner.

Respondent presented witness Jeni Batson, who is the human resources officer and worker's compensation coordinator for Respondent. She testified that in her position she has access to, and is familiar with, employees' personnel and worker's compensation files. She identified Respondent's Exhibit 7 as the wage statement that she prepared to calculate Petitioner's average weekly wage. She testified it accurately reflected the document she created, which showed Petitioner's earnings between December 15, 2013, and May 31, 2014. She testified that during that six month period Petitioner was an extra help position building service worker, which is a temporary position. The hourly rate for that position was $14.76. Ms. Batson testified Petitioner was hired again in a temporary extra help position as a lamper with the physical plant, at an hourly rate of $28.21. She testified that the initial contract date for the extra help lamper position was from December 2, 2014, to June 30, 2015, but it was terminated on January 23, 2015, as the permanent employee Petitioner was replacing returned to work from a non-occupational disability leave. The temporary position was terminated at that point.

On cross-examination, Ms. Batson acknowledged that Petitioner was paid worker's compensation benefits from the time of his injury until September 26, 2015, and that at least some of Petitioner's medical had been paid. She was unaware of which bills were paid and which were not. Her understanding was that Petitioner's claim was initially approved by the claims administrator, Tri-Star. She agreed that when Petitioner was hired as a temporary lamper his hourly rate was $28.21 and that was for 40 hours per week.

Petitioner was recalled as a rebuttal witness. He testified Mr. Morehead's testimony as to the facts of carrying the ladder up the stairs was correct. He testified he did not tell Mr. Morehead that he had done anything to his knee while walking up the stairs with the ladder, as he did not want him to know. Upon prompting by his attorney, he testified he was concerned that if he filed a claim he would lose his job.

An Employer's First Report of Injury was completed on December 24, 2014, which indicated that Petitioner stated he was walking up stairs the night before and his left knee buckled. He further stated that after sleeping and not being on it, he stood up and felt pain like a bolt of lightening. RX1.

Petitioner first presented for treatment at 9:30 a.m. on December 24, 2014, when he went to the emergency room at Ferrell Hospital. He reported that while moving a ladder up stairs at work the previous night his left knee gave way. He denied falling. He stated the pain continually increased through the night and increased with weight bearing. One of the handwritten notes from the hospital indicated Petitioner injured his knee when he fell off a ladder, and the Arbitrator notes this discrepancy is most likely due to an error in the recording of the history by that particular person. Left knee x-rays showed mild arthrosis about the patellofemoral and medial compartments, but no acute bone abnormality. The discharge diagnosis was left knee sprain of the medial collateral ligament. Petitioner was instructed to ice his knee every one to two hours, to use crutches for two to three days, and to use an ace wrap for seven to ten days. He was instructed to follow up with his family physician in two to five days, on or before December 30, 2014. There was no reference to whether or not Petitioner should remain off work. PX1.

Petitioner next sought treatment on January 5, 2015, when he presented to Ferrell Hospital Family Practice and was seen by Physician's Assistant Pennie Smith. He reported he injured his knee at work, was seen in the ER and told to stay off work until seen in that office, and that he needed to know what to do about work. Examination revealed edema and the assessment was knee sprain. Petitioner was prescribed Norco, was referred to physical therapy and was instructed to follow up in two weeks. PX2.

On January 8, 2015, Petitioner completed an Employee's Notice of Injury form. He reported he injured his left knee when he and Don Morehead were carrying a ladder up the stairs of the engineering room in the library. He indicated he did not report it on the day it occurred because when it first happened he did not realize it was as bad as it was, and it got progressively worse through the course of the night, to the point he could not put weight on it. He stated he did not say anything at the time and did not know whether Don Morehead witnessed the incident or not. RX2.

On January 8, 2015, a Supervisor's Report of Injury was completed by William Everly. It was noted on the report that Mr. Everly was the fill-in foreman on duty at the time of the injury. He stated he did not receive notice of the accident and the details of the accident and injury were listed as unknown. RX4.

On January 8, 2015, a Witness Report was completed by Don Morehead. He stated he did not see the accident and that nothing was said to him about an injury during the time in question. He stated Petitioner assisted moving a ladder up a small flight of stairs, that Petitioner was in front of him during this process, and that he never noticed any change in Petitioner, as if he was injured. He further stated that later in the evening he was with Petitioner and never noticed he was injured. Petitioner was walking fine until Mr. Morehead took him to the bus stop at 10:00 p.m. He reiterated he saw nothing and heard nothing when moving the ladder. RX6.

On January 12, 2015, a Supervisor's Report of Injury was completed by Duane Spencer, Electrician Foreman. He stated Petitioner reported helping a co-worker lift a ladder when his knee gave out. He thought he just twisted it and could put weight on it at that time. Petitioner reported he rode the bus home and when he got off the bus he could barely walk. Mr. Spencer

reported that at 3:00 a.m. Petitioner texted him and reported he was unable to put weight on his left knee. He further stated he was off duty the night of the alleged incident and that the temporarily upgraded foreman that evening was Chester Everly. RX3.

On January 20, 2015, Petitioner underwent an initial physical therapy evaluation at Strictly Rehab/Ferrell Hospital, upon referral by PA Smith. He reported he was at work, stepping up steps, when his left knee gave way, buckled, and went out on him. He finished his shift and after work he was unable to walk or put weight on it. He reported he was not currently working and that he had been resting, icing, and wrapping his knee. He reported prior surgery to his right knee and a three-level fusion. He stated he worked as a lamper at SIU and that he needed to be able to climb ladders for his job. He complained of sharp, shooting, nagging pain on the medial side of his left knee, which was constant. It was noted he had no ambulation aides with him at the evaluation and he was wearing a loose ace wrap around the outside of his pant leg. He had a mild limp on the left when he ambulated. Assessment was possible meniscus tear, but the therapist was unable to fully assess due to Petitioner guarding with all testing and palpation. It was noted there was no edema or decreased quadricep tone. It was recommended he discontinue the use of the ace wrap, as it provided no support, and work on ambulation. Petitioner participated in therapy from January 20, 2015, through March 12, 2015. He reported continued pain toward the inside of the knee and difficulty with weight bearing and ambulating on stairs. It was noted that his range of motion and strength were essentially unchanged. It was further noted that an MRI had been requested and was awaiting approval. PX3.

On March 13, 2015, Petitioner underwent a left knee MRI, which revealed (1) moderate arthrosis about the patellofemoral, medial compartments with mild arthrosis laterally, and full thickness cartilage defect of the medial femoral condyle; (2) small joint effusion without synovitis; (3) moderate chondromalacia; and (4) popliteal cyst measuring 3.4 x 4.5 x4.7. PX5.

Petitioner returned to PA Smith on March 18, 2015. It was noted he had been attending physical therapy and had not been able to work due to instability in his left knee. PA Smith reviewed the MRI findings with Petitioner and referred him to an orthopedic surgeon. He was kept off work. PX5.

On March 25, 2015, Petitioner presented to Dr. John Wood at The Orthopaedic Institute of Southern Illinois. He completed several intake forms, on which he reported he had injured his left knee at work while carrying a ladder up stairs. He reported to Dr. Wood that he was carrying a ladder up some stairs when his left knee gave way, that his symptoms were unchanged, and that physical therapy had not helped. Dr. Wood reviewed the MRI film, which he interpreted as showing moderate arthrosis of the patellofemoral joint with a full-thickness cartilage defect. Petitioner reported he had mild swelling following the injury and had tried occasional anti-inflammatories. He reported they did not help and that he was interested in surgery. On examination, Petitioner's left knee had crepitation, positive McMurray's with pain referable to the medial joint line, and mildly positive patellofemoral compression. Assessment was osteochondritis dissecans. Dr. Wood opined Petitioner sustained a traumatic injury to his medial femoral condyle that resulted in a full-thickness cartilage defect. He noted Petitioner had a similar problem on the opposite knee which was treated with surgery, but Petitioner denied any pain on the left prior to the reported accident. He further opined that, although Petitioner may

have surgery, the results were fairly poor. Dr. Wood injected the left knee and ordered physical therapy. He allowed Petitioner to work with restrictions of walking no more than 15 minutes per hour, no lifting, no carrying, and no climbing. PX5.

Petitioner presented to physical therapy on April 2, 2015. It was noted he was unchanged since discharge on March 20, 2015, and that he was limited with progressing into higher level activities. The therapist believed Petitioner as at his maximum potential with therapy until further intervention by his physician. She spoke with Petitioner's nurse case manager, who agreed. On April 7, 2015, the nurse case manager reported to the therapist that Dr. Wood wanted Petitioner seen until his follow up appointment on April 15, 2015. He was seen on April 9, at which time he reported his knee felt better for two days after the injection, but then the pain had gone back to the same as before. Petitioner was seen on April 10, 13, and 14, and on May 11, 2015, at which time he was discharged pending surgery. PX3.

On April 15, 2015, Petitioner returned to Dr. Wood and reported his symptoms had not changed and were moderate to severe. He reported the injection had not helped significantly. On examination, Petitioner ambulated with a slow steady gait and was very protective of his left leg. He had slight effusion and had discomfort with McMurray's test but no palpable pop. Assessment was traumatic osteochondritis of the left knee and surgery was recommended, as conservative care had failed. PX5.

On May 12, 2015, Petitioner underwent surgery on his left knee. Procedures performed were chondroplasty with osteochondral pick medial compartment, chondroplasty with osteochondral pick patellofemoral joint, and extensive synovectomy. Post-operative diagnoses were osteochondral defect of the medial femoral condyle, osteochondral injury of the patellofemoral joint, and extensive synovitis. He followed up with Dr. Wood on May 28, 2015. He was to start using a continued passive motion machine (CPM) and was kept off work at that time. PX6.

On June 23, 2015, Petitioner was evaluated by Respondent's Section 12 examiner, Dr. Richard Lehman of U.S. Center for Sports Medicine. He gave a history of injuring his left knee when it gave way when going up stairs. He complained of significant swelling in the left calf, significant left knee pain, pain with bending, and soreness in the left knee. He also complained of significant swelling in his right calf. He reported he had never had an injury to his left knee before. He further reported he had had significant swelling in his lower extremities which had been problematic for a long period of time, with the swelling in his lower leg actually causing some skin damage. Petitioner stated he climbed ladders and installed lighting as part of his job. He reported past right knee surgery, right ankle surgery, and back fusion. RX8.

Examination by Dr. Lehman revealed post-surgical healed portals in the medial and lateral aspect of the knee. Petitioner did not have any swelling intraarticularly. Dr. Lehman noted, however, that Petitioner's lower leg was grossly edematous to the point of having venous stasis disease and venous ulcers. Dr. Lehman noted there was no anterior or posterior instability and McMurray's test was negative. Petitioner had diffuse tenderness in the patellofemoral articulation and significant grinding. There was no evidence of laxity. There was some grinding

in the anterior aspect of the knee, which appeared to be inconsequential. Dr. Lehman noted the biggest problem was swelling. RX8.

Dr. Lehman reviewed treatment records to date. He also reviewed x-rays taken in the office, which did not show any acute fracture or other acute pathology. Petitioner's pre-operative MRI likewise showed no acute effusion or acute changes. He also reviewed Petitioner's operative report and noted Petitioner's main disease pattern was degenerative. He noted there was no bone marrow fluid on the MRI, indicating no apparent acute component to the condition. Although Dr. Wood noted some of the chondral breakdown was acute, Dr. Lehman opined this was not corroborated by the MRI, which showed moderate arthrosis about the patellofemoral joint medial compartments with minimal effusion. He noted there did not appear to be any type of bony changes. Dr. Lehman noted mild degenerative spurring throughout the knee and thinning of the articular cartilage. RX8.

Dr. Lehman opined Petitioner's preexisting problems included morbid obesity, possible congestive heart failure, long-standing problems with his contralateral knee, and significant overload due to his accentuated BMI. Objectively, Petitioner had excellent range of motion and his knee was stable. He had mild grinding, had no varus or valgus instability, and the patella tracked centrally. He had significant lower extremity peripheral edema, which Dr. Lehman opined was secondary to congestive heart failure. His examination was good other than his severe swelling. RX8.

Dr. Lehman diagnosed Petitioner with preexisting degenerative arthritis and congestive heart failure. He opined there was no causal relationship between Petitioner's objective findings and the accident. He did not believe the incident of simply walking up a step and having Petitioner's knee give way was the etiology for the problems he had. He further did not believe there was a causal connection between the operative findings and Petitioner's symptoms, the severity of arthritis, or the pathology noted on the MRI, as the findings appeared to be chronic and long term rather than acute. RX8.

Dr. Lehman opined Petitioner's medical treatment had been reasonable to date, but now needed to focus on his peripheral vascular disease. He opined Petitioner had had excellent care and treatment for his knee, but that it was not in anyway related to his work injury. He believed Petitioner's prognosis was poor, due to his obesity and the amount of severe degenerative arthritis in his knee. He stated Petitioner was able to work with no repetitive squatting or kneeling, and limited stairs and weight carrying. Dr. Lehman opined Petitioner was at maximum medical improvement as respects his work injury and needed no further treatment; however, he did need to have his lower leg addressed to resolve the swelling, which was unrelated to his job or the injury. RX8.

Petitioner returned to Dr. Wood on June 24, 2015. He reported some increased pain in his right knee due to increased pressure on it, and it was noted he had some chronic problems with the right knee. He was allowed to return to full weightbearing and to return to work with restrictions of standing or walking no more than 15 minutes per hour, no climbing, and no lifting or carrying more than 15 pounds. He was referred to physical therapy. PX7.

On June 30, 2015, Petitioner underwent an initial physical therapy evaluation. He reported edema and difficulty walking, and stated his knee "feels weird". On July 1, he attended therapy and inquired about being able to lift weights in his arms. He was advised he should be able to do biceps, triceps, chest, and shoulders if sitting in a chair and someone handed him the weights, but that he was not to do standing arm exercises or lifting arm weights while standing or pick the weights up by himself. Petitioner attended therapy on July 6, 8, and 10, 2015. PX4.

Petitioner returned to Dr. Wood on July 22, 2015, and complained of moderate pain and weakness. He reported he had recently been hospitalized for pneumonia, and physical therapy had therefore been postponed. On examination, Petitioner ambulated with a good steady gait with no assistive device. Dr. Wood noted his recent hospitalization and pausing of therapy would slow down his recovery. Petitioner's work restrictions were continued. PX7.

Petitioner participated in therapy on July 28 and 31, and August 4, 7, 13, 14, and 18, 2015, and reported intermittent worsening of his pain. PX4.

On August 19, 2015, Petitioner returned to Dr. Wood with complaints of intermittent pain and swelling. Examination revealed an antalgic gait, mild swelling, and tenderness over the medial joint line. Petitioner was released to return to work four hours a day for three weeks, then to full duties. He was to continue therapy. Dr. Wood noted Petitioner was "at significantly higher risk for long-term arthritis". PX7.

Petitioner participated in physical therapy on August 24, September 8, 11, 17, and 28. He reported on September 8, 2015, that he had not heard from work about returning, as they did not have half days available. He was discharged on September 28, 2015. PX4.

On September 24, 2015, Petitioner followed up with Dr. Wood, who noted he had gone through the post-operative protocol of nonweightbearing with continued passive motion machine and therapy. He further noted Petitioner had recently been in the hospital for increased blood pressure. Dr. Wood opined that Petitioner was at maximum medical improvement. He advised he should avoid ballistic activity, running, impact activities, carrying heavy loads, and doing a lot of climbing particularly on ladders. He noted these activities tended to aggravate Petitioner's knee. Dr. Wood further opined that Petitioner would likely need future care for arthritis, which was post-traumatic and due to his work injury. Dr. Wood recommended and ordered a Functional Capacity Evaluation. PX7.

Dr. Wood testified by way of deposition on December 2, 2015. He is a Board Certified Orthopedic Surgeon with a subspecialty certification in sports medicine. His practice includes work with the knee, hip, shoulder, elbow, and hand. He testified consistent with Petitioner's treating records. His assessment at the initial examination was traumatic osteochondritic defect, or osteochondritis dissecans. He explained that the surface of the knee joint, the articular cartilage, can be sheared off, taking a piece of cartilage and a piece of bone with it, leaving behind exposed bone. The exposed bone does not have any cushion effect, which is what arthritis starts as. Dr. Wood testified this condition can be caused by or aggravated by a traumatic injury, such as the one sustained by Petitioner. He further testified that Petitioner's left

knee condition was caused by his work injury, based on the fact that Petitioner had no symptoms before this injury, and did have symptoms after the injury. PX8.

Dr. Wood testified he treated Petitioner conservatively for a period, and eventually performed surgery. During surgery he found a fair amount of swelling within the knee, swollen tissue called synovitis. The meniscus was normal. Petitioner did have an osteochondritic defect, which Dr. Wood described as clearly traumatic. He described an arthritic abnormality as one where the cartilage is worn away to the point where bone is exposed. Dr. Wood testified when a patient has a traumatic event, there is a very different look to it. There is a sharp edge and a bloody hole, where the piece of bone and cartilage used to exist. He noted in Petitioner's surgery there was such a hole, which measured three millimeters by one centimeter, which is about half an inch. He testified that while that may sound relatively small, it was a fairly significant portion of cartilage to be missing from the knee. During surgery the area was debrided, with abnormal tissue removed and edges smoothed. Dr. Wood testified that based on a reasonable degree of medical certainty, Petitioner's need for surgery was related to his work accident. PX8.

Dr. Wood testified Petitioner is at a significantly higher risk for long term arthritis because of his work injury. He explained arthritis is a loss of articular cartilage. The initial cartilage is called hyaline cartilage, which is extremely durable. With the surgery performed, cartilage is allowed to form, but it is fibrocartilage, which can last five to ten years but usually not much longer than that. Dr. Wood testified that the loss of cartilage with the injury, combined with the fact that the cartilage replacing it is not normal cartilage, it will lead to arthritis in most patients. He testified there is no way of knowing if Petitioner will need further treatment in the future, but that he is at higher risk. PX8.

Dr. Wood testified the last time he saw Petitioner was on September 24, 2015, at which time he recommended a functional capacity evaluation. He typically recommends this in worker's comp cases, particularly when there is permanency, and when there are medical legal issues involved, to give an idea of disability. He was not sure if the functional capacity evaluation was ever done in this case, as he never received a copy of one. PX8.

On cross-examination, Dr. Wood testified that approximately 60 percent of his practice is dedicated to the knee. He testified Petitioner gave a history of walking with a ladder on an incline when his knee buckled. He agreed that an osteochondral defect, when traumatic in nature, was usually caused by a twisting or direct impact. He disagreed that that kind of injury is frequently accompanied by a tear to other knee structures such as a ligament or tear, though it sometimes can be. He testified that walking up a step, carrying something, and the knee giving out can cause an osteochondral defect, as it can cause a shearing force within the knee. He described a twist as a shear force coming across the surface, which is the same thing as when a knee buckles, as the knee gives way and there is a tremendous amount of force as it flexes. PX8.

Dr. Wood agreed that Petitioner's MRI showed moderate arthrosis, or arthritis, and further agreed that arthritis takes a long time to develop. He testified Petitioner was 45 years old at the time he began treating, and he testified that moderate arthritis in a 45 year old's knee is becoming more frequent, though not common. He conceded that Petitioner's weight of about 270 pounds on a five foot ten inch frame created a load on his knee that would lead to faster

degeneration in the knee. He conceded it could also cause additional problems and make Petitioner more susceptible to injuries and problems with his knees. He agreed that Petitioner's BMI of 38.7 put him in the category of morbidly obese. Dr. Wood acknowledged that Petitioner had a history of multiple surgeries and problems with his right knee, and that it was common with someone his size to have problems in both knees. PX8.

Dr. Wood acknowledged it was possible Petitioner had just experienced pain on the date of injury, and that the incident had not actually caused the osteochondral defect. However, Petitioner told him specifically that he had not had problems with his left knee previously, that he had this incident, and then had a problem. In addition, what he found at the time of surgery looked traumatic and looked different than what simple arthritis or arthrosis very typically looks like. Dr. Wood conceded that if Petitioner had experienced prior problems or pain with his knee it could change his opinion, if he had a single traumatic episode that led to pretty significant increased pain within just a month or so before being seen. However, at the time of surgery he found not only chronic changes, the early arthritis, but also found traumatic lesions called osteochondritis dissecans. He testified there was something traumatic that occurred that left a hole behind. He testified the MRI showed a small amount of fluid within the joint, which is fairly typical, but agreed it did not show a great amount of fluid, a finding sometimes seen after injury. Dr. Wood testified it was unlikely that the swelling in Petitioner's leg was caused by congestive heart failure. PX8.

Dr. Wood confirmed that on August 19, 2015, he released Petitioner to return to work for four hours a day, five days a week, for three weeks. Then on September 14, 2015, he released him to return to work fully duty, with no restrictions. Then on September 24, 2015, he placed Petitioner at maximum medical improvement with permanent restrictions of avoiding running, jumping, impact activities, climbing, or lifting over 40 pounds. Dr. Wood testified that when he released Petitioner to full duty, he believed Petitioner would not do any of the activities that were beyond what he wanted him to do. However, when he saw Petitioner back for the MMI determination, he had to define what he could do long term and address not only his current job but also his future possibility of working. He acknowledged that this appeared inconsistent, but in fact was not. He conceded there is a possibility Petitioner could improve, but also a possibility he could get worse. He testified that although he recommended an FCE, whether it is done or not, it does not change what he is going to do with regard to recommendations. PX8.

Dr. Lehman testified by way of deposition on January 19, 2016. He is a Board Certified Orthopedic Surgeon with a subspecialty certification in sports medicine. His practice is primarily surgical and deals with sports medicine. A significant percentage of his practice is treating knee and shoulder injuries, including professional athletes, college athletes, and high school athletes. He performs 15 to 20 surgeries a week. He performs independent medical examinations only on an infrequent basis, and they comprise only about a half of one percent (.5%) of his practice. RX9.

Dr. Lehman testified consistent with his report of July 23, 2015. He testified he reviewed Petitioner's MRI films and noted there was minimal, if any, fluid in the knee, so there was no real effusion. He testified the MRI evidenced breakdown of the patellofemoral joint, arthritis of the patellofemoral joint and medial compartment, full thickness defect all the way down to the

bone on the medial femur, chondromalacia and arthritis on the back surface of the patella with areas of significant wear and some subchondral bone breakdown, and a large popliteal or Baker's cyst in the back portion of the knee. The MRI also showed arthritic changes of spurring on the medial aspect of the knee, which is normally seen after a long period of time with arthritis. He testified that generally an arthritic spur of the kind seen on Petitioner's MRI takes many years to develop. He explained that many years of microtrauma such as walking, especially in someone who is clinically obese, puts a lot of stress on their knee and the subsequent pathological process is the development of a spur. Dr. Lehman testified there was nothing on Petitioner's MRI films that suggested an acute component of his left knee condition. The same was true for the x-ray films reviewed from December 24, 2014, taken post-accident. RX9.

Dr. Lehman testified Petitioner had a full thickness cartilage defect in his left knee and that he had previously had the same problem in his right knee. He testified that when this defect is in both knees, it is considered "symmetrical" and is consistent with a degenerative arthritic process. It is common to have that condition in one knee, then in the other. Dr. Lehman explained that a full thickness cartilage defect is one in which the articular cartilage has been completely denuded, and that component of the knee is worn away or thin all the way down to the bone. Dr. Lehman testified he has researched this extensively and has written a number of articles and presented nationally and internationally on the topic. He has been treating full thickness cartilage defects for 30 years and has had 7,000 or 8,000 such cases. Dr. Lehman testified that when a full thickness cartilage defect is diffuse on the femur and on the back surface of the kneecap, as in Petitioner's situation, the cause is generally long-term and degenerative. Dr. Lehman testified the MRI did not show any bone marrow fluid, which indicated Petitioner did not have any effusion and that there was no acute process. He explained with an acute defect the knee would be extremely swollen, would stay swollen until the defect was addressed, and there would be bone marrow edema, which is stress where the honeycomb parts of the bone crack due to the stress. He explained if there was an acute component there would be bone marrow edema and either fluid or generally blood in the subchondral surface. He testified that he reviewed Petitioner's operative report and that there were no acute findings during surgery. RX9.

Dr. Lehman testified that Petitioner had comorbidities that caused or contributed to his left knee condition. The biggest comorbidity was Petitioner's weight of 290 pounds and his accentuated BMI of 41.6, which is considered morbidly obese and which stresses his knees. He testified there is an increase in the percentage of people with degenerative arthritis after a BMI of 29 or 30. A person with a BMI of 35 has a 60-70% chance of having degenerative arthritis. A person with a BMI of 40 or 41 has an 85% or better chance of having degenerative arthritis at Petitioner's age, and by age 60 100% of those people have degenerative arthritis. He testified there is a direct correlation between the percentage and severity of degenerative arthritis and a person's BMI, and after age 30 the curve is substantially steeper. RX9.

Dr. Lehman testified that after examining Petitioner, he believed his biggest problem was significant edema in the lower extremity and swelling to the point of having venous stasis disease. He testified the issue with that disease is that blood goes in but not much blood goes out, and it cannot be cured. It rarely, if ever, gets resolved and frequently ends up with an

amputation. He testified this had nothing to do with Petitioner's knee, but it looked very bad upon examination. RX9.

Dr. Lehman testified Petitioner's diagnosis was pre-existing degenerative arthritis of the left knee. He did not believe that walking up steps could be the mechanism of injury for the kind of damage that was found in Petitioner's knee. The biomechanics of walking up a step are pretty clear, and stress dissipated is in the patellofemoral joint underneath the knee, in the kneecap. Most of Petitioner's damage was found on the medial aspect of his knee, which is not where one would expect to find damage, based on the way the stress is dissipated in the patella and the trochlea. He testified Petitioner's disease process is totally incongruous with the history given in terms of the medial side of his knee and the wear patterns in the medial side and underneath the kneecap. Dr. Lehman testified Petitioner's left knee condition and his treatment for same were not related to the alleged work injury of December 23, 2014. Aside from causation, he testified Petitioner did not require any additional treatment and that he was at maximum medical improvement. He opined Petitioner could work with restrictions of no repetitive squatting or kneeling, but that those restrictions were not related to the alleged work accident. RX9.

Dr. Lehman testified if Petitioner challenged his knee with walking up or down stairs, walking on uneven ground, squatting, and the like, he would have had discomfort in the knee. He had two surgeries on the right knee and had a similar wear pattern. Based on that, he opined if Petitioner were to do normal activities he would have been potentially symptomatic. RX9.

On cross-examination, Dr. Lehman did not agree that it is easier to offer a causal relationship opinion when the person is examined closer to the date of the accident. He testified a causal opinion is most related to the doctor's experience, how much orthopedic research and literature he or she has done, their interest in the discipline, whether the doctor is actively doing research, and whether they subspecialize or have expertise in it. He testified the medical records he reviewed gave a history of Petitioner walking up steps with a heavy ladder, and the history Petitioner gave him was that he was walking up a step and had discomfort, which was a little different history. Dr. Lehman testified that with either history, carrying or not carrying a heavy ladder, his opinion was the same that it was not causally related to Petitioner's condition. He explained then when going up a stair, whether carrying something or not, stress is dissipated in the kneecap, and the pathology identified in Petitioner's MRI and operative report is not consistent with that mechanism. RX9.

Dr. Lehman acknowledged that arthritis can develop after an accident, but it is dependent upon many factors. He further acknowledged that Petitioner did not report he had prior symptoms, nor did he review medical records indicating prior symptoms. He agreed that a traumatic injury could aggravate someone's arthritis to the point of making it symptomatic, but only if there is a true traumatic injury. He testified that the mechanism of simply carrying a heavy ladder up or down stairs would not aggravate someone's preexisting arthritis. Rather, the mechanism of a twisting injury or a deceleration where the foot is planted and the body twists, is generally what would exacerbate a preexisting arthritic pattern. Dr. Lehman testified that an accident can aggravate arthritis, but that in this case there was no accident, as Petitioner was simply walking up stairs. RX9.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the above Findings of Fact, and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After review of the evidence and due deliberations, the Arbitrator finds on the issues presented at trial as follows.

In support of the Arbitrator's decision relating to issue (C), whether an accident occurred which arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

To obtain compensation under the Illinois Workers' Compensation Act, a claimant must show by a preponderance of the evidence that he suffered a disabling injury arising out of and in the course of his employment. 805 ILCS 305/2; *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill.App.3d 1010, 1013 (1st Dist. 2011); *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d 52, 57 (1989). In order to satisfy the "arising out of" requirement of the act, the Petitioner must show the injury was in some way incidental to his employment, creating a causal connection between his employment and the injury. *Caterpillar Tractor Co. v. Indus. Comm'n.*, 129 Ill.2d 52, 58 (1989).

In this case, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he sustained an accident which arose out of and in the course of his employment.

Petitioner testified he was walking up the stairs when he "felt a shift and a pop", followed by a burning sensation and sharp pain on the inside of his left knee. He did not fall, stumble, misstep, twist his knee, or otherwise have an actual mechanism of an accident. He was merely walking up steps when he experienced pain in his left knee. Mr. Morehead testified he was with Petitioner at the time of the alleged accident, that he was behind him when going up the stairs, and that he did not see Petitioner stumble, fall, or misstep in any way. Mr. Morehead further testified that he did not see anything out of the ordinary with Petitioner, such as limping or favoring his left leg, the remainder of that day, or when he took him to the bus stop later.

The Arbitrator is mindful, and the record is clear, that Petitioner and Mr. Morehead were carrying a heavy ladder up the stairs at the time Petitioner stated he began having pain in his knee. However, there is no indication that carrying the ladder caused or contributed to Petitioner's knee hurting. The Arbitrator is also mindful that Petitioner testified the stairs were a little steeper than normal. However, again, there is no indication that this caused or contributed to Petitioner's knee spontaneously hurting. The record is consistent that Petitioner reported his knee simply "buckled" or "gave way" as he was walking up the stairs. The Arbitrator finds significant the history of injury as documented in the following:

1. Ferrell Hospital Emergency Room, December 24, 2014—The nurse wrote, "While moving ladder up the stairs last night left knee gave way. Denies fall." (PX1)
2. Employer's First Report of Injury, December 24, 2014—"Employee stated he was walking up the stairs and left knee 'buckled'." (RX1)
3. Employee's Notice of Injury, January 8, 2015—Petitioner wrote, "I stepped down onto step and knee 'buckled', gave way." (RX2)

4. Supervisor's Report of Injury, January 12, 2015—Duane Spencer wrote, "Marcus Shane Walker reported that he was helping his co-worker Don Morehead lift a ladder in Morris Library when his left knee allegedly gave out." (RX3)
5. Ferreli Hospital/Strictly Rehab, physical therapy initial evaluation, January 20, 2015—The therapist wrote, "Patient reports that he was at work and stepping up steps and the knee gave way, buckled and went out on him." (PX3)
6. Eldorado Family Medicine, Accident Information form, March 16, 2015—Petitioner wrote, "Carrying ladder up stairs, knee gave out." (PX5)
7. The Orthopaedic Institute of Southern Illinois/Dr. Wood, Workers Compensation Information form, March 25, 2015—Petitioner wrote, "Carrying ladder up stairs, left knee gave out." (PX5)
8. Dr. Richard Lehman IME report, July 23, 2015—Petitioner reported "he stepped with his left leg onto ladder stairs and it gave way". (RX8)

In addition, during trial Petitioner was asked what happened with regard to his left knee as he was walking up the stairs. Petitioner testified, "Well, actually, I just felt a shift and a pop."

The Arbitrator finds Petitioner's history of his knee giving out or buckling as he was going up the stairs to be suspect. If the knee buckles, the leg bends and is no longer straight, and if the leg is no longer straight, then the body drops down. One would assume that if Petitioner's left knee actually gave out or buckled, then there would physiologically be a shift of his weight on the left side. One would also assume that there would be some corresponding shift in the weight of the 100 pound ladder he was carrying. Mr. Morehead was on the other end of the ladder that was being carried, and was behind Petitioner as they went up the stairs. He testified he did not see Petitioner stumble, fall, or misstep. Even if he did not see anything, it is reasonable to conclude that he would have felt the weight of the ladder shift if Petitioner's left knee buckled and his own body weight shifted. Mr. Morehead's statement on his Witness Report was, "I never noticed any change in him, as if injured." The Arbitrator finds it unlikely, if not impossible, for Petitioner's knee to have physically gone out or buckle, and Mr. Morehead to have not noticed any shift in the weight of the 100 pound ladder on the other end.

Arguendo, if Petitioner's knee did in fact give out while going up the stairs, the Arbitrator turns to the medical evidence to determine the cause for it to have given out, and the cause of the resulting injury. Dr. Wood conceded on cross-examination that an osteochondral defect, when traumatic in nature, was usually caused by a twisting or direct impact. He then testified that walking up a step, carrying something, and the knee giving out, could cause an osteochondral defect, as it could cause a shearing force within the knee. In other words, the defect was due to a trauma, and the trauma was Petitioner's knee going out, or buckling. His opinion presumed that Petitioner's knee did, in fact, buckle or give out. He did not, however, testify as to what actually would have caused Petitioner's knee to give out. He made no reference to the weight of the ladder or the condition of the stairs. He conceded on cross-examination that Petitioner's weight of 270 pounds on his five foot ten inch frame created a load on his knee that would lead to faster degeneration in the knee. He conceded that Petitioner's BMI of 38.7 put him in the morbidly obese category and that it was common for someone of his size to have problems in both knees, and he acknowledged that Petitioner had a history of multiple surgeries and problems with his right knee, including an osteochondral defect. Dr. Wood testified it was possible Petitioner had just experienced pain on the date of the reported accident, and that the incident had not actually

caused the osteochondral defect. He further testified that what he found during surgery looked traumatic, and that "something traumatic" had occurred. Dr. Wood's opinion as to causation is based upon Petitioner's history that his knee buckled as he was going up the stairs. If the knee did not buckle, as addressed by the Arbitrator above, what caused the osteochondral defect?

The Arbitrator relies upon Dr. Lehman's testimony in answering this question. Dr. Lehman testified that Petitioner had a full thickness cartilage defect in his left knee, and that he had previously had the same problem in his right knee. He testified that when this defect is in both knees, it is considered symmetrical and is consistent with a degenerative arthritic process. He interpreted the MRI as showing arthritic changes, which took many years to develop, but he found nothing on the MRI that suggested an acute component of Petitioner's left knee. Like Dr. Wood, he testified that Petitioner's weight of 290 pounds and his accentuated BMI of 41.6 put him in the morbidly obese category, which stressed his knees. Dr. Lehman testified that a person with a BMI of 40 or 41 had an 85% or better chance of having degenerative arthritis at Petitioner's age.

Dr. Lehman went into great detail about the biomechanics of walking up a step. He explained that stress dissipated is in the patellofemoral joint underneath the knee, the kneecap. Most of Petitioner's problems, however, were on the medial aspect of his knee, in the tibiofemoral joint. He explained that the knee is made to go up and down stairs and to carry things. He did not believe walking up steps could be the mechanism of injury for the kind of damage that was found in Petitioner's knee. His opinion did not change when cross-examined regarding the weight of the ladder that was being carried, as the stress of that weight was dissipated in the kneecap. He explained you would not expect the damage found on the medial side of the knee, nor would you expect thinning that was seen in the patellofemoral joint, from simply walking up stairs. The Arbitrator finds compelling Dr. Lehman's testimony that "the disease process is totally incongruous with the history". He conceded that a traumatic injury could aggravate someone's arthritis to the point of making it symptomatic, but only if there was a true traumatic injury, such as a twisting injury or a deceleration where the foot is planted and the body twists. He opined that there was not such a traumatic injury in this case, and the Arbitrator agrees. The Arbitrator finds Dr. Lehman's testimony to be compelling.

The medical evidence is overwhelming as to the extent of Petitioner's arthritic condition in his left knee, especially in light of the extent of his previous problems in the opposite knee, and the extent to which his weight and BMI contributed to these problems. The condition for which Petitioner was treated was not caused or aggravated by his employment.

The Arbitrator found Petitioner to be less than credible with regard to four areas of testimony in particular. First, he testified and reported to his medical providers that his knee buckled or gave out as he was going up stairs. Yet, as discussed in detail above, Mr. Morehead was right behind him carrying the other end of the ladder, and did not see Petitioner stumble, fall, or misstep. Even if he did not see anything, it would make sense that he would have felt some shift in the weight of the ladder if such knee buckling had occurred. Second, Petitioner testified he did not say anything to Mr. Morehead at the time he hurt his knee because he "didn't want anyone to know". Although he may not have said anything, he was observed by Mr. Morehead while carrying the ladder up and back down the stairs, after they were done with that particular

job, and again when Mr. Morehead took him to the bus stop. At no time did Mr. Morehead observe anything out of the ordinary with the way Petitioner was walking or otherwise behaving. In fact, he reported on the Witness Report that Petitioner "was walking fine". Yet, after Petitioner had been home, woke up on his couch about 1:30 or 2:00 a.m. and got up to use the restroom, he could not put weight on his leg. The Arbitrator finds Mr. Morehead's observations to be compelling and further finds his testimony to be more credible than that of Petitioner. Third, Petitioner testified that he was told the lamper position was going to be permanent. Yet, both Mr. Morehead and Ms. Batson testified it was a temporary contract while the permanent lamper was out on leave. In addition, Petitioner knew nothing about the state exam that was required before a person could become a permanent full time employee, and he admitted on cross-examination that when he started the lamper job he was "given an end date". Fourth, Petitioner testified he had been looking for a job but had been unable to find one, and that he needed vocational assistance in that regard. However, as the Arbitrator noted above, the purported job logs have no dates on them, either on the individual employer lines or at the top of the pages. In addition, it appears only five of the 28 employers were contacted in person, versus by phone, and only four job applications were actually completed. This does not appear to be a good faith effort at finding employment, and Petitioner's testimony regarding same is viewed as less than candid.

Based upon the foregoing and the record in its entirety, the Arbitrator is not convinced that Petitioner's knee buckled while going up the stairs on the day in question, as discussed in detail above. The Arbitrator finds Petitioner failed to prove by a preponderance of the evidence that he sustained an accident on December 23, 2014, that arose out of and in the course of his employment. All other issues are rendered moot and the Arbitrator makes no findings regarding same.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Rahshun Miller,
Petitioner,

vs. No. 14 WC 33271

State of Illinois, Dept. of Transportation,
Respondent.

18IWCC0196

DECISION AND OPINION ON REVIEW

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

Petitioner testified that on June 27, 2014 he had been employed as an Engineering Technician for Respondent for 13 years. The vast majority of his duties involved repetitive use of his hands at a computer, which he used to make highway drawings. He estimated he spent 90% of his time at work entering data into a computer. He did take occasional breaks, and performed other tasks away from his computer such as answering the phone, reviewing spec books and occasionally doing work in the field.

In May 2014 Petitioner first noticed tingling and numbness in the fingertips of both hands, and occasional sharp pain shooting from his right elbow to his pinky finger. He sought treatment with Dr. Joseph Eckert, his primary physician, who ordered an upper extremity NCV test. That test suggested right carpal tunnel syndrome. When Petitioner asked Dr. Eckert for a note stating his carpal tunnel syndrome was related to his work activities, Dr. Eckert deferred to Dr. S. Vic Glogovac, the surgeon to whom Dr. Eckert referred Petitioner.

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Petitioner saw Dr. Glogovac only once, August 5, 2014. Dr. Glogovac diagnosed bilateral carpal tunnel syndrome, which he found to be "notable" on the right, but "less so" on the left. Dr. Glogovac offered no opinion regarding the etiology of Petitioner's carpal tunnel syndrome.

Petitioner then switched primary physicians to Dr. Philip Chu, who reported on August 19, 2014, "Carpal tunnel is very likely work related." Dr. Chu referred Petitioner to Dr. Kosit Prieb, who performed a right carpal tunnel release on October 8, 2014, and a left release on November 15, 2014. Petitioner was off work for those surgeries from October 8, 2014 through January 4, 2015.

Dr. Prieb testified at a May 6, 2015 deposition that Petitioner gave a history of spending most of his 40-hour work week typing on a computer. Dr. Prieb did not go to Petitioner's work site, see photos of it, or know the number or duration of breaks which Petitioner took during the day. Dr. Prieb opined that Petitioner's work activities could cause or aggravate his bilateral carpal tunnel syndrome. He further opined the carpal tunnel surgeries he performed were causally related to Petitioner's work activities. Regarding Petitioner's right elbow, Dr. Prieb diagnosed that condition as tendinitis, which he believed was helped by Motrin. Petitioner never returned to Dr. Prieb for treatment to his right elbow, and Dr. Prieb offered no opinion that Petitioner's right elbow condition was causally related to his repetitive work activities.

At Respondent's request, Dr. Ryan Calfee conducted a Section 12 exam on Petitioner on July 1, 2015. He also reviewed Petitioner's pertinent medical records and job description. He concurred that Petitioner's diagnosis was carpal tunnel syndrome, and that Petitioner's treatment was appropriate. However, he did not believe Petitioner's computer work caused his carpal tunnel syndrome because while it was repetitive, Petitioner's job duties involved no substantial heavy lifting or use of vibrating equipment. Dr. Calfee did not believe that there was any strong evidence that office-type work using a computer would produce or accelerate carpal tunnel syndrome. He also believed Petitioner's diabetes and elevated body mass index of 34.8 were conditions which have been associated more frequently with carpal tunnel syndrome. Dr. Calfee offered no causation opinion regarding Petitioner's right elbow, and after performing an AMA Disability rating of Petitioner, he determined Petitioner had a 0% impairment of his right upper extremity, and a 1% impairment of his left upper extremity.

Petitioner offered into evidence a copy of his Employee Notice of Injury form, in which he reported, "Numbness & tingling in hands and fingers on 6/27/14 [from] repetitive use of CADD machine and typing." He also offered the June 30, 2014 report of his supervisor, Gwen Lagermann, which noted, "Parts of Body Injured: Wrists – carpal tunnel syndrome." Neither of those reports mentioned injury or symptoms to Petitioner's right elbow.

18IWCC0196

The Arbitrator found Petitioner's right elbow and bilateral carpal tunnel conditions were casually related to a repetitive trauma work injury of June 27, 2014. The Arbitrator awarded Petitioner 12-5/7 weeks of temporary total disability (October 8, 2014 through January 4, 2015), reasonable and necessary medical expenses of $29,309.93, and permanent partial disability of 10% each hand and 2½% right arm under §8(e) of the Act.

Bilateral Carpal Tunnel Syndrome

The Commission finds the causation opinions of Dr. Chu and Dr. Prieb more persuasive than Dr. Calfee's. Petitioner used his hands repetitively at a computer for most of his workday. Although Dr. Prieb neither visited Petitioner's work site nor knew the number of breaks he took from keyboarding, that does not require Dr. Prieb's causation opinion be disregarded, given Petitioner's testimony and histories of spending 90% of his workday at his computer. The Commission does not consider Petitioner's requests to his treaters for causation reports to be a reason to disregard their opinions, as it is reasonable to conclude that they would not have provided such opinions had they not believed them to be true.

While other factors may have contributed to Petitioner's bilateral carpal tunnel syndrome, the Commission finds that Petitioner's repetitive keyboarding at work was a contributing cause of his condition. The Commission finds, after review of all the evidence, that the Arbitrator's award of 10% loss of use of each hand was appropriate.

Right Elbow Condition

The Commission views the evidence regarding Petitioner's right elbow condition differently than did the Arbitrator. While Drs. Chu and Prieb both opined Petitioner's carpal tunnel syndrome was causally related to his repetitive work activities, neither opined that his right elbow condition – described in the records as both cubital tunnel syndrome and tendinitis – was causally related. There was no mention of a right elbow injury or symptoms in Petitioner's initial treating records, his Notice of Injury form or his Supervisors Report. Dr. Prieb testified that Petitioner's right elbow complaints abated with the use of Motrin, and that Petitioner never returned to him for elbow treatment. The Commission finds that Petitioner failed to prove any right elbow condition was causally related to his work activities, and that he is not entitled to any medical expenses or permanent partial disability relating to any right elbow condition.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 11, 2016, is hereby modified as stated herein and otherwise affirmed and adopted.

18IWCC0196

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of medical expenses is modified. The Commission vacates the Arbitrator's award of medical treatment related to Petitioner's right elbow. Respondent shall pay Petitioner only the reasonable and necessary medical expenses related to his left and right wrists and hands, as provided by §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of 2½% loss of use of the right arm is vacated. Respondent shall pay Petitioner permanent partial disability benefits of $612.10 per week for a period of 38 weeks, as provided in §8(e)9 of the Act, because the injuries sustained caused a 10% loss of use of the right hand (19 weeks) and a 10% loss of use of the left hand (19 weeks).

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

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

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

DATED: MAR 30 2018

o-01/31/18
jdl/mcp
68

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MILLER, RAHSHUN
Employee/Petitioner

Case# **14WC033271**

SOI/IL DEPT OF TRANSPORTATION
Employer/Respondent

18IWCC0196

On 8/11/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.44% 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:

0071 BONIFIELD & ROSENSTENGEL PC
JON E ROSENSTENGEL
16 E MAIN ST
BELLEVILLE, IL 62220

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62794-9255

3291 ASSISTANT ATTORNEY GENERAL
DIANA E WISE
201 W POINTE DR SUITE 7
SWANSEA, IL 62226

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

1430 CMS BUREAU OF RISK MANAGEMENT
WORKERS' COMPENSATION MANGER
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

AUG 11 2016

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

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

RAHSHUN MILLER
Employee/Petitioner

v.

SOI/IL DEPT. OF TRANSPORTATION
Employer/Respondent

Case # 14 WC 33271

Consolidated cases: N/A

18IWCC0196

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael K. Nowak**, Arbitrator of the Commission, in the city of **Collinsville**, on **08/19/15**. 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 **06/27/14**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$53,048.86**; the average weekly wage was **$1,020.16**.

On the date of accident, Petitioner was **41** years of age, ***married*** with **0** dependent children.

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

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of $29,309.93, as provided in Sections 8(a) and 8.2 of the Act.

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

Respondent shall pay Petitioner temporary total disability benefits of $680.11/week for 12 5/7 weeks, commencing 10/08/14 through 01/04/15, as provided in Section 8(b) of the Act.

Based on the factors enumerated in §8.1b of the Act, which the Arbitrator addressed in the attached findings of fact and conclusions of law, and the record taken as a whole, Respondent shall pay Petitioner the sum of **$612.10**/week for **44.325** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **10 % loss of the right hand (19 weeks), 10 % loss of the left hand (19 weeks), and 2.5% of the right arm.**

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

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

Signature of Arbitrator

08/4/16
Date

AUG 11 2016

FINDINGS OF FACT

Petitioner, Rahshun Miller, works for respondent, Illinois Department of Transportation, as a senior design technician. In that position he aids in the design and construction of highways for the State of Illinois. Petitioner testified that this is a hand-intensive job with the vast majority of the time spent at the computer. He has worked for respondent for 13 years in the same position.

October 1, 2014, Petitioner filed an Application for Adjustment of Claim with the Illinois Workers' Compensation Commission, listing the Illinois Department of Transportation as the Respondent and alleging an accident on June 16, 2014 due to "CAD Engineer - repetitive trauma 13 years" causing "Bilat carp tunn & cubital tunnel requiring surgery" in "Both hands, arms & R elbow." (AX 2)

Petitioner first sought medical treatment on June 27, 2014 when he saw Dr. Joseph Eckert, a primary care physician at Chambers Medical Group. Dr. Eckert noted Petitioner was complaining of tingling in his fingers and diagnosed bilateral "probable carpal tunnel." (PX 2, P 7)

On June 30, 2014, Petitioner filled out an Employee's Notice of Injury, stating that his "typing, drafting" and "repetitive use of CAD machine and typing" had caused "numbness and tingling in hand and fingers." Petitioner listed the Date of Injury or Illness as June 27, 2014. (RX 1)

Petitioner returned to Dr. Eckert on July 2, 2014 and Dr. Eckert noted he still had tingling in his right and left hands. Dr. Eckert noted Petitioner did not have any swelling or an injury. Dr. Eckert noted Petitioner used a computer and designed highways. Dr. Eckert noted Petitioner had been scheduled for an EMG. (PX 2, P 8) On July 15, 2014, Petitioner underwent an EMG at Gateway Regional Medical Center. (PX 5, RX 6, P 3)

Petitioner returned to Dr. Eckert on July 25, 2014. Dr. Eckert noted Petitioner had mostly right hand numbness and that his EMG had been positive for carpal tunnel. As such, Dr. Eckert noted he would refer Petitioner to Dr. Glogovac. (PX 2, P 9)

On August 5, 2015, Petitioner saw Dr. Vic Glogovac. Dr. Glogovac diagnosed notable right carpal tunnel syndrome, less so on the left, and a right cubital tunnel syndrome. Dr. Glogovac noted Petitioner did not feel his splint for the right wristwas helping much at night, but he was to continue wearing it. Dr. Glogovac added an anterior pad to the right elbow and prescribed Petitioner a left cock-up splint, as well. Dr. Glogovac's record references possible surgery on August 29, 2014 for R carpal and R cubital tunnel releases pending workers'compensation authorization. A subsequent note from August 19, 2014 notes "Mr. Miller called and cancelled surgery – pursuing work comp." (PX 3)

On August 19, 2014, Petitioner saw Dr. Dr. Philip Chu, a primary care physician at Fairview Heights Medical Group. Petitioner testified that in an effort to be closer to home, he switched family physicians and saw Dr. Chu. Dr. Chu diagnosed Petitioner with carpal tunnel syndrome and referred him to Dr. Mirly or Dr. Prieb for an evaluation. Dr. Chu noted "carpal tunnel is very likely work related." (PX 4; RX 7, P 23-26)

On August 28, 2014, Petitioner first saw Dr. Kosit Prieb, a surgeon at Vascular and Hand Surgery, Ltd. Dr. Prieb noted Petitioner complained of numbness, pain and tingling in both hands and at the right elbow for the past two months. Dr. Prieb noted Petitioner was wearing his splints at night, but was not taking anti-inflammatory medication. He reviewed Petitioner's 7/15/14 EMG and diagnosed Petitioner with "bilateral

carpal tunnel syndrome" and started him on Motrin 400 mg three times per day. Dr. Prieb asked Petitioner to continue wearing his wrist splints and to return in two weeks for a follow up. (PX 5; RX 3, P 3)

Petitioner returned to Dr. Prieb on September 11, 2014. Dr. Prieb noted the Motrin and splints did not provide any relief. As such, Dr. Prieb recommended right carpal tunnel release. Dr. Prieb also noted, "Doing same job for 13 years. Using hands all the time. Possible work related or aggravation by his work." (PX 5; RX 3, P 6)

On October 8, 2014, Petitioner underwent a "decompression of right carpal tunnel" with Dr. Prieb at St. Elizabeth's Hospital. (PX 5; RX 4)

On October 16, 2014, Petitioner returned to Dr. Prieb, noting that his cast had been pushing on his palm. As such, Dr. Prieb discontinued the use of Petitioner's splint and prescribed Petitioner #30 Vicodin. (RX 3, P 10)

Petitioner saw Dr. Prieb again on October 23, 2014. Dr. Prieb noted Petitioner had much less numbness in his right hand since surgery. Dr. Prieb's Impression was status/post decompression of right carpal tunnel with good results. As such, Dr. Prieb scheduled Petitioner' left carpal tunnel release. (RX 3, 11)

On November 5, 2014, Petitioner underwent a "decompression of left carpal tunnel" with Dr. Prieb at St. Elizabeth's Hospital. (PX 5; RX 4)

Petitioner returned to Dr. Prieb's office on November 20, 2014 to have his sutures removed from his left hand. It was noted Petitioner had no pain, swelling or drainage. Petitioner was told to call with signs of an infection. (PX 5; RX 3, P 16)

On December 29, 2014, Petitioner returned to Dr. Prieb, who noted that Petitioner no longer had any numbness in his hands. Dr. Prieb noted Petitioner's right grip strength is 55 pounds and 55 pounds on two tests, and the left grip strength is 30 pounds and 30 pounds on two tests. Dr. Prieb released Petitioner back to full duty work on January 5, 2015 and asked to see him back in six weeks. (PX 5; RX 3, P 19) Petitioner was off work from the date of his first surgery on October 8, 2014 through January 4, 2015 on the recommendation of Dr. Prieb.

On February 17, 2015, Petitioner returned to Dr. Prieb for the final time. Dr. Prieb noted Petitioner had undergone bilateral carpal tunnel syndrome releases. Dr. Prieb's Impression was "status post decompression, bilateral carpal tunnel, with good results" and he released Petitioner from his care without restriction. (PX 5; RX 3, P 25)

Petitioner has received no further treatment for his bilateral wrists or his right elbow

The record contains evidence regarding Petitioner's job duties. A job description prepared by Respondent contains a job description for the senior design technician position. (RX 2, PX 6) In addition to the official written description Petitioner's supervisor, Gwen Lagemann, a Senior Design Squad Leader and Engineer for the Illinois Department of Transportation, sent an e-mail containing a typical work week for Petitioner. (RX 9, P 9) Petitioner reviewed the e-mail and the job description and agreed with both. As

indicated above, Petitioner testified that this is a hand-intensive job with the vast majority of the time spent at the computer.

The Arbitrator finds the "typical work week" prepared by Gwen Lagemann significant. Ms. Lagemann wrote:

> A typical work week for Rahshun Miller would include:
>
> Drawing in CAD files/importing schedules/SOQ (60% - 22.5 hours/week)
> Researching microfilm/old CAD files/old plan sets (5% - 2 hours/week)
> Preparing schedules by hand/in spreadsheets (20% - 7.5 hours/week)
> Reviewing policy, standards and spec book (3% - 1 hour/week)
> Coordinating with other sections/Bureaus by phone/e-mail/memo (5% - 2 hours/week)
> Answering questions from Construction (2% - 0.5 hours/week)
> Field Work (5% - 2 hours/week)... (RX 9, P 9)(emphasis added)

As the underscored time estimates indicate that Petitioner worked at a computer up to 35 hours in a 40 hour work week.

Dr. Prieb testified by deposition. (PX 5) Dr. Prieb testified that he first saw Petitioner on August 28, 2014 and that Petitioner stated he had numbness, pain and tingling in both hands and right elbow since June of 2014. (PX 5, P 6) Dr. Prieb testified that Petitioner's 7/15/14 EMG was inconclusive, but that Dr. Prieb performed an ultrasound on Petitioner's right and left wrists that showed dilated median nerves at both wrists, which suggested nerve compression at both wrists at the carpal tunnel levels. (PX 5, P 8-9) His diagnosis was bilateral carpal tunnel syndrome and right elbow tendonitis. *Id.*, at 13. Dr. Prieb indicated that Petitioner was temporarily and totally disabled from the date of his first surgery on October 8, 2014 through January 4, 2015. *Id.*, at 12. Dr. Prieb also stated that he had given Petitioner an anti-inflammatory (Motrin) for his elbow pain, which he called tendinitis, but that it must have improved, as Petitioner did not ever come back to him for that. *Id.*, at 10, 13. Dr. Prieb testified that he has no plans to see Petitioner in the future, as he asked Petitioner to return as needed and Petitioner had not been back since February 17, 2015. *Id.*, at 14.

Dr. Prieb opined that Petitioner's job duties, specifically his work on the computer, more probably than not contributed to cause or aggravate his carpal tunnel syndrome. *Id.*, at 9-10. On cross examination Dr. Prieb was questioned regarding the extent of his understanding of Petitioner's job duties. Dr. Prieb indicated it was his understanding that Petitioner's "main work, main occupation, typing. He might not be typing all the time, but, you know, that's his work, so most of the time he'd be doing the work with the computer, typing." Dr. Prieb understood that Petitioner did not work at a computer each minute of every day. He knew Petitioner would periodically retrieve physical files, speak on the telephone and perform other activities to gain information needed in his computer work. *Id.*, at 15-18. Dr. Prieb also testified that Petitioner's treatment for bilateral carpal tunnel syndrome was related to his work activities. *Id.*, at 11. The Arbitrator finds that Dr. Prieb's understanding of Petitioner's job duties was consistent with the "typical work week" prepared by Gwen Lagemann. Working with a computer up to 35 hours in a 40 hour week indicates that Petitioner indeed perform work with a computer for the vast majority of the time he was at work.

On July 1, 2015, Petitioner underwent a Section 12 examination at the Respondent's request by Dr. Ryan Calfee. (RX 8) Dr. Calfee produced a report outlining his opinions, after performing a physical examination of

Petitioner and reviewing documents provided to him by Respondent, including the email from Petitioner's supervisor, Gwen Lagemann, which described Petitioner's job duties. Dr. Calfee also spoke to Petitioner about his job duties, stating "[t]his gentleman has worked an engineer technician for 13 years he says in the same position. He works 40 hours per week. He largely does computer work for most of the day he describes. He says there is occasional fieldwork, but most of his job involves putting information into computers." (RX 8).

Dr. Calfee performed a physical exam of Petitioner after which he noted full range of motion in the fingers and full supination and pronation. Elbow motion was full. Wrist motion on the left was 70 degrees of extension, 60 degrees of flexion. On the right motion was 70 degrees of extension and 70 degrees of flexion. Grip was 82 pounds on the right, 92 pounds on the left. He found no subjective numbness, noted well-healed carpal tunnel incisions in both palms without any excessive scar tissue or tenderness, and no muscular atrophy.

Dr. Calfee opined Petitioner's current diagnosis is bilateral carpal tunnel syndrome status post bilateral carpal tunnel release. He failed to address the right elbow. He felt Petitioner's current objective findings are consistent with his report that his subjective complaints have largely resolved. He has normal two-point sensibility and no muscular atrophy. His incisions are nicely healed and provocative signs around the median nerves are now negative. His intermittent pain on the left side would not be expected to produce any objective findings on examination today. His medical records support his diagnosis and appropriate treatment.

Dr. Calfee, however does not believe that Petitioner's job duties caused, aggravated or accelerated his nerve compression condition. Dr. Calfee noted that "from the patient's history and his records it appears that his job is largely sedentary with routine use of a computer mouse and writing. His job does not entail substantial heavy lifting or use a vibratory equipment [sic]. I do not believe that there is strong evidence that office-type work using a computer is going to produce or accelerate carpal tunnel syndrome. *Id.*, at 8. He felt that Petitioner is at maximal medical improvement and does not require any restrictions regarding his hands, wrists or forearms. He is already back working full duty without restriction and should be able to continue to do so. *Id.* Dr. Calfee prepared an AMA rating for Petitioner's bilateral carpal tunnel syndrome. He indicated on Mr. Miller's right side, he has had a conduction delay by electro-diagnostic testing, but now has no symptoms and normal physical examination findings. Therefore, I do not believe that he has any impairment of the right upper extremity. On the left side, nerve conduction testing was normal, although ultrasound had positive findings. He has mild intermittent symptoms at this point with a normal physical examination. I would estimate that he has a 1% permanent partial impairment of the left upper extremity as a result of his left carpal tunnel syndrome that has been treated with surgery. *Id.*

At the time of hearing Petitioner testified that a couple times a week he will get a stinging pain if he lifts something heavy. He also testified that occasionally he gets a little pain if he grips something too hard.

CONCLUSIONS

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

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

An injury is accidental within the meaning of the Act if "a workman's existing physical structure, whatever it may be, gives way under the stress of his usual labor." *Laclede Steel. Co. v. Industrial Commission*,

128 N.E.2d 718, 720 (Ill. 1955); *General Electric Co. v. Industrial Commission*, 433 N.E.2d 671, 672 (Ill. 1982). In a repetitive trauma case, issues of accident and causation are intertwined. *Elizabeth Boettcher v. Spectrum Property Group and First Merit Venture,* 99 I.I.C. 0961 (1999). Accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it is a causative factor in the resulting condition of ill-being. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672-73 (Ill. 2003) (emphasis added). As in establishing accident, to show causal connection Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury. *Fierke v. Industrial Commission*, 723 N.E.2d 846 (3rd Dist. 2000).

In *Edward Hines Precision Components v. Indus. Comm'n,* 825 N.E.2d 773, (2nd Dist. 2005). the Court expressly stated, "There is no legal requirement that a certain percentage of the workday be spent on a task in order to support a finding of repetitive trauma." *Id.* at N.E.2d 780. Similarly, the Commission recently noted in *Dorhesca Randell v. St. Alexius Medical Center*, 13 I.W.C.C. 0135 (2013), a repetitive trauma claim, a claimant must show that work activities are a cause of his or her condition; the claimant does not have to establish that the work activities are the sole or primary cause, and there is no requirement that a claimant must spend a certain amount of time each day on a specific task before a finding of repetitive trauma can be made. *Randell* citing *All Steel, Inc. v. Indus. Comm'n*, 582 N.E.2d 240 (2nd Dist. 1991) and *Edward Hines supra.*

The Appellate Court in *City of Springfield v. Illinois Workers' Comp. Comm'n*, 901 N.E.2d 1066 (4th Dist., 2009) issued a favorable decision in a repetitive trauma case to a claimant whose work was "varied" but also "repetitive" or "intensive" in that he used his hands, albeit for different tasks, for at least five (5) hours out of an eight (8) hour work day. *Id.* "While [claimant's] duties may not have been 'repetitive' in a sense that the same thing was done over and over again as on an assembly line, the Commission finds that his duties required an intensive use of his hands and arms and his injuries were certainly cumulative." *Id.*

In this case, the evidence shows that Petitioner used his hands and arms extensively during the performance of his job duties for Respondent. Further, the Arbitrator finds the opinions and testimony of Dr. Prieb much more persuasive than those of Dr. Calfee in this case.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met his burden of establishing that he sustained accidental injuries which arose out of and in the course of his employment with Respondent and that his current condition(s) of ill-being are causally related to the employment.

Issue (D): What was the date of the accident?

The Workers' Compensation Act is a humane law of a remedial nature that should be liberally construed to achieve its purpose. *Hagene v. Derek Polling Const.*, 388 Ill. App. 3d 380, 902 N.E.2d 1269 (2009). Hence, the Supreme Court has established a flexible but fair standard for determining manifestation dates in repetitive trauma claims. *Durand v. Industrial Commission*, 224 Ill.2d 53, 862 N.E.2d 918 (Ill. 2007). Although the date on which the employee becomes aware that he has a condition related to work was the first method for determining a manifestation date, it is not the only permissible means for alleging or proving manifestation. The manifestation date can be set as: (a) the date the employee actually became aware of the physical condition and its relation to work through medical consultation; (b) the date the employee requires medical treatment; (c) the date on which the employee can no longer perform work activities; or (d) when a reasonable person would have

plainly recognized the injury and its relation to work. *Durand v. Industrial Commission*, 224 Ill.2d 53, 862 N.E.2d 918 (Ill. 2007), *see also Peoria County Belwood Nursing Home v. Industrial Commission*, 115 Ill.2d 524, 505 N.E.2d 1026 (Ill. 1987); *Oscar Mayer & Co. v. Industrial Commission*, 176 Ill.App.3d 607, 531 N.E.2d 174 (3rd Dist. 1988); *Three "D" Discount Store v. Industrial Commission*, 198 Ill.App.3d 43, 556 N.E.2d 261 (4th Dist. 1989). The Supreme Court in *Durand* noted that the manifestation date is typically set on the date the employee requires medical treatment or the date on which the employee can no longer perform work activities. *Durand,* 862 N.E.2d at 929. T

In *Linda Peters v. Village of Caseyville*, the Commission set a manifestation date different from that to which the parties stipulated. *Linda Peters v. Village of Caseyville*, 14 I.W.C.C. 0796 (2014). The Commission stated:

> The Commission finds that the manifestation date of Petitioner's right carpal tunnel syndrome was March 1, 2012. Although the parties had stipulated to an accident date of September 1, 2010, we find that it is within our discretion to change the accident date to conform-to the evidence. *See Beal v. Town of Normal*, 10 IWCC 380 (2010). The medical records are clear that the first mention of any correlation between Petitioner's right carpal tunnel syndrome and her work duties is the March 1, 2012, office note of Dr. Mirly. Although Petitioner's report of injury on March 2, 2012, indicates a date of accident of "Sept 2011," we find that this is not an appropriate manifestation date in this case because Petitioner did not have a confirmed diagnosis at that time. *Id.*

In this case Petitioner filed an Application for Adjustment of Claim on October 1, 2014 alleging an accident on June 16, 2014 due to "CAD Engineer - repetitive trauma 13 years" causing "Bilat carp tunn & cubital tunnel requiring surgery" in "Both hands, arms & R elbow." (AX 2) Petitioner first sought medical treatment on June 27, 2014 when he saw Dr. Joseph Eckert, a primary care physician at Chambers Medical Group. Dr. Eckert noted Petitioner was complaining of tingling in his fingers and diagnosed bilateral "probable carpal tunnel." (PX 2, P 7) On June 30, 2014, Petitioner filled out an Employee's Notice of Injury, stating that his "typing, drafting" and "repetitive use of CAD machine and typing" had caused "numbness and tingling in hand and fingers." Petitioner listed the Date of Injury or Illness as June 27, 2014. (RX 1)

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that June 27, 2014, the date Petitioner first sought treatment for his upper extremity symptoms, is an appropriate manifestation date under the Act.

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?

Petitioner's Exhibit 1 contains the medical bills incurred by petitioner as a result of his treatment for bilateral carpal tunnel syndrome and right elbow tendonitis. The total of the expenses is $29,309.93. Both Dr. Prieb and Dr. Calfee agree that the treatment Petitioner received was reasonable and necessary. The dispute was as to Respondent's liability for payment in light of issues C and F above. Having ruled in Petitioner's favor with regard to those issues, Respondent shall pay reasonable and necessary medical services of $29,309.93, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have

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

Issue (K): What temporary benefits are in dispute?

It is undisputed that Petitioner was temporarily and totally disabled from 10/08/14 through 01/04/15. The dispute was as to Respondent's liability for payment in light of issues C and F above. Having ruled in Petitioner's favor with regard to those issues, Respondent shall pay Petitioner temporary total disability benefits of $680.11/week for 12 5/7 weeks, commencing 10/08/14 through 01/04/15, as provided in Section 8(b) of the Act.

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

Pursuant to §8.1b of the Act, permanent partial disability from injuries that occur after September 1, 2011 is to be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of §8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. The Act provides that, "No single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b(b)(v).

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that Dr. Calfee assessed Petitioner's impairment rating at 1% of the left and 0% of the right upper extremity. However, impairment does not equal disability. The impairment rating is part of the determination for permanent partial disability benefits, but is not the sole or main factor. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes Petitioner continues to work as a senior design technician. In that position he aids in the design and construction of highways for the State of Illinois. This is a hand-intensive job with the vast majority of the time spent at the computer. Petitioner experiences periodic symptoms in his bilateral wrists. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 41 years old at the time of his injuries. He has many years remaining in the work force and will have to deal with the conditions for more time than an older worker. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes there is no direct evidence of reduced earning capacity contained in the record. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner was a credible witness. Petitioner has had successful treatment of bilateral carpal tunnel syndrome as well as right elbow tendonitis. Petitioner still feels a stinging and pain in his hands from time to time when he lifts anything heavy. Likewise, petitioner occasionally feels a sharp pain in his right elbow when he lifts certain objects. The Arbitrator therefore gives *some* weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 10% loss of use of each hand and 2.5% of the right arm pursuant to §8(e) of the Act.

Respondent shall pay Petitioner the sum of $612.10/week for 44.325 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused 10 % loss of the right hand (19 weeks), 10 % loss of the left hand (19 weeks), and 2.5% of the right arm.

STATE OF ILLINOIS)
) SS.
COUNTY OF McLean)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jeremy Reynolds,
Petitioner,

vs.

NO: 13WC 40126

Multibrand,
Respondent,

18IWCC0197

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causation, temporary total disability, medical, permanent partial disability, penalties, fees, "Intoxican Defense" and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 27, 2016, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 2 - 2018

Charles J. DeVriendt

Joshua D. Luskin

o013018
CJD/rlc
049

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

REYNOLDS, JEREMY D
Employee/Petitioner

Case# **13WC040126**

MULTIBAND
Employer/Respondent

18IWCC0197

On 7/27/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.42% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4367 SCHUM LAW PC
ANNA KALUZNY
2105 N DUNLAP SUITE 1A
CHAMPAIGN, IL 61820

1454 THOMAS & ASSOCIATES
ROBERT E HOFFMAN
500 W MADISON ST SUITE 2900
CHICAGO, IL 60661

18IWCC0197

STATE OF ILLINOIS)
)SS.
COUNTY OF MC LEAN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jeremy D. Reynolds
Employee/Petitioner

v.

Multiband
Employer/Respondent

Case # 13 WC 40126

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Bloomington, on June 29, 2016. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On November 14, 2013, Respondent was operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned $44,138.12; the average weekly wage was $848.81.

On the date of accident, Petitioner was 29 years of age, single with 2 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

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

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

ORDER

Based upon the Arbitrator's Conclusions of Law attached hereto, claim for compensation is denied.

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

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

William R. Gallagher, Arbitrator

July 24, 2016
Date

JUL 27 2016

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment for Respondent on November 14, 2013. According to the Application, Petitioner sustained an accident while "driving on the job" and sustained injuries to the "Head, neck, back and associated body parts" (Arbitrator's Exhibit 2). There was no dispute that Petitioner sustained an accident; however, Respondent disputed liability pursuant to Section 11 of the Act. Petitioner claimed that he was entitled to payment of temporary total and permanent partial disability benefits, medical bills as well as Section 19(k) and Section 19(l) penalties and Section 16 attorneys' fees (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a cable/satellite installer and he worked through the central Illinois area. He drove a company van that he kept at his residence. On November 14, 2013, Petitioner was scheduled to attend a meeting at 7:00 AM in Bloomington where various business things would be discussed with other installers. Petitioner would also drop off and pick up equipment and supplies.

Petitioner testified that while he was driving the van from his residence to the meeting, the van experienced brake failure. Petitioner lost control of the vehicle which caused it to roll. Petitioner's recollection of the specific details of the accident was unclear.

According to the police report, the brakes failed in the vehicle driven by Petitioner. Petitioner was unable to stop the vehicle at an intersection which caused it to strike another vehicle. Afterward, the vehicle driven by Petitioner went into a ditch and rolled over before coming to rest on its wheels (Petitioner's Exhibit 1).

Following the accident, Petitioner was seen in the ER of St. Joseph Medical Center. At that time, Petitioner stated that when he stepped on the brake pedal, it went to the floor and the van did not stop. Petitioner had abrasions on his left hand, left ear and head and also had complaints of pain in his right elbow (Petitioner's Exhibit 2).

When seen in the ER, a urine sample was obtained and Petitioner was tested for drugs. The test was positive for marijuana (Petitioner's Exhibit 2; Respondent's Exhibit 1). Petitioner testified that he was fired by Respondent because of the fact that he tested positive for marijuana.

In regard to the medical treatment, Petitioner was treated at Carle Occupational Medicine from November 18, 2013, through March 10, 2014, for neck/back symptoms and post-concussive syndrome (Petitioner's Exhibit 3). Petitioner also received physical therapy from December 13, 2013, through January 26, 2014 (Petitioner's Exhibit 5).

At trial, Petitioner testified that he had ongoing complaints of neck/back pain, sleep disruption and memory issues. Petitioner stated that he takes over-the-counter medications on an as needed basis.

Cathy Reynolds, Petitioner's mother, testified on his behalf at trial. Reynolds' testimony was consistent with the testimony of Petitioner and she stated that she has noted that Petitioner now

has sleep and memory issues that he did not have prior to the accident. She also stated that she has observed Petitioner with neck/back pain.

At the direction of Respondent, the vehicle that was driven by Petitioner was inspected by Clifford Bigelow, an engineer. The primary focus of Bigelow's inspection of the vehicle was to determine if there was, in fact, a brake failure at the time of the accident. Bigelow inspected the vehicle on May 2, 2014, and, in connection with his inspection of the vehicle, various photographs of it were obtained. Bigelow concluded that there was no indication of any problems with the braking system that would have prevented the brakes from functioning at the time of the accident (Respondent's Exhibit 3; Deposition Exhibit 2).

Clifford Bigelow was deposed on March 25, 2016, and his deposition testimony was received into evidence at trial. Bigelow's testimony was consistent with his report and he reaffirmed the opinions contained therein. Specifically, Bigelow stated that the brake pads and rotors were in very good condition and showed very little wear. He also did not find any defects or condition in the hydraulic systems which would have caused brake failure (Respondent's Exhibit 3; pp 13-16).

Daniel Beale testified on behalf of the Respondent when this case was tried. Beale is Respondent's general manager and was Respondent's operations manager at the time of the accident. Beale identified the service records of the vehicle that Petitioner drove and stated that there was no record of any work having been performed on the vehicle because of brake issues (Respondent's Exhibit 2).

At trial, Petitioner denied having smoked marijuana any time prior to the accident. He opined that the positive finding was due to his exposure to "second-hand smoke." When Petitioner was questioned about whether he had been around individuals who smoked marijuana, he said that it was not uncommon for various customers of Respondent that he visited to smoke marijuana. He was not specific about any times or places when he was exposed to marijuana under these circumstances. Petitioner also stated that he was not under any obligation to report such an occurrence to the company.

Conclusions of Law

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

The Arbitrator concludes that Petitioner did not sustain an accidental injury arising out of and in the course of his employment for Respondent on November 14, 2013.

In support of this conclusion the Arbitrator notes the following:

The Arbitrator finds that Petitioner's claim is barred by Section 11 of the Act. Shortly after the accident a urine test was performed which was positive for marijuana.

Petitioner denied having used marijuana prior to the accident and stated that he had been exposed to "second-hand smoke" from individuals who were customers of Respondent. Petitioner did not

provide any specifics at all as to when or where he was purportedly exposed to this "second-hand smoke." The Arbitrator finds that this testimony is not credible.

Petitioner's testimony that the accident was caused by a failure of the vehicle's brake system is also questionable. Respondent tendered service records of the vehicle which contained no reference to any brake work as having been performed on the vehicle. Further, Clifford Bigelow, an engineer, inspected the vehicle and concluded that there was no evidence of brake failure.

In regard to disputed issues (F), (J), (K), (L) and (M) the Arbitrator makes no conclusions of law as these issues are rendered moot because of the Arbitrator's conclusion of law in disputed issue (C).

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) 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 Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Eugene Hardimon

Petitioner,

vs. No. 15 WC 013278

CTA,

18IWCC0198

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, prospective medical care and temporary disability, and being advised of the facts and law, reverses the Decision of the Arbitrator for the reasons stated below. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation, medical benefits or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327 (1980).

Petitioner was a 41year old bus operator employed by Respondent CTA on April 17, 2015 when a vehicle impacted the rear end of his bus as it was stopped in traffic. Petitioner had a prior history of a two-level spinal fusion performed by Dr. Alexander Ghanayem in 2008. In 2014 Petitioner sustained a back strain after hitting a pothole but had returned to full duty by September 2014. Petitioner testified that he was asymptomatic and working full-duty at the time of the subject collision. At the time of the collision Petitioner felt a jolt in his back.

The bus that Petitioner was operating was equipped with a video dash cam that recorded the interior of the bus at the time of the collision. Following the collision Petitioner exited the

bus to survey the damage, checked on the well-being of his passengers, and called Control to report the accident and request medical assistance for himself. None of the passengers aboard the bus reported any injuries. Petitioner was transported to Little Company of Mary Hospital by ambulance where he was diagnosed with acute lumbar strain and prescribed hydrocodone.

Petitioner returned to the CTA garage upon discharge from the emergency department and filled in an accident report as required by protocol. On April 20, 2015 Petitioner consulted Dr. Foreman at Beverly Medical who diagnosed lumbar strain and radiculitis. Dr. Foreman charted in his records that the diagnosis was causally related to the April 17, 2015 work accident and took Petitioner off work. Petitioner was prescribed physical therapy and pain medication.

Dr. Foreman subsequently referred Petitioner to Dr. Agrawal for pain management. On May 14, 2015 Petitioner complained to Dr. Agrawal of severe and persistent low back pain and reported that Tramadol and Valium produced drowsiness but did not provide adequate pain relief. Dr. Agrawal recommended consultation with Dr. Ghanayem, who had performed the 2008 fusion, recommended lumbar epidural injections, and continued Petitioner's off work status.

On June 11, 2015 a Section 12 examination was performed by Dr. Mash, an orthopedic specialist, at the request of Respondent. Dr. Mash diagnosed post-laminectomy syndrome. Dr. Mash noted that Petitioner had a significant pre-existing back injury. He stated the opinion that Petitioner appeared to have suffered a new or recurrent injury to his low back and opined that the medical treatment to date was reasonable and necessary. Dr. Mash charted that Petitioner was not capable of returning to work and was uncertain whether the work accident had caused a temporary aggravation or a significant aggravation of Petitioner's back symptoms. Dr. Mash reported that Petitioner had not reached MMI.

Petitioner consulted with Dr. Ghanayem on July 13, 2015. Dr. Ghanayem charted that he did not have a surgical solution to Petitioner's symptoms and released him from his care.

A functional capacity evaluation was performed on August 6, 2015. Petitioner was using a cane due to reported right leg weakness. The FCE revealed deficits along with an invalid dynamic lifting test.

Dr. Agrawal noted that Petitioner had plateaued with conservative care and therapy and determined Petitioner was at MMI from a pain management standpoint. She continued him off work pending re-evaluation with Dr. Kuo, a spine specialist. Dr. Kuo examined Petitioner on September 27, 2015 and recommended bilateral SI injections and possible consideration of a spinal cord stimulator.

A second Section 12 examination was performed by Dr. Mash on October 1, 2015. Dr. Mash noted the invalid functional capacity evaluation and observed symptom magnification. Dr. Mash stated the opinion that Petitioner had not yet reached MMI and that he was not yet capable of returning to work operating a bus. He found all medical care rendered had been reasonable

and necessary. Dr. Mash did not recommend surgery or neurostimulation. Dr. Mash's diagnosis remained post-laminectomy, post- fusion syndrome. He noted that the April 17, 2015 work injury produced an aggravation to Petitioner's pre-existing back condition. Dr. Mash agreed with the plan for bilateral SI joint injections. Dr. Mash stated that if the SI injections did not produce significant improvement that Petitioner should be considered at MMI. Petitioner subsequently underwent a right sacroiliac joint injection on October 5, 2015 which gave him no relief.

On February 22, 2016 Petitioner had a trial placement of a spinal cord stimulator by Dr. Agrawal. Petitioner reported complete pain relief across his low back and lower extremities. He was placed off work by Dr. Agrawal pending re-evaluation by Dr. Kuo for permanent placement of spinal cord stimulator.

A third Section 12 examination was performed by Dr. Mash on March 3, 2016. In addition to updated medical records Respondent also provided to Dr. Mash the dash cam video taken from the bus at the time of the accident for his review. Dr. Mash issued a report following this examination which stated that having now viewed the video his opinion is that Petitioner did not suffer a significant injury as a result of the April 17, 2015 work accident. Dr. Mash stated "While Petitioner may offer ongoing symptoms, I am unable to understand his ongoing symptoms and do not believe the symptoms relate in any way to the injury of April 17, 2015."

The arbitrator, in his decision, relied upon Dr. Mash's opinion, stated for the first time in his March 3, 2016 Section 12 report, that the impact to Petitioner as depicted in the dash cam video did not display movement inside the bus and was not significant enough to have caused injury to Petitioner. The arbitrator concluded that "Petitioner did not sustain an accident that arose out of and in the course of employment. Petitioner's current condition of ill-being is not related to the April 17, 2015 accident."

We disagree with the arbitrator's determination that Petitioner failed to meet his burden of proof that an accident occurred on April 17, 2015. There was a rear-end impact to the bus Petitioner was operating. Having viewed the video we do not find it to be of value in determining the significance of the trauma to Petitioner at the time of the collision. Petitioner's treating physician stated in his notes that the work accident caused his condition of ill-being. Dr. Mash, in his two Section 12 reports that preceded his March 3, 2016 report, found that there was causal connection. The Commission finds the causation opinion stated by Dr. Foreman and Dr. Mash in his first two reports to be persuasive and relies on these opinions in finding accident and causation.

The Commission does find that Petitioner's condition of ill-being arising from the accident had resolved by March 3, 2016 and that he was at MMI and capable of returning to full duty employment on that date. For this reason we do not award medical expenses incurred by Petitioner after March 3, 2016. We do not award penalties pursuant to Sections 19(k) or 19(l) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 20, 2017, is hereby reversed.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is not entitled to temporary total disability or medical benefits beyond the Section 12 examination of March 3, 2016.

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

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

No bond is required for removal of this cause to the Circuit Court. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 2 - 2018
o-02/15/18
SM/msb
44

Stephen Mathis

David L. Gore

Deborah Simpson

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

HARDIMAN, EUGENE
Employee/Petitioner

Case# **15WC013278**

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

18IWCC0190

On 7/20/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0314 KUMLIN & FROMM LTD
MARK L FROMM
205 W RANDOLPH ST SUITE 1030
CHICAGO, IL 60606

0515 CHICAGO TRANSIT AUTHORITY
ANDREW ZASUWA
515 W LAKE ST 6TH FL
CHICAGO, IL 60661

18IWCC0198

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Eugene Hardimon
Employee/Petitioner

Case # **15** WC **13278**

v.

Consolidated cases: _____

Chicago Transit Authority
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gary Gale**, Arbitrator of the Commission, in the city of **Chicago**, on **August 4, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **April 17, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$33,366.86**; the average weekly wage was **$641.67**.

On the date of accident, Petitioner was **39** years of age, *married* with **6** dependent children.

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

Respondent shall be given a credit of **$26,820.93** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of **$26,820.93**.

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

ORDER

Petitioner did not sustain an accident that rose out of and in the course of employment. Petitioner's current condition of ill-being is not related to the April 17, 2015 claimed accident. All other issues are therefore moot.

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

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

#001 George J. Andros

Signature of Arbitrator

July 12, 2017

Date

ICArbDec19(b)

JUL 20 2017

FINDINGS OF FACT 15 WC 13278

Petitioner is a 41 year old male who is employed by the respondent, Chicago Transit Authority ("CTA") as a Bus Operator. Petitioner has a prior history of lumbar pain. In 2008, Petitioner underwent a two level lumbar fusion performed by Dr. Alex Ghanayem. (Tr. 30) He reported a back strain while working for the CTA in 2014. He alleged that the pain was caused by driving over a pothole.

On April 17, 2015, he was driving his bus on 103rd Street in Chicago, IL, and was stopped in traffic. Another vehicle made contact with the rear end of the bus that Petitioner was driving. Petitioner was in the driver's seat at the front of the bus at the time of the incident. Petitioner got up out of his seat and checked on his passengers, per protocol. He got off the bus to assess the situation, and called CTA control on his cell phone. He requested medical assistance and complained of "some numbness and pain in his lower back." Petitioner was walked to the ambulance and taken to Little Company of Mary Hospital.

On April 17, 2015 Petitioner filled out and signed a CTA form titled "CONTACT WITH VEHICLE/PEDESTRIAN/FIXED OBJECT", which states that there were six passengers on the bus at the time of the incident and nobody else besides Petitioner claimed injury. Petitioner stated that the other driver was driving at an approximate speed of 20 miles per hour (R.X. 2) At trial, Petitioner identified the document as one he personally filled out and signed. (Tr. 77-78)

At trial, Petitioner testified that nobody else on the bus was injured. (Tr. 78)

Petitioner was examined at the emergency room and x-rays were taken of his lower back. He was discharged the same day. Petitioner filed a report with CTA and went home. Petitioner sought treatment with Dr. Michael Foreman at Beverly Park Medical Center. Physical therapy was prescribed and Petitioner was taken off of work.

An MRI of the lumbar spine was ordered and performed on May 6, 2015. The MRI noted postsurgical changes at L4-L5 and L5-S1 levels. There was no evidence for significant disk herniations or re-herniations at L4-L5 and L5-S1. The rest of the lumbar spine was intact and unremarkable. (P.X.3,5) Petitioner was referred to Dr. Agrawal, a pain specialist, who recommended a series of injections.

Petitioner presented to Orthopedic Surgeon Dr. Steven Mash for section 12 examination. Mention is made of Petitioner's 2008 lumbar injury in which he suffered injuries to 3 disks and underwent a multi-level instrumented fusion. Further mention is made of the 2014 lumbar strain allegedly caused by a pothole. Dr. Mash reviewed the May 6, 2015 MRI and noted postsurgical changes at L4-L5 and L5-S1. Dr. Mash did not see any evidence of significant disk herniation or re-herniation at L4-L5 or L5-S1. (R.X. 3)

Dr. Mash was able to review medical records from May of 2014, about 11 months prior to Petitioner's April 17, 2015 work incident. It was noted that Petitioner was seeing Dr. Adam Cifu and complaining of severe low back pain with radiation into the leg. Petitioner underwent an epidural steroid injection. (R.X.3)

Dr. Mash diagnosed Petitioner with postlaminectomy syndrome. He noted that Petitioner was to follow up with his former treating surgeon, Dr. Ghanayem, and believed such a visit was appropriate. He believed that Petitioner's symptoms related to the incident as reported by Petitioner. He was unable to state whether Petitioner's current condition of ill-being was a temporary aggravation of a pre-existing condition or a significant aggravation. Dr. Mash concluded that Petitioner had significant pre-existing difficulty. Based on the incident as reported by Petitioner, Dr. Mash believed he had suffered a recurrent or new injury to his low back. Dr. Mash noted that "to date, MRI study has not documented the reason for the patient's ongoing difficulty and further evaluation of this patient's pre-existing underlying condition and evaluation of his fusion status is necessary at this date." (R.X.3)

Petitioner presented to Dr. Alex Ghanayem, the surgeon who performed his multi-level lumbar fusion in 2008, on June 22, 2015. A physical examination was performed. There was tenderness at the lumbar base and increased pain with lumbar range of motion, but no neurologic deficits in the lower extremities. Dr. Ghanayem was interested in reviewing the MRI scan from May 6, 2015. (P.X.5)

On July 13, 2015, Petitioner again presented to Dr. Ghanayem. The doctor reviewed the May 6, 2015 lumbar MRI scan and opined that his fusion had healed nicely at L4-L5 and L5-S1. There were no ectopic bone and implants were in a good position. The disc levels above his fusion showed no abnormalities, there were no bone spurs, herniations, or other traumatically induced findings. Dr. Ghanayem noted that Petitioner's sacrum and tailbone looked normal. Dr. Ghanayem informed Petitioner that he did not have a surgical answer for his problems and released Petitioner from his care. (P.X. 5)

Petitioner completed a Functional Capacity Evaluation on August 4, 2015. Petitioner testified that he could not finish the FCE. The FCE was invalid. (P.X.5)

Petitioner was referred to a spine specialist, Dr. Kuo. He first saw her on August, 14, 2015. He informed her that he was injured when a teenager rear ended him at high speed.(P.X.3) Dr. Kuo reviewed the MRI from May 6, 2015 as well as x-rays and opined that it demonstrated a "very solid fusion" at L4-L5 and L5-S1. There was no residual stenosis at L4-L5 or L5-S1. The remaining discs were completely within normal limits with no stenosis, no herniations, and no injury. (P.X.5)

Petitioner underwent a sacroiliac injection in October of 2015.

Petitioner saw Dr. Mash again for a section 12 exam on October 1, 2015. Dr. Mash believed an SI injection may be indicated, but took concern over Petitioner's symptom magnification and lack of validity in the FCE, and believed that surgery would not be necessary unless a pain source could be clearly identified. Dr. Mash believed that Petitioner's complaints were a result of an April 17, 2015 injury "based upon the history as provided by the patient." Dr. Mash noted that unless Petitioner had a very positive response to the SI injection, he would not recommend surgery or the neurostimulator. (R.X.3)

Dr. Kuo saw Petitioner on November 20, 2015 and concluded that "Once again with the negative MRI and solid fusion, it is difficult to know exactly why he is having the symptoms he is having." (P.X.3)

Dr. Kuo recommended a spinal cord nerve stimulator trial. The stimulator was approved by the CTA adjuster on January 27, 2016. (P.X.6) The trial stimulator was inserted on February 22, 2016. It was present for four days. On February 25, 2016 Dr. Agrawal noted that Petitioner would like to proceed with a permanent spinal stimulator. (P.X.5)

Petitioner returned to Dr. Mash for a third section 12 exam on March 3, 2016. It was noted that Petitioner was to have a permanent stimulator placed. Dr. Mash reviewed a video of the actual accident on April 17, 2015 and stated that his opinion concerning causality had significantly changed. He noted that the video showed the Petitioner allowing a rider to exit the bus. The bus operator was then seen to get up from his seat, turn around and exit the bus and walking toward the back. Dr. Mash observed "no motion to the bus, or jar that can be seen, no significant trauma of any sort that would be considered even slight..." He noted that Petitioner did not demonstrate any pain behavior in the video. Dr. Mash concluded that based on the video, no significant injury was identified. (R.X.3

Dr. Mash did not believe any further treatment was required, he believed that Petitioner did not appear to suffer a significant injury based on the video of April 17, 2015. He believed that any further treatment would be related to Petitioner's preexisting lumbar condition. (R.X.3)

Dr. Mash noted Petitioner's ongoing symptoms and was unable to understand the symptoms and did not believe they related in any way to the April 17, 2015 reported injury. Dr. Mash further noted that Petitioner failed an FCE and only responded to spinal cord stimulation. Dr. Mash believed this treatment was related to a pre-existing condition. Dr. Mash stated that he agreed with Dr. Kuo that it is difficult to understand the Petitioner's condition given his normal MRI and solid fusion. He noted that the video did not support the injury as alleged by the Petitioner. (R.X.3)

Dr. Mash concluded that the video significantly affected his opinions as it showed no significant episode of trauma. (R.X.3)

Petitioner's request for authorization of the spinal stimulator was submitted to Utilization Review. A Peer Review Report dated March 21, 2016 found the proposed spinal stimulator "not medically necessary" in this patient . (R.X.4)

Dr. Kuo wrote a medical narrative dated March 22, 2016. She reviewed the March 3, 2016 Dr. Mash IME and noted his reliance on the video. Dr. Kuo opined that relying on the video could lead to false presumptions on the etiology of pain. Dr. Kuo did not review or request to review the video footage. Dr. Kuo opined that she believed, with certainty, that the bus crash supplied sufficient force to cause an acute-on-chronic pain requiring a spinal cord stimulator implant. (P.X.5)

Petitioner testified that he has not received any TTD benefits since March 3, 2016. He continued to treat with Dr. Kuo after this time, who on April 15, 2016 continued to recommend the permanent spinal stimulator and kept him off work. (P.X.5) He presented for re-training at CTA. He testified that there are two parts to the retraining –a classroom setting and a bus driving setting. Petitioner testified that he attended the classroom setting but did not finish. He testified that he did not make it to the bus driving training, because was deemed unfit for duty due to the fact that he was ambulating with a cane. (Tr. 61-71)

Petitioner followed up with Dr. Kuo on June 10, 2016. He was given a trial release to work with a scheduled follow up visit. He was not given any work restrictions. (R.X.5) There are no further medical records in evidence after June 10, 2016.

Respondent's Exhibit 1 is a bus surveillance video of the April 17, 2015 incident. The Arbitrator notes that the parties stipulated that the video shows the Petitioner and that the video at trial is the same video that the parties previously viewed.

Petitioner's written report in Respondent's Exhibit 2 states that the contact between the vehicles occurred at 15:14 hours. The video begins at 15:09 hours. The point of contact can be seen in Channel 7, which is a view showing the outside of the right side of the bus. At 15:14:49, the silhouette of another vehicle can be seen approaching the rear end of the bus. (R.X.1)

Viewing the video in Channel 1, which is a view above the driver's seat looking out to the front door of the bus, a passenger is seen boarding and paying at 15:14 hours. The bus begins to accelerate. At 15:14:49, the point of contact, the bus comes to a stop and a passenger is seen standing. He does not significantly move or demonstrate any jarring or jolting motion. At 15:15 a passenger walks up to where Petitioner is seated and appears to be speaking with him. At 15:15:07 Petitioner opens the bus door and walks off of the bus. Channel 7 at 15:15:20, shows a side view of the bus, with Petitioner having walked behind the bus to speak with the driver of the personal motor vehicle. (R.X.1)

Channel 5 shows an overhead view of the rear portion of the bus. Beginning at 15:14, we see the bus in motion. A passenger in orange is seated in front of the rear door. At 15:14:49 the passenger does not significantly move, jar, or visibly jolt. The passenger remains stationary in his seat until 15:15:29 when he looks behind him at the bus driver walking to the outer rear of the bus. (R.X.1)

Channel 6 is a video showing the view out of the windshield. No significant movement of the bus is seen after it comes to a stop at 15:14:49, which is the point of contact. (R.X.1)

Channel 2 shows the interior of the bus from a camera placed at the front of the bus. At 15:14, multiple passengers are visible. The passenger closest to the camera is standing for the entire time in the same place, and does not make any significant movements until he leans forward to talk to the Petitioner at 15:14:59. No significant movement, jolting or jarring is observable. (R.X.1)

Channel 4 shows a view of the bus interior from the very back of the bus. Multiple seated passengers are seen in this video. As the car made contact with the bus, these passengers were closest to the point of impact. From 15:14 to 15:14:59, these passengers are seated without any significant movement until they collectively look out the left side windows. There is a standing passenger who remains standing upright without significant movement throughout this time as well. (R.X.1)

By visual observation by the Arbitrator , at no time in the video does the Petitioner visually appear to ambulate with any difficulty. Petitioner is seen ambulating freely outside of the bus throughout Channel 7. (R.X.1)

Conclusions of Law

C. In regard to issue "C" – Did an accident occur that arose out of and in the course of Petitioner's employment by the Respondent? The Arbitrator finds as follows:

Based upon the totality of the evidence , the Arbitrator finds that Petitioner failed to meet his burden of proof by a preponderance of the credible evidence that an accident in the course and scope of his employment occurred on April 17, 2015.

The Arbitrator has carefully reviewed the bus video admitted into evidence as Respondent's Exhibit 1. The video shows minimal impact between the car and Petitioner's bus. The Arbitrator notes that Petitioner testified that he felt a "jolt" when he was rear ended by the other vehicle. The Arbitrator has reviewed all of the camera angles on the bus video and cannot discern any significant movement of Petitioner's bus. Petitioner was accompanied on the bus by multiple passengers, none who make any significant movement at the point of contact between the vehicles. The standing passengers remain standing before and after contact between the vehicles is made (R.X.1)

The Arbitrator further notes that Petitioner's testimony and recorded statement admitted into evidence confirm that none of the passengers on the bus claimed injury. The Arbitrator finds it significant that Petitioner, being at the front of the bus, was the furthest from the point of impact. The passengers sitting closest to the point of impact demonstrated no significant movement at the point of contact. (R.X.1, 2) The Arbitrator finds it difficult to imagine that any individual on the bus, including Petitioner, would have suffered the type of injuries alleged by Petitioner from what appears to be a minor collision.

The Arbitrator further notes that Petitioner's behavior following the incident speaks to the true severity of the incident. Namely, from 15:15 in the video onward, Petitioner is seen walking around showing no visual signs of physical impairment.

F. In regard to issue "F" is the Petitioner's current condition of ill-being causally related to the injury? the Arbitrator finds as follows:

Based upon the totality of the evidence, Petitioner's current condition of ill-being is not causally related to the alleged work accident on April 17, 2015. Petitioner did not experience a significant episode of trauma on April 17, 2015 when a personal motor vehicle made contact with the rear bumper of Petitioner's bus.
or impact.

The Arbitrator notes that Petitioner testified that he felt a "jolt" when he was rear ended by the other vehicle. The Arbitrator has reviewed all of the camera angles on the bus video and cannot discern any significant movement of Petitioner's bus. Petitioner was accompanied on the bus by multiple passengers, none who make any significant movement at the point of contact between the vehicles. The standing passengers remain standing before and after contact between the vehicles is made (R.X.1)

The Arbitrator finds it significant that Petitioner, being at the front of the bus, was the furthest from the point of impact. The passengers sitting closest to the point of impact demonstrated no significant movement at the point of contact. (R.X.1, 2 The Arbitrator further notes that Petitioner's behavior following the incident speaks to the true severity of the incident. Namely, from 15:15 in the video onward, Petitioner is seen walking around showing little sign of injury. (R.X.1)

Dr. Mash reviewed the bus video, and opined that Petitioner did not experience significant trauma as a result of the vehicle contact.

Until the IME on March 3, 2016, Dr. Mash's causality opinion was based on the history as provided by Petitioner. (R.X.1) Dr. Mash took Petitioner at his word. Once Dr. Mash viewed the video of the incident, he significantly altered his causality opinion, finding that the video demonstrated "no motion to the bus, no jar that can be seen, no significant trauma of any sort which would be considered even slight…" (R.X.3)

The Arbitrator notes that prior to viewing the bus video, Dr. Mash had previously questioned Petitioner's symptomatology and the etiology of his pain. Dr. Mash noted that the MRI had not documented the reason behind his ongoing problems, and he was unsure whether Petitioner had suffered a temporary aggravation or a permanent aggravation. He also noted issues with symptom magnification and validity with the FCE. (R.X.3) It is important to note that both Dr. Ghanayem and Dr. Kuo also expressed uncertainty behind the cause of Petitioner's lumbar condition. "I do not have a surgical answer for his bladder, leg, and back symptoms" –Dr. Ghanayem. "Once again with the negative MRI and a solid fusion, it is difficult to know exactly why he is having the symptoms he is having." –Dr. Kuo. (P.X.5) Dr. Mash pointed out that he agreed with Dr. Kuo that it was difficult to understand Petitioner's condition given his normal MRI and solid fusion. Dr. Mash has a more credible causality opinion than Dr. Kuo.

Dr. Mash concluded that Petitioner did not suffer a significant episode of trauma on April 17, 2015. He did not believe Petitioner's current condition of ill-being was related to the event on April 17, 2015. In contrast, Dr. Kuo stated in her medical narrative dated March 22, 2016 that "I certainly do believe that the bus crash supplied sufficient force to cause an acute-on-chronic pain requiring a spinal cord stimulator implant." (P.X.5) Unlike, Dr. Mash, Dr. Kuo did not view the bus video. It is clear from Dr. Kuo's narrative that she is aware that a video of the reported accident exists, and that the video may contradict her understanding of the accident and mechanism of injury. Nevertheless, Dr. Kuo claims that she is certain that the bus accident, which she has not seen, supplied the sufficient amount of force necessary to require a spinal cord stimulator.

Furthermore, Dr. Kuo's understanding of the mechanism of injury is based on Petitioner's history of events. Petitioner's history of events is contradicted by his written statement and the video evidence, neither of which were seen by Dr. Kuo. Petitioner told Dr. Kuo at the initial visit in August of 2015 that he was rear ended by a teenager driving at high speed. (P.X.5) But Petitioner's written statement made on the date of accident describes the other vehicle as travelling at 20 miles per hour. (R.X.2) The Arbitrator notes that the event depicted in the video evidence is clearly not a high speed collision. (R.X.1)

The Arbitrator notes that the causality opinions of Dr. Kuo and Petitioner's other treating physicians was informed by the history of the event as provided by Petitioner. Petitioner's treating physicians did not review Petitioner's written statement or the bus video. This is significant because the full evidentiary record demonstrates that Petitioner's history regarding April 17, 2015 has not been consistent. On August, 14, 2015, Petitioner gave a history of the incident to Dr. Kuo stating that he was injured when a teenager rear ended him at high speed. (P.X.3) But Petitioner's statement written on the day of the event describes the other car as travelling 20 miles per hour. (R. X.2) The Arbitrator notes that the bus video does not demonstrate a high speed collision. (R. X.1)

Petitioner gave testimony regarding his work restrictions and medical treatment that is not corroborated by the medical records in evidence. Petitioner testified that he saw Dr. Kuo in June of 2016. He testified that he desired to return to work, and that Dr. Kuo gave him a 30 pound weight restriction and permitted him to use his cane. (Tr. 64) Petitioner was asked by the Arbitrator whether he was given a light duty release and Petitioner answered in the affirmative. (Tr. 65). The Arbitrator notes that Respondent's Exhibit 5 is a record of the visit with Dr. Kuo dated June 10, 2016. The record demonstrates that Dr. Kuo continued to recommend the spinal cord stimulator, and wrote "we will let him go back to work for now. We will have him back in follow up in about a month. This will be a trial period of work." (R.X.5) The Arbitrator finds it significant that there is no mention of "light duty" in Dr. Kuo's June 10th office note. In fact, the June 10, 2016 note is devoid of any work restrictions and there is no mention of a cane. The June 10th note contradicts Petitioner's testimony that he had a light duty release.

Petitioner initially testified that he saw Dr. Kuo in June of 2016 and then presented to CTA for retraining, only to be dismissed. Upon further questioning, Petitioner then changed his story, stating that he had possibly attempted to go back to work around the end of April, beginning of May of 2016, but was denied participation in his retraining due to having a cane. (Tr. 70) Petitioner admitted on re-cross examination that the retraining which he was unable to complete was prior to the June 10th appointment where Dr. Kuo gave him a trial work release, with no restrictions and no mention of a cane. (Tr. 74, R.X.5)

The Arbitrator has reviewed the evidentiary record and notes that Petitioner's last appointment with Dr. Kuo prior to June 10, 2016 is dated April 15, 2016. The Arbitrator notes that on April 15th, Dr. Kuo concluded in her Plan Summary that "we will keep him off work for now." There is no mention of any effort to return Petitioner to work. (P.X.5) Petitioner's testimony regarding his visits with Dr. Kuo is not corroborated in the medical records and calls his credibility as a witness into question.

Petitioner has a significant prior medical history of a multilevel lumbar fusion performed in 2008 by Dr. Ghanayem. Subsequently in 2014 he treated for a back strain with an injection and physical therapy. He alleges a new injury to his lumbar spine on April 17, 2015. A new lumbar MRI performed on May 6, 2015 demonstrated only postsurgical changes and was otherwise unremarkable. Petitioner was reexamined by Dr. Ghanayem in June and July of 2015 and was informed that he did not have a surgical answer for his problems. Dr. Ghanayem noted that the new MRI was devoid of traumatically induced findings. (P.X.5)

Petitioner then treated with Dr. Kuo, who described his new MRI as "negative" and demonstrative of a solid fusion. She wrote that she had trouble understanding his condition in light of these findings. Petitioner underwent an FCE which was found to be invalid. (P.X.5)

In reviewing medical records and examining Petitioner on three separate occasions, Dr. Mash concluded that he agreed with Petitioner's treating physician as to the difficulty of understanding his condition. He watched a video of the incident and determined that the collision could not have contributed to the Petitioner's current lumbar condition. Dr. Mash credibly opined that Petitioner's condition was related to his longstanding preexisting lumbar issues, or from a yet undiagnosed condition that could not have been caused by the minor incident on April 17, 2015. (R.X.3)

Based upon the totality of the evidence as highlighted above, the Arbitrator finds that Petitioner's current condition of ill-being is not causally related to the incident/ minor vehicle collision on April 17, 2015.

J. In regard to issue "J" were the medical services provided to petitioner reasonable and necessary? Has the Respondent paid all appropriate charges for all reasonable and necessary medical services? the Arbitrator finds as follows:

The Arbitrator finds that the issue of whether medical services were reasonable and necessary is moot based on the finding that Petitioner did not suffer a compensable injury on April 17, 2015 and that Petitioner's current condition of ill-being is not causally related to the April 17, 2015 incident.

K. In regard to issue "K" is the petitioner entitled to prospective medical care? the Arbitrator finds as follows:

The Arbitrator finds that the issue of future medical is moot based on the finding that Petitioner did not suffer a compensable injury on April 17, 2015 and that Petitioner's current condition of ill-being is not causally related to the April 17, 2015 incident.

L. In regard to issue "L" is the petitioner entitled to Temporary Total Disability benefits? the Arbitrator finds as follows:

The Arbitrator finds that the issue of TTD is moot based on the finding that Petitioner did not suffer a compensable injury on April 17, 2015 and that Petitioner's current condition of ill-being is not causally related to the April 17, 2015 incident. Even so, the last medical from Dr. Kuo, Petitioner's treating physician, states that as of June 10, 2016 Petitioner would be permitted to go back to work "for now". No restrictions are given. There are no medical records in evidence taking Petitioner back off of work after the June 10, 2016 release to work. (R.X.5)

M. In regard to issue "M' should penalties or fees be imposed upon Respondent? The Arbitrator finds as follows:

Petitioner seeks an award of Section 19(l) and Section 19(k) penalties and fees based on unpaid medical bills and unpaid TTD benefits. Petitioner alleges that Respondent authorized a neurostimulator which Petitioner had inserted, thereby incurring medical expenses. Petitioner alleges that Respondent then refused to pay for the medical expenses. Petitioner alleges that Respondent's refusal to pay medical expenses and TTD was unreasonable and vexatious.

Respondent must show, once a demand for payment is made, that it acted in an objectively reasonable manner, under all of the existing circumstances, in denying, or delaying the payment of, benefits. Crockett v. Industrial Commission, 218 Ill.App.3d 116, 121 (1st Dist. 1991)

In this case, Respondent's denial of benefits to Petitioner is based upon the video admitted into evidence as Respondent's Exhibit 1 as well as Dr. Steven Mash's medical opinion finding that Petitioner's did not suffer a significant injury on April 17, 2015 and that his current condition of ill-being is not causally connected in any way to the April 17, 2015 incident.

The Arbitrator notes that on March 21, 2016 Respondent's IME doctor, Steven Mash, reviewed a video of the April 17, 2015 incident and concluded that his prior opinion as to causality had significantly changed. Dr. Mash now believed, having seen an objective view of the incident as it actually unfolded, that Petitioner did not suffer an injury on April 14, 2015. Respondent denied benefits in reliance on Dr. Mash's March 21, 2016 opinon. Respondent was not unreasonable or vexatious in relying on the medical opinion of a qualified Orthopedic Surgeon in denying benefits. Respondent's actions, though unfavorable to Petitioner, were not without merit.

Therefore, Petitioner is not owed penalties under Section 19(l) and Section 19(k).

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tammy Morgan,
Petitioner,

vs. NO: 11 WC 10879

General Mills, Inc.
Respondent.

18IWCC0199

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that, other than as stated above, the Decision of the Arbitrator filed September 9, 2016 is hereby affirmed and adopted.

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

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: APR 2 - 2018

Joshua D. Luskin

Charles J. DeVriendt

Elizabeth Coppoletti

o-03/21/18
jdl-wj
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MORGAN, TAMMY
Employee/Petitioner

Case# **11WC010879**

11WC010880

GREEN MILLS INC
Employer/Respondent

18IWCC0199

On 9/9/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.47% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2489 BLACK AND JONES
JASON ESMOND
308 W STATE ST SUITE 300
ROCKFORD, IL 61101

2986 PAUL A COGHLAN & ASSOC PC
15 SPINNING WHEEL RD
SUITE 100
HINSDALE, IL 60521

STATE OF ILLINOIS)
)SS.
COUNTY OF Winnebago)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Tammy Morgan
Employee/Petitioner

v.

General Mills Inc.
Employer/Respondent

18IWCC0199

Case # 11 WC 10879

Consolidated cases: 11 WC 10880

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Rockford**, on **July 13, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **February 10, 2009**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned **$43,097.60**; the average weekly wage was **$828.80**.

On the date of accident, Petitioner was **47** years of age, ***married*** with **0** dependent children.

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

Respondent ***has*** 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 **$12,610.00** for other benefits, for a total credit of **$12,610.00**.

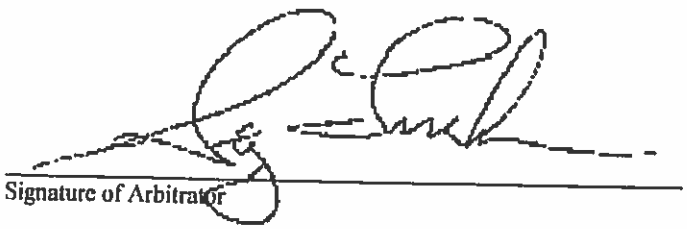
Respondent is entitled to a credit under Section 8(j) of the Act.

ORDER

BECAUSE PETITIONER FAILED TO PROVE BY A PREPONDERANCE OF THE EVIDENCE THAT SHE SUSTAINED ACCIDENTAL INJURIES ARISING OUT OF AND IN THE COURSE OF HER EMPLOYMENT AND FURTHER FAILED TO PROVE THAT HER CONDITION OF ILL BEING IS CAUSALLY CONNECTED TO ANY ACCIDENTAL INJURY SUSTAINED ON OR ABOUT FEBRUARY 10, 2009, PETITIONER'S CLAIM FOR COMPENSATION IS HEREBY DENIED.

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

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



Signature of Arbitrator

September 7, 2016
Date

ICArbDec p. 2

SEP - 9 2016

18IWCC0199

Statement of Facts

This matter was tried in conjunction with consolidated case 11 WC 10880 (date of accident August 2, 2010). Prior to trial, Petitioner's motion to amend the Application for Adjustment of Claim to correct the name of the Respondent to General Mills, Inc. was granted. These matters were consolidated for hearing and a single transcript was prepared. The Arbitrator has issued separate decisions with respect to each of these claims.

Petitioner Tammy Morgan testified that she worked for Respondent General Mills for approximately 26 years. She has worked as a machine operator for 22 -23 years. She worked first shift, from 6am – 2pm, on a full time basis. Her job was to make sure the right product was running. Her job duties included putting cartons into the machine and lifting films for packaging products. The films weighed approximately 80-90 pounds and were kept on a pallet. They would be pulled from a pallet to the arbor arm. She then had to tip the films to the side and slide them on the machine. The lowest level was 2 to 3 inches off the ground. She testified that she would lift the films 3 times a day, usually without assistance. On change over, she would take out heavy dies. If there was a jam in the machine, she would lift the safety and pull out the jammed cartons. She testified the frequency of jams depending on how the machine was running. Most of the day, she would clean her area, load cartons and cover breaks. She also performed work as a line grader and dumper operator. This required her to push product into a dumper.

Petitioner testified that on February 10, 2009, she experienced pain in her left leg down to her foot with lifting of the films. She testified to having experienced such pain for a couple of years with worsening pain while doing her job. She described feeling a shooting, burning pain down her leg when she bent down to put a film roll on. Petitioner testified that over the years, her back hurt more and more. She bent down and it hurt so bad she told her team leader that she needed to see a doctor for her back.

Petitioner testified that she told Kelly Tolsma. She also told her that she had pain after picking up a small ball at home. Petitioner testified that after work, she went to seek medical care. Petitioner testified that when she returned from the doctor's office, Ms. Tolsma had stopped 3 lines and made Petitioner explain how she had hurt herself to her coworkers. Ms. Tolsma and the safety rep were present for the explanation as well. Petitioner testified that she explained she had picked up a tennis ball at home and that she had wear and tear on her back from operating an electric jack to move the pallets of film. Petitioner testified that her grandkids had been playing with a ball and she bent down to pick it up and couldn't get back up.

Ms. Tolsma testified that she is currently the Associate Safety Manager for Respondent. In 2009, she was a team leader. She testified that she had a conversation with the Petitioner on February 10, 2009, at which time the Petitioner related that she injured her back while playing with her grandchildren. Ms. Tolsma testified that Petitioner said it was not work injury. She testified that Petitioner never reported a work related injury. She did not recall any team meeting the next day. She testified that if an injury is reported, they go through an investigation and communicate the results to the team. There was no investigation done in this matter.

Petitioner was initially seen by Bonnie Pulkowski, APN, at OSF Medical Group on February 10, 2009. Petitioner reported increasing back pain with all activities, walking lifting, sitting, even lying down. She denied having injured her back before. She described her employment as including heavy lifting of 80-90 lbs. Her pain is progressively worsening. Petitioner was scheduled for an MRI (PX 1, p 15-17). The impression on the MRI performed on February 12, 2009 was congenitally slender spinal canal with facet arthropathy and chronic disc

disease most pronounce at L4-5 and L5-S1. This causes a mild central and foraminal stenosis at L5-S1. Mild central stenosis is also seen at L4-5. A small lateral disc protrusion produces mild to moderate foraminal stenosis on the left but no definitive nerve root compression. Ms. Pulkowski referred Petitioner to Dr. Chang on February 20, 2009. On March 16, 2009, Petitioner reported that when she overdoes certain activities such as going up and down stairs she may experience numbness (RX 8).

Petitioner was seen by Dr. Chang for a neurosurgical consultation on March 11, 2009. She reported low back pain for approximately two years. She reported a sudden onset of worsening low back symptoms associated with left sciatica in November, 2008 after she bent over to pick up something at work in a work related capacity. This has not improved or subsided within the last several months (RX 4). Petitioner underwent injections into her lower back in March and April of 2009. On May 13, 2009, she reported to Dr. Chang that neither the injections nor physical therapy provided any meaningful improvement. Dr. Chang advised Petitioner that she could either do nothing or consider an L4-S1 fusion (PX 4).

Petitioner underwent chiropractic care from April 25, 2009 through May 26, 2009. On the April 25, 2009 Patient Questionnaire, Petitioner recorded that her low back and leg pain happened when she bent down to pick up a ball. Petitioner did not check the "Work Injury" box (RX 2). Petitioner testified that the chiropractic was not helpful. On July 1, 2009, Petitioner saw Bonnie Pulkowski. She reported chronic low back pain. Bending over is most painful. Petitioner reported that she often finds it difficult to make it through her work day as her job was physical. Petitioner does ask for help with lifting. Petitioner reports, "I cannot continue like this but I don't want surgery." The assessment was degenerative disc disease. Petitioner was advised to try an inversion table and to use ice and medication (PX 1).

Petitioner followed up at OSF on December 3, 2009. She reported that she had been through physiotherapy and was using an inversion table twice per day. Petitioner notes her job is fairly physical but she was given 15 pound work restrictions which had been beneficial. Petitioner saw Dr. Bitsas at OSF on April 18, 2010 for back pain. Petitioner continued to treat her pain with combination of heat/ice and prescriptions. Petitioner continued to work with the fifteen-pound restriction (RX 8).

Petitioner testified that she developed neck pain shooting into her head in August, 2010. The neck claim is the subject of the consolidated case 11 WC 10880 and is addressed more fully in the decision in that claim decided in conjunction with this matter.

Petitioner presented to OSF on August 28, 2010. Petitioner noted increased back pain, tripping more often, and sharp neck pain. It was recommended by Dr. Bitsas that Petitioner undergo further MRIs for her cervical and lumbar spine (RX 8). The September 14, 2010MRI of her cervical spine showed mild degenerative disease and uncovertebral DJD of the mid to lower cervical spine without spinal canal stenosis. The lumbar MRI showed multilevel degenerative changes involving the L4-5 and L5-S1 level and broad based disc protrusion on L5-S1 (RX 1). On October 6, 2010, Petitioner saw Dr. Bitsas to discuss the results of the MRIs. Petitioner reported leg cramps, left arm numbness and lower back pain. Petitioner was prescribed further medication and instructed to return in one month. On February 14, 2011, Dr. Zaheer evaluated Petitioner for her complaints in the low back and neck with radiation to the right shoulder. His assessment was L4-5 central canal stenosis, canal stenosis at L5-S1 due to disc bulge with disc herniation. He referred Petitioner to Dr. Alexander (RX 8).

On March 21, 2011, Petitioner saw Todd Alexander, M.D. The registration information prepared by Petitioner states that her injury occurred in March, 2009 when she bent down to remove a ball from the kitchen. The history recorded by Dr. Alexander states that she has been having symptoms since March of 2009 after bending and lifting a ball with her grandchildren. Dr. Alexander's records state "she apparently had wanted to claim this as a work-related injury because of the work she does although she admits there was no specific work incident." Dr. Alexander performed a physical examination and reviewed the MRI studies. Dr. Alexander opined that the Petitioner had back pain without significant radiculopathy secondary to mild disc bulges at L4-5 and L5-S1 and some degenerative disc disease at L5-S1. He states that she would not benefit from surgery. He states she may require chronic pain relieving measures (RX1).

Petitioner underwent physical therapy from April 28, 2011 through December 28, 2011at Belvidere Rehab and Sports Medicine (PX 6). Petitioner reported additional symptoms while camping on June 23, 2011, floating on a noodle in a swimming pool on July 27, 2011, standing and walking over the weekend on August 29, 2011, sitting and driving on September 14, 2011 and October 10, 2011, watching her grandchildren on October 21, 2011, and sitting or driving on several occasions (PX 6).

Petitioner worked with restrictions until July 11, 2011. She testified that on that day, she provided her restrictions to HR. She was told that no accommodating work was available and FMLA was recommended.

Petitioner had a further lumbar MRI on June 21, 2011 finding degenerative disc changes at L4-5 and L5-S1 with a broad based disc bulge at L4-5 and a broad based disc protrusion on L5-S1 impinging the exiting nerves. On August 15, 2011, Dr. Chang diagnosed degenerative disc disease L4-5, L5-S1, retrolisthesis L5-S1, central stenosis, bilateral foraminal stenosis at L4-5, L5-S1. Based upon failure of medical therapy, he recommended surgery. Dr. Chang performed an L4-S1 fusion on March 6, 2012.

Petitioner testified that the surgery improved the sciatic pain into her leg. She still had the same pain in her lower back. Petitioner underwent post operative rehabilitation and physical therapy at Belvidere Rehab & Sports Medicine from June 13, 2012 through November 30, 2012. Petitioner provided a history of having a very strenuous job for years which she believed led to her history of back pain. Petitioner reported increased aching and stiffness with increased activities such as dancing, or prolonged walking, standing, or sitting (RX3). On November 19, 2012, Dr. Chang's notes indicate Petitioner was not sure she could do her job. She complained of difficulty lifting 2 gallons of milk or sitting or standing for any length of time. She reports she would have to lift 70-80 pounds to return to work. She does not feel she could lift over 40 pounds. Petitioner was scheduled for an FCE (PX 2).

The FCE was performed on December 27, 2012. The Petitioner was found to be capable of work in the Light physical demand level. The FCE noted signs of symptom magnification and 4/5 positive Waddell's. Petitioner testified that she provided her Functional Capacity Evaluation to HR and was told work was not available within her restrictions. On February 18, 2013, Petitioner saw Dr. Chang for a one year follow up. The record states she reports doing well with no back pain per se and no leg pain. Dr. Chang notes the FCE release to light work. He notes no neurosurgical work restriction and states her work duties should be a combination of the FCE specifications and what is agreeable to her employer (PX 2).

Petitioner continued to treat with Dr. Zaheer. On March 18, 2013, she complained of left knee pain for the last 4 months. She also has a left foot drop. She treated for her back pain on June 4, 2013 and July 9, 2013. She

continues to take Norco. Dr. Zaheer provided a work release per the FCE restrictions and Dr. Chang's release. Petitioner treated in November, 2013 for her back, knee and depression. On May 10, 2014, Petitioner complained of her left leg giving out and falling down. Dr. Zaheer states this could be related to her back or her knee. He prescribed physical therapy, and a CT scan of the neck. Dr. Chang also requested an updated CT scan of the lower back (PX 2).

On October 24, 2012, Petitioner was seen for a medical examination by Dr. Jeffrey Coe at her attorney's request. Dr. Coe testified by evidence deposition on May 2, 2014 (PX 8). He testified that Petitioner gave him a description of her job as a machine operator. The bulk of her job was filling machines. This included rolls of film weighing about 80 pounds four times per shift. She loaded cartons. The position was awkward. She would bend forward and over the equipment to place the cartons in the machine. She would clear jams and use a pallet jack. He testified to the medical histories he reviewed of low back complaints including episodic back pain which became worse in late 2008 and an acute exacerbation when she bent over to pick up a tennis ball. He noted the February, 2009 MRI with findings of disc bulging, facet joint hypertrophy and ligamentous thickening. The repeat September 14, 2010 MRI showed similar findings. On physical examination he found trigger points, tenderness, loss of motion and sensory changes. He diagnosed Petitioner with degenerative disc disease and degenerative arthritis in the lumbar spine with chronic pain. He opined that Petitioner was in need of additional treatment and work restrictions in the light physical demand level. He opined that her job duties were a causative factor in causing an aggravation of her pre-existing degenerative conditions in her low back (PX 8). He testified that Petitioner provided a history to her treating doctors of a specific episode while playing with her grandchildren. He testified that the non-work related event was not the sole cause of her back pain (PX 8).

Petitioner was seen by Dr. Soriano at Respondent's request for Section 12 examination on March 23, 2013. His report was admitted as Respondent's Exhibit 6. Dr. Soriano testified by evidence deposition on July 31, 2014 (RX 7). Dr. Soriano's report contains Petitioner's history of accident on March 1, 2009. Petitioner stated that she hurt her back moving pallets over 26 years. Dr. Soriano notes that she does this 3 times per day with a coworker. He notes she told her supervisor that is was not work related. Dr. Soriano reviewed the medical treatment records. He notes the history given to Dr. Alexander of her low back pain starting when she was lifting a tennis ball with her grandchildren. He performed a negative physical examination including negative straight leg raising and negative neurological testing. He reviewed the diagnostic films. Dr. Soriano opined that Petitioner could return to regular work. She does not require any further treatment. He opined that the knee, foot and hip complaints are not related to her surgery or any injury that occurred at work. He opined that Petitioner's back condition is not causally related to her employment. She has a long standing and pre-existing degenerative facet disease at L4-5 and L5-S1. The MRI findings are consistent with the degenerative conditions consistent with normal aging processes. Dr. Soriano agreed that picking up a ball did not cause Petitioner's lower back condition, but did not feel her work activities were causative either. He disagrees with Dr. Coe. He states that there is no data to support the concept that the low repetition lifting she describes is the source of her problems (RX 6).

Dr. Soriano testified that his diagnosis was a soft tissue strain with preexisting multilevel degenerative disc and facet disease in the lumbar spine, all unrelated to her working environment. He states that, by her own admission, there was no particular injury. He stated there were no highly repetitive activities in her job. He testified that repetitive in his opinion requires hundreds of repetitions per hour. It is possible to rupture a disc lifting 45 pounds. He does not believe that occurred in Petitioner's case. It is not his opinion that the lifting of the tennis ball caused or permanently aggravated the condition of her lumbar spine (RX 7).

Petitioner testified that she has not returned to work. She has not looked for work. Petitioner testified that she continues to experience burning and stiffness in her back. Dr. Zaheer continues to prescribe medication. She has difficulty getting down into a car. Bending over to tie her shoes or shave her legs is painful. She can lift only 10 lbs. and has difficulty playing with her grandchildren. Petitioner was awarded Social Security Disability as of June, 2015. Petitioner testified that various things now caused her back pain, such as sitting, standing, walking, and cold weather. Prior to her injury, these were things she was capable of performing without pain.

Conclusions of Law

In support of the Arbitrator's decision with respect to (C) Accident, and (F) Causal Connection, the Arbitrator finds as follows:

The claimant in a workers' compensation case has the burden of proving, by a preponderance of the evidence, all of the elements of her claim. The claimant must show, by a preponderance of the evidence, that she suffered a disabling injury that arose out of and in the course of her employment. An injury occurs "in the course of' employment when it occurs during employment and at a place where the claimant may reasonably perform employment duties, and while a claimant fulfills those duties or engages in some incidental employment duties. An injury "arises out of" one's employment if it originates from a risk connected with, or incidental to, the employment and involves a causal connection between the employment and the accidental injury. Included within that burden is proof that her current condition of ill-being is causally connected to a work-related injury.

While Petitioner testified that on February 10, 2009, she experienced pain in her left leg down to her foot with lifting of the films, she testified to having experienced such pain for a couple of years with worsening pain. She testified she told Mr. Tolsma that she had wear and tear on her back from operating an electric jack to move the pallets of film. Petitioner never provided a history to any treating doctor of a specific injury on February 10, 2009. On February 10, 2009, Petitioner reported increasing back pain with all activities, walking lifting, sitting, even lying down. She denied having injured her back before. She described her employment as including heavy lifting of 80-90 lbs. Her pain is progressively worsening. On March 11, 2009, she told Dr. Chang that she had low back pain for approximately two years. She reported a sudden onset of worsening low back symptoms associated with left sciatica in November, 2008 after she bent over to pick up something at work. Dr. Alexander's records state "she apparently had wanted to claim this as a work-related injury because of the work she does although she admits there was no specific work incident." She admitted to Dr. Soriano that there was no particular injury, but claims her job over 26 years required her to lift and push. The Arbitrator finds that there was no specific injury and Petitioner's claim must be addressed as a claim for repetitive trauma.

An employee who alleges injury from repetitive trauma must still meet the same standard of proof as other claimants alleging accidental injury. The employee must show that the injury is work related and not the result of a normal degenerative aging process. In repetitive trauma cases, the claimant generally relies on medical testimony establishing a causal connection between the work performed and claimant's disability. Although medical testimony as to causation is not required in every workers' compensation case, where the question is one within the knowledge of experts only and not within the common knowledge of laypersons, expert testimony is necessary to show that claimant's work activities caused the condition complained of. Cases involving aggravation of a preexisting condition primarily concern medical questions and not legal questions,

and this is especially true in repetitive trauma cases. Repetitive trauma claims involving the alleged aggravation of a preexisting condition, like the claim asserted here, cannot succeed unless the claimant presents medical evidence suggesting that (1) the claimant had a preexisting condition that was or could have been aggravated by her repetitive work activities, and (2) her current condition of ill-being was or could have been caused (at least in part) by this work-related trauma and is not simply the result of a normal, degenerative aging process.

The treating records do not contain any clear statement of medical causation from the treating medical providers. The Arbitrator notes that, although Petitioner repeatedly advised her treaters of the physical nature of her job, the only specific incidents mentioned are a bending episode in November, 2008, a two year history of complaints and the specific incident when she bent to pick up a tennis ball while playing with her grandchildren. This incident is specifically reported to her the chiropractor, Dr. Chang and Dr. Alexander. Ms. Tolsma testified that this is the only incident reported to her in February, 2009. Petitioner's initial history does note increased pain with everyday activities such as ascending stairs.

Petitioner must rely on the causation opinion of Dr. Coe. He testified that Petitioner gave him a description of her job as a machine operator. The bulk of her job was filling machines. This included rolls of film weighing about 80 pounds four times per shift. She loaded cartons in an awkward position. She would bend forward and over the equipment to place the cartons in the machine. She would clear jams and use a pallet jack. He opined that her job duties were a causative factor in causing an aggravation of her pre-existing degenerative conditions in her low back. He does not specify any particular job duty or determine if the performance of such duties was done a particular number of repetitions except loading the film 3-4 times per day.

Dr. Soriano's report contains Petitioner's history of accident on March 1, 2009. While Petitioner stated that she hurt her back moving pallets over 26 years, Dr. Soriano notes that she does this 3 times per day with a coworker. He opined that Petitioner's back condition is not causally related to her employment. She has a long standing and pre-existing degenerative facet disease at L4-5 and L5-S1. The MRI findings are consistent with the degenerative conditions consistent with normal aging processes. Dr. Soriano did not feel her work activities were causative. He stated there were no highly repetitive activities in her job. He states that there is no data to support the concept that the low repetition lifting she describes is the source of her problems.

The Arbitrator notes Petitioner's testimony as to the onset of her symptoms is contradicted by the other evidence submitted. Her testimony as to the work activity varies among the multiple facets of her job. She admits that the lifting of the film pallet is only done 3 or 4 times per shift. Dr. Soriano's opinion that this is not repetitive is persuasive to the Arbitrator. Petitioner also advances simply bending at work in 2008, and having pain for two years before seeking treatment, both inconsistent to her testimony at trial. Petitioner advised Dr. Soriano that the injury occurred March 1, 2009 rather than February 10. Dr. Coe testified to components of Petitioner's job that she did not describe at trial. Some activities, such as unjamming the machine would only be performed periodically.

The Petitioner did consistently describe the onset of her problem relating to the bending over to pick up a tennis ball while playing with her grandchildren. This is the only history provided to the employer. Dr. Coe discounts the tennis ball incident as having occurred in March, 2009 after the initial treatment began February, 2009, but Petitioner and Ms. Tolsma both testified that Petitioner reported this incident at the time of the initial reporting of her low back problems on the day she first sought treatment in February. The physical therapy records also document increased symptoms from many activities of ordinary life such as ascending and

descending stairs, bending, extensive walking, standing or sitting. The diagnostics and diagnoses confirm the extensive degenerative condition of her lumbar spine. The Arbitrator also notes Petitioner's development of multiple other degenerative conditions in her cervical spine, left knee and hip and her attribution of all of these conditions to her work activities even though she was either on light duty or off work completely at the time of the onset of these additional conditions of ill being.

After reviewing the opinions of Dr. Soriano and Dr. Coe in light of the other medical and factual evidence admitted, the Arbitrator finds the opinions of Dr. Soriano, that Petitioner's work activities are not repetitive and that Petitioner's condition of ill being in the lumbar spine is not causally related to her work activities with Respondent but rather the result of the normal aging process, more persuasive than the causation opinion of Dr. Coe.

Based upon the record as a whole, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that she sustained accidental injuries to her low back on or about February 10, 2009 and further failed to prove that her condition of ill being in the low back is causally connected to her work activities for Respondent.

In support of the Arbitrator's decision with respect to (E) Notice, (J) Medical, (K) Temporary Compensation, (L) Nature and Extent, and (N) Credit, the Arbitrator finds as follows:

Based upon the Arbitrator's findings with respect to Accident and Causal Connection, the remaining issues of Notice, Medical, Temporary Compensation, Nature and Extend, and Credit are moot.

Petitioner's claim for compensation is hereby denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tammy Morgan,
Petitioner,

vs. NO: 11 WC 10880

18IWCC0200

General Mills, Inc.
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that, other than as stated above, the Decision of the Arbitrator filed September 9, 2016 is hereby affirmed and adopted.

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

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: APR 2 - 2018

Joshua D. Luskin

Charles J. DeVriendt

Elizabeth Coppoletti

o-03/21/18
jdl-wj
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MORGAN, TAMMY
Employee/Petitioner

Case# **11WC010880**

11WC010879

GREEN MILLS INC
Employer/Respondent

18IWCC0200

On 9/9/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.47% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2489 BLACK AND JONES
JSON ESMOND
308 W STATE ST SUITE 300
ROCKFORD, IL 61101

2986 PAUL A COGHLAN & ASSOC PC
15 SPINNING WHEEL RD
SUITE 100
HINSDALE, IL 60521

STATE OF ILLINOIS)
)SS.
COUNTY OF Winnebago)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Tammy Morgan
Employee/Petitioner

v.

General Mills Inc.
Employer/Respondent

18IWCC0200

Case # **11** WC **10880**

Consolidated cases: **11 WC 10979**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Rockford**, on **July 13, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **August 2, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident ***was not*** given to Respondent.

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

In the year preceding the injury, Petitioner earned **$43,097.60**; the average weekly wage was **$828.80**.

On the date of accident, Petitioner was **49** years of age, ***married*** with **0** dependent children.

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

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

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

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

ORDER

BECAUSE PETITIONER FAILED TO PROVE BY A PREPONDERANCE OF THE EVIDENCE THAT SHE SUSTAINED ACCIDENTAL INJURIES ARISING OUT OF AND IN THE COURSE OF HER EMPLOYMENT WITH RESPONDENT, FAILED TO PROVE THAT SHE PROVIDED NOTICE PURSUANT TO THE PROVISIONS OF THE ACT, AND FAILED TO PROVE ANY CONDITION OF ILL BEING CAUSALLY CONNECTED TO ANY WORK RELATED EVENT ON OR ABOUT AUGUST 2, 2010, PETITIONER'S CLAIM FOR COMPENSATION IS HEREBY DENIED.

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

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

Signature of Arbitrator

September 7, 2016
Date

SEP - 9 2016

ICArbDec p. 2

Statement of Facts

This matter was tried in conjunction with consolidated case 11 WC 10879 (date of accident February 10, 2009). Prior to trial, Petitioner's motion to amend the Application for Adjustment of Claim to correct the name of the Respondent to General Mills, Inc. was granted. These matters were consolidated for hearing and a single transcript was prepared. The Arbitrator has issued separate decisions with respect to each of these claims.

Petitioner Tammy Morgan testified that she worked for Respondent General Mills for approximately 26 years. She has worked as a machine operator for 22 -23 years. She worked first shift, from 6am – 2pm, on a full time basis. Her job was to make sure the right product was running. Her job duties included putting cartons into the machine and lifting films for packaging products. The films weighed approximately 80-90 pounds and were kept on a pallet. They would be pulled from a pallet to the arbor arm. She then had to tip the films to the side and slide them on the machine. The lowest level was 2 to 3 inches off the ground. She testified that she would lift the films 3 times a day, usually without assistance. On change over, she would take out heavy dies. If there was a jam in the machine, she would lift the safety and pull out the jammed cartons. She testified the frequency of jams depending on how the machine was running. Most of the day, she would clean her area, load cartons and cover breaks. She also performed work as a line grader and dumper operator. This required her to push product into a dumper.

Petitioner testified that on February 10, 2009, she experienced pain in her left leg down to her foot with lifting of the films. This incident is the subject of consolidated claim 11 WC 10879. The facts of the February 10, 2009 incident are addressed in greater detail in the decision issued in that matter decided in conjunction with this claim. Those facts as relevant hereto are incorporated herein. Petitioner began treatment at OSF Medical Group and Dr. Chang, a neurosurgeon for her low back complaints. She underwent chiropractic care, physical therapy and injections. On December 3, 2009, Petitioner notes her job is fairly physical but she was given 15 pound work restrictions which had been beneficial. Petitioner saw Dr. Bitsas at OSF on April 18, 2010 for back pain. Petitioner continued to treat her pain with combination of heat/ice and prescriptions. Petitioner continued to work with the fifteen-pound restriction (RX 8).

Petitioner testified that on August 2, 2010 she felt sharp pain in her neck shooting into her head while she was washing her hair. She testified that she did not report this to the Respondent. She did not want to explain it, so she just left it. Kelly Tolsma testified that she is currently the Associate Safety Manager for Respondent. She previously was a team leader. She testified that she had a conversation with the Petitioner on February 10, 2009, at which time the Petitioner related that she injured her back while playing with her grandchildren. She testified that Petitioner never reported a work related injury to her.

Petitioner presented to OSF on August 28, 2010. Petitioner noted increased back pain, tripping more often, and sharp neck pain. It was recommended by Dr. Bitsas that Petitioner undergo further MRI's for her cervical and lumbar spine (RX 8). The September 14, 2010 MRI of her cervical spine showed mild degenerative disease and uncovertebral DJD of the mid to lower cervical spine without spinal canal stenosis with suspected mild to moderate foraminal stenosis. Thereafter, Petitioner continued treatment for her back and neck as detailed more fully in the decision in 11 WC 10879, including an L4-S1 fusion surgery by Dr. Chang on March 6, 2012. An FCE was performed on December 27, 2012. The Petitioner was found to be capable of work in the

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Light physical demand level. The FCE noted signs of symptom magnification and 4/5 positive Waddell's (PX 7). Dr. Zaheer continued to diagnose chronic neck pain, multi level degenerative disc disease (PX 4).

On October 24, 2012, Petitioner was seen for a medical examination by Dr. Jeffrey Coe at her attorney's request. Dr. Coe testified by evidence deposition on May 2, 2014 (Ex. 8). His evaluation and opinions were limited to the 2009 low back injury.

Petitioner was seen by Dr. Soriano at Respondent's request for Section 12 examination on March 23, 2013. His report was admitted as Respondent's Exhibit 6. Dr. Soriano testified by evidence deposition on July 31, 2014. Petitioner provided a history that, in August of 2010, she began experiencing neck pain, which she now also states is related to her work because of the stress at work. He reviewed the medical records. He notes the September 14, 2010 cervical MRI shows mild degenerative disc disease at C3-4, C4-5 and C5-6 with bulging. No acute findings were noted. He opines that her neck complaints are not related to her work activities for Respondent.

Petitioner worked with restrictions until July 11, 2011. She testified that on that day, she provided her restrictions to HR. She was told that no accommodating work was available and FMLA was recommended. Petitioner testified that she has not returned to work. She has not looked for work. Petitioner testified that she continues to experience burning and stiffness in her back. She has difficulty getting down into a car. Bending over to tie her shoes or shave her legs is painful. She can lift only 10 lbs. and has difficulty playing with her grandchildren. Petitioner was awarded Social Security Disability as of June, 2015. Petitioner testified that various things now caused her back pain, such as sitting, standing, walking, and cold weather. Prior to her injury, these were things she was capable of performing without pain.

Conclusions of Law

In support of the Arbitrator's decision with respect to (C) Accident and (F) Causal Connection, the Arbitrator finds as follows:

The claimant in a workers' compensation case has the burden of proving, by a preponderance of the evidence, all of the elements of her claim. The claimant must show, by a preponderance of the evidence, that she suffered a disabling injury that arose out of and in the course of her employment. An injury occurs "in the course of' employment when it occurs during employment and at a place where the claimant may reasonably perform employment duties, and while a claimant fulfills those duties or engages in some incidental employment duties. An injury "arises out of" one's employment if it originates from a risk connected with, or incidental to, the employment and involves a causal connection between the employment and the accidental injury. Included within that burden is proof that his current condition of ill-being is causally connected to a work-related injury.

Petitioner's own testimony is that she developed her neck complaints at home while washing her hair. She admitted to Dr. Soriano that she did not have any specific work injury but rather attributed her neck complaints to the stress of work. She testified to her work activities including lifting pallets of films. Her claim must be addressed as a claim for repetitive trauma.

An employee who alleges injury from repetitive trauma must still meet the same standard of proof as other claimants alleging accidental injury. The employee must show that the injury is work related and not the result

of a normal degenerative aging process. In repetitive trauma cases, the claimant generally relies on medical testimony establishing a causal connection between the work performed and claimant's disability. Although medical testimony as to causation is not required in every workers' compensation case, where the question is one within the knowledge of experts only and not within the common knowledge of laypersons, expert testimony is necessary to show that claimant's work activities caused the condition complained of. Cases involving aggravation of a preexisting condition primarily concern medical questions and not legal questions, and this is especially true in repetitive trauma cases. Repetitive trauma claims involving the alleged aggravation of a preexisting condition, like the claim asserted here, cannot succeed unless the claimant presents medical evidence suggesting that (1) the claimant had a preexisting condition that was or could have been aggravated by her repetitive work activities, and (2) her current condition of ill-being was or could have been caused (at least in part) by this work-related trauma and is not simply the result of a normal, degenerative aging process.

The treating records provide no opinion that the condition of ill being in Petitioner's cervical spine is causally connected to her work activities. The MRI of her cervical spine on September 14, 2010, showed mild degenerative disease. Zaheer diagnosed chronic neck pain, multi level degenerative disc disease. Dr. Coe is silent on this issue. The Arbitrator notes that at the time of the development of neck symptoms in August, 2010, Petitioner had been working with a 15 pound weight restriction. Dr. Soriano states that the September 14, 2010 cervical MRI shows mild degenerative disc disease at C3-4, C4-5 and C5-6 with bulging. No acute findings were noted. He opines that Petitioner's neck complaints are not related to Petitioner's work activities for Respondent. The Arbitrator finds Dr. Soriano's opinion persuasive.

Based upon the record as a whole, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that she sustained accidental injuries to her neck and cervical spine on or about August 2, 2010 and further failed to prove that her condition of ill being in the neck and cervical spine is causally connected to her work activities for Respondent.

In support of the Arbitrator's decision with respect to (E) Notice, the Arbitrator finds as follows:

Petitioner testified that her complaints in the neck began while washing her hair, not at work. She also testified that she never reported any August, 2010 injury to the employer. Ms. Tolsma's testimony confirms that Petitioner never reported any work injuries to her while she was team leader.

Based upon the record as a whole, the Arbitrator finds that Petitioner failed to provide timely notice of the alleged accident on August 2, 2010 to Respondent.

In support of the Arbitrator's decision with respect to (J) Medical, (L) Nature and Extent, and (N) Credit, the Arbitrator finds as follows:

Based upon the Arbitrators findings with respect to Accident, Causal Connection and Notice, the remaining issues of Medical, Nature and Extent, and Credit are moot.

Petitioner's claim for compensation is hereby denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Joseph A. Cascio,

Petitioner,

vs.

NO: 10 WC 28949

18IWCC0201

City of Rockford Fire Dept.,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission modifies the decision of the Arbitrator to find that, in addition to his lumbar spine condition, Petitioner's gastric issues were likewise causally related to the accident on 2/12/10. More to the point, the Commission finds that said gastric issues -- in the form of a diagnosis of GI bleeding and possible iron deficient anemia at the time of his emergency room visit and admission to Rockford Memorial Hospital on 8/4/12 -- were related to the medications prescribed to and utilized by Petitioner, including multiple nonsteroidals/aspirin for pain, during the course of his treatment relative to his lumbar spine. This finding is based on the chain of events and Petitioner's credible testimony as to his complaints in this regard as well as the medical records submitted into evidence.

However, the Commission affirms the Arbitrator's finding that Petitioner failed to prove that his current condition of ill-being relative to his cervical spine is causally related to the accident on 2/12/10, for the reasons already enunciated by the Arbitrator in his decision.

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The Commission further finds that Respondent is entitled to a credit pursuant to §8(j) of the Act for any and all amounts paid with respect to the bills in question, specifically those relating to treatment for the aforesaid lumbar and gastric conditions, and that Petitioner shall be held harmless for any outstanding balances relative to the expenses for which Respondent is receiving said credit and which may have been paid by Blue Cross Blue Shield.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 10/5/15 is modified as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner reasonable and necessary medical expenses relative to Petitioner's lumbar condition as well as his gastric issues but not his cervical condition, as set forth in PX1-11, pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $664.72 per week for 250 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the loss of use of 50% person-as-a-whole.

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; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

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

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

DATED: APR 3 - 2018
o:2/20/18
TJT/pmo
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CASCIO, JOSEPH A
Employee/Petitioner

Case# **10WC028949**

10WC028947
10WC028948

CITY OF ROCKFORD FIRE DEPARTMENT
Employer/Respondent

18IWCC0201

On 10/5/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0529 GREG TUITE & ASSOC
PO BOX 59
ROCKFORD, IL 61101

1408 HEYL ROYSTER VOELKER & ALLEN
KEVIN J LUTHER
321 W STATE ST 2ND FL
ROCKFORD, IL 61105

STATE OF ILLINOIS)
)SS.
COUNTY OF WINNEBAGO)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JOSEPH A. CASCIO
Employee/Petitioner

v.

CITY OF ROCKFORD FIRE DEPARTMENT
Employer/Respondent

Case # **10** WC **28949**

Consolidated cases: **10 WC 28948, 10 WC 28947**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert Falcioni**, Arbitrator of the Commission, in the city of **Rockford**, on **8/25/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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FINDINGS

On **2/12/10**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being ***is*** causally related to the accident except for his alleged neck condition.

In the year preceding the injury, Petitioner earned **$73,009.56**; the average weekly wage was **$1,404.03**.

On the date of accident, Petitioner was **51** years of age, ***married*** with **0** dependent children.

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

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

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

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

ORDER

The Arbitrator awards the petitioner 50% person-as-a-whole pursuant to Section 8(d)(2) which is 250 weeks at a PPD rate of $664.72 which totals $166,180.00. The Arbitrator awards Section 8(a) medical expenses totaling $1,780.57 TO BE PAID PURSUANT TO THE MEDICAL FEE SCHEDULE.

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

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

Signature of Arbitrator

9/28/15
Date

OCT - 5 2015

15339-T2791
KJL/vlb/yrb

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ARBITRATION DECISION

ATTACHMENT

Joseph A. Cascio v. City of Rockford Fire Department
Case No. 10 WC 28949

STATEMENT OF FACTS

On 11/25/07, Mr. Cascio was kneeling on a roof as part of his job fighting a fire. He indicates that he felt something abnormal in his left knee, which he describes as "a feeling of a tendon slipping across the front of my knee." He tried to manipulate the knee by sticking it out to the side and putting his weight on the knee. He indicates he felt a painful pop in the knee, which was followed by swelling.

He came under the care of Dr. Chmell, an orthopedist. X-rays showed degenerative joint disease of the knee. An MRI showed severe central medial compartment chondromalacia and a medial meniscal tear along with quadriceps tendinosis.

When Mr. Cascio did not significantly improve with physical therapy, he was taken to surgery on 2/21/08. Dr. Chmell performed a left medial meniscectomy and documented the presence of Grade II – IV femoral chondromalacia.

Mr. Cascio was significantly improved by the surgery and was able to return to full activities but continued to have some pain with twisting, climbing stairs, kneeling, or when he was on his feet for a long period of time.

In July of 2009, he returned to Dr. Chmell because of increasing pain. An MRI was performed, which showed full-thickness cartilage loss but no new meniscal tear.

Mr. Cascio underwent Synvisc knee injections in October of 2009 and was seen by Dr. Cole, an orthopedist, for a second opinion. Various options, including a high tibial osteotomy, were discussed in January of 2010.

On 2/12/10, Mr. Cascio fell approximately 16 feet, landing directly on his heels, and had immediate low back pain running down to his right foot. He also had documented neck pain. Diagnostic studies revealed a significant unstable burst fracture of L2 with fractures of the laminae, as well as a fracture of L1. These produced severe spinal stenosis. CT scan of the cervical spine showed degenerative disc disease from C5 through C7. Mr. Cascio did have pain on passive cervical motion in the emergency room.

He came under the care of Dr. Roh. Dr. Roh performed a posterior T12 through L3 fusion that day. Several days later, he performed an anterior fusion from T12 through L3. It was also noted that he had a sacral fracture.

Mr. Cascio, upon starting to ambulate, noted pain in his left heel. He came under the care of Dr. Zusman. X-rays were felt to show an occult fracture of the calcaneus, which was heeling. Dr. Zusman did not feel that any specific treatment was required for the heel fracture, as symptoms were significantly improving. Mr. Cascio indicates that is no longer an issue.

Because of ongoing complaints with his left knee, Dr. Cole again injected the knee, suggesting that any surgery be deferred until a full recovery from his back injuries.

Because of ongoing complaints of pain in the neck and numbness and tingling in both hands, he underwent a cervical MRI, which showed neuroforaminal stenosis from C4 through T1.

He came under the care of Dr. Dahlberg, a pain physician, and underwent a cervical epidural steroid injection, which produced significant, long-lasting relief. Mr. Cascio indicates

that he actually had two injections performed within a week of each other, and the second one significantly improved him.

On 7/13/11, a unicondylar arthroplasty was performed on his left knee by Dr. Levine. Mr. Cascio also was complaining of pain in the left abdomen, which was felt to be due to intercostal neuritis from his prior surgeries. Mr. Cascio indicates that has not gone away. He indicates that it will vary in intensity, but he has learned to live with the pain and it does not interfere with his activities.

Mr. Cascio noted a gradual worsening of his low back pain. In December of 2012, Dr. Roh performed an L3 through L5 fusion, along with removal of previous hardware, for a spinal transitional syndrome. Prior to this, Mr. Cascio had been complaining of pain running down both lower extremities, had received several epidural steroid injections, and had gone to the emergency room with back pain on two occasions.

Mr. Cascio indicates that he was significantly helped by this second surgery on his low back. He did have a recurrence of his upper extremity numbness and tingling, and an MRI was performed at the end of 2013. This again showed C5-6 degeneration. An epidural steroid injection was performed around New Year's of 2014, and, once again, Mr. Cascio was significantly improved as a result of this epidural steroid injection.

On 1/24/14, he underwent bilateral facet joint injections for the low back and also was significantly improved. A record of 2/25/14 indicated that he was "pain-free."

Mr. Cascio indicates to Dr. Steven Weiss (Petitioner's Section 12 examiner) that his left knee is "good." He indicates that he can walk for an hour without difficulty, but he indicates that

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if he is on his feet for longer than that, his knee is "achy." He is performing full work activities without restrictions.

REVIEW OF RECORDS

11/21/06	Initial record – Dr. Jarrett. Claimant injured on 10/16/06 walking along the ridge line on a roof. His right leg slipped and twisted and had sharp pain in his right knee. Was to do exercises. The injury occurred on 10/16/06. No effusion was noted. The exam was unremarkable. Diagnosis was a strain.
1/03/07	An MRI of the right knee showed mild chondromalacia of patella.
12/12/07	Seen by Dr. Chmell. Knelt on a roof and injured his knee on 11/25/07. There was tenderness over the pes. Pain on varus stress. X-rays showed medial joint space narrowing with diffuse degeneration.
12/18/07	An MRI of the knee showed severe medial compartment chondromalacia. Probably medial meniscal tear. Quadriceps tendinosis and posterior ganglion.
12/21/07	Was to have physical therapy.
2/21/08	Op report. Had a left partial medial meniscectomy. There was Grade II to III chondromalacia.
4/02/08	Was doing well. Discharged to return as needed.
7/01/09	The patient was seen by Dr. Chmell. Had been seen before and given an exercise prescription. Was improved. Was to return as needed.
10/08/09	MRI showed a full-thickness cartilage loss, medial compartment. No new tear.
10/21/09	He started the first of three Synvisc injections.
11/16/09	Seen by Dr. Cole for a second opinion. Options were discussed.
1/11/10	Seen by Dr. Cole. Discussed a high tibial osteotomy.

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2/12/10	Seen by Dr. Roh at Rockford Memorial Hospital. Had fallen 16 feet off a roof. Landed immediately on his heels and had low back pain. Had numbness and tingling down the right leg. He had mild neck pain. Had a history of intermittent back pain but no sciatica. CT showed a burst fracture at L2 with significant displacement, 70-80 percent canal occlusion, and severe spinal stenosis. There were multiple laminar fractures at L2 and fracture at L2. Cervical CT scan showed degenerative changes, primarily C5 through C7. MRI was felt to show ligamentous disruption T12-L1 and L1-2.
2/12/10	Emergency room record indicated there was pain on passive neck motion.
2/12/10	An operative report. Underwent a T12 through L3 spinal fusion with open reduction and treatment of T12-L1 ligamentous disruption, L1 fracture, and L2 unstable burst fracture. Laminectomies also at L1 and L2.
2/12/10	Cervical CT scan showed degenerative changes, primarily at C6-7.
2/12/10	A CT scan showed a sacral coccygeal fracture.
2/16/10	Underwent an anterior fusion T12 though L3, L2 corpectomy.
2/17/10	X-rays showed postoperative changes.
2/19/10	Discharge summary indicated there was also a sacral fracture. He also had left heel pain and left lower extremity pain.
3/04/10	Uneventful postoperative visit. Coccyx fracture showed early healing.
3/04/10	Started therapy.
3/26/10	Dr. Zusman. X-rays showed a probable healing fracture, occult, of the calcaneus. Minimally symptomatic. There was minimal tenderness of the coccyx.
5/20/10	The left knee was injected by Dr. Roh.
6/17/10	Seen by Dr. Cole. Previously, there had been a decision to perform arthroscopy and possible open high tibial osteotomy, but because of his back injury, this was deferred. The knee was injected.
10/05/10	Was doing very well, Dr. Roh.
2/23/11	A cervical MRI showed multilevel cord compression, especially at C5-6 and C6-7, and with possible myelomalacia at C7-T1.

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3/01/11	He was noted to have neuropathic pain in the left lower quadrant.
3/10/11	Seen by Dr. Dahlberg at the Pain Clinic. He had right upper extremity pain felt to be due, by Dr. Roh, to neuroforaminal stenosis and was to also have a sacroiliac joint injection. Had a right sacroiliac joint injection and a cervical epidural steroid injection.
3/25/11	His buttock pain had resolved. Had a cervical epidural steroid injection.
5/12/11	Dr. Roh. Was having paresthesias and a C6 distribution. On the right side, there was severe C6 nerve root compression on MRI. Options were discussed. Wanted non-operative.
6/30/11	Dr. Dahlberg's note indicated Mr. Cascio had been evaluated by Dr. Roh for his radiculopathy, but no treatment was going to be undertaken.
7/13/11	Underwent a unicondylar arthroplasty performed by Dr. Levine.
8/29/11	Was doing very well regarding his knee.
10/12/11	Seen at the Pain Clinic. Still had low back pain and also intercostal neuritis.
12/12/11	Seen by Dr. Levine. His knee was doing very well.
1/27/12	Dr. Dahlberg. He was developing bilateral radicular pain and was to have a new MRI.
2/09/12	A lumbar MRI showed multilevel degeneration, postoperative changes, and extrusion at L5-S1.
2/10/12	Underwent an epidural steroid injection.
3/23/12	Had an epidural steroid injection.
4/12/12	Had an epidural steroid injection.
6/18/12	His knee was doing very well.
7/17/12	Epidural steroid injection.
8/01/12	Epidural steroid injection.
9/04/12	Seen in the emergency room with severe low back pain.

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9/11/12	Seen by Dr. Roh for severe right-sided low back and sacroiliac pain. Sacroiliac joint was injected.
10/03/12	It was noted that the sacroiliac joint injection had not significantly helped.
11/06/12	Epidural steroid injection.
11/09/12	There was an IME by Dr. Noren, who felt his complaints were due to the fall.
12/14/12	An op report. An L3 through L5 decompression and fusion and removal of instrumentation. The surgery was for a transition syndrome.
1/25/13	Started therapy.
12/27/13	Seen by Dr. Dahlberg. Now had bilateral hand pain, numbness, and tingling. Had severe narrowing at C5-6 on a recent MRI. Underwent an epidural steroid injection.
1/24/14	Underwent bilateral facet joint injections.
2/25/14	He was pain-free.

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FINDINGS OF FACT AND CONCLUSIONS OF LAW

The parties stipulated that an accident took place on 2/12/10. Based on the Arbitrator's review of the testimony, as well as exhibits entered on behalf of both the Petitioner and the Respondent, the Petitioner sustained an L2 burst fracture, which resulted in low back surgery by Dr. Roh at the Rockford Memorial Hospital on 2/14/10. The Arbitrator finds that the Petitioner's low back condition, including the low back surgeries, is causally related to the 2/12/10 accident. The Petitioner did not testify that he injured his left knee or right knee in the 2/12/10 accident. The medical records do not contain any information or physician opinions that the Petitioner's right knee or left knee were affected or somehow made worse after the 2/12/10 accident. The Arbitrator notes the Petitioner does have two prior left knee claims with injury dates identified as 11/25/07 and 5/01/09.

In reviewing Respondent's Exhibit No. 1, the 2/26/14 report of Dr. Kornblatt, the Arbitrator notes that on the issue of causal connection, there is a disagreement as to whether or not the Petitioner's neck condition was caused or aggravated by the 2/12/10 accident. In reviewing the Petitioner's exhibits, the Arbitrator notes that at the initial treatment at the Rockford Memorial Hospital, the Petitioner underwent a CT scan of the neck, which demonstrated cervical spondylosis that is "age appropriate," and that CT scan also showed osteophytes at the C5-6, C6-7 levels. The 2/10/10 discharge note states that, "CT scan of the cervical spine was negative for injury." (Petitioner's Exhibit No. 4.) During the initial hospitalization, the Petitioner underwent low back surgery.

In reviewing the remaining portion of the Rockford Memorial Hospital records, the Petitioner followed up for several months. During the year 2012, there is no identification of any

ongoing complaints relative to the neck or cervical spine. For example, on 9/05/12, the Petitioner was complaining of worsening low back pain with no complaints to the neck. On 9/04/12, the Petitioner went to the emergency room at Rockford Memorial Hospital and was seen by Dr. Jane Kotecki. It was noted, "Neck: Normal ROM. Cervical spine nontender." (Petitioner's Exhibit No. 4.)

The Petitioner identified his primary care physician as Dr. Susan DeGuide. These records were introduced as Petitioner's Exhibit No. 9. These records include comprehensive examinations running from 8/30/10 through 10/10/12. At least ten "comprehensive examinations" took place and were included in these records. None of these records show that the Petitioner was complaining of any neck problems or any complaints of symptoms with respect to his cervical spine.

The Respondent's evaluating physician, Dr. Kornblatt, is the only neurosurgeon who commented on the issue of medical causal connection between the Petitioner's 2/12/10 accident and his cervical spine. Dr. Kornblatt concluded that the Petitioner's cervical spine was not causally related to the 2/12/10 occurrence. Accordingly, on the issue of medical causal connection, the Arbitrator finds the Petitioner's current condition of ill-being with respect to his neck or cervical spine is not related to the 2/12/10 claim.

On the issue of permanency, the Arbitrator finds that the Petitioner is entitled to an award of 50 percent permanent partial loss of use of the person as a whole pursuant to Section 8(d)2 of the Illinois Workers' Compensation Act. This translates into 250 weeks at a PPD rate of $664.72, which totals $166,180.00.

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With respect to medical bills, the Arbitrator has reviewed the issues of causal connection and excessive treatment. The Petitioner's medical bill exhibit is marked as Petitioner's Exhibit No. 1. The Arbitrator notes that BlueCross BlueShield made payments totaling $19,722.21 for treatment of conditions that are not related to the 2/12/10 claim. Accordingly, the Arbitrator specifically finds that the BlueCross BlueShield payments of $19,722.21 are not the responsibility of the Respondent in the worker's compensation claim, and specifically finds that the Respondent is not required to reimburse BlueCross BlueShield in the amount of $19,722.21 as a result of this worker's compensation decision. The Arbitrator does find that the Respondent is responsible for the outstanding medical balances totaling $1,780.57.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Carolyn Schoonover,

Petitioner,

vs.

NO: 05 WC 51841
05 WC 51842
08 WC 15248

Porta CUSD #202,

18IWCC0202

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission per the Order of the Circuit Court of the Eighth Judicial Circuit, Menard County, the Honorable Michael L. Atterberry presiding, remanding the matter to the Commission "... for a determination as to whether Plaintiff was owed TTD benefits from March 31, 2006 through August 10, 2006." Pursuant to the Remand Order, and having considered the entire record, the Commission modifies the decision of the Arbitrator as set forth herein. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Comm'n*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

I. HISTORY OF THE CASE

A) Arbitration Decision

In a decision dated 11/5/14, the Arbitrator found Petitioner was entitled to TTD benefits from 1/13/03 through 1/20/03 (1-1/7 weeks) and from 2/3/03 through 7/18/05 (128 weeks) at a rate of $179.83/week, and from 11/10/07 through 2/1/10 (116-2/7 weeks) at a rate of $253.00/week. (Arb.Dec., p.2). In support of this finding, the Arbitrator found the following:

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On 7/7/05, Petitioner reported feeling a lump in her throat, which the Arbitrator noted was the first documented complaint along these lines following surgery in February of 2004. (Arb.Dec., p.25). Dr. MacGregor then released Petitioner to full duty work (with respect to her cervical and lumbar spine) on 7/11/05.

On 8/26/05 Petitioner presented to Dr. Aldridge with a feeling that something was stuck in her throat. She claimed this problem had been present since her surgery. She also complained of hoarseness.

Petitioner then began treating with Dr. Woodson for her throat problems on 9/9/05. She admitted to having a history of acid reflux for which she took medication. Dr. Woodson performed surgery and found laryngipharyngeal reflux and leukoplaxia. Dr. Woodson performed a second surgical procedure on 3/23/06 where he excised some vocal cord lesions.

On 5/1/06 Dr. Woodson performed another procedure that revealed left true vocal cord hyperkeratosis, left false cord papilloma, and gastroesophageal reflux disease with associated laryngopharyngeal reflux. Petitioner treated with Dr. Syed for those symptoms. She reported discomfort when swallowing solid food, and it was noted that this problem did not occur until after her cervical surgery. Dr. Syed ordered a colonoscopy which noted no significant evidence of reflux esophagitis. Dr. Syed ordered that Petitioner stop taking Nexium and Zantac when no improvement in her symptoms were noted.

On 8/10/06 Petitioner visited Dr. Aziz for her ongoing throat problems. Dr. Aziz believed that Petitioner had scarring on her vocal cord, and that her hoarseness may not improve given this scarring.

Dr. Woodson opined that her throat symptoms did not appear until after her cervical surgery in February of 2004 and could not heal because of her underlying problems. Dr. Woodson believed that the use of the intubation tube during surgery is when the whole process started, and that her acid reflux and having to speak a lot in her work environment may have aggravated her condition. As a result, Dr. Woodson was of the opinion that the treatment she provided Petitioner was at least in part related to the damage caused by the use of the intubation tube, and that the level of speech required by her job caused further damage to her injured larynx.

The Arbitrator concluded that since Petitioner reported to Dr. Syed that the medications she was taking for acid reflux were not helping her condition, the acid reflux was not causing Petitioner's [throat] problems.

The Arbitrator further noted that Dr. Fletcher offered a different opinion – namely, that there was no causal connection between Petitioner's cervical fusion and her ENT problems that required surgery on 3/23/06. Dr. Fletcher recorded that Petitioner was a smoker and had acid reflux, which along with smoking is another risk factor for the development of laryngeal problems, especially hoarseness. Dr. Fletcher indicated that while an injury to the laryngeal nerve can be a complication of cervical surgery, those patients develop hoarseness soon after

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surgery, and that Petitioner did not have documented complaints until 15 months after surgery.

The Arbitrator found it significant that even though Petitioner did not seek treatment until 15 months after surgery, she reported that the symptoms she complained of at that time had been present since the cervical fusion.

Therefore, the Arbitrator found "... the opinions of Dr. Woodson more persuasive than those of Dr. Fletcher as it relates to petitioner's current condition of ill-being related to her hoarseness and the lump in her throat. The arbitrator finds Dr. Woodson's opinions more persuasive given the fact that although petitioner admitted that she had acid reflux and smoked prior to the cervical surgery in 2004 she never had any problems with respect to a swelling feeling in her throat and hoarseness. It was not until after this surgery that petitioner testified she started having problems, albeit she did not seek treatment for them until 15 months later. The arbitrator finds Dr. Woodson's opinion that although the intubation associated with the surgery may not have been the sole cause of her ongoing symptoms, it was at least a contributing factor, more persuasive that [sic] Dr. Fletcher's opinion that there could be no causal relationship, especially in light of Dr. Syed's opinion that the Nexium and Zantac were not helping her, thus minimizing somewhat the relationship between petitioner's acid reflux and her current hoarseness and lump in her throat." (Arb.Dec., pp.25-27).

B) Commission Decision

In a Decision and Opinion on Review dated 8/18/15 (15 IWCC 0634), the Commission, in relevant part, modified the Arbitrator's decision and found that "... the causal connection of the Petitioner's cervical spine condition ended as of 7/7/05. At that time, Dr. MacGregor , who had been treating Petitioner for her lumbar and cervical conditions related to her January 31, 2003 accident (the subject of case number 05 WC 51842), indicated the Petitioner had reached maximum medical improvement and was able to return to her regular duty job. The Petitioner then continued to work, other than for a period of time in 2006 unrelated to the cervical spine, until sustaining an accident on November 7, 2007 (the subject of case number 08 WC 15248) ... Based on the July 7, 2005 full duty release of Petitioner at maximum medical improvement and a lack of ongoing cervical complaints, the Commission finds that the causal connection of the Petitioner['s] cervical condition to the January 31, 2003 accident [05 WC 51842] ended on July 7, 2005. Because there is no evidence of complaints or treatment to the cervical spine after the November 7, 2007 accident until October 14, 2011, the Commission also finds that any ongoing cervical condition is not related to the November 7, 2007 accident." (Com.Dec., p.2). The Commission went on to award 129-1/7 weeks of TTD at a rate of $179.83 per week and 116-2/7 weeks of TTD at $253.00. (Id., p.3).

C) Circuit Court Order

In an Order dated 4/19/17, Circuit Court Judge Michael L. Atterberry affirmed the Commission on all counts other than the question of temporary total disability benefits. In its order, the circuit court specifically determined that the Commission's finding that Petitioner had reached MMI as of 7/7/05 with respect to her cervical spine condition was not against the manifest

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of the evidence. Likewise, the circuit court found that the Commission's holding regarding prospective medical treatment relating to Petitioner's lumbar spine was not against the manifest weight of the evidence. In addition, the circuit court found that the Commission's denial of TTD benefits through the date of arbitration (10/15/14) was not against the manifest weight of the evidence. Similarly, the circuit court found that the Commission's denial of sanctions (i.e. penalties) was not against the manifest weight of the evidence. However, the circuit court determined that the Commission failed to address the issue of whether Petitioner was entitled to TTD from 3/31/06 through 8/10/06, and remanded the matter to the Commission for consideration of same. (Circuit Court Order, pp.1-3).

II. FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission notes that pursuant to the aforementioned circuit court Order, the sole issue on remand is whether or not Petitioner was entitled to TTD from 3/31/06 through 8/10/06, or the period that Ms. Schoonover was off work as a result of her throat condition.

As previously noted, the Arbitrator essentially found a causal relationship existed between Petitioner's throat condition and the cervical surgery in February of 2004, and by extension the accident on 1/31/03 (05 WC 51842). (Arb.Dec., pp.27-28). The Commission notes that while the Arbitrator found the first documented complaint with respect to her throat occurred on 7/7/05, the records actually show that Petitioner had complaints of a burning sensation like heartburn as early as her visit to Dr. MacGregor on 3/3/04 (PX4), or less than a month after the cervical fusion on 2/17/04. Thus, while the causal relationship between the accident and Petitioner's cervical spine condition may have ended as of 7/7/05, per the Commission's prior §19(b) decision, the causal relationship between the accident and Petitioner's subsequent throat condition did not.

The Commission affirmed the Arbitrator's decision in this respect, or at least did not reverse the Arbitrator on the question of causation as it relates to Petitioner's throat condition. Likewise, the circuit court did not find fault with the Commission's decision along these lines. Accordingly, the question of causation relative to Petitioner's throat condition is a matter of res judicata and cannot be revisited at this time.

As to her throat condition, Petitioner testified that after her cervical fusion surgery "… I just kind of felt like there was – when you go to swallow I felt like something was in there, like a lump or, you know, it was just there every time I swallowed. I'd have to clear my throat a lot." (T.32). She noted that she "… mentioned it to Dr. MacGregor a couple of times." (T.32). She indicated that Dr. MacGregor told her to see her regular doctor, Dr. Aldridge. (T.39). Dr. Aldridge in turn referred her to Dr. Woodson, who she noted thought she had "… heartburn and stuff, acid reflux" and who prescribed acid suppression medication, which she took from approximately September of 2005 to March of 2006. (T.40). Petitioner further testified that Dr. Woodson took her off work "[b]ecause she didn't want me to stress my throat", noting that sometimes at work she would have to raise her voice. (T.41). Petitioner agreed that Dr. Woodson then performed a laryngoscopy in March or May of 2006 – she couldn't recall the dates. (T.42). She noted that it still felt like she "had something there" after the procedure, and that Dr. Woodson continued to keep her off work at that time. (T.42). She agreed that she was eventually released by Dr. Woodson on 8/10/06. (T.42). Petitioner also agreed that she returned to work following this release. (T.43-

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44).

On cross examination, Petitioner claimed that when she saw Dr. McGregor from April of 2004 through February of 2005 she told the latter "... that it felt like there was something in my throat and I think I've told her that on a number of occasions but it did not get wrote [sic] down." (T.95). Petitioner also agreed that she continued to smoke during this period as well as when she started treating with Dr. Woodson. (T.95-96).

The medical records show Petitioner first visited Dr. Woodson on 9/9/05. (PX12). In her report on that date, Dr. Woodson recorded Petitioner was being seen "... for globus sensation and hoarseness in the throat. The patient reports that she had fusion of her C-spine in February, 2004, and several months after that surgery, she developed some hoarseness and a globus sensation. She feels like she has to constantly clear her throat and sometimes loses her voice or is horse. She additionally has a sore throat at times. She does rarely have dysphagia, although normally has no trouble with this." (PX12). Dr. Woodson's impression was "[s]evere laryngitis, probably reflux in origin, plus leukoplakia of the larynx." (PX12). Dr. Woodson's plan was "1. The patient would be maximized on acid suppression therapy including Nexium b.i.d. and Zantac at night in hopes of reducing some of her laryngitis. 2. RE-evaluate in two months." (PX12). There is no indication that Petitioner was restricted from work at that time. (PX12).

Petitioner returned to Dr. Woodson's office on 12/5/05. (PX12). At that time it was noted that her globus sensation and hoarseness had not gotten any better. (PX12). A flexible larygoscopy was performed in the office on that date. (PX12). The impression was "1. Laryngopharyngeal reflux. 2. Leukoplakia in the left false vocal cord." (PX12). The plan was to continue with maximum acid suppression therapy. (PX12). It was noted that the patient had been encouraged "... to stay on her therapy as we are visually seeing signs of improvement." (PX12). Once again, there is no indication Petitioner was taken off work at that time. (PX12).

In an office note dated 3/3/06, Dr. Woodson recorded that "[w]e have been following her for laryngeal discomfort ever since some surgery two years ago. We have been treating her for acid reflux. Her hoarseness has improved, but she still has a really strong foreign body sensation stemmed by coughing." (PX12). Dr. Woodson noted that Petitioner was "... examined today by flexible endoscopy... The patient was noted to have a palpable mass on the left false cord, as well as thickening and an exophytic lesion in the center of the posterior commissure, as well as diffuse edema of the vocal folds. Overall, the exam is markedly improved in terms of inflammation and erythema, but she does have these persisting masses." (PX12). Dr. Woodson's plan was "... to perform micro direct larygoscopy in the near future and remove these masses." (PX12). In a separate slip dated 3/3/06, it was noted that Petitioner was unable to work "[u]ntil one month from above date, and work clearance in clinic." (PX13). Petitioner was also restricted from work in similar notes dated 5/1/06, 6/29/06 and 8/4/06. (PX13).

In a slip dated 8/10/06, Dr. Woodson's office indicated that Petitioner could return to work as of that date. (PX13).

Based on the above, and the record taken as a whole, the Commission finds that Petitioner is entitled to temporary total disability benefits associated with her throat condition from 3/3/06, when Dr. Woodson took her off work, through 8/10/06, when Dr. Woodson released her to return

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to work, for a period of 23 weeks. This period of TTD is in addition to that previously awarded by the Commission and relates to the second claimed date of injury on 1/31/03 (05 WC 51842), and would be paid at a rate of $179.83/week.

The Commission notes that in its previous §19(b) decision, Respondent was ordered to pay 129-1/7 weeks of TTD at a rate of $179.83/week and 116-2/7 weeks at $253.00/week. (Com.Dec., p.3). However, the Commission neglected to set forth the dates associated with this award in its decision. The Commission also notes that the minimum TTD rate for a date of accident of 11/7/07, with one (married) dependent, equals $230.00 (not $253.00 as set forth in both the Arbitrator's and Commission's decisions). The Commission hereby corrects these oversights, as well as any other computational/clerical errors, and finds that Petitioner was temporarily totally disabled (1) from 1/13/03 through 1/20/03, for a period of 1-1/7 weeks at a rate $179.83/week with respect to claim 05 WC 51841 (D/A=1/10/03); (2) from 2/3/03 through 7/7/05 [126-4/7 weeks] and from 3/3/06 through 8/10/06 [23 weeks], for a total period of 149-4/7 weeks at a rate $179.83/week with respect to claim 05 WC 51842 (D/A=1/31/03); and (3) from 11/10/07 through 2/17/10, for a period of 118-5/7 weeks at a rate $230.00/week with respect to claim 08 WC 15248 (D/A=11/7/07). This award includes the additional period of TTD relating to Petitioner's throat condition, the subject of the circuit court's remand order.

All else otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $179.83/week per week for a period of 1-1/7 weeks with respect to claim 05 WC 51841, the sum of $179.83/week for a period of 149-4/7 weeks with respect to claim 05 WC 51842 and the sum of $230.00/week for a period of 118-5/7 weeks with respect to claim 08 WC 15248, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner all reasonable and necessary medical services incurred between January 10, 2003 and October 15, 2014, related to her lumbar spine, throat and smoking cessation, pursuant to §8(a) and §8.2 of the Act. The Respondent also shall pay to Petitioner all reasonable and necessary medical services incurred between January 10, 2003 and July 7, 2005, related to her cervical spine pursuant to §8(a) and §8.2 of the Act.

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

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

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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; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

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

DATED: APR 3 - 2018

o: 3/6/18
TJT/pmo
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Cady,

Petitioner,

vs.

NO: 10 WC 34549

18IWCC0203

Caterpillar,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation, TTD, maintenance and nature and extent, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission modifies the decision of the Arbitrator to find that Petitioner was temporarily totally disabled from 7/23/10, the day after the accident, through 1/26/11, the date Dr. Rhode released him to full duty work on a trial basis, and from 8/10/11, when Dr. Rhode released Petitioner with permanent "medium heavy" work restrictions which Respondent was unable or unwilling to accommodate, through 6/4/12, when Petitioner refused a reasonable job offer within his restrictions from Respondent, for a period of 69-5/7 weeks (including leap year day in 2012).

In support of this holding, the Commission notes that Respondent offered, and Petitioner attempted to return to work on 4/17/12. However, it appears that confusion was the order of the day at that time, starting with the consternation created by the fact that Petitioner was not "in the system", given his prior termination on 9/29/10 (said termination forming the basis of a successful grievance action filed by Petitioner). More importantly, Petitioner was never actually cleared to return to work by Caterpillar's medical department on 4/17/12 even though this

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appears to have been an essential step in Respondent's return to work protocol. Instead, Caterpillar's medical department, in the form of plant physician Dr. Miller and his staff, simply noted that Petitioner was to be evaluated by an orthopedist in Chicago in May of 2012 and that Mr. Cady was advised "... to return/call when he has report from Chicago Do – He voices understanding." (PX9). It wasn't until the following day, 4/18/12, that Dr. Miller issued a letter indicating that Mr. Cady could return to work within the guidelines outlined by Dr. Watson. (PX9). As a result, absent the requisite clearance, Petitioner had no job to report to, and as such his decision to leave the premises on that date was reasonable under the circumstances.

However, the Commission finds that Petitioner unreasonably refused Respondent's second offer to return him to work by failing to report for duty as requested on 6/4/12. By that time Petitioner had been released and cleared by his personal as well as the plant physician and had been advised of his need to report to work on that date via mail as well as telephone conversations with Mr. Cullen, Respondent's employee relations manager. Instead, Petitioner demanded further written verification of the job offer, and the fact that the position was within his restrictions, and when he failed to receive same he refused to appear on the designated date. The Commission finds this refusal unreasonable under the circumstances, and as such finds that Petitioner failed to prove his entitlement to temporary total disability and/or maintenance benefits subsequent to 6/4/12.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 12/12/16 is modified as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $509.58 per week for a period of 69-5/7 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 reasonable and necessary medical expenses as set forth in PX17, with the exception of the bills of Dr. Jonathan Renkas, pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $458.62 per week for 51.25 weeks, as provided in §8(e)9 of the Act, for the reason that the injuries sustained caused the loss of use of 25% of the left hand.

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; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

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

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Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $50,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 3 - 2018
o:2/6/18
TJT/pmo
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CADY, MICHAEL
Employee/Petitioner

Case# **10WC034549**

CATERPILLAR
Employer/Respondent

18IWCC0203

On 12/12/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.61% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5559 CROWLEY BUNGER & PRILL
ED PRILL
3012 DIVISION ST
BURLINGTON, IA 52601

5035 CATERPILLAR INC
DARCY K GIBSON
100 N E ADAMS ST
PEORIA, IL 61629-4340

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Michael Cady
Employee/Petitioner

v.

Caterpillar
Employer/Respondent

Case # 10 WC 34549

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 Peoria, on October 18, 2016. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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FINDINGS

On July 22, 2010, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $39,747.24; the average weekly wage was $764.37.

On the date of accident, Petitioner was 46 years of age, married with 2 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $11,734.20 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $11,734.20.

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

ORDER

Respondent shall pay reasonable and necessary medical expenses as identified in Petitioner's Exhibit 17, excepting those of Dr. Jonathan Renkas, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Respondent shall pay Petitioner temporary total disability benefits of $509.58 per week for 26 6/7 weeks commencing July 22, 2010, through January 26, 2011, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $458.62 per week for 51.25 weeks because the injury sustained caused the 25% loss of use of the left hand as provided in Section 8(e) of the Act.

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

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

William R. Gallagher, Arbitrator

December 6, 2016
Date

DEC 12 2016

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment for Respondent on July 22, 2010. According to the Application, the accident occurred when "Hand struck by falling part" and Petitioner sustained injuries to the "Left hand, middle finger, ring finger, and thumb" (Petitioner's Exhibit 1). Respondent disputed liability on the basis of causal relationship (Arbitrator's Exhibit 1).

Petitioner claimed that he was entitled to temporary total disability benefits of 26 6/7 weeks, commencing July 22, 2010, through January 26, 2011. At trial, Respondent disputed liability for temporary total disability benefits for the aforestated period of time; however, in its proposed decision, this issue was conceded (Arbitrator's Exhibit 1).

Petitioner also claimed that he was entitled to payment of maintenance benefits of 225 5/7 weeks, commencing August 10, 2011, through July 6, 2015, and October 28, 2015, through October 3, 2016. Respondent disputed liability for maintenance benefits (Arbitrator's Exhibit 1).

Petitioner's employment was terminated by Respondent in September, 2010. A union grievance was filed which was arbitrated in November, 2011. Petitioner won that arbitration and he was awarded back pay from January, 2011, through April 17, 2012, as well as reinstatement of his employment. Further, the Arbitrator in that proceeding also ordered that Petitioner be examined by another physician to assess his ability to return to work. The net dollar amount of that award to Petitioner was $70,703.17 (Respondent's Exhibit 12). Respondent's position was that payment of that award removed any potential liability for payment of temporary total disability benefits/maintenance through April 17, 2012.

At trial, Petitioner tendered into evidence various medical bills for which Respondent disputed liability (Petitioner's Exhibit 17; Arbitrator's Exhibit 1). However, counsel for Petitioner and Respondent agreed that all of the medical bills tendered by Petitioner were causally related to the accident and Respondent is liable for payment of same with the exception of the medical charges of Dr. Jonathan Renkas.

Petitioner worked for Respondent in the foundry and, on July 22, 2010, he was in the process of running parts through a machine. When he removed a part from the machine, the part struck the ring finger of his left hand.

Following the accident, Petitioner was treated by Dr. James Williams, an orthopedic surgeon. Dr. Williams saw Petitioner on July 22, 2010, and noted that Petitioner sustained a comminuted intra articular fracture of the distal phalanx of the left ring finger. Dr. Williams performed a closed reduction pinning surgical procedure on the left ring finger on July 23, 2010. Dr. Williams also put a cast on Petitioner's left hand to immobilize the finger (Petitioner's Exhibits 2 and 3).

When Dr. Williams saw Petitioner on September 23, 2010, the condition of the ring finger was improved. However, Petitioner had complaints of burning in his hand that extended up to the elbow and shoulder. Dr. Williams opined that Petitioner had carpal tunnel syndrome of the left

hand. In regard to causality, Dr. Williams opined that it was probably related to Petitioner's injury and may have developed as a result of Petitioner's hand swelling when it was in the cast. He recommended Petitioner undergo left carpal tunnel release surgery (Petitioner's Exhibit 2).

Petitioner subsequently sought treatment from Dr. Blair Rhode, an orthopedic surgeon, who evaluated Petitioner on September 29, 2010. Dr. Rhode agreed that Petitioner had left carpal tunnel syndrome and surgery was indicated. Dr. Rhode performed an open carpal tunnel release on Petitioner's left hand on October 5, 2010 (Petitioner's Exhibits 4 and 5).

At the direction of Respondent, Petitioner was examined by Dr. Thomas Gleason, an orthopedic surgeon, on December 28, 2010. In regard to his examination of that date, Dr. Gleason was deposed on May 3, 2011, and his deposition testimony was received into evidence at trial. Dr. Gleason testified that Petitioner's left carpal tunnel syndrome was related to the accident, Petitioner was at MMI and that Petitioner could return to work without restrictions (Respondent's Exhibit 3; pp 7-8, 12-13).

Petitioner continued to be treated by Dr. Rhode. When Dr. Rhode saw Petitioner on December 29, 2010, he continued to authorize Petitioner to work, but with restrictions. However, Dr. Rhode subsequently released Petitioner to return to work without restrictions and opined Petitioner was at MMI on January 26, 2011 (Petitioner's Exhibit 4).

Petitioner did not return to work for Respondent when he was released by Dr. Rhode. As aforestated, Petitioner's employment with Respondent had been terminated in September, 2010.

Petitioner did not seek any further medical treatment until he was seen by Dr. Rhode on August 10, 2011. At that time, Petitioner had left palm/wrist pain that lasted about 20 minutes. Dr. Rhode opined that work/activity restrictions of "modified-medium" were indicated as well as limited exposure to vibratory tools. He opined that these were permanent restrictions and Petitioner was at MMI (Petitioner's Exhibit 4).

Dr. Michael Watson, an orthopedic surgeon, examined Petitioner on February 22, 2012, and again on March 28, 2012. Dr. Watson examined Petitioner pursuant to the arbitration decision entered in the proceeding regarding Petitioner's termination of employment by Respondent.

In connection with his examination of Petitioner, Dr. Watson reviewed medical records regarding Petitioner's treatment. When seen by Dr. Watson, Petitioner stated that the numbness and tingling had resolved, but he continued to have pain/stiffness with electrical type shocks and burning sensations in his wrist and forearm. Dr. Watson opined that Petitioner may have had residual carpal tunnel syndrome and imposed work restrictions of no lifting greater than 75 pounds, no frequent lifting greater than 35 pounds, limited use of vibratory tools and only occasional work that involve grasping with the left hand. He also opined Petitioner was at MMI (Petitioner's Exhibit 8).

Petitioner was directed to return to work for Respondent on April 17, 2012. At trial, Petitioner testified that he arrived at work and reported to his supervisor. Petitioner then stated that he was instructed to go to the plant medical department. When he was seen there by Dr. Kent Miller

(Respondent's medical director) and a nurse, he stated that he was informed that he was not supposed to be there because he was not in the system as an employee. Petitioner stated that he was later directed to leave Respondent's premises.

George Nelson testified on behalf of Respondent when this case was tried. Nelson was Petitioner's section manager when Petitioner attempted to return to work on April 17, 2012. After meeting with Petitioner, Nelson directed him to go to the plant medical department to assess his work restrictions. When Petitioner returned from the medical department, Nelson informed him that he had work for him to do which consisted primarily of computer data entry. He stated that Petitioner experienced some difficulties logging into the computer system because, having just been reinstated, Petitioner was not in the computer system. Nelson explained that this was just a delay in getting a reinstated employee back into the computer system.

Nelson repeatedly stated that he had work for Petitioner to do on April 17, 2012, and informed Petitioner of that fact on several occasions. Petitioner advised Nelson that he was not an employee and was going to leave the premises. Nelson made a typewritten record of his conversations with Petitioner that occurred on April 17, 2012, which was received into evidence at trial. This written record was consistent with Nelson's testimony (Respondent's Exhibit 13).

Dr. Miller's medical record of April 18, 2012, was received into evidence at trial. Contrary to Petitioner's testimony, Dr. Miller's record stated that he did not see Petitioner on that occasion. The record did make specific reference to the restrictions imposed by Dr. Rhode and Dr. Watson, but that Petitioner was going to be seen by Dr. Gleason for another opinion. It was also noted that Petitioner was offered computer work, but he walked off the job (Respondent's Exhibit 1).

Brent Cullen, Respondent's HR manager also testified when this case was tried. In regard to Petitioner's returning to work on April 17, 2012, he confirmed that computer work had been made available to Petitioner, but that Petitioner refused same and left the plant. He also stated that following the events of April 17, 2012, Petitioner filed another grievance.

At the direction of Respondent, Petitioner was examined by Dr. Gleason for the second time on May 1, 2012. In connection with his re-examination of Petitioner, Dr. Gleason reviewed additional medical records provided to him by Respondent. Dr. Gleason's findings on examination were consistent with the findings of his prior examination of Petitioner. He again opined that Petitioner was at MMI and could return to work without restrictions (Respondent's Exhibit 4; Deposition Exhibit 2).

Pursuant to an order from Dr. Miller, a Functional Capacity Evaluation (FCE) was performed on May 30, 2012. Sean McGinn, the physical therapist who performed the FCE, noted that Petitioner demonstrated less than a full effort during the testing and that there were inconsistencies with various portions of the test. He opined that Petitioner could not perform the job he was previously employed in, but that was based on Petitioner's performance with self limitations (Respondent's Exhibit 2).

When Cullen testified, he stated that another effort was made by Respondent to return Petitioner to work for Respondent in June, 2012. Cullen sent a letter to Petitioner dated June 1, 2012, which

directed Petitioner to return to work on June 4, 2012 (Petitioner's Exhibit 14). Cullen testified that he also called Petitioner on June 1, 2012, and verbally informed him that Petitioner was to return to work on June 4, 2012. Cullen stated that when he spoke to Petitioner on June 1, 2012, Petitioner informed him that he needed the job offer in writing (Respondent's Exhibit 13).

Cullen stated that he subsequently spoke to Petitioner via telephone on June 4, 2012, and Petitioner informed him that he was not going to come to work that day. Petitioner acknowledged receipt of Cullen's letter of June 1, 2012, but stated that he had permanent work restrictions. Cullen made a written record of his conversation with Petitioner of that date (Respondent's Exhibit 13). Cullen subsequently sent another letter to Petitioner dated June 5, 2012, which informed Petitioner that because he did not report to work on June 4, 2012, that his employment was terminated (Petitioner's Exhibit 15).

At trial, Petitioner repeatedly testified that before he would return to work for Respondent he needed the job offer in writing. He also stated that Respondent had lied to him on April 17, 2012, but did not provide any details or specifics.

Subsequent to June 4, 2012, Petitioner tendered a demand to Respondent for vocational rehabilitation and also did a self-directed job search. The logs of the job search were received into evidence at trial (Petitioner's Exhibit 10). In July, 2015, Petitioner became employed at a Holiday Inn as a maintenance person, but that job only lasted a few months. Petitioner later became employed by Carvey Painting and was employed by them at the time of trial. Carvey Painting has accommodated Petitioner's work restrictions.

At trial, Petitioner complained of persistent swelling and a knot in the palm of his left hand. Petitioner also stated that he has cramps, a lack of strength, throbbing at night and "lightning" strike sensations. He stated that the restrictions imposed by Dr. Rhode had never been removed.

Dr. Rhode was deposed on July 11, 2012, and his deposition testimony was received into evidence at trial. Dr. Rhode's testimony was consistent with his medical records and he reaffirmed the opinions contained therein including the permanent restrictions he imposed. On cross-examination, Dr. Rhode agreed that he did not perform any range of motion or strength tests and that the restrictions he imposed on Petitioner were because of Petitioner's ongoing symptoms (Petitioner's Exhibit 11; pp 16-17, 27-32).

Dr. Gleason was deposed for the second time on August 28, 2012, and his deposition testimony was received into evidence at trial. Dr. Gleason's testimony was consistent with his narrative medical report and he reaffirmed the opinions contained therein (Respondent's Exhibit 4).

Sean McGinn was deposed on September 4, 2012, and his deposition testimony was received into evidence at trial. McGinn's deposition testimony was consistent with his report and he reaffirmed the opinions contained therein. McGinn reaffirmed the fact that Petitioner exhibited self-limiting behaviors and inconsistencies during the testing (Respondent's Exhibit 6; pp 33-35).

Dr. Watson was deposed on November 13, 2012, and his deposition testimony was received into evidence at trial. Dr. Watson's deposition testimony was consistent with his medical records and he reaffirmed the opinions contained therein including the work restrictions he imposed (Petitioner's Exhibit 12; pp 23).

Dr. Miller was deposed on July 12, 2013, and his deposition testimony was received into evidence at trial. Dr. Miller's testimony was consistent with his medical records and he reaffirmed the opinions contained therein. He confirmed that he recommended an FCE be performed to assess Petitioner's functionality. Based upon the FCE and the opinion of Dr. Gleason, he stated that Petitioner could return to work without restrictions (Respondent's Exhibit 10; pp 18-26).

Conclusions of Law

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

The Arbitrator concludes that Petitioner's current condition of ill-being is causally related to the accident of July 22, 2010.

In support of this conclusion the Arbitrator notes the following:

Petitioner sustained an accidental injury arising out of and in the course of his employment for Respondent on July 22, 2010, when a part fell striking the ring finger of his left hand. Petitioner subsequently developed carpal tunnel syndrome as a result of that injury.

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

The Arbitrator concludes that all of the medical services provided to Petitioner were reasonable and necessary and Respondent is liable for payment of the medical bills incurred therein, excepting the charges of Dr. Jonathan Renkas.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 17, excepting those of Dr. Jonathan Renkas, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

In support of this conclusion the Arbitrator notes the following:

At trial, Petitioner and Respondent stipulated to Respondent's liability for the medical bills excepting those of Dr. Renkas.

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

The Arbitrator concludes Petitioner is entitled to payment of temporary total disability benefits of 26 6/7 weeks, commencing July 22, 2010, through January 26, 2011.

The Arbitrator concludes that Petitioner is not entitled to any further payment of either temporary total disability benefits or maintenance.

In support of these conclusions the Arbitrator notes the following:

Petitioner was injured on July 22, 2010, and was released return to work by the treating physician, Dr. Rhode, on January 26, 2011.

Respondent attempted to provide work to Petitioner initially on April 17, 2012. At that time, there were some logistical problems encountered primarily because Petitioner had just been reinstated as an employee. Rather than cooperate with the effort to return him to work, Petitioner chose to leave the plant.

In Respondent's second effort to provide work to Petitioner in June, 2012, Petitioner totally refused to make any effort at all to return to work.

In the arbitration decision pertaining to Petitioner's termination of employment, Petitioner was awarded full salary to April 17, 2012. It was undisputed that Respondent made payment in full of that award. Because Petitioner received full salary, no temporary total disability benefits or maintenance are owed from January 27, 2011, through April 17, 2012.

The Arbitrator finds that Petitioner, in effect, abandoned his job with Respondent and is therefore not entitled to any further payment of either temporary total disability benefits or maintenance.

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

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of 25% loss of use of the left hand.

In support of this conclusion the Arbitrator notes the following:

Petitioner sustained a fracture of the left ring finger which required closed reduction and pinning. Petitioner subsequently developed carpal tunnel syndrome which also required surgery.

Petitioner still has significant complaints regarding the left hand and Dr. Rhode and Dr. Watson agreed that he has restrictions in regard to the use of his left hand.

The validity of the work restrictions imposed by Dr. Rhode and Dr. Watson are questionable given the opinions of Dr. Gleason and Dr. Miller, Petitioner can return to work without restrictions. Further, the FCE indicated that Petitioner exhibited self-limiting behavior and inconsistencies when tested.

William R. Gallagher

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Olando Watkins,
Petitioner,

vs. NO: 07 WC 47006

M&M Mars,
Respondent.

18IWCC0204

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 6, 2017, is hereby affirmed and adopted.

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

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

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

DATED: APR 4 - 2018
o032218
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION CC MMISSION
NOTICE OF ARBITRATOR DECISION

WATKINS, OLANDO
Employee/Petitioner

Case# **07WC047006**

M&M MARS
Employer/Respondent

18IWCC0204

On 7/6/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1920 BRISKMAN BRISKMAN & GREENBERG
ROBERT I BRISKMAN
351 W HUBBARD ST SUITE 810
CHICAGO, IL 60654

1109 GAROFALO SCHREIBER HART ETAL
JAMES R CLUNE
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

OLANDO WATKINS
Employee/Petitioner

v.

M&M MARS
Employer/Respondent

Case # 07 WC 47006

Consolidated cases: D/N/A

18IWCC0204

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **February 22, 2017, February 23, 2017 and May 19, 2017.**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ 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 **Admissibility of certain testimony of Dr. Conroe, one of Respondent's examiners**

FINDINGS

On **5/6/04**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

For the reasons set forth in the attached decision, the Arbitrator finds that Petitioner established causation as to cervical spine and psychological conditions of ill-being. Petitioner reached maximum medical improvement as to his cervical spine condition on May 24, 2010 and as to his psychological condition on July 23, 2013. Petitioner did not establish causation as to any left hand, fibromyalgia or foot condition(s).

In the year preceding the injury, Petitioner earned **$60,684.00** ; the average weekly wage was **$1,167.00**.

On the date of accident, Petitioner was **42** years of age, ***single*** with **2** dependent children.

Petitioner ***has in part*** received 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 **$243,908.88** for TTD, **$0** for TPD, **$0** for maintenance, and **$5,048.98** for other benefits, for a total credit of $248,957.86.

The parties agree Respondent is entitled to Section 8(j) credit for medical bills paid through its group medical plan, with Respondent holding Petitioner harmless against said payments. Arb Exh 1.

ORDER

Medical benefits

For the reasons set forth in the attached decision, the Arbitrator declines to award the following claimed medical expenses: 1) Dr. Vondrak's bill in the amount of $100.00, which includes a $50.00 fee for a report and an unspecified $50.00 balance (PX 36); 2) Hinsdale Orthopaedics, $373.36 (left hand treatment rendered by Dr. Schiffman in 2009 and 2010) (PX 36); 3) Hillcroft Medical Clinic, visits in 2014 and 2015 for general health examinations, blood work, colorectal screenings and a colonoscopy (PX 21, 36). The Arbitrator finds Respondent liable for Dr. Bauer's records review bill of $500.00. PX 36. Dr. Bauer was one of Respondent's Section 12 examiners.

With respect to Petitioner's causally related cervical spine condition, the Arbitrator awards any medical expenses incurred for treatment of that condition through Dr. Bauer's examination of May 24, 2010, subject to the fee schedule. With respect to Petitioner's causally related psychological condition, the Arbitrator awards any medical expenses incurred for treatment of that condition through Petitioner's July 23, 2013 visit to Dr. Trum, including but not limited to the expenses associated with the treatment Petitioner underwent at Linden Oaks in 2010 at the recommendation of Respondent's examiner, Dr. Conroe.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $778.00/week for 284 2/7 weeks, commencing 2/10/2008 through July 23, 2013, as provided in Section 8(b) of the Act, with Respondent receiving credit for the $243,908.88 in temporary total disability benefits it paid prior to trial.

18IWCC0204

Permanent Partial Disability

The Arbitrator finds that Petitioner is permanently partially disabled to the extent of 30% loss of use of the person as a whole, equivalent to 150 weeks of benefits, pursuant to Section 8(d)2. The Arbitrator awards permanency at the maximum applicable rate of $550.47 per week.

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

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

Molly C Mason

Signature of Arbitrator

7/6/17
Date

JUL 6 - 2017

Olando Watkins v. M & M Mars
07 WC 47006

18IWCC0204

Summary of Disputed Issues

The parties agree Petitioner sustained an accident on May 6, 2004, while working for Respondent. The disputed issues include causal connection, medical expenses (with Respondent claiming Petitioner has not required care since May 24, 2010, the date of Dr. Bauer's Section 12 examination), temporary total disability (with Petitioner claiming benefits from February 10, 2008 through the hearing) and nature and extent. Petitioner claims he is permanently and totally disabled while Respondent maintains Petitioner failed to prove causation as to any current condition of ill-being. The parties agree that, as of the hearing, Respondent had paid $243,908.88 in temporary total disability benefits and $5,048.98 in short- and long-term disability benefits for which it was entitled to 8(j) credit. Arb Exh 1.

Arbitrator's Findings of Fact

At the hearing of February 22, 2017, Petitioner testified he was born on October 31, 1961. T. 2/22/17 at 10.

Petitioner testified he began experiencing trembling of his right hand and right foot and leg at some point after his May 6, 2004 work accident. T. 2/22/17 at 11.

Petitioner testified he has been married to Bridget Watkins for about eleven years. He was previously married to Angela Watkins, with whom he had two sons. He and Angela were divorced before the accident. He was single as of the accident. T. 2/22/17 at 12-13.

Petitioner testified he grew up in Chicago. His father was a pastor. He and his family were active in their church and community. He was seven or eight when he began working. His first job was to clean the church. Later he began performing odd jobs for neighbors. He graduated from high school and can read and write. T. 2/22/17 at 22. Before he began working for Respondent, on November 13, 1989, he worked for Safety Cleaning. T. 2/22/17 at 14.

Petitioner testified he actively engaged with his sons before the May 6, 2004 work accident. He taught them how to play basketball and attended their games. T. 2/22/17 at 15.

Petitioner testified he worked as a material handler for Respondent. His duties included operating a forklift, handling incoming products and mixing ingredients. T. 2/22/17 at 16. By the time of the accident, only he and Mark Strong worked in the "cream room" and "master batch." T. 2/22/17 at 17. He liked his job and got along with his co-workers. T. 2/22/17 at 18.

Petitioner testified he weighed 180 or 185 pounds as of the accident. He lost about 40 pounds after the accident. He now weighs "170 something." T. 2/22/17 at 20. He has worn

prescription glasses for 20 years. Since the accident, he has worn tinted glasses a lot. T. 2/22/17 at 21-22.

Petitioner testified he sustained several work-related injuries prior to his May 6, 2004 accident. Several of these injuries involved his left knee. He underwent an anterior cruciate ligament repair in April 2003. He was off work for a couple of months following this surgery but lost no time after his other injuries. No light duty was available in the department where he worked. T. 2/22/17 at 26-27.

Petitioner denied having any other medical problems prior to the May 6, 2004 accident. He does not believe he took any prescription medication before that accident. T. 2/22/17 at 30. [RX 10, a Walgreen's print-out, lists medications prescribed for Petitioner by various physicians before and after the accident. The print-out reflects that Dr. Mian, a physician located in Berwyn, prescribed Wellbutrin 150 mg tablets for Petitioner on July 29, 1999. [Petitioner did not provide the Arbitrator with Dr. Mian's records. The records were marked as PX 30 but Petitioner's attorney withdrew that exhibit.]

Petitioner testified he was injured on May 6, 2004, while returning to his work area after helping Mark Strong move rail cars. He went through an opening, took a step or two and slipped on the floor, which was wet. The floor had not been wet when he left his area. When he slipped, his neck "snapped back" and he tried to grab a railing that extended up to a crane tank. He "twisted" and "rode down." His body "sort of hit" the floor. T. 2/22/17 at 33-34.

Petitioner testified he felt excruciating pain in his head, neck and back after the accident. Strong came to his aid and then sent out an alert. After the manager and safety team arrived, Petitioner told them what had happened and complained of pain. They took him to the nurse's station but the nurse was not there. His manager called someone and then told him to see the nurse the following day. T. 2/22/17 at 36.

Petitioner offered into evidence a group of documents obtained from Respondent. Some of these documents appear to be in-house medical records. A "patient assessment form" apparently completed by Barbara Smith on May 6, 2004 reflects that Petitioner complained of 7-9 back pain secondary to a work accident that had occurred earlier that day. The accident is described as follows: "going to take levels on crème tank – water was on floor. Slipped, grabbed railing, twisted back."

Petitioner testified he remained in the nurse's station until his shift ended. He then drove home. The drive took 15 to 20 minutes. By the time he got home, he was feeling a lot of pain in his head, neck and lower back. T. 2/22/17 at 37.

Petitioner testified he went to work the next day, reported to the nurse and complained of 7-8/10 pain that was preventing him from sleeping.

A "workers' compensation medical record" dated May 7, 2004 (PX 2) reflects Petitioner reported twisting his upper back the previous day. The provider, who is not identified, noted a complaint of pain in the right upper back and neck. On examination, the provider noted slight tenderness in the right trapezius area. The provider prescribed physical therapy.

Attendance records in PX 2 reflect that, between the week of May 9, 2004 and the week of April 17, 2005, Petitioner frequently worked at least 40 hours per week, often worked overtime and sometimes worked double time. The records also reflect Petitioner took almost no sick time until the week of April 17, 2005. During that week, he worked 8 hours and took 32 hours of sick time.

Petitioner testified that, on May 13, 2004, he started seeing Dr. Mayor at his workplace. He testified the doctor allowed him to continue full duty.

A note dated May 13, 2004 reflects Petitioner was still complaining of mild posterior right neck pain. The note also states "regular work." PX 2. A subsequent note dated May 26, 2004 describes Petitioner as "training with fitness trainer – jumping rope and working with hand weights." PX 2. A note dated June 10, 2004 reflects that Petitioner described his back as "perfect" and his neck as "tender." A provider, whose signature is not legible, prescribed Ibuprofen and instructed Petitioner to not work out. The provider released Petitioner to regular work. PX 2. A note dated August 10, 2004 reflects that Petitioner reported seeing his own doctor (who is not identified), with that doctor prescribing an MRI. The provider then communicated with Gene Roy at CNA, who purportedly stated "no MRI at present." A note dated August 24, 2004 reflects Petitioner complained of "occasional R neck pain – approximately 4x/day" and had attended one therapy session. A note dated September 4, 2004 states "PT not helping." The provider prescribed Vioxx. Subsequent notes reflect that Petitioner continued attending therapy and complaining of neck pain.

Petitioner testified he continued performing his regular job after the May 6, 2004 accident but did not feel his job performance was as good. He obtained help from his co-workers because he did not feel well. T. 70. He began attending therapy, through Respondent. He testified his care was inconsistent since it depended on the doctors' schedules. The therapy did not help. T. 2/22/17 at 41. Over time, his back started feeling better but his shoulder and neck pain increased. T. 2/22/17 at 41.

On October 22, 2004, Dr. Mayor wrote a prescription for a cervical spine MRI to "r/o disc disease." PX 2. Petitioner underwent this MRI on November 8, 2004. The interpreting radiologist described the MRI as normal. He saw no disc bulge or herniation and no demonstrable stenosis at any level. PX 2, 4.

Petitioner testified that Dr. Mayor eventually referred him to a pain clinic. This testimony is borne out by a handwritten "workers' compensation medical record" in PX 2 dated January 21, 2005. The note reflects a persistent complaint of right neck pain and tenderness in the right suboccipital area. It goes on to state: "refer to pain clinic – take MRI." PX 2.

On February 18, 2005, Petitioner saw Dr. Goodman at Pain Specialists of Greater Chicago. The doctor's note of that date reflects that Petitioner primarily complained of right-sided suboccipital pain secondary to slipping on water at work in May 2004. The doctor indicated that Petitioner "felt his head snap back but there was no actual fall." He noted that Petitioner denied upper extremity complaints and that there were "no symptoms of migraine headache." He indicated that Petitioner denied any previous neck or psychiatric problems.

Dr. Goodman described Petitioner as "alert, oriented and in mild distress." On examination, he noted a full range of cervical spine motion with Petitioner complaining of discomfort in the suboccipital region on rotation to the right. He reviewed the MRI report and indicated the images were not available. He indicated that Petitioner appeared to be suffering from cervical facet arthropathy at C1-C2, "consistent with his mechanism of injury of his head snapping back." He prescribed Ultracet, Bextra and nightly icing, along with diagnostic intra-articular facet injections C1-C2. He did not address work capacity. PX 2.

Dr. Goodman administered cervical facet injections on April 18 and May 16, 2005. He released Petitioner to resume regular duty within days of each injection. PX 2. Petitioner testified these injections did not relieve his pain. T. 2/22/17 at 44.

On July 15, 2005, Dr. Goodman noted that Petitioner reported no sustained benefit following a third cervical facet injection. He also noted that Petitioner continued to complain of severe headache pain and some dizziness with neck extension. He indicated that Darvocet had become "decreasingly effective at night for controlling" Petitioner's symptoms. He recommended radio frequency lesioning of the C2 dorsal root ganglion and started Petitioner on Vicodin "to help with pain and sleep." PX 2.

On November 11, 2005, Dr. Goodman administered an initial trigger point injection. He continued the Vicodin. PX 2.

On January 12, 2006, Dr. Mayor authored a note indicating Petitioner reported mild daily improvement but was still having trouble sleeping. The doctor recommended that Petitioner follow up with Dr. Goodman. He also suggested consideration of "another medical approach" and directed Petitioner to see Dr. Kazan. PX 2.

On January 30, 2006, Petitioner saw Dr. Kazan, a neurosurgeon. Dr. Kazan wrote to Dr. Mayor the same day. In his letter, he indicated Petitioner complained of "neck pain in the right occipital nerve distribution and some limitation of right lateral bending and suboccipital headaches" secondary to slipping at work and hyper-extending his neck. He did not view Petitioner as a surgical candidate. Instead, he suggested Petitioner see a neurologist. He specifically recommended Dr. Frank or Dr. Bijari. PX 2. There is no evidence indicating Petitioner saw either of these physicians.

Petitioner did see another neurologist, Dr. Neri, on April 28, 2006. Petitioner testified that Dr. Mayor and Respondent's nurse set up all his doctor appointments. T. 2/22/17. He remains under Dr. Neri's care. He sees Dr. Neri when he returns to Chicago. He last saw the doctor the day before the hearing. T. 2/22/17 at 46-47.

Petitioner testified that, on April 28, 2006, he gave Dr. Neri a history of the work accident and subsequent care. He complained to the doctor of neck and shoulder pain, migraines, nausea, dizziness, vomiting and sleep problems. T. 2/22/17 at 47-48. The doctor began treating him, prescribing different medications.

On May 31, 2006, Dr. Neri noted that Petitioner was "considerably drowsy" due to "taking more than the allotted Fioricet." He restarted Petitioner on Lexapro and recommended he start physical therapy in two weeks "to reduce the significant cervical strain." He indicated that Petitioner's mental status remained unstable and unchanged since the initial visit. PX 4.

On April 2, 2007, Dr. Neri noted that Petitioner had undergone surgery to correct a deviated septum and had discontinued the Diazepam. He started Petitioner on Cymbalta. PX 7.

On May 22, 2007, Dr. Neri noted that Petitioner had recently developed hypertension. He reduced the Diazepam dosage due to sleepiness. He discontinued the Cymbalta and continued the Vicodin. He noted Petitioner was still working full-time. PX 7.

On July 16, 2007, Dr. Neri noted a recent 20-pound weight loss "of unknown etiology." He also noted that Petitioner had seen his primary care physician. He started Petitioner on Cymbalta and indicated he was continuing to work full-time "despite his maladies." PX 7.

On July 17, 2007, Petitioner underwent another cervical spine MRI.

On October 3, 2007, Dr. Neri took Petitioner off work for one month due to "post-traumatic migraines" and upper trapezius spasms. He increased Petitioner's Topamax and Diazepam dosages. PX 7.

According to RX 11, Petitioner began receiving sick benefits from Respondent on October 3, 2007. T. 49-50.

On November 7, 2007, Dr. Neri decreased Petitioner's Topamax and prescribed Vicodin, to be taken occasionally. He took Petitioner off work for two more weeks. PX 7.

On November 20, 2007, Dr. Neri noted that Petitioner remained symptomatic and that the insurance carrier had denied payment for Verapamil because it viewed this drug as being used to address hypertension. He directed Petitioner to remain off work for six more weeks and gave him Lexapro samples. PX 7.

On behalf of Respondent, Dr. Schaffer, a board certified neurosurgeon (Schaffer Dep Exh 1), examined Petitioner on December 10, 2007. PX 11 at 4-6. In his report of December 14, 2007, the doctor recorded a history of the work accident and subsequent care. He indicated Petitioner's initial back pain had largely resolved but that Petitioner was still experiencing neck and right arm pain radiating to the scapular wing. He diagnosed cervical spondylosis and radiculitis, citing the imaging studies, and occipital headaches. He found the headaches to be "likely stemming" from the cervical spine based on their location. He indicated a CT cervical myelogram would be a treatment consideration. He addressed causation as follows:

> "Due to the time lag, it is difficult to attribute the relationship to the patient's injury although one cannot rule out the possibility of some aggravation of pre-existing degenerative changes in the neck."

He recommended Petitioner limit his lifting to 30 to 40 pounds "at this time." He did not view Petitioner's condition as permanent, indicating it "should resolve over time." Schaffer Dep Exh 2.

On January 9, 2008, Dr. Neri noted complaints of lightheadedness and nausea, often associated with driving. He indicated that Petitioner's chances of returning to work were "dimming" due to the insurance carrier's denial of Verapamil. He described this drug as widely used for migraines. He indicated that Petitioner's sleep problems and need to nap during the day would make it difficult for him to work. He directed Petitioner to avoid driving, remain off work and return in six weeks. PX 7.

On January 16, 2008, a nurse associated with Respondent wrote to Petitioner indicating that his absence from October 3, 2007 to December 11, 2007 was FMLA qualified and that, as of December 11, 2007, he had exhausted his FMLA entitlement for the rolling calendar year. The nurse advised Petitioner his sick pay benefits "will be exhausted on 4/2/08" and recommended he apply for long term disability benefits. RX 11.

Dr. Schaffer issued a one-paragraph addendum on January 29, 2008, without re-examining Petitioner. He indicated that, after reviewing additional [unidentified] records, he viewed Petitioner's current injuries as, "in great part . . . a direct aggravation of his pre-existing cervical spondylosis and degenerative changes by the incident." He did not re-visit the issues of work capacity or treatment options. Schaffer Dep Exh 2.

On February 7, 2008, Dr. Neri issued a letter addressed "to whom it may concern" indicating that Petitioner had been directed to return to work as of February 11, 2008 but that he had "great concerns" about this, due to Petitioner's ongoing cognitive difficulties and migraines. PX 13.

It is not clear to the Arbitrator whether Petitioner attempted to return to work on or about February 11, 2008. Petitioner did not testify to this.

On February 19, 2008, a member of Dr. Neri's staff sent a facsimile to an adjuster at CIGNA, indicating that the doctor does not perform functional capacity evaluations and that Petitioner would have to go to a physical therapist to have such an evaluation performed. PX 7. There is no evidence indicating Petitioner underwent this evaluation.

On February 20, 2008, Dr. Neri noted that Petitioner was experiencing "marked stress" as well as increased headaches "secondary to no work." He directed Petitioner to return in six weeks. PX 13.

On February 26, 2008, Dr. Neri issued another letter addressed "to whom it may concern," responding to a request for "more specific information concerning [Petitioner's] abilities or disabilities in the absence of the functional capacity test." The doctor indicated it would be dangerous for Petitioner to drive or operate heavy machinery due to his "frequent debilitating post-traumatic migraines secondary to his work-related injury." The doctor also indicated that "a big part of [Petitioner's] disabilities are cognitive." PX 13.

On April 3, 2008, Dr. Neri noted complaints of increased neck pain and pain in the right axilla/chest area. He provided Petitioner with Cymbalta samples. PX 13.

On April 25, 2008, Dr. Neri completed a form indicating Petitioner "cannot function in a competitive environment," citing severe neck pain and constant headaches. PX 2.

On April 29, 2008, Petitioner began seeing a therapist, Roberta Vondrak, LCPC, CADC, at Heritage Counseling Center. Petitioner testified that Dr. Neri referred him to Vondrak. T. 57. At the initial visit, Vondrak interviewed Petitioner and his wife. She recorded a history of the work accident and noted complaints of chronic pain, depression, difficulty sleeping, memory problems, occasional auditory hallucinations and dizziness. Vondrak described Petitioner as wearing dark glasses, struggling to speak and exhibiting a right hand tremor. She indicated Petitioner appeared oriented but was "repetitive in his responses." She developed a treatment plan to help Petitioner "try to accept his disability and cope with his chronic pain." She began seeing Petitioner on a regular basis.

On May 15, 2008, Dr. Neri noted that Petitioner was wearing a splint on his left hand/wrist secondary to "? CTS." PX 13.

On June 10, 2008, Vondrak referred Petitioner to a psychiatrist, Dr. Trum.

Dr. Schaffer testified by way of evidence deposition on July 7, 2008. He indicated it was difficult to ascertain whether Petitioner would continue to require a 30- to 40-pound lifting restriction, as he had recommended in his initial report, "due to the long lag between" the work accident and his examination. PX 11 at 9. He opined that the accident aggravated underlying degenerative cervical spine changes. PX 11 at 9. He testified that, as of his December 2007 examination, he felt Petitioner was at maximum medical improvement "but should be followed

subsequently for any signs of possible improvement over time." PX 11 at 10. He viewed Petitioner's symptoms as accident-related, based on their severity, rather than developing spontaneously. PX 11 at 11-12.

Under cross-examination, Dr. Schaffer did not recall reviewing any job description or video. PX 11 at 13-14. He agreed it would not be unusual for trauma to aggravate cervical spondylosis, a degenerative arthritic condition. PX 11 at 15. He viewed Petitioner's headaches as "coming from the neck" because of their anatomic position, i.e., posterior occipital. He explained that the scalp behind the ears is "innervated by nerves that come from the neck." PX 11 at 16. He did not believe Petitioner required surgery but did view a CT myelogram as reasonable, to check for any surgical lesion. PX 11 at 18-19. He arrived at a 30- to 40-pound lifting restriction based on his 30 years of experience. PX 11 at 19. He found it "difficult to see somebody in 2007 for an accident that happened three years earlier and draw definitive conclusions." PX 11 at 20. He did not really "release" Petitioner to restricted duty because he is not Petitioner's treating physician. He "just gave an independent medical opinion." PX 11 at 21. He has not seen Petitioner since the examination. PX 11 at 23. He "probably" reviewed Dr. Neri's records but his notes do not reflect this. PX 11 at 23-24. He typically relies on other doctors' records "only to a minimal degree." PX 11 at 24. Instead, he tries to get as much information as possible from the patient. PX 11 at 24-25.

Petitioner first saw Dr. Trum on July 29, 2008. The doctor described Petitioner as "unable to work" secondary to a work injury of May 6, 2004 for which he was taking Vicodin, Cymbalta, Valium and Ambien. She also noted that Petitioner reported sometimes hearing voices when he was in a lot of pain. She prescribed Risperdal "for auditory hallucinations and to augment the anti-depressant response of the Cymbalta." PX 15.

On August 11, 2008, Respondent advanced $2,752.35, representing 1% loss of use of the person. PX 2.

On September 4, 2008, Petitioner began seeing Dr. Schiffman, an orthopedic surgeon, for left hand and wrist complaints. Petitioner completed a form indicating his left hand symptoms started on May 15, 2008. Dr. Schiffman's note contains no mention of the 2004 work accident. The doctor obtained left hand X-rays, which were negative. He recommended an EMG to check for carpal tunnel syndrome. PX 12.

At Respondent's request, Dr. Conroe, a board certified psychiatrist, saw Petitioner for purposes of an independent examination on December 10, 2008. T. 59-60. Petitioner testified that, in response to a question posed by the doctor, he denied any prior history of mental disorders. T. 62-63.

In his report of December 20, 2008, Dr. Conroe indicated he reviewed records from Dr. Neri and Trum in connection with his examination. He described Petitioner as "somewhat disheveled," slow-moving and sometimes tearful during the examination. He also noted a "steady tremor" in Petitioner's right leg.

Dr. Conroe recorded a history of the work accident and subsequent care. He noted that a doctor took Petitioner off work in October 2007 and that Petitioner denied working after that date. He noted that Petitioner complained of severe, disabling headaches and denied having headaches before the accident. He indicated that Petitioner reported feeling unable to go to church or participate in his sons' sporting events as he did before the accident. He noted that Petitioner reported having significant difficulty sleeping and complained of libido problems, a 20-pound weight loss, decreased concentration, suicidal ideation, occasional panic attacks and sometimes hearing voices telling him to come to the window. He noted that Petitioner reported feeling as if his "wife's family is trying to harm him."

Dr. Conroe noted that Petitioner reported seeing a psychotherapist and a psychiatrist. He also noted that Petitioner was currently taking Diazepam, Cymbalta, Vicodin as needed, Ambien for sleep, Risperdal (an anti-psychotic) and Lotrel for hypertension.

Dr. Conroe noted that Petitioner reported receiving Social Security disability benefits for the past two months due to the effects of the work accident.

Dr. Conroe noted that Petitioner denied performing any household tasks and reported having given up a position at his church.

Dr. Conroe described Petitioner's immediate retention as poor, his recent memory as good, his remote memory as intact and his concentration as "moderately impaired."

On February 11, 2009, Dr. Neri completed a Physician's Statement of Disability indicating he started treating Petitioner on April 27, 2006 and took him off work as of October 3, 2007. On this form, the doctor described Petitioner as suffering from cervical strain, headaches, depression and anxiety. He found Petitioner physically capable of sedentary work but indicated he had been fired. PX 2.

On April 17, 2009, Dr. Schiffman injected Petitioner's left carpal tunnel and directed Petitioner to call him in one week. On May 5, 2009, Petitioner called the doctor and reported no relief. The doctor recommended that Petitioner return to Dr. Neri. PX 12.

On October 20, 2009, Dr. Trum described Petitioner as experiencing problems with sleep, anxiety, lack of energy and memory deficits. She increased Petitioner's Cymbalta dosage. PX 15.

On November 14, 2009, Dr. Conroe issued an addendum, after reviewing additional records from the Heritage Counseling Center and Dr. Trum. He noted that, despite his prior recommendation, Petitioner's medication regimen had not changed. He described Petitioner's visits to Dr. Trum as "too infrequent to adequately monitor the medication regimen of someone who is still significantly symptomatic." He indicated that Petitioner "cannot follow through with the therapist's behavioral recommendations until better control of his psychiatric

symptoms is established with medications." He indicated he would address other questions posed in a letter dated September 21, 2009 after re-interviewing Petitioner. Conroe Dep Exh 3.

At Respondent's request, Dr. Bauer conducted a Section 12 examination of Petitioner on May 24, 2010. Dr. Bauer is a board certified neurosurgeon. Bauer Dep Exhibit 1.

In his report of June 4, 2010, Dr. Bauer indicated that Petitioner's sister was present in the examination room throughout the encounter.

Dr. Bauer indicated that Petitioner reported being unemployed and spending "much of the day resting." He described Petitioner as last working in October 2007 and weighing about 145 pounds. He noted that Petitioner was wearing a brace on his left hand and complained of left hand numbness, especially at night.

Dr. Bauer indicated he reviewed various documents, including pre-accident injury-related records and post-accident records from Drs. Goodman, Kazan, Neri, Zelby, Shaffer, Schiffman, Vondrak and "possibly Dr. Trum", in connection with his examination. He noted that Petitioner's current medications included Risperidone, Benztropine, Diazepam, Cymbalta, Ambien and Butalbital with Codeine. He noted that Petitioner reported weight loss, memory, speech and sleep difficulties, delusions, depression, anxiety, panic disorder and shaking of his right leg and right arm. He indicated Petitioner reported taking Vicodin for his migraines, although Vicodin was not on his list of current medications. He stated that Petitioner denied having headaches or neck pain prior to the accident.

Dr. Bauer indicated that during the hour he spent with Petitioner, Petitioner exhibited a "to and from movement, bouncing on the ball of his right foot." He also noted an occasional tremor of the right hand. He indicated the movement and tremor "disappeared when [Petitioner] was focused on task performance." He described Petitioner as right-handed and appearing "reasonably healthy."

On examination, Dr. Bauer noted no paracervical muscle spasm, mild tenderness along the right trapezius muscle, a limited range of neck motion, limited extension and flexion, good strength "which was somewhat limited by volition," no obvious weakness of the hands or arms, no atrophy, no spasticity, clonus or Babinski sign, no Tinel's sign at the wrist or elbow, hemihypesthesia to pain on the right side of the body, including the right arm, chest and leg "in a nondermatomal distribution" and diminished vibratory sensation in his right ankle and arm. He described Petitioner as performing "position sensation" less well on the right than the left, "neither of which was normal," but indicated that Petitioner's Romberg sign was negative.

Overall, Dr. Bauer described his neurologic examination as "normal with some non-physiologic findings." He noted that, while Dr. Neri was treating Petitioner for "post-traumatic migraines," he was not familiar with this diagnosis and did not treat migraines.

Dr. Bauer found "no indication that [Petitioner] has any work-related injury" attributable to the May 2004 accident. He found Petitioner to be at maximum medical improvement and, with respect to the accident, capable of performing his former material handler job. He added that, "on the other hand, [Petitioner] has a number of complaints and symptoms that would prevent him from returning to work, unrelated to his work injury." He saw "no indication" of post-traumatic migraines and "no indication that [Petitioner's] treatment or continued complaints of right-sided neck pain is based on an anatomic abnormality in his neck." He did not attribute Petitioner's stress, tremors or left hand numbness to the work accident. Bauer Dep Exhibit 2.

On July 21, 2010, Petitioner was admitted to an intensive outpatient program at Linden Oaks, where he saw Dr. Keller for an initial evaluation. The doctor's lengthy note concerning that evaluation sets forth a history of the 2004 work accident. The note also reflects Petitioner stopped working in 2007 "at the urging of his wife," secondary to neck pain, migraines and depressive symptoms. Petitioner reported being "let go" by Respondent six months earlier. On August 20, 2010, Dr. Keller issued a note addressed "to whom it may concern" indicating that Petitioner's prognosis was guarded "based on his own and his family's confusion and resistance regarding his treatment." A subsequent note of September 8, 2010 reflects that Petitioner reported an incident a week earlier when he heard voices, came to believe food his wife had brought home was poisoned and threw out this food due to that fear. A note dated September 15, 2010 reflects that Petitioner described his tremors as "back" but Dr. Keller was unable to observe any increase in the tremors. Petitioner also expressed irritation at not having been brought to court to testify. In a note dated September 23, 2010, Dr. Keller documented tearfulness throughout the session and psychomotor agitation. [See below for a summary of Dr. Keller's deposition testimony concerning her findings and opinions.]

On behalf of Respondent, Dr. Conroe re-examined Petitioner in October 2010. Petitioner testified that, at this examination, the doctor asked him if he had taken a drug known as Wellbutrin. Petitioner testified he did not know what this drug was and did not know what the doctor was talking about. He has no recollection of a Dr. Mian or any July 29, 1999 prescription for Wellbutrin. T. 64-66. As of July 1999, he and his first wife were experiencing marital problems and saw a counselor. T. 66.

A report in evidence reflects that, on November 24, 2010, December 1, 2010 and December 6, 2010, several investigators conducted surveillance outside a residence in Plainfield, Illinois where Petitioner was believed to live. The report reflects that Petitioner was not seen on November 24th or December 1st. On the morning of December 6, 2010, an investigator briefly saw a man matching Petitioner's description peering out of a window from inside the residence. The report reflects that, "according to neighbors, [Petitioner's] wife is observed outside of the residence most of the time." RX Group Exhibit 12.

A report in evidence reflects that investigators conducted additional surveillance outside the Plainfield residence on December 9, 11 and 16, 2010 but did not observe Petitioner. The

report reflects that efforts were terminated "due to the claimant becoming suspicious." RX Group Exhibit 12.

On January 25, 2011, Vondrak noted that Petitioner "appeared anxious and agitated, relating that apparently years ago he saw someone to deal with his past divorce and that now it is being said that he was depressed since then." Vondrak went on to state that Petitioner wanted the truth to be known, stating that "even though he was upset a long time ago about his divorce, that he did not feel then like he does now and was then able to still work and do things with his family."

Vondrak issued a four-page report on February 3, 2011, indicating she was continuing to see Petitioner twice monthly and opining that Petitioner would continue to need long-term care, including medication management and counseling, "due to the chronicity and severity of his symptomatology." She addressed causation as follows:

> "Based on information reported to me, it appears that the physical symptoms that resulted from the patient's injury after he slipped at work in May of 2004, leading to his injury, chronic pain and inability to work, along with the complications, trauma and stressors of this situation have resulted in the patient developing his current diagnosis of severe major depression with psychotic features."

On March 29, 2011, Dr. Trum noted that Petitioner's right foot and hand were "very tremulous." She also noted complaints of nightmares and "flashbacks" to the accident, with Petitioner "see[ing] himself on the floor." PX 15.

On October 18, 2011, Dr. Trum saw Petitioner and issued a report outlining the treatment she had rendered to him since July 29, 2008. She indicated that Petitioner was still complaining of pain and having difficulty walking and speaking. She diagnosed depression "secondary to medical condition (physical pain and disability from [the work accident])." She indicated Petitioner was still taking Cymbalta and Risperdal.

Dr. Trum addressed Petitioner's work capacity as follows:

> "[Petitioner] has been unable to work since the day I met him [7/29/08] until this day [10/18/11]. I cannot say if he could have worked prior to my meeting him. At this time it appears that he will never be able to return to full-time gainful employment in his previous field or any other because of his continuing pain issues and resultant continued depressive symptoms."

She went on to state that Petitioner's care "has not been terminated." PX 15.

Dr. Conroe, who is board certified in both psychiatry and forensic psychiatry (Conroe Dep Exh 1), testified by way of evidence deposition on March 20, 2013. PX 17. Dr. Conroe testified he devotes 60% of his time to clinical practice and 40% to forensic issues. He is the regional medical advisor for the Social Security medical disability program and chief psychiatrist for the Midwest region. PX 17 at 5. He authored a chapter about how Social Security handles the issue of malingering in a textbook called Neuropsychology and Malingering Casebook. PX 17 at 8. Respondent's prior counsel retained him. He has testified for both sides in workers' compensation and disability cases. PX 17 at 9-10. He charges $395 per hour for reviewing records and testifying. He saw Petitioner on several occasions dating back to December 2008. He has been named as an expert hundreds of times. PX 17 at 17-18. His role with the Social Security Administration is supervisory. He does not testify for the Administration. PX 17 at 18.

Dr. Conroe testified that, when he first obtained Petitioner's history, in December 2008, Petitioner did not say his head hit the floor. He described his head as snapping back. There is no indication of a head injury in Petitioner's records. PX 17 at 22. Petitioner denied any psychiatric history. PX 17 at 22-23.

Dr. Conroe found it significant that Petitioner had a long work history. Petitioner seemed to be "someone who had functioned rather well for a long period of time." PX 17 at 24. Petitioner reported hearing voices and feeling depressed. From a cognitive standpoint, his immediate recall was poor and his concentration was moderately impaired. It is possible that Petitioner faked the answers he gave to various test questions. PX 17 at 26. When he interviews a person from a forensic standpoint, he always considers the issue of credibility. He compares the person's responses to the treatment records. He tries to have a "dual narrative" in his head, listening to the person's story while simultaneously trying to determine whether the story holds up. PX 17 at 28-29.

Dr. Conroe testified he initially concluded that Petitioner had major depressive disorder, recurrent and severe, with psychotic features. He believed the prognosis for recovery was good, since Petitioner had a long work history, an adequate family support system and no history of mental disorders or drug/alcohol abuse. PX 17 at 30. He did, however, view the 2004 event as "disproportionate to the mental symptoms that occurred subsequently." He cannot comment on the physical symptoms. PX 17 at 30. He has reviewed thousands of Social Security cases and has never seen any other individual where there is "such a disproportionate emotional reaction." "It doesn't mean it couldn't occur but it's rare." PX 17 at 32-33.

Dr. Conroe testified that, when he next saw Petitioner, in December 2009, he was concerned that the treatment Petitioner was receiving was not aggressive enough. Based on the history Petitioner provided, Petitioner should have shown a better response to treatment. He recommended an intensive outpatient program so that Petitioner's medications could be better monitored. He did not believe that Petitioner had reached maximum medical improvement. PX 17 at 36-37. At the request of Respondent's prior counsel, he later made a recommendation as to where Petitioner could participate in such a program. PX 17 at 39-40.

Dr. Conroe testified he next examined Petitioner in October 2010, following Petitioner's course of care at Linden Oaks Hospital. Petitioner seemed a little different in that he perhaps conversed more actively but he "still struggled to speak and his right leg shook and he remained depressed." PX 17 at 43. On this occasion, he was provided with new information, i.e., an insurance profile showing that Petitioner had received a prescription for Wellbutrin, an anti-depressant, in July 1999. Wellbutrin is used for only two things: smoking cessation and depression. Petitioner denied smoking. PX 17 at 44. The prescription was filled at a dosage that was "clinically significant, 300 milligrams." The prescription caused him to doubt Petitioner's and his wife's denial of any pre-accident treatment for depression. PX 17 at 46. Once the prescription came to light, he changed his previous causation opinion and concluded that Petitioner's psychiatric disorder is not likely related to the work accident. PX 17 at 48. Playing into this was the fact that Petitioner continued to work for Respondent for several years after the accident. PX 17 at 49-50.

Dr. Conroe testified that, in his subsequent report of May 21, 2011, he concluded that, due to the chronic nature of Petitioner's symptoms, he did not foresee Petitioner discontinuing psychiatric medication anytime soon. He recommended that Petitioner take effective medication rather than continue taking ineffective medication. PX 17 at 49.

Under cross-examination, Dr. Conroe testified he is an expert in detecting malingering. He did not note any malingering in terms of Petitioner's presentation. Petitioner's symptoms "seemed to be credible." Nevertheless, based on the prescription, he does not feel Petitioner was truthful. PX 17 at 53. He does not deny that Petitioner "is a man who has a significant psychological problem" but it is inconsistent that, before the accident, Petitioner had a long work history and relatively stable life. He is aware Petitioner was going through a divorce in 1999 but Petitioner never said the problems associated with that were significant enough to cause him to need medication. PX 17 at 55. He has seen no pre-accident records indicating a diagnosis of depression. PX 17 at 55. However, Petitioner's reaction to the accident, as described, seemed disproportionate. Petitioner's failure to respond to treatment "may very well have been related to things that preceded" the work accident. PX 17 at 55. Dr. Mian prescribed the Wellbutrin. He is unable to testify that Petitioner presented to Dr. Mian for psychiatric evaluation. PX 17 at 57. He has no idea how many times, if any, Petitioner presented to Dr. Mian. PX 17 at 57. Petitioner lost time from Respondent in 2002, due to a knee injury, but otherwise there is no evidence he lost time from work. PX 17 at 58. He reviewed Respondent's medical records. He saw no indication in those records or Petitioner's personnel file that Petitioner was diagnosed with depression before the accident. PX 17 at 59. He does not know what might have been going on in Petitioner's life in 1999 to cause someone to prescribe Wellbutrin for him. PX 17 at 63. Petitioner's tremor could have been related to anxiety or medication. PX 17 at 64. He has not seen Petitioner since October 2010. Based on what he saw at that time, Petitioner would not be able to return to work. PX 17 at 65. The fact Petitioner was not receiving workers' compensation benefits as of 2008 would be a financial stressor. PX 17 at 66. That kind of stressor could have an impact on someone who is already suffering from a depressive disorder. PX 17 at 72. People are "biologically predisposed very

early on to depression. It doesn't just come out of nowhere." PX 17 at 67. Wellbutrin, under the brand name "Zyban," is used to help people quit smoking but there is nothing in Petitioner's records indicating he smoked. PX 17 at 72-73.

On redirect, Dr. Conroe testified that, as of May 2011, some of the medications Petitioner was taking, such as Diazepam, Valium and Butalbital, "would make him more sedated." PX 17 at 78.

On July 23, 2013, Dr. Trum saw Petitioner in follow-up. She noted that Petitioner reported that "workman's comp has sent detectives to spy on him." She also noted that her staff observed Petitioner "drive himself to appointment." PX 15.

Surveillance video obtained on December 29, 2013 showed Petitioner lifting suitcases into the trunk of a vehicle inside his garage at about 10:17 AM, removing suitcases from the vehicle at an airport check-in area about an hour later, running down the sidewalk at about 11:18 AM, walking inside a clothing store from about 11:30 AM to 11:44 AM, walking into a dollar store at about 1:41 PM, exiting the store several minutes later and driving away.

Reports in evidence show that an investigator positioned himself near Petitioner's residence throughout the morning on both Monday, December 30, 2013 and Friday, January 3, 2014, but observed no claimant activity. RX 3B; 4B.

Surveillance video obtained on Sunday, January 26, 2014, showed Petitioner riding with his wife to a church in Richmond, Texas, walking into the church while carrying a small case in his left hand, exiting the church about 1 ½ hours later, riding with his wife to a restaurant, where they stayed for about an hour, returning home and later riding with his wife to a Wal-Mart and mall. The reporting investigator described Petitioner as wearing a suit to church and appearing to walk and move his neck in a normal manner. RX 5B, 6B.

Reports in evidence reflect that an investigator positioned himself outside Petitioner's residence for about six hours on the morning of Thursday, January 30, 2014, but did not observe any activity by Petitioner. RX 5B, 6B.

Surveillance video obtained on Sunday, February 9, 2014 showed Petitioner arriving at church at about 8:10 AM (having driven himself there), walking into the church while carrying a Bible, leaving the church at 9:47 AM, removing his suit jacket, entering his vehicle and driving home. Additional video obtained later the same day showed Petitioner leaving a store, while carrying a bag in his right hand, entering his vehicle, driving to a nail salon, remaining at the nail salon for about an hour and driving away. RX 7B.

At Respondent's request, Andrew Brylowski, M.D. interviewed and administered various tests to Petitioner on April 30, 2014. Surveillance video obtained on this date showed Petitioner riding with a female to the doctor's office, exhibiting a "noticeable limp" while

walking from the car to the building, exiting the building about 5 1/2 hours later and walking to the car. The video obtained on April 30, 2014 is 58 seconds long. RX 8B.

Dr. Brylowski, who is based in Texas, completed a psychiatry residency and is board certified in psychiatry, neurology and pain medicine. Brylowski Dep Exh 1.

Dr. Brylowski issued a 33-page report on May 17, 2014. Brylowski Dep Exh 2. On neurological examination, he noted a tremor he described as "bizarre." He described Petitioner's affect as "flat, distant and guarded." He described Petitioner's thought processes as "paranoid" and indicated Petitioner endorsed some suicidal ideation. He noted some memory deficits and described Petitioner's insight as poor, indicating Petitioner had "assumed the disability role."

Dr. Brylowski noted that, after he proposed urine drug screening, Petitioner's wife interceded and refused, on the advice of Petitioner's attorney.

Dr. Brylowski described the results of Beck Depression and Anxiety Inventory testing as "consistent with multiple possibilities, including over reporting." He went on to state the results "could be overlap with medical problems." He described the results of memory malingering testing as "consistent with malingered memory deficits." He noted that Petitioner expressed "irrational fear avoidant beliefs about work."

Dr. Brylowski went on to describe the results of MMPI-2 testing. He noted that Petitioner's "F" scores were over 100 and that, in general, scores in this range are indicative of "emotional turmoil including anxiety and depression." He indicated that Petitioner's FB score of 107 could be indicative of either over reporting or significant delusions and psychotic processes. He described the FP scale score of 102 as "consistent with frank over reporting of psychiatric pathology." He described the FBS raw score of 37 as "consistent with extreme over reporting of somatic and/or cognitive complaints."

Dr. Brylowski opined that Petitioner's neurologic status is self-imposed and over-reported. He indicated he "could find no neurologic diagnosis." He described Petitioner as "uncooperative with the examination process, specifically the urine drug screen." In response to a question asking whether Petitioner requires additional care, he stated: "Yes – everybody needs medical care . . . however, no further treatment in the workers' compensation setting could be considered reasonable." He recommended that Petitioner "get out of the workers' compensation setting" and "get appropriate treatment without the effects of a disability management context." He indicated that, due to Petitioner's over reporting, it would be difficult to make any treatment recommendations "until [Petitioner] is forthright with examiners." He found Petitioner capable of resuming full duty as a material handler. He did not view Petitioner as sustaining an injury, given the normal results of objective studies. He went on to state that, assuming there was a compensable event, Petitioner would have reached maximum medical improvement within six to eight weeks of that event. Brylowski Dep Exh 2.

Surveillance video obtained on Sunday, June 1, 2014 showed Petitioner driving himself to church, carrying a Bible in a case into church, leaving the church about 1 ½ hours later, again carrying the Bible, opening a car door for his wife (who had arrived in a separate vehicle), getting into his vehicle, driving to an automatic car wash and returning home. The investigator described Petitioner as wearing a suit and appearing to utilize his neck and extremities in an unrestricted manner. RX 9B.

Based on billing in PX 22, it appears Petitioner first saw Dr. Gandhi, a psychiatrist, on August 29, 2014. No note of that date is in evidence.

Dr. Neri testified by way of evidence deposition on October 17, 2014. PX 8. Dr. Neri testified he obtained board certification in neurology and psychiatry in 1981. PX 8 at 5. He has been in private practice since 1979. PX 8 at 6. He first saw Petitioner on April 27, 2006. Petitioner provided a history of the accident, indicating he slipped, snapping his neck back, but did not fall to the floor. Petitioner complained of right suboccipital headaches, significant dizziness with neck extension, right shoulder, difficulty sleeping and irritation and depression. PX 8 at 7-8. Petitioner denied any prior head or neck problems. He was still working and taking pain medication, including Vicodin, Ibuprofen and aspirin. PX 8 at 8.

Dr. Neri testified that, on initial examination, he noted significant spasm in the neck muscles, particularly on the right, and in the upper trapezius, cervical and sternomastoid muscles. He diagnosed a flexion-extension injury of the cervical spine and a secondary sleep disorder. PX 8 at 8. He prescribed Ambien for sleep, Lexapro (an anti-depressant) and Lyrica. PX 8 at 8-9. In his opinion, Petitioner's symptoms were consistent with the injury he described. PX 8 at 8.

Dr. Neri testified that, when he next saw Petitioner, on May 31, 2006, Petitioner was experiencing drowsiness and difficulty working due to Fioricet, a medication some other doctor had prescribed. Petitioner reported that Ambien was helping him sleep. Dr. Neri testified he restarted the Lexapro and prescribed physical therapy with no traction or strengthening exercises. PX 8 at 9-10.

Dr. Neri testified that, at a subsequent visit, on October 16, 2006, Petitioner reported being unable to take Ambien twice a week because he was going to bed too late to allow for seven hours of sleep. The doctor testified he prescribed half strength Ambien. In February 2007, he changed Petitioner from Lexapro to Cymbalta, which treats both depression and chronic pain. He discontinued the Cymbalta in May because Petitioner was reporting drowsiness at work. PX 8 at 12-13. Petitioner was still taking Vicodin at that point. On July 16, 2007, Petitioner reported having lost 20 pounds. Petitioner looked "very thin and gaunt." He recommended that Petitioner see his primary care physician and re-prescribed Cymbalta. PX 8 at 13-14. As of August 27, 2007, Petitioner reported losing a total of 25 pounds over the preceding few months, for no apparent reason. The doctor discontinued the Cymbalta and started Petitioner on Topamax. PX 8 at 14-15. Petitioner reported that his primary care

physician had prescribed an MRI and sent him to a neurosurgeon. The doctor increased the Topamax and Diazepam dosages to address ongoing muscle spasms. PX 8 at 15.

Dr. Neri testified that, as of the next visit, November 7, 2007, Petitioner's "mental status appeared to be deteriorating." Petitioner was "getting more depressed and more anxious." PX 8 at 15-16. Petitioner had seemed depressed at the first visit but depression was "now more of a factor than originally." PX 8 at 16. Sleep deprivation causes depression because it inhibits serotonin production. He prescribed Verapamil to address Petitioner's headaches. On November 20, 2007, Petitioner expressed anger because the insurance carrier had not approved the Verapamil, since it is also used to address high blood pressure. Dr. Neri testified he did not prescribe Verapamil to address hypertension. This was "the start of [Petitioner's] anger issues." Petitioner was angry because he had worked for Respondent for 19 years and felt as if he was being "treated like a piece of meat." PX 8 at 17-18. In January 2008, Petitioner reported ongoing sleep issues, along with lightheadedness with driving. PX 8 at 18-19. On February 20, 2008, Petitioner complained of "very severe headeaches" and reported having been "cut off" by Respondent. Petitioner was "very angry and upset" about this. PX 8 at 19-20. He was not working and his headaches were increasing. PX 8 at 20.

Dr. Neri testified that, while "some people work with pain" and Petitioner had been working, at this point he did not feel Petitioner could be working, the way that he was. PX 8 at 20. He was sleep deprived, depressed, anxious and experiencing significant, post-traumatic migraines. If Petitioner had still been working at this point, he would have taken Petitioner off work. PX 8 at 21. At the next visit, on April 3, 2008, Petitioner expressed frustration with being off work. Petitioner indicated he had worked since his teens and "just hated not working." PX 8 at 21. Petitioner also complained that being off work was "affecting his manhood." PX 8 at 22.

Dr. Neri testified that, at the next visit, on May 15, 2008, Petitioner "began developing a tremor in his right arm." This tremor has since worsened. PX 8 at 22. He attributes the tremor to severe stress and severe spasms in the right upper trapezius area. PX 8 at 22-23. He believes the tremors relate back to the May 2004 work accident. PX 8 at 23.

Dr. Neri testified that, at the next visit, on June 25, 2008, "everything was spiraling down." Petitioner had started seeing a therapist, Roberta Vondrak, and his cognition was deteriorating. Petitioner reported that he had been approved for Social Security disability. PX 8 at 23. Petitioner had also been referred to a psychiatrist, who had started him on Risperidone. PX 8 at 24.

Dr. Neri testified that, on October 22, 2008, Petitioner reported having seen a hand specialist, Dr. Shiffman, due to left hand numbness. Dr. Neri testified he is not certain what this numbness is due to. PX 8 at 24.

Dr. Neri testified that, at the visit of December 15, 2008, Petitioner reported that his sister and son had moved in with him to help care for him while his wife worked. PX 8 at 25.

This was difficult for Petitioner to accept. PX 8 at 25. As of the next visit, on April 2, 2009, Petitioner was experiencing two migraines per week. On May 14, 2009, Petitioner reported having developed carpal tunnel syndrome in his left hand. On September 1, 2009, Petitioner exhibited "very slow cognition," "very poor immediate memory" and was "in obvious despair." He felt "very useless." PX 8 at 27. Dr. Neri testified that, on that date, for the first time he viewed Petitioner's work status as permanently and completely disabled. PX 8 at 27. Petitioner later began displaying "dystonic posturing" of his right foot, meaning his foot was "pulling in" and he was "walking on the lateral margin of the foot." PX 8 at 29. Dr. Neri opined that this was due to Petitioner's stress and depression. PX 8 at 29. He attaches no significance to the idea that someone prescribed Wellbutrin for Petitioner five years before the work accident. It is a very mild anti-depressant with "multiple uses." Family doctors often prescribe short courses of it. PX 8 at 30. If Petitioner had a history of psychiatric problems before the accident, some evidence of this would appear in his records. Instead, the evidence shows Petitioner worked regularly. If records surface, he will examine them but he "would be shocked if there is anything significant prior to" the accident. PX 8 at 31. Dr. Neri testified he described Petitioner as "absolutely demented" on December 16, 2009. Petitioner could not perform normal activities of life as of that date. PX 8 at 31. There is "no possible way" Petitioner could have held a job at that point. PX 8 at 32. Dr. Neri testified he was upset that IME physicians viewed the situation differently. Dr. Neri opined that Petitioner needed the case to be settled "because it's just hanging on him like a rock." PX 8 at 33. Thereafter, Petitioner continued to decline. Dr. Trum tried to address the tremors, via medication, but they worsened. PX 8 at 33. As of May 2010, Petitioner was having nightmares about the accident and exhibiting what sounded like symptoms of PTSD. PX 8 at 34. Petitioner's benefits were cut off after Dr. Bauer examined him. PX 8 at 35. As of late September 2010, after his treatment at Linden Oaks, Petitioner's right arm tremor was a little better but his leg tremor persisted. PX 8 at 37. As of January 2011, there were "huge problems with the stress of the case also fanning the fire." PX 8 at 38. On October 21, 2013, Petitioner reported having moved to Houston due to his wife's job. He was not happy about the move. Petitioner needed to be the "man in the house" and this was "just another blow to his ego." PX 8 at 40. As of April 2014, Petitioner was "very paranoid" and "starting to have auditory hallucinations." PX 8 at 41. He (Dr. Neri) alerted Dr. Trum to this because he felt very uncomfortable. PX 8 at 42. In October 2014, Petitioner reported feeling very stressed due to a psychiatric IME in Texas. PX 8 at 43.

Dr. Neri testified that, throughout the time he has treated Petitioner he has never believed Petitioner was exaggerating his symptoms or malingering. PX 8 at 43. His notes reflect that Dr. Trum "bailed" because she "decided all of a sudden that [Petitioner] was symptom magnifying." In his opinion, Dr. Trum wanted to withdraw from care because Petitioner had moved out of state. PX 8 at 43. He will discontinue treating a patient if he suspects malingering because further care would be a waste of time. PX 8 at 43-44. A doctor can perform neuropsychological tests to determine whether a patient is attempting to deceive. PX 8 at 45. Before she issued a report on July 22, 2014, referencing an office note of July 2013, Dr. Trum did not note any secondary gain. **[The Arbitrator has been unable to find any July 22, 2014 report of Dr. Trum in the extensive record. This report does not appear in PX 15, the doctor's chart.]** In his opinion, Dr. Trum lacked a sufficient basis for discontinuing care. It was

easier for her to "wash her hands of the case" and recommend Petitioner see someone in Texax. PX 8 at 46.

Dr. Neri opined that, since February 20, 2008, Petitioner has been unable to work in any capacity, due to physical and psychiatric problems stemming from the 2004 accident. PX 8 at 46. Petitioner requires ongoing neurological care for his neck injury along with psychiatric care and follow-up. PX 8 at 47. He does not believe Petitioner will reach a point where he requires no care or can work. PX 8 at 47.

Under cross-examination, Dr. Neri acknowledged he is an "advocate for [his] patients." PX 8 at 48. In his view, there is no way of separating Petitioner's physical and psychiatric problems. PX 8 at 49. The cervical spondylosis, or arthritis, is not the problem. The problem is the soft tissue injury and associated muscle spasm. It is the spasm that is causing the migraines, the pain in the neck and arm and "probably the tremor in the arm as well." PX 8 at 50. He last saw Petitioner on October 3, 2014. Petitioner was accompanied by a relative. Petitioner "can't drive" or come to the office on his own. PX 8 at 51. He has never come to a visit by himself. PX 8 at 51. He has observed Petitioner when Petitioner did not know he was being watched. He has never seen Petitioner without the tremor. PX 8 at 52. Petitioner continues to walk on the side of his foot. PX 8 at 53. The person who accompanies Petitioner responds to questions but Petitioner will add commentary. PX 8 at 53. Petitioner's sister moved in with him in December 2008, in order to help. "That was their decision at that point" but he (Dr. Neri) "wouldn't disagree with it." PX 8 at 54. Petitioner "has gotten steadily worse under [his] careful treatment," he is "embarrassed to say." PX 8 at 56. Petitioner is not capable of fooling him. He is at a point in his career where he "can't be fooled." He has seen other whiplash-type injuries evolve in a similar way. PX 8 at 57. He has not spoken with Dr. Trum about her decision to "bail out" on Petitioner. PX 8 at 58. Dr. Trum apparently relied on observations made by one of her staff members but such individuals are not professionals. PX 8 at 58. He has to rely on Petitioner's reporting because "nobody can measure pain." PX 8 at 59. He has heard about the reports of Drs. Zelby, Bauer and Brylowski but he has not read them. PX 8 at 59-60. Petitioner's MRI showed spondylosis. "MRIs don't show muscle." PX 8 at 61. He agrees with Drs. Zelby and Kazan that Petitioner is not a surgical candidate. PX 8 at 61. Petitioner is "horribly anxious." He does not believe Petitioner can drive, shop or perform office work. Petitioner would not be able to focus long enough to perform a job. PX 8 at 63. Petitioner is "very down on himself" due to being unable to work. He "starts crying and breaks your heart." PX 8 at 63. From a neurologist's standpoint, he believes Petitioner has post-traumatic stress disorder, even if he does not meet every DSM requirement. PX 8 at 65. Psychological tests have built-in validity scales but "the interpretations of the tests can be adjusted according to who reads them." In the right hands, they can be very useful. PX 8 at 66.

On redirect, Dr. Neri testified he would "expect" video showing Petitioner attempting to drive, shop and act independently. He would not encourage Petitioner to drive "because that's just not safe" but he would otherwise encourage him to be active. It makes no sense to him that Petitioner would refrain from working for secondary gain purposes. PX 8 at 68. Petitioner's personality does not lend itself to a secondary gain scheme. PX 8 at 69.

Under re-cross, Dr. Neri testified he has not seen Petitioner in a functional state. PX 8 at 71.

Petitioner returned to Dr. Gandhi on November 20, 2014, accompanied by his wife. The doctor noted that Petitioner's wife complained Petitioner was still hearing voices, not sleeping well and isolating himself. The doctor diagnosed a "mood disorder with psychosis." She recommended chronic pain management and suggested psychotherapy. PX 22.

Records in PX 32 reflect Petitioner saw a licensed clinical social worker, Carol Velasquez, on January 14 and 15, 2015. In her notes of those dates, Velasquez described Petitioner as a poor historian. She recorded a history of the work accident and noted that Petitioner reported experiencing migraines, "shaking," anger, marital issues and nightmares about the accident. She described Petitioner as stating that he felt as if the walls were bugged. She diagnosed "PTSD by history." PX 32.

On January 28, 2015, Dr. Gandhi noted that Petitioner reported sleeping better with Buspar but continuing to hear voices and believe that someone was following him. The doctor noted that Petitioner was taking Cymbalta, Ambien, Buspar and Zyprexa. She recommended that Petitioner "watch for over-medication." PX 22.

On February 18, 2015, Velasquez described Petitioner as anxious, paranoid and obsessed with his symptoms. Her note appears to be incomplete. PX 32.

Dr. Brylowski testified by way of evidence deposition on May 1, 2015. RX 2.

Dr. Brylowski testified he reviewed approximately 530 pages of medical records in connection with his evaluation of Petitioner. RX 2 at 28. He also reviewed the complete depositions of Drs. Shaffer and Conroe along with part of Ms. Vondrak's deposition. RX 2 at 28-29. He met with Petitioner for almost two hours. Petitioner's wife was also present. RX 2 at 31, 41. He charged $6000 for his deposition. RX 2 at 33. He wanted to perform a urine drug screening. In the hundreds of pages of records he reviewed, he saw one such screening from 1997 but no post-accident screenings, even though Petitioner reported taking narcotic pain medication. He testified such screenings are performed "to verify compliance" with a drug regimen and to make sure there are no co-morbid conditions. RX 2 at 35-36.

Dr. Brylowski testified that Petitioner voiced numerous psychiatric and pain complaints along with memory problems, general fatigue and lack of motivation. RX 2 at 38. Petitioner walked very slowly and wore sunglasses. He appeared "kind of dejected" and "hunched over." RX 2 at 38-39. His eye contact was poor. RX 2 at 39. When he sat, his feet were "jiggling and moving." Petitioner told him he avoids physical activity because he fears it will be painful. RX 2 at 40. Petitioner answered some questions spontaneously but sometimes had to be prompted. RX 2 at 41.

Dr. Brylowski testified he found it significant that Petitioner continued working for more than three years after the accident. RX 2 at 45.

Dr. Brylowski testified that the records he reviewed showed Petitioner was started on Hydrocodone and Darvocet in 2005. Darvocet has since been taken off the market. RX 2 at 49. Both of these drugs can cause mental status changes, addiction and heightened sensitization to pain. RX 2 at 50. In 2006, a physician prescribed Firoinal. This is a barbiturate frequently prescribed for headaches. It has "significant concern for rebound," meaning that, the longer a patient takes it, the worse the headaches become. RX 2 at 51. It is intended only for very short-term use. RX 2 at 51. Lexapro is classified as an antidepressant. Diazepam is the generic of Valium and is potentially addictive. Petitioner's records reflect he was on "three different sedative hypnotics" as of 2007. RX 2 at 52. Petitioner started Lexapro in November 2007, per Dr. Neri, due to depression. Verapamil, which Petitioner took for a blood pressure problem, can cause dizziness and headaches.

Dr. Brylowski testified that Petitioner completed a registration packet at his office. His complaints were primarily psychiatric but he also complained of headaches, neck pain and right leg and arm problems. RX 2 at 61.

Dr. Brylowski testified that, when he examined Petitioner, he noted a significantly elevated blood pressure of 154/111 and a significantly elevated pulse of 110. For someone of Petitioner's size, the pulse would normally be between 60 and 80. RX 2 at 64-65. There could be many different explanations for this. If Petitioner was taking Amlodipine for high blood pressure, as prescribed, it did not seem to be working. RX 2 at 65.

Dr. Brylowski testified he noted no abnormalities on neck and upper extremity examination. RX 2 at 67. On finger-nose-finger testing, Petitioner was shaking. Dr. Brylowski described the shaking as "bizarre" because it did not follow any physiologic tremor pattern.

Dr. Brylowski testified he administered MMPI and other testing to Petitioner mainly to cross check the validity of his subjective complaints. RX 2 at 77. Petitioner's Beck Depression Inventory score of 48 was very high. This would be consistent "if everything was 100% valid with a severe major depressive disorder." RX 2 at 79. It could also be indicative of over reporting. RX 2 at 80. The Beck Anxiety Inventory score was 52, which is consistent with severe anxiety. The patient has 100% control over the results of the Beck Inventory testing. RX 2 at 81. The TOMM, or Test of Memory Malingering, is a test of perceptual memory, "which is the last type of memory to go away even in people with cognitive decline or dementia and even in people with severe traumatic brain injuries." Petitioner's score was consistent with over reporting. RX 2 at 81. Petitioner's responses to the Fear Avoidance Beliefs Questionnaire indicated he was not particularly afraid of physical activity but was "avoidant or afraid of work." RX 2 at 82. MMPI-2 testing consists of 567 true-false questions. The test has a number of built-in validity measures. Petitioner's variant verbal response scale was 54. This was "very good." It meant that Petitioner was paying attention and could concentrate. RX 2 at 83. Petitioner's thought dysfunction was "so high that you would expect [him] to not be able to communicate,

be floridly psychotic and probably be hospitalized." The score spoke to over reporting. RX 2 at 86. Under Axis 1, he diagnosed malingering and "rule out substance disorder." RX 2 at 88. He believes Petitioner, like all people, needs medical care but that, for Petitioner, that care should be administered in a non-workers' compensation setting. He believes Petitioner could resume full duty as a material handler. He does not view the slip and fall as causing any injury. RX 2 at 90. The data he reviewed does not support a diagnosis of post-traumatic stress disorder or pain-related depression. RX 2 at 93.

Under cross-examination, Dr. Brylowski testified that he recalls Dr. Conroe diagnosing a major depressive disorder and recommending hospitalization. Petitioner was "partially hospitalized" at Linden Oaks for three months in 2010. He does not recall seeing anything in the records indicating Petitioner refused urine drug screening at Linden Oaks. RX 2 at 100-101. He is aware Petitioner was under active treatment during the three years he continued working after the 2004 accident. RX 2 at 104. It is possible that a person could become depressed after sustaining a minor soft tissue injury that does not resolve. RX 2 at 105. He agrees he reached different conclusions than Dr. Conroe, an examiner, reached in December 2008. RX 2 at 106. He cannot comment on Dr. Conroe's changed causation opinion, which was based on his review of a pre-accident prescription. RX 2 at 108. The Axis 1 diagnoses that Dr. Keller of Linden Oaks reached are different from those he reached. RX 2 at 109. Petitioner reported having a stressor due to Respondent withholding his benefits. Withholding income and an inability to work can be valid stressors. RX 2 at 113. Ideally, a patient should close his eyes during Romberg testing but a physician can obtain Romberg information "with eyes open or eyes closed." RX 2 at 118. He asked Petitioner to close his eyes. RX 2 at 118-119. He has no opinion as to whether Petitioner's medication regimen has been appropriate. That would be a "judgment call" for a treating physician to make. RX 2 at 119-120.

On redirect, Dr. Brylowski testified that a treating physician makes a "judgment call" based on the symptoms the patient reports. RX 2 at 120. Just because Petitioner may have met the criteria in DSM for depressive disorder does not mean he actually has this condition. RX 2 at 121. None of Petitioner's counsel's questions prompted him to change his opinions. RX 2 at 121.

Dr. Bauer testified by way of evidence deposition on June 22, 2015. RX 1. He testified he completed medical school in 1974, underwent training thereafter and began practicing neurosurgery at Lutheran General Hospital in 1979. He obtained board certification in neurosurgery in 1981. RX 1 at 5-6. He sub-specializes in brain and spinal surgery. RX 1 at 6. Bauer Dep Exh 1.

Dr. Bauer testified he examined Petitioner on May 24, 2010 and issued a report on June 4, 2010. Bauer Dep Exh 2. He typically dictates an examination report shortly after the examination. He reviewed a number of records in connection with his examination. RX 1 at 8-9. He typically conducts one or two medical-legal examinations per week. RX 1 at 10. Almost all of these examinations are for the defense. RX 1 at 10. As of 2010, he charged $1,500 for such an examination. RX 1 at 10. He charges for deposition time as well. RX 1 at 10.

Dr. Bauer testified he reviewed the medical records prior to examining Petitioner. RX 1 at 12. He obtained a history from Petitioner. Petitioner reported slipping on a wet floor on May 6, 2004, snapping his neck backward and grabbing a pole to keep from falling. Petitioner indicated he believed he used his left hand to grab the pole. Petitioner denied falling. He indicated he lay on the floor for an unknown period, due to right-sided neck pain, and eventually got up and went to the nurse. He further indicated the accident occurred near the end of his shift and he went home.

Dr. Bauer testified that Petitioner complained of two to three migraines per week, for which he used ice and Vicodin. The migraines started on the right side of the neck and extended up the head. They were associated with nausea. Petitioner also complained of right-sided neck pain. He denied having headaches or neck pain before the work accident. He listed his current medications. The list did not include Vicodin. RX 1 at 13-14. He was wearing a brace on his left hand due to numbness. He reported that Dr. Schiffman had injected his left wrist with cortisone. He also reported undergoing an EMG that showed carpal tunnel syndrome. He further complained of shaking of his right leg for over one year and some shaking of his right arm. RX 1 at 14.

Dr. Bauer proceeded to summarize the records he reviewed. These records show Petitioner complained of tenderness in the front of his neck about a week after the accident and was described as performing a workout with a trainer about thirteen days thereafter. The workout consisted of jumping rope and using hand weights. Dr. Bauer testified he would not expect someone with neck pain to perform such a workout "because it would just irritate things." RX 1 at 15-16. Subsequent records from 2004 showed that Petitioner participated in physical therapy and took Vioxx but, by his report, did not improve. Thereafter, Petitioner began going to a pain clinic, where he complained of pain in a different area, i.e., on the right side of the back of his skull. He underwent a cervical spine MRI, which was normal, and then underwent a series of facet joint injections at C1-C2 and a rhizotomy. Dr. Bauer testified this would not be a typical way to treat someone with a normal cervical spine MRI. RX 1 at 18-19. According to Petitioner, the injections did not help. Based on Dr. Goodman's records, the injections provided only temporary relief. Dr. Kazan found no abnormalities when he examined Petitioner. He recommended Petitioner see a neurologist for his headaches. Petitioner later began seeing Dr. Neri, who diagnosed a flexion/extension neck injury with secondary sleep deprivation. RX 1 at 23. This was the first mention of a sleep disorder. RX 1 at 23-24. Dr. Neri prescribed Ambien, a sleeping pill, Lexapro, an anti-depressant, and Lyrica, a pill that treats nerve disorders. RX 1 at 24. On May 31, 2006, Dr. Neri recommended that Petitioner decrease his Fioricet intake. Fioricet is a combination of aspirin, Phenacetin and caffeine. It is an over the counter medication used to treat migraines. Some of the medications that were prescribed for Petitioner can cause dizziness. RX 1 at 27. A repeat MRI performed on July 17, 2008 showed minimal cervical spondylosis, by report. Spondylosis is a "degenerative condition of the spine." RX 1 at 28. Minimal spondylosis would certainly not cause nerve root or spinal cord compression. Around this time, Petitioner began taking Topamax, a non-narcotic mood elevator. RX 1 at 29. Dr. Neri prescribed a brain MRI. Dr. Bauer testified he is not sure why Dr.

Neri prescribed this. He is also not sure whether Petitioner ever underwent a brain MRI. There is no indication Petitioner ever sustained a traumatic brain injury. RX 1 at 30. Petitioner later saw Dr. Zelby, who noted complaints of pain extending to the anterior arms and three fingers of the hands, along with daily right arm pain, intermittent left arm pain, constant right-sided headaches and numbness on the right side of the neck. On examination, Dr. Zelby noted mild tenderness to deep palpation of the cervical spine and diminished sensation and vibration in the right hand. He interpreted the most recent MRI as showing slight kyphosis at C4-C5 with a mild, broad-based osteophyte. He diagnosed cervical spondylosis and recommended home exercises, anti-inflammatory medication and muscle relaxants. He recommended that Petitioner continue full duty. RX 1 at 31-32. Dr. Bauer testified that the complaints Petitioner voiced to Dr. Zelby were different in that he was now complaining of his arms and fingers. Such complaints could be consistent with stenosis but the MRI did not show stenosis. RX 1 at 32-33. On October 3, 2007, two days after Dr. Zelby examined Petitioner and more than three years after the accident, Dr. Neri took Petitioner off work for one month. This was the first time since the accident that any physician took Petitioner off work. RX 1 at 33. Dr. Neri's subsequent records reflect subjective complaints of neck stiffness and headaches. Dr. Neri continued to keep Petitioner off work. Dr. Bauer testified there is no way to determine whether a patient is in fact experiencing headaches. RX 1 at 35.

Dr. Bauer testified that, in December 2007, Dr. Shaffer examined Petitioner and diagnosed cervical spondylosis and radiculitis. Dr. Bauer testified it was "not clear where the radiculitis came from." Dr. Shaffer found Petitioner to be at maximum medical improvement. Petitioner continued seeing Dr. Neri thereafter. Dr. Neri noted complaints of persistent headaches and lightheadedness. Dr. Bauer testified that Petitioner could have become lightheaded due to the medications he was taking. RX 1 at 36. In January 2008, Dr. Neri diagnosed cognitive difficulties as well as migraines. This is the first note to mention cognitive difficulties. Neuropsychological tests can be done to determine whether someone has cognitive difficulties. Dr. Bauer testified that, as of his 2010 examination, there was no indication Petitioner ever underwent such tests. RX 1 at 37-38.

Dr. Bauer testified that Dr. Neri noted tremors in April 2008. Dr. Bauer opined that, from a medical standpoint, it makes no sense for someone to develop tremors secondary to trauma four years after the trauma occurs. RX 1 at 38. Dr. Bauer further opined that tremors can be functional. A patient can intentionally make a body part shake. RX 1 at 39.

Dr. Bauer testified he sees no connection between the work accident and the left hand/wrist treatment Dr. Schiffman provided years afterward. RX 1 at 40.

Dr. Bauer testified that, by this time, Petitioner had begun seeing Dr. Trum, a psychotherapist, and Roberta Vondrak, a therapist. These individuals suspected depression. RX 1 at 40.

Dr. Bauer testified that the leg and arm shaking and bouncing movement he observed while examining Petitioner "would disappear during [the] examination and also when

[Petitioner] was focused on task performance." This told him the shaking and movement were not physiologic, meaning Petitioner could stop them when he wanted to. RX 1 at 42.

Dr. Bauer testified he noted no spasm on examination, even though Petitioner had been treated for neck spasms in the past. Petitioner did report mild tenderness along the right trapezius muscle. RX 1 at 44. The fact that Petitioner did not exhibit nystagmus excluded the possibility of certain conditions. RX 1 at 44-45. He noted "no overt evidence of significant nerve damage." Petitioner exhibited good strength in his extremities but "didn't try real hard." He noted no weakness of the arms or hands. He also noted no atrophy. A person who has significant nerve damage affecting an extremity will typically have atrophy due to the muscles shrinking. RX 1 at 46. Tinel's was negative at the wrist and elbow, meaning Petitioner did not have carpal or cubital tunnel syndrome. RX 1 at 47. Petitioner had reduced sensation in the entire right side of his body, including his right arm, chest and leg. This reduced sensation "did not have a dermatomal distribution," meaning the finding did not make sense. RX 1 at 48. He put a tuning fork against Petitioner's sternum. The vibration should feel the same on both sides of the sternum but Petitioner felt the sensation was different on the right. This was "not consistent with a neurologic disorder." RX 1 at 48-49. Petitioner's reactions to testing called "position sensation," which is performed with the eyes closed, was also not consistent with any neurologic problem. RX 1 at 49.

Dr. Bauer testified he noted no objective abnormalities on examination. The MRIs showed no evidence of an injury to Petitioner's neck. He relied on the MRI reports. He did not have access to the MRI images. RX 1 at 51-52. He found no injury stemming from the May 2004 work accident. He found Petitioner to be at maximum medical improvement with respect to that accident. RX 1 at 53-54. He found Petitioner capable of resuming full material handler duties with respect to that accident. Petitioner did, however, have a number of complaints, including migraines, that would prevent him from returning to work. Those complaints did not stem from the work accident. There is no way to measure migraines. RX 1 at 54.

Under cross-examination, Dr. Bauer testified he has been conducting independent medical examinations for 15 to 20 years. He agreed that the physicians who treated Petitioner before his examination based their treatment on the symptoms Petitioner reported. Petitioner indicated those symptoms started after the accident. A patient's history is a very significant diagnostic tool. RX 1 at 57. He does not know whether any doctor noted symptom magnification. He did note that, in 2006, Dr. Neri described his neurologic examination as normal. RX 1 at 57. Dr. Neri later "came up with the idea that [Petitioner] had a mild traumatic brain injury." This was not consistent with the doctor's original evaluation. RX 1 at 58-59.

Dr. Bauer testified his examination focused on neurological, not psychiatric, issues. He reviewed only a couple of April 2010 notes from Dr. Trun. RX 1 at 59.

Dr. Bauer testified he personally obtained a history from Petitioner. He believes his direct one-on-one interaction with Petitioner lasted about one hour. The mechanism Petitioner

reported, i.e., slipping with his neck going backward, and grabbing a pole to keep from falling, could cause a neck injury. RX 1 at 60.

Dr. Bauer did not remember whether he reviewed any records from Respondent's medical department. The records he reviewed were likely scanned into his computer in 2010. RX 1 at 60-61.

Dr. Bauer testified he has no reason to doubt the account Petitioner provided of the accident. Petitioner provided a generally similar account to other doctors, although he sometimes reported falling. Petitioner did not tell him that he fell. RX 1 at 62.

Dr. Bauer testified he did not use the term "unnecessary" when he testified on direct as to the treatment Petitioner underwent. He simply is not sure why Dr. Goodman injected the C1-C2 joint since no imaging study showed arthritis on that joint. RX 1 at 63-64. He is also unsure why Dr. Goodman concluded the injections and rhizotomy would help when Petitioner reported only very short-lived relief in response to these measures. RX 1 at 63-64. When Dr. Shaffer examined Petitioner, in December 2007, he recommended lifting restrictions of 30 to 40 pounds. In an addendum, Dr. Shaffer opined that the accident aggravated an underlying cervical spondylosis. Dr. Bauer testified that, in his view, Petitioner did not have an underlying cervical spondylosis. The first post-accident MRI, performed in November 2004, was normal. RX 1 at 65-66. He would not relate any reported post-accident weight loss to the accident. RX 1 at 66. There is "rarely" any way of diagnosing a headache. RX 1 at 67.

On redirect, Dr. Bauer testified the dates of Petitioner's cervical spine MRIs were November 8, 2004 and July 17, 2007. RX 1 at 67-68.

On October 14, 2015, Dr. Gandhi noted that Petitioner had switched therapists and was now seeing Dr. Joanne Carlson "to help him with his PTSD." She refilled Petitioner's medication. PX 22.

Petitioner returned to Dr. Gandhi on January 28, 2016, accompanied by his wife. According to the doctor, Petitioner's wife reported being very upset with Petitioner's last therapist, "who didn't help him with his pain and anxiety." The doctor refilled Petitioner's medications. PX 22.

Petitioner saw Dr. Gandhi again on April 21, 2016. The doctor noted that Petitioner was working with a new therapist to improve his social skills and was "sleeping better with Buspar." The doctor refilled Petitioner's medications. PX 22.

Reports in evidence reflect that an investigator conducted surveillance outside Petitioner's residence on six days between May 12 and 23, 2016. The investigator did not observe Petitioner on any of those days. On Sunday, May 15, 2016, she observed two females at the residence. In her report, she indicated she saw "no evidence that [Petitioner] is employed." She obtained no information concerning Petitioner via a neighborhood canvass.

Dr. Keller testified by way of evidence deposition on May 12, 2016. Dr. Keller testified she is a board certified psychiatrist. She completed her residency at Lutheran General shortly before she began working at Linden Oaks, a psychiatric hospital affiliated with Edwards Hospital. PX 20 at 6-7. She has a fuzzy recollection of Petitioner. Petitioner attended a half-day intensive outpatient program at Linden Oaks in the summer of 2010. She was the psychiatrist associated with Petitioner's treatment team. PX 20 at 8. During the course of Petitioner's care, she communicated with Drs. Neri and Trum because she had some concerns about the potential side effects of the medication Petitioner was taking. PX 20 at 14-15. At the initial assessment of July 21, 2010, Petitioner complained of both physical and depressive symptoms which he attributed to a 2004 work accident. PX 20 at 17-19. Petitioner denied undergoing any psychiatric care before that accident. PX 20 at 20. Petitioner reported tremors. She examined him for this because tremors can result from certain medications. She "didn't see a twitch per se." PX 20 at 20-21. She performed a mental status assessment on July 21, 2010. Petitioner exhibited decreased hygiene and grooming. He was "quite guarded with poor eye contact" and exhibited "psychomotor agitation which was more prominent" in his right leg. His right leg was "constantly in motion." PX 20 at 23. Petitioner was resistant to right arm evaluation due to pain. PX 20 at 24. Petitioner had difficulty spelling the word "world." He added an "l" at the end. His "level of confusion was pretty evident." PX 20 at 25. His thought process was disorganized and paranoia was evident. He "didn't seem like somebody who was manipulating or pretending or acting." PX 20 at 28. She did not suspect malingering at any point during Petitioner's participation in the program. PX 20 at 28-29. She concluded that Petitioner's unemployment, health and workers' compensation claim had some significance in his disorders. PX 20 at 30.

Dr. Keller testified she was concerned that Petitioner was experiencing confusion as a side effect of Congentin, which had been prescribed to prevent side effects of Risperdal. She "cross-tapered" Petitioner from Risperdal to Zyprexa. PX 20 at 32.

Petitioner's strengths, in terms of potential for recovery, were that he had a fairly supportive family and had not previously had psychiatric problems, by his history. PX 20 at 33.

Dr. Keller testified she next saw Petitioner on July 28, 2010. She focused on Petitioner's passive suicidal ideation and his psychotic symptoms, i.e., his auditory hallucinations. PX 20 at 35. Petitioner had a lot of guilt about being unable to work and interact with his family. PX 20 at 35. It is her understanding Petitioner slipped and fell at work, injuring his neck. Chronic pain is a stressor and "can precipitate psychiatric symptoms for sure." PX 20 at 36. Initially, Petitioner was paranoid about some of the other patients and even some of the Linden Oaks staff. PX 20 at 38. He felt as if everybody was against him. PX 20 at 38. He felt as if family members were moving items at home to confuse him. PX 20 at 39.

Dr. Keller testified Petitioner was discharged on September 23, 2010. Petitioner remained "somewhat psychotic" at that time, despite the change in his medication. PX 20 at

42. The plan at discharge was for Petitioner to continue outpatient care with his therapist and Dr. Trum. PX 20 at 43.

Dr. Keller opined that Petitioner derived some benefit from the Linden Oaks program but was still in need of care at discharge. She was concerned that, without the help or support of family, his ability to maintain his gains would not last. PX 20 at 43. She has not seen Petitioner since September 23, 2010 and thus cannot comment on his current condition. PX 20 at 44. She knew his migraines had lessened because he had reduced his migraine medication intake, at her recommendation. PX 20 at 46.

Dr. Keller opined that the work accident "likely set the stage for the psychiatric symptoms that developed in the context of the pain and the physical limitations." If, in 2007, Petitioner was anything like the way he was when she saw him in 2010, she could understand his inability to work from a psychiatric perspective. PX 20 at 48-49.

Under cross-examination, Dr. Keller agreed there are three possibilities in this case: 1) Petitioner suffered an accident, developed chronic pain and then developed psychiatric problems; 2) Petitioner had an accident from which he recovered and independently developed psychiatric symptoms; and 3) Petitioner really has no pain and is faking. While she leans "much more strongly" toward the first of these possibilities, she cannot say the third scenario is impossible. PX 20 at 49-50. She tries to give patients the benefit of the doubt. She has not seen any records created since September 2010. PX 20 at 51-52. She did not administer MMPI testing to Petitioner. PX 20 at 52. There are tests that can determine whether a patient is malingering. PX 20 at 52-53. She had 10 to 15 individual visits with Petitioner during his stay at Linden Oaks and likes to think she would have seen some sign of malingering during that time, if Petitioner was indeed malingering. PX 20 at 53. A very consistent individual might fool a doctor but she doubts whether someone could be that consistent over 10 to 15 visits. PX 20 at 53-54. She is sure she has been fooled by some of her patients. Other patients believe they have fooled her and they have not. PX 20 at 54. You always have to be concerned about malingering in the context of a workers' compensation claim. However, Petitioner would have had to be an "Oscar winning actor if he really was malingering that whole time and presenting as he did." PX 20 at 55. When she asked Petitioner to identify parts of a watch, he could subjectively control his answers. PX 20 at 57. If a person is depressed, it does not mean he cannot have a moment when he laughs or enjoys something. PX 20 at 61. When she first evaluated Petitioner, she was concerned about whether he was capable of driving, due to his level of confusion. PX 20 at 65. Her notes reflect that Petitioner reported falling at work. Even if Petitioner did not actually fall, potential falling can be serious. PX 20 at 67.

On redirect, Dr. Keller testified she collaborates with the therapists who work at Linden Oaks. She does not remember anyone alerting her to Petitioner attempting to control his evaluations. PX 20 at 72.

Petitioner returned to Dr. Gandhi on July 14, 2016. In her note of that date, the doctor referenced a note from Petitioner's wife indicating Petitioner was "still struggling with PTSD

symptoms" and not in counseling due to financial issues. The doctor noted that Petitioner reported napping a lot during the day, isolating himself, being "very resistant to going out" and experiencing a lot of memory issues. The doctor refilled the Olanzapine, Cymbalta and Buspirone and recommended Petitioner continue psychotherapy. PX 22.

Petitioner testified his "life turned upside down" after the accident. He is "not the same person [he] used to be." T. 70.

Under cross-examination, Petitioner testified it is conceivable he was a little depressed around July 1999, at which point his marriage was breaking up. He was upset about his children. T. 74-75. He does not know what the drug Wellbutrin is used for. T. 75. He stopped seeing Dr. Trum because he moved to Texas. Dr. Trum never told him she stopped seeing him because one of her employees saw him in a parking lot and he looked different than he had looked in the office. T. 76. Dr. Neri never relayed this information to him. T. 76. When he saw Dr. Conroe, it was at Respondent's request. T. 77. He believes he stopped working around October 2007. T. 77. Other than going to the doctor, he does not remember exactly what he did between that time and October 2008. He was married at that point. He married Bridget in 2005. T. 77-78. Bridget performs most of the household tasks or arranges for someone else to perform them. He tries to do a "little bit," depending on how he is feeling, but he does not do laundry or wash dishes. He makes up his bed, which is on the floor. He reheats prepared food in the microwave. Some days his migraines are so bad he "can't do anything." On those days, he has to lie down in a dark room. His daughter lives with him and Bridget. T. 80. He does not mow the lawn or do painting. T. 80-81. He probably moved to Texas in 2013. He cannot recall the exact date. T. 82. In Texas, he does not mow the lawn but he might pick up papers or something. He had a driver's license when he lived in Illinois. He and his wife owned two Cadillacs. He now has a Texas driver's license. They still own the Cadillacs. He "may drive once in a while." T. 84. His doctors have urged him to get out of the house. He might go out to purchase items from a list his wife creates. T. 84. His sister has visited him in Texas and his mother has come there "to help." T. 84. His doctors told him not to lift or carry anything heavy. T. 84-85. On a good day, he might help his wife or daughter carry some groceries. T. 85. If Vondrak described him as walking slowly while holding onto the walls, that would "not really" sound familiar to him. It has been a while since he saw Vondrak. T. 85. Sometimes when he gets to his feet he has to touch something to steady himself. T. 85. He wishes he could interact with other people more often. "Most of the time [he doesn't] get out of the house." T. 87. At times he has felt hopeless. He is not sure whether he told Dr. Conroe he felt helpless. He does not remember word for word what he said to Dr. Conroe. T. 88. He is sad "a lot of times." T. 89. He does not remember whether he was tearful each time he saw Dr. Neri. T. 89. Most of the time he is withdrawn. T. 90. He tries not to cry but he does cry sometimes. T. 91. He did not feel better after he stopped working for Respondent. T. 92. Nothing Dr. Neri has done for him, treatment-wise, has improved his condition in a permanent way. T. 92.

At the February 22, 2017 hearing, several witnesses testified on behalf of Petitioner. **Mark Strong**, who worked for Respondent between November 1989 and October 2007, testified he and Petitioner worked shifts together. Petitioner provided him with assistance at

work just before the May 6, 2004 accident. He was maybe 12 or 13 feet away from Petitioner when he saw Petitioner slip. Petitioner did not actually hit the ground. He does not believe Petitioner grabbed onto anything but Petitioner was near a tank staircase and "probably caught his balance there." T. 2/22/17 at 99-100. Afterward, he saw Petitioner "standing there . . . grabbing his neck or something." He grabbed Petitioner and asked him if he was okay. Petitioner said he was in a lot of pain. He (Strong) then contacted Michelle, their manager. Petitioner was taken to a nurse's office. Petitioner later finished out the workday. He continued working with Petitioner for more than three years after the accident. Petitioner was "just constantly in pain." Whenever Petitioner needed to lift something, he (Strong) would do it. No light duty was available in the area where he and Petitioner worked. Strong testified he performed all the heavy lifting that needed to be done. For example, he lifted salt bags, cocoa butter and slurry while Petitioner "did most of the computer work." He and Petitioner did not discuss the treatment Petitioner was undergoing. Petitioner complained to him of headaches. He (Strong) stopped working for Respondent in October 2007, after he sustained a back injury at work. He underwent three back surgeries following this injury and pursued a workers' compensation claim of his own against Respondent. T. 2/22/17 at 95-96, 110. **Under cross-examination,** Strong testified Respondent has no union. He saw Petitioner outside of work on some occasions after Petitioner's accident. They did not see one another regularly because they lived far apart from one another. T. 2/22/17 at 108-109. After his own accident in 2007, he next saw Petitioner at the Commission in late 2016. Petitioner seemed "a lot different." Petitioner still seemed to be in pain but he looked depressed and upset. Petitioner did not seem withdrawn or anxious. T. 2/22/17 at 110-111.

Bridget Watkins testified she first met Petitioner around 1998, at which point Petitioner was separated. She and Petitioner started living together in February 2005 and got married on December 22, 2005. She is aware of Petitioner's May 6, 2004 work accident. Petitioner's health was fine before that accident. He had no headaches, mental disorders or physical impairments, to her knowledge. T. 2/22/17 at 116-117. He was able to work regularly. Before the accident, she and Petitioner would go bowling, go to the movies and take walks together. T. 2/22/17 at 118. Petitioner told her about the accident via phone on May 6, 2004. Right after the accident, Petitioner began complaining about neck and head pain. He seemed very tired when he got home from work and had difficulty sleeping. He "just became a different person literally." Before the accident, Petitioner regularly attended his sons' games. Afterward, he no longer felt up to this. It was "really hard for [her] to get [Petitioner] out on a regular basis." T. 2/22/17 at 119-120. After they got married, she had to hire people to perform home repairs. T. 2/22/17 at 121. She accompanied him to at least three of his appointments with Dr. Goodman. After Dr. Goodman's last neck injection, Petitioner complained of dizziness. Petitioner became dizzy in the shower the morning after this injection and stumbled up against the wall. T. 2/22/17 at 122. Petitioner was taking prescription pain medication at night, per Drs. Mayor and Goodman, at this point. T. 2/22/17 at 123. Petitioner began seeing Dr. Neri after Dr. Kazan recommended a neurological consultation. T. 2/22/17 at 125. Petitioner's symptoms worsened over time. Initially, Petitioner complained of head and neck pain. Later, he began complaining of severe, migraine headaches. These headaches triggered nausea and vomiting. T. 2/22/17 at 126-127. Before she and Petitioner moved to Texas, she noticed that

Petitioner's concentration and memory began to diminish. In approximately 2007 or 2008, she also noticed tremors in Petitioner's hand, arm and leg. T. 2/22/17 at 127. Petitioner worked until October 2007. Before October 2007, it was really difficult for Petitioner to work a day shift, due to his narcotic pain medication regimen and difficulty sleeping. T. 2/22/17 at 128-129. Petitioner told her he had to obtain assistance from co-workers. T. 2/22/17 at 129. After October 2007, Petitioner found it difficult to get through the day, due to his pain and inability to engage in activity. T. 2/22/17 at 130. Petitioner continued attending church, when he felt up to it. T. 2/22/17 at 130. Petitioner did not have many household tasks. He occasionally slept on the floor because it was difficult for him to get comfortable while lying on a mattress. T. 2/22/17 at 131-132. She accompanied Petitioner to some of his consultations with Dr. Vondrak. The doctor tried to help Petitioner find ways to cope with chronic pain. At the doctor's recommendation, she (Watkins) would assign tasks to Petitioner to distract him. She would give Petitioner a shopping list once or twice a week. T. 2/22/17 at 133. Petitioner would forget to buy items on these lists. T. 2/22/17 at 134. She had to remind Petitioner to take a shower. T. 2/22/17 at 136.

Watkins testified the accident has had a "tremendous impact" on her relationship with Petitioner, from both an emotional and financial standpoint. Petitioner's condition did not improve after they moved to Texas. Petitioner continued to experience migraines and other issues, including foot and back pain, began to surface. Petitioner is both withdrawn and agitated. T. 2/22/17 at 137-138. During the day, when she is at work, he tries to sleep. There are "days at a time where [Petitioner] doesn't leave the house." T. 2/22/17 at 138. She still assigns tasks to him but he often does not complete them. She and her daughter clean the house. They rely on a service to take care of the lawn. She does not trust Petitioner to cook because he will leave the burners on. T. 2/22/17 at 140. Petitioner goes to church most Sundays if he is feeling well. He withdraws when he does not feel well. He will socialize and converse with church members on occasion. T. 2/22/17 at 141-142. He is not happy about being off work. He feels inadequate and is "pretty gloomy." T. 2/22/17 at 142. He passed a driving test in Texas and has a valid license. His mother, sister and sons, along with her own relatives, have visited them in Texas. T. 2/22/17 at 142-143.

Watkins testified Petitioner continues to undergo care in Texas. He sees a psychiatrist, Dr. Gandhi, every three months. He also sees his primary care physician, Dr. Feng, and other doctors for urological and foot problems. He has nerve problems in both feet. He also has fibromyalgia. T. 2/22/17 at 143-144. Petitioner saw Dr. Neri the day before the hearing. Dr. Neri examined Petitioner's neck, shoulder area and feet. The doctor prescribed medication that is supposed to help with fibromyalgia. T. 2/22/17 at 146. He also renewed Petitioner's pain medication. T. 2/22/17 at 147. Her health insurance pays for the visits to Dr. Gandhi and other treatment in Texas. No one pays for the visits to Dr. Neri. T. 2/22/17 at 147.

Under cross-examination, Watkins testified she has no medical background. She has a master's degree in learning and development. When Petitioner tells her he is in pain, she believes him. T. 2/22/17 at 148-149. Essentially, she takes care of everything around the

house. T. 2/22/17 at 149. Petitioner is capable of driving to and from the airport, when visitors come to town. T. 2/22/17 at 150.

Angela Watkins, Petitioner's ex-wife, testified she and Petitioner were married for about 18 years before they divorced in 2000. They had two sons, who are now adults. T. 2/22/17 at 152-153. She works as a coder at Hartgrove Behavioral Hospital. T. 2/22/17 at 153.

Watkins testified Petitioner had a good work ethic during their marriage. Petitioner never called in to take a day off. T. 2/22/17 at 155.

Watkins testified that, to her knowledge, Petitioner did not undergo treatment for any mental disorders during the time they were married. Nor did he treat for any conditions other than work-related injuries. T. 2/22/17 at 155. During their marriage, they were very active in church and school activities. Between their divorce and the work accident, Petitioner had visitation rights. He visited their sons as often as he could. T. 2/22/17 at 156-157. He and their sons were very close. T. 2/22/17 at 157. Petitioner regularly paid child support. T. 2/22/17 at 158.

Watkins testified she learned of the May 2004 work accident from Petitioner. After the accident, she sometimes had to take their sons to visit him because he did not feel well enough to come get them. Petitioner would be sitting in a room with the curtains closed. Between the accident and the current time, Petitioner became "more withdrawn, more closed into himself." T. 2/22/17 at 160. He visited his sons less often. T. 2/22/17 at 161. She could tell Petitioner was in pain. He would sit a lot and tell her he did not feel well. T. 2/22/17 at 162.

Watkins testified that, prior to the divorce, she and Petitioner saw a female counselor on one or two occasions. She cannot recall the counselor's name. T. 2/22/17 at 164. She does not know whether this counselor prescribed medication for Petitioner. To her knowledge, Petitioner did not take Wellbutrin during their marriage. T. 2/22/17 at 164.

Watkins testified that both the divorce and the accident adversely affected Petitioner's relationship with his sons. Regardless, Petitioner still sees and talks with his sons, both of whom live in the Chicago area. T. 2/22/17 at 166. Olando, the older son, is now 25. The younger son, Olan, is 20. T. 2/22/17 at 166. Olan still lives with her. T. 2/22/17 at 167.

Belinda Weems, Petitioner's sister, testified she is six years older than Petitioner. She lives in Mississippi and no longer works. She takes care of her mother, who is elderly. She has visited Petitioner in Texas on several occasions. T. 2/22/17 at 169-170. She has noticed changes in Petitioner since the May 2004 accident. Petitioner now has a short temper and is agitated. When he is in pain, he wants to be alone. She can tell he is in pain by the way he acts. T. 2/22/17 at 172. She last visited Petitioner and his wife two years ago. She stayed for eight days. Petitioner tended to stay up after she went to bed. She saw him take medication. She did not observe Petitioner do laundry or otherwise help out. Petitioner told her he was in pain. T. 2/22/17 at 174. On the days that Belinda went to work, she watched television while

Petitioner would stay in his room. She would check on him periodically. T. 2/22/17 at 175. On some occasions, they went to the grocery store to pick up items on a list that Brenda left for Petitioner. She did not observe Petitioner doing anything out of the ordinary. T. 2/22/17 at 176.

Several investigators testified on behalf of Respondent. **Christopher Rose** testified concerning activity he observed and videotaped on December 29, 2013, outside Petitioner's residence, at the airport and at a clothing store. Rose testified that Petitioner did not appear to be dizzy, unbalanced or teary. He observed Petitioner driving a car and lifting luggage. Petitioner did not appear to lack energy. T. 2/22/17 at 189-191. He identified RX 3A and 4A as the video he obtained and RX 3B and 4B as the reports he prepared. **Under cross-examination,** Rose testified he "could believe" that surveillance of Petitioner was conducted in 2010 and thereafter. Such surveillance was authorized but it would have conducted in Illinois, whereas he conducted surveillance in Texas. T. 2/22/17 at 215. At times, his view of Petitioner was obstructed. T. 2/22/17 at 218. He did not observe Petitioner limping. T. 2/22/17 at 218. He does not know the weight of the suitcases Petitioner lifted. T. 2/22/17 at 219. He conducted surveillance of Petitioner for eight hours on December 30, 2013 and January 3, 2014 but did not observe any activity on those days. T. 2/22/17 at 219-221. **George Robinson** testified he conducted surveillance of Petitioner on January 26 and February 9, 2014. On January 26, 2014, he saw Petitioner drive a Cadillac to a church and then walk into the church while carrying what appeared to be a Bible. Petitioner did not seem to have trouble walking, driving or carrying the Bible. T. 2/22/17 at 228. Petitioner was not teary. T. 2/22/17 at 229. He identified RX 5A and 6A as the video he obtained and 5B and 6B as the reports he prepared. T. 2/22/17 at 231. On January 26, 2014, he also observed Petitioner and a woman entering and later exiting a restaurant and entering and later exiting a Wal-Mart. Petitioner lifted the trunk of a vehicle after exiting the Wal-Mart and later drove away. T. 2/22/17 at 237. On February 9, 2014, he observed Petitioner drive to the same church and walk into the church, again carrying an object. **Under cross-examination,** Robinson testified he is not familiar with any surveillance of Petitioner conducted prior to January 26, 2014. Petitioner moved about in a normal fashion. T. 2/22/17 at 249-250. He conducted surveillance outside Petitioner's residence on February 6, 2014, from 6:13 AM until 5:15 PM, but did not observe Petitioner that day. T. 2/22/17 at 253. **Christopher Rose** (recalled to the stand) testified he again conducted surveillance of Petitioner on April 30, 2014. He conducted this surveillance outside Petitioner's residence and at a medical facility [the office of Dr. Brylowski, a Section 12 examiner]. When Petitioner entered the facility, in the morning, he was limping and moving slowly. When he exited, at 3:18 PM, he again moved slowly toward his vehicle. **Angela Willis** testified she conducted surveillance of Petitioner on June 1, 2014. On that date, she followed Petitioner from his residence to a church, where she observed Petitioner get out of a vehicle and walk into the church, while carrying an object. **Under cross-examination,** Willis testified she also conducted surveillance on May 29 and June 6, 2014 but only observed Petitioner on Sunday, June 1, 2014. T. 2/22/17 at 300. She assumes Petitioner was carrying a Bible when he entered the church. T. 2/22/17 at 304.

Dr. Conroe also testified on behalf of Respondent on February 22, 2017. He testified that, on the occasions he examined Petitioner, Petitioner was tearful and disheveled. Petitioner also seemed very tired and withdrawn. T. 2/22/17 at 257. The doctor testified that, at the request of Respondent's attorney, he looked at some surveillance videos of Petitioner that the attorney "drop boxed" to him the Friday before the hearing. The surveillance footage he viewed was obtained on December 29, 2013 and the following dates in 2014: January 24, February 9, April 30 and June 1. T. 2/22/17 at 259. [At this point in the doctor's testimony, the Arbitrator sustained Petitioner's Ghere-based objection, since Respondent's counsel acknowledged he did not tender the videos or any supplemental reports from Dr. Conroe to Petitioner's counsel 48 hours in advance of the hearing. T. 2/22/17 at 265-266. Respondent's counsel then made an offer of proof, with Dr. Conroe testifying that, on all the videos other than the one dated April 30, 2014, Petitioner was very neatly dressed, presented himself well, did not appear sad, displayed no tremor and seemed to have adequate energy. In the footage dated April 30, 2014, Petitioner was disheveled and appeared to be limping or shuffling. T. 2/22/17 at 267-268.

Under cross-examination, Dr. Conroe acknowledged that Respondent's counsel contacted him the Friday before the hearing, asking him to look at surveillance footage and comment thereon. He had previously examined Petitioner and issued reports concerning those examinations. At one point, he recommended more aggressive psychiatric care than Petitioner was receiving. When he examined Petitioner in December 2009, he saw no evidence of malingering. T. 2/22/17 at 272. He last examined Petitioner in October 2010. At that time, he reviewed a prescription for Wellbutrin dated July 23, 1999. That prescription caused him to refine his previous causation opinion. Wellbutrin is an anti-depressant. It can also be used to help people quit smoking but Petitioner told him he never smoked. T. 2/22/17 at 274. He does not know whether Petitioner actually took the Wellbutrin. T. 2/22/17 at 275. He testified by way of deposition in 2013. T. 2/22/17 at 275.

On redirect, Dr. Conroe testified he reached conclusions about Petitioner at the time of his examinations, based on Petitioner's behavior and appearance. T. 2/22/17 at 276.

The parties appeared before the Arbitrator again on February 23, 2017. Petitioner called his wife, Bridget Watkins, in rebuttal. Watkins testified she reviewed the surveillance videos the previous night. She confirmed she and Petitioner own two black Cadillacs. She purchased these vehicles in 2013. Petitioner uses his to go to the store and doctors' offices. The investigators captured footage of Petitioner only on Sundays. She is home on Sundays and encourages Petitioner to get out of the house. She explained Petitioner's demeanor on the December 29, 2013 footage as follows: "every now and then there is a switch in Petitioner's behavior and he becomes more upbeat." Petitioner had "unusual energy" on December 29, 2013. He was "super excited" to take a drive to the airport. As of that date, Petitioner was taking pain medication and Ambien for sleep. The suitcase Petitioner lifted contained a duvet cover and a down coat. Petitioner can be seen walking "briskly" on the video because he was going to get help for her parents. She and he stopped at a store after dropping her parents at the airport. She stayed in the store longer than Petitioner. Petitioner became sad again after

her parents left to return home. Petitioner was at home on December 30, 2013 and January 3, 2014. She set out Petitioner's clothes for him on January 26, 2014 and helped him get ready to go to church. Petitioner was more depressed at that point but was trying to socialize. On February 9, 2014, Petitioner resisted going to church and was "combative" with her. Petitioner did not feel well on April 30, 2014, the day that Dr. Brylowski examined him. Petitioner used the railings while climbing stairs at the doctor's facility.

After Bridget Watkins testified, Petitioner's counsel offered his exhibits and requested any videos that might exist concerning surveillance conducted before December 2013. The case was then continued. On May 18, 2017, Respondent's counsel sent Petitioner's counsel all of the reports concerning attempted or actual surveillance. He indicated that all of the video that was obtained was produced at the February 22, 2017 hearing. RX 12A. Proofs were closed on May 19, 2017.

Arbitrator's Credibility Assessment

While there are some variances in the histories as to the mechanism of injury, Petitioner's May 6, 2004 accident is not in dispute. Petitioner reported the accident immediately and submitted to treatment rendered or directed by Respondent.

The etiology and reliability of Petitioner's ongoing physical and psychiatric complaints is very much at issue, however. The evidence bearing on this issue is mixed. Some of the evidence is also stale. Dr. Neri, who was still treating Petitioner as of the 2017 hearing, testified in 2014. He apparently never viewed the surveillance footage. Dr. Schaffer, who examined Petitioner once, in December 2007, testified in July 2008, approximately nine years before the hearing. He complained of the time lag he faced, in addressing causation (PX 11), but that time lag is insignificant compared to that faced by the Arbitrator. Dr. Bauer, another Section 12 examiner, saw Petitioner only once, in 2010, and testified about five years later.

Respondent argues Petitioner's injuries could not have been that serious, given that he continued working for more than three years after the accident. Petitioner, on the other hand, testified he was able to continue working only because he obtained help from his co-workers. Mark Strong confirmed he provided such help to Petitioner. Attendance records in PX 2 show Petitioner regularly worked overtime and sometimes worked double time during the period between the accident and April 2005. [No subsequent attendance records appear in PX 2.] These records cut both ways. On the one hand, it is difficult to reconcile them with Petitioner's testimony that his injuries were so serious they prevented him from performing aspects of his job. On the other, they are consistent with the many notes, in both treatment and examination records, that reflect Petitioner derived great satisfaction from working.

In the years following the accident, Respondent's medical staff took Petitioner at his word and made treatment recommendations and referrals. Respondent's first examining psychiatrist, Dr. Conroe, also found Petitioner believable and specifically stated in his last report that he noted no malingering. He did view the 2004 work accident as "somewhat

disproportionate to the mental symptoms" that Petitioner subsequently developed, and ultimately changed his mind about causation [based on an isolated 1999 Wellbutrin prescription] but, until the hearing, continued to opine that Petitioner has a significant psychiatric condition that requires care. PX 17 at 30. Dr. Bauer noted inconsistencies and did not link Petitioner's complaints to the work accident but indicated those complaints would prevent Petitioner from working. Dr. Trum, a treating psychiatrist, stopped seeing Petitioner based on inconsistent behavior observed by one of her staff members.

In the Arbitrator's view, there is a "disconnect" between the way Petitioner presented at the hearing and the way he looked in the surveillance videos. Petitioner claims to be very disabled due to his physical and psychiatric condition. He paints himself as a person who rarely feels well enough to perform simple tasks, let alone leave home. The videos, in contrast, show him lifting luggage into the trunk of a car, breaking into a jog, interacting with relatives, driving on his own (despite Dr. Neri's opinion that it would not be safe for him to drive) and walking jauntily into church. In rebuttal, Petitioner's wife testified that Petitioner can rise to an occasion, only to regress later on. In general, Petitioner points to the unsuccessful surveillance, i.e., the days that investigators went to his residence but observed nothing, as evidence that he is only occasionally able to be active and enjoy life. The Arbitrator gives this argument little weight. Investigators indicated they believed Petitioner was aware of their presence as early as 2010. Dr. Trum's records show Petitioner knew of the surveillance as of 2013. This could well account for the investigators' lack of success.

The Arbitrator recognizes that the surveillance footage is limited in scope and duration. Nevertheless, it undermines Petitioner's claim of ongoing significant physical and psychiatric disability stemming from the work accident. It also undermines Dr. Neri's testimony that Petitioner is essentially not functional.

The Arbitrator further finds that Petitioner's credibility was undermined by his denial of any pre-accident psychological or psychiatric care. The July 1999 prescription for what Dr. Conroe described as a "clinically significant" dose of Wellbutrin came to light well after the accident. At the hearing, Petitioner claimed to have no knowledge of this prescription. This testimony is in direct conflict with what Petitioner told Vondrak on January 25, 2011. Petitioner's attorney opted not to offer the prescribing doctor's [Dr. Mian's] records [which were marked as PX 30] into evidence. The Arbitrator finds it reasonable to infer that the records do not advance Petitioner's claim. See REO Movers, Inc. v. Industrial Commission, 226 Ill.App.3d 216, 223 (1st Dist. 1992), in which the Appellate Court held that "where a party fails to produce evidence in his control, the presumption arises that the evidence would be adverse to that party." The Arbitrator is also troubled, however, by the amount of weight Dr. Conroe attached to the prescription, an isolated document that pre-dates the accident by about five years. The Arbitrator notes that, even though the prescription caused Dr. Conroe to question Petitioner's veracity, he continued to believe (at that time, i.e., 2010) that Petitioner had a significant psychiatric disorder that required effective medication. PX 17 at 48-49.

Arbitrator's Conclusions of Law

Did Petitioner establish a causal connection between his undisputed work accident of May 6, 2004 and his various claimed current conditions of ill-being? Has Petitioner reached maximum medical improvement? Is Petitioner entitled to temporary total disability benefits?

The Arbitrator finds that the undisputed work accident of May 6, 2004 aggravated an underlying cervical spine condition and caused headaches and a soft tissue right trapezius condition. The Arbitrator further finds that these conditions brought about the need for the conservative care that Respondent rendered and/or directed, via Dr. Mayor and his referrals. In making these findings, the Arbitrator relies on Dr. Schaffer's opinions and the treatment records. The Arbitrator further finds that, by the time of Dr. Bauer's examination in 2010, Petitioner had obtained maximum benefit from that care. Petitioner candidly admitted deriving no lasting benefit from the care Dr. Neri has rendered to date. Moreover, Dr. Neri has continued to render care based on the assumption that Petitioner is so impaired he should not attempt to drive. The surveillance shows this assumption to be faulty.

The Arbitrator further finds that Petitioner's causally related physical conditions impaired his ability to perform full duty after October 2007. It was at this point that Mark Strong, who had been helping Petitioner with heavier tasks, went off work due to his own back injury. The Arbitrator finds it reasonable for Dr. Neri to have taken Petitioner off work for a period as of October 2007. The Arbitrator also finds it reasonable, however, for Petitioner to have resumed working, subject to the lifting restrictions Dr. Schaffer recommended, by February 2008. There is evidence indicating Respondent directed Petitioner to report to work on February 11, 2008 but no evidence indicating what type of job he was to perform. Respondent did not call any witness to establish it offered Petitioner work within the 30- to 40-pound range recommended by Dr. Schaffer. Dr. Neri continued to keep Petitioner off work thereafter and a dispute developed, with Petitioner ultimately developing a significant psychological reaction to being away from the workplace. The Arbitrator finds this reaction to be related, at least in part, to the work injury. The Arbitrator relies on Dr. Conroe, Respondent's first examining psychiatrist, in finding that Petitioner established causation as to the need for the intensive treatment he underwent at Linden Oaks in 2010. Respondent authorized this treatment but ultimately did not pay for it, a circumstance that may have further aggravated Petitioner's psychological condition. PX 36.

In short, the Arbitrator finds that the undisputed work accident of May 6, 2004 resulted in permanent physical and psychological disability but not to the extent claimed by Petitioner. The Arbitrator views Petitioner as reaching maximum medical improvement with respect to his cervical spine condition as of Dr. Bauer's examination of May 24, 2010. The Arbitrator does not, however, find that Petitioner was capable of full duty from a physical standpoint as of said date. The Arbitrator relies on Dr. Schaffer with respect to the need for lifting restrictions and finds no evidence indicating Respondent offered Petitioner a specific job within those restrictions. The Arbitrator views Petitioner as reaching maximum medical improvement for his psychological condition as of July 23, 2013, the date Dr. Trum noted an inconsistency reported by one of her staff members. Petitioner obtained deposition testimony from several of his

providers but, significantly, did not depose Dr. Trum. The Arbitrator awards temporary total disability benefits from February 10, 2008 (the first date of disability claimed by Petitioner) through July 23, 2013, a period of 284 2/7 weeks, with Respondent receiving credit for its payment of $243,908.88, per the parties' stipulation. Arb Exh 1.

The Arbitrator finds that Petitioner failed to establish causation as to any left hand condition. At Dr. Neri's recommendation, Petitioner saw Dr. Schiffman for left hand and wrist symptoms in September 2008. Petitioner completed a form indicating he began experiencing these symptoms in May 2008, i.e., four years after the accident. Neither he nor Dr. Schiffman linked the symptoms to the 2004 accident. At his deposition, Dr. Neri acknowledged he does not know what Petitioner's left hand problem stemmed from.

The Arbitrator also finds that Petitioner failed to establish causation as to any fibromyalgia condition. Petitioner did not offer any medical opinion linking this recently diagnosed condition to the 2004 work accident.

The Arbitrator further finds that Petitioner failed to establish causation as to any foot condition. There is no indication Petitioner injured either of his feet in the accident. Dr. Neri testified that Petitioner has foot dystonia. He attributed this condition to "stress," implying a causal relationship. The Arbitrator assigns no weight to this opinion. It is not well-explained. To the extent Dr. Neri's bills (PX 36) contain charges for foot care, the Arbitrator denies these charges.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claims numerous medical and prescription expenses. See PX A and B attached to the Request for Hearing form and PX 36.

At the outset, the Arbitrator notes that one of the bills Petitioner claims is a $500.00 records review bill from Dr. Bauer (of the Center of Brain and Spine Surgery), one of Respondent's Section 12 examiners. PX 36. Respondent is liable for this bill. It is not clear why the doctor charged Petitioner. Another claimed bill, in the amount of $100.00, includes a charge of $50.00 for a report Vondrak wrote on February 1, 2011, presumably at the request of Petitioner's counsel. The balance of $50.00 is carried over from another date and is not explained. PX 36. The Arbitrator declines to award the claimed $100.00. The Arbitrator also declines to award Petitioner claimed charges of $373.36 for left hand treatment rendered by Dr. Schiffman of Hinsdale Orthopaedics in 2009 and 2010. PX 36. The Arbitrator has previously found that Petitioner failed to establish causation as to any claimed left hand condition. The Arbitrator declines to award the claimed $373.36 bill. The Arbitrator also declines to award claimed bills from Drs. Feng and Lang (of the Hillcroft Medical Clinic in Houston, Texas) for treatment rendered in May, June and July 2014 and May 2015. PX 36. Based on the itemized charges and corresponding records (PX 21), this treatment relates to a general health examination/blood work on May 15, 2014, a colorectal screening on June 3, 2014, a colonoscopy performed on June 21, 2014, additional lab work and colorectal screening on July

14, 2014 and a general health examination on May 21, 2015. Petitioner failed to establish any connection between these services and the work accident.

The Arbitrator has previously found that Petitioner reached maximum medical improvement with respect to his cervical spine condition as of Dr. Bauer's examination of May 24, 2010. The Arbitrator awards any claimed expenses relating to treatment of this condition rendered through May 24, 2010.

The Arbitrator has also found that Petitioner reached maximum medical improvement with respect to his psychological condition as of his July 23, 2013 visit to Dr. Trum. The Arbitrator awards the claimed expenses relating to treatment of this condition rendered through July 23, 2013, including but not limited to the expenses associated with the care Petitioner underwent at Linden Oaks between July and September 2010. PX 36. Dr. Conroe, Respondent's Section 12 examiner, recommended this care. He noted no malingering when he made the recommendation. Dr. Keller, who treated Petitioner at Linden Oaks, testified the care was absolutely necessary. She also noted no malingering. There is no surveillance from 2010 which could potentially undermine the opinions of Drs. Conroe and Keller.

What is the nature and extent of the injury?

This is a pre-amendatory case. Petitioner's undisputed accident occurred long before September 1, 2011.

As noted earlier, Petitioner claims he is permanently and totally disabled while Respondent claims he is not entitled to any permanency award.

The Arbitrator has previously found that Petitioner established causation as to permanent physical and psychological conditions of ill-being but not to the extent he claims. Petitioner has "assumed a disabled role," to quote Dr. Brylowski.

The Arbitrator awards permanency equivalent to 30% loss of use of the person as a whole, equivalent to 150 weeks of benefits under Section 8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dagne Love,
Petitioner,

vs.

NO: 12 WC 06559

State of Illinois DOC Stateville,
Respondent.

18IWCC0205

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 10, 2017, is hereby affirmed and adopted.

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

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

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

DATED: APR 4 - 2018
o021518
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LOVE, DAGNE
Employee/Petitioner

Case# **12WC006559**

STATE OF IL DOC STATEVILLE
Employer/Respondent

18IWCC0205

On 8/10/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.14% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0924 BLOCK, KLUKAS & MANZELLA PC
MICHAEL D BLOCK
19 W JEFFERSON ST
JOLIET, IL 60432

4980 ASSISTANT ATTORNEY GENERAL
COLIN KICKLIGHTER
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62794-9255

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

AUG 10 2017

DONALD A. DARIA, Acting Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Dagne Love
Employee/Petitioner

v.

State of IL DOC Stateville
Employer/Respondent

Case # **12** WC **06559**

Consolidated cases: _____

18IWCC0205

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Carolyn Doherty**, Arbitrator of the Commission, in the city of **New Lenox**, on **June 12, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 **04/13/09**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned **$53,961.00**; the average weekly wage was **$1,037.71**.

On the date of accident, Petitioner was **46** years of age, ***single*** with **0** dependent children.

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

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

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

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

ORDER

As explained in the Arbitration Decision the Arbitrator finds that Petitioner failed to establish that she sustained a compensable repetitive trauma arising out of and in the course of her employment for Respondent. Accordingly, all other issues are rendered moot and all requested compensation and benefits are denied.

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

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

Carolyn M. Doherty

Signature of Arbitrator

8/8/17

Date

ICArbDec p 2

AUG 10 2017

FINDINGS OF FACT

At trial, Petitioner testified that she began working for Respondent as a correctional officer at Stateville Prison in 1996. Petitioner testified that she had no health problems when she began the job. Petitioner testified that from 1996 through 2007 she was a detail officer at the prison working on adjustment committees which involve house hearings to deal with prison problems. During this time period up to 2007, Petitioner also worked "gates" and cell houses requiring the use of keys. In January 2008, Petitioner was assigned to work to work at gate 1 at the prison main entrance. She testified that when she began the assignment her shoulders and upper extremities were fine.

Petitioner testified that the gate 1 weighs 170 to 300 pounds, is 7 feet tall, 3 feet wide and made of iron. Petitioner testified that the manual hinges have been pained numerous times over the 80 year prison history likely increasing the weight of the gate. She testified that she was required to turn the lock on the gate, pull the gate open toward her with both arms and her body weight, and then push the gate forward to close it, again using both arms and body weight. She testified that on occasion she would start to close the gate and then see someone coming which required her to pull the gate open again. Petitioner testified that forceful gripping was required to grip the gate and the key and that she was required to squeeze her hands around the bars to open and close the gate while using her body weight to operate the gate.

Petitioner further testified that she had to open and close the gate constantly. She worked an 8 hour shift at gate 1 approximately 3 to 4 times per week. Petitioner estimated that she opened and closed the gate 2 to 3 times per minute during the shift. Petitioner had a ½ hour lunch break and two short breaks during the 8 hour shift.

Petitioner described the key she used to open the gate locks. She testified that the key was approximately 4 to 5 inches attached to a key ring and weight about 1 pound. Unlocking the door requires a twisting motion and turn of the wrist with the operator simultaneously pulling on the door. Petitioner testified that the locks are old and stiff and require a lot of force to turn.

Petitioner further testified that in addition to working at gate 1 three to four days per week she also worked at gate 5 one to two days per week for an entire shift. On the days she was assigned to work at gate 5 for an entire shift she was also assigned to work at gate 2 for relief. She testified that gate 5 had multiple doors used by employees and inmates. Gate 5 had metal doors with wire mesh openings. At gate 5, Petitioner was required to use 3 to 4 keys including regular keys and Folger-Adams keys which were "big, old fashioned, heavy keys." She testified that she again worked entire shifts opening and closing doors at gate 5 with the same regularity although she testified that less force was involved with the gate 5 doors. She testified that she also used keys in the bull pen to open and close cuffs and leg irons on the inmates.

Petitioner testified that when she covered gate 2 she on her breaks from gate 5, she operated another heavy gate with the same regularity. She described her gate 2 assignment as "relief work" as she was assigned to gate 2 during the breaks of co-workers. Petitioner testified that she worked these gates for a total of 8 months. In October of 2008, she asked to be taken off gate work as she felt pain in her shoulders and swelling in her hands. Petitioner testified that as of October 2008, her right thumb was locking and her shoulders, hands, and elbows were painful. No report of injury was filed with Respondent by Petitioner documenting the requested change.

Petitioner was next assigned to tower work and to writ work. In the tower, Petitioner was in the guard tower and required to hold a rifle and a shot got. Specifically, Petitioner testified that she worked 2 to 3 times per week in the tower which required her to open a heavy tower door, load the 3 to 4 pound weapons and grip the weapons 3 to 4 hours per day. Petitioner gripped the weapons with her right hand near the trigger and her left

hand forward on the weapon. Petitioner then stood in the tower and watched the ground level. Writ work required Petitioner to transport prisoners throughout the prison. When transporting a prisoner, Petitioner was required to use "tedious little keys" to lock the hand cuffs and leg irons.

Petitioner testified that she performed tower and writ work through April 7, 2009, approximately 13 months. Petitioner testified that during this time she noticed that her right thumb was locking more, her hands were swollen and that she could not longer turn the keys. In addition, she testified that her bilateral upper extremity symptoms also slightly worsened while working the tower and writ assignment. Petitioner testified that icing her hands did not help and she could not sleep due to the symptoms. Petitioner testified that she could no longer tolerate the symptoms and sought medical care.

On April 7, 2009, Petitioner saw her general practitioner at the offices of Dr. Azeem Ahsan. On that date, Petitioner was examined by Dr. Villasenor and reported right hand pain, numbness, tingling and weakness, worse with twisting-grasping, shooting pain symptoms, worse at night and wakes up with numbness pain. On right hand and wrist exam, the doctor noted an abnormal palpation over the interior wrist with positive signs for CTS like Tinel's and Phalen's (Pet's. Ex. 1 pp. 11 – 12). He also noted poor grip of thumb and index and long fingers. The doctor diagnosed her with carpal tunnel syndrome of the right hand and obesity. The records do not refer to Petitioner's job duties.

Petitioner was referred to Dr. Mukund Komanduri, an orthopedic surgeon whom she saw April 12, 2009. Petitioner completed a history form where she described her correctional officer job as requiring "repetitive work cuffing inmates, writing, …" PX 8. Dr. Komanduri noted a history of Petitioner working as a correction officer complaining of thumb and hand pain and locking of her right thumb and on assessment noted "obvious catching and locking of the thumb A1 pulley consistent with trigger thumb. He injected the thumb and provided a thumb splint. He ordered an EMG of the right wrist. On 4/21/09, an EMG revealed borderline carpal tunnel on the right. Dr. Komanduri testified that at his April 12, 2009 visit with Petitioner she reported "doing some sort of repetitive unlocking maneuver on a door of some kind and it was causing significant pain in her hand." PX 27.

Dr. Komanduri took Petitioner off work pending the prescribed right trigger thumb release surgery totally disabled her at that time pending surgery, (Pet's. Ex. 8 pp. 8-9). When she returned to Dr. Ahsan May 5, 2009, his records showed a diagnosis of right thumb trigger finger and tendinitis. He also noted symptoms of right carpal tunnel and obesity. (Pet's. Ex. 1 p. 17). When Petitioner returned to Dr. Ahsan, May 5, 2009, it was for pre-op for right thumb trigger finger release. Petitioner was 66 inches tall and her weight was 274 lbs. (Pet's. Ex. 1, pp. 14 – 17).

Petitioner testified that she had worked up until April 13, 2009. She then called the HR Person the same day as she saw Dr. Komanduri and advised that she was disabled from work with a diagnosis of carpal tunnel syndrome and trigger finger. The HR Person advised her that she should not file as an on-the-job injury, as going for retirement would get her benefits quicker. Petitioner was not completely certain they talked about the repetitive trauma, but in light of her memory that an OJI was discussed she testified: "I guess we did talk about the Gates."

May 26, 2009, Petitioner had a surgery at Provena St. Joseph Medical Center, a right thumb trigger finger release performed by Dr. Komanduri. (Pet's. Ex. 8, p. 59.). Petitioner attended therapy thereafter and in June 2009 was noted as having minimal pain but some strength deficit. Therapy was continued with an anticipated one month final release date. PX 8, p. 67. On July 20, 2009, additional therapy was ordered due to continued complaints. On September 11, 2009, Dr. Komanduri performed a right wrist carpal tunnel release, open, a right

open elbow lateral epicondylar release, and partial right lateral epicondylectomy with the doctor noting significant tears in the ECRV and ECRL (extensor tendons). PX 27. Dr. Komanduri testified that Petitioner's condition of lateral epicondylitis was related to her job duties as "any sort of repetitive pushing-pulling maneuver could also contribute" to the condition. PX 27. Specifically in response to a hypothetical, Dr. Komanduri testified "The gist of this is that she had a number of gripping, grabbing, lifting activities as part of her job. She told me that she had about a year of pain before I saw her and came in with a pain scale 10 out of 10 on narcotics. From my perspective, many, if not all, of those activities could have contributed to hand pain and elbow pain and shoulder pain." PX 8, p. 15-17. He further testified that Petitioner's weight had no relation to her conditions of trigger thumb or lateral epicondylitis. With regard to carpal tunnel, he testified that her job activities aggravated her pre disposition to carpal tunnel due to her weight. PX 8, p. 18.

On February 16, 2010, Petitioner underwent a diagnostic right elbow arthroscopy with removal of loose bodies, a chondroplasty and debridement of distal humerus Olecranon articular surface and open cubital tunnel release with ulnar nerve sub muscular transposition, with a post-operative diagnosis of right elbow cubital tunnel syndrome, right elbow chronic arthritis with inter-articular loose bodies, and extensive degenerative disease in the radiocapitellar joint and the ulnohumeral joint with multiple inter-articular loose bodies (Pet's. Ex. 11). With regard to that condition, Dr. Komanduri testified that he could not say it was a condition aggravated by Petitioner's work duties but that he "doubted" it was totally unrelated. PX 27, p. 19,22. Upon further questioning, he testified that her work duties more likely than not aggravated the underlying arthritis in her right elbow. PX 27, p. 23.

After diagnostic testing and failed conservative care of right shoulder complaints, on July 13, 2010, Petitioner had an arthroscopic right shoulder subacromial decompression, a mini open rotator cuff repair, an arthroscopic labral repair, and injection of a shoulder joint with platelet rich plasma, with a post-operative diagnosis of anterior labral tear, full thickness rotator cuff tear involving the supraspinatus, and chronic subacromial bursitis and subacromial osteophytes (Pet's. Ex. 12). When asked if Petitioner had this right shoulder condition when she first started treating in 2009, Dr. Komanduri testified "I can't tell you that she had a rotator-cuff tear on day one. I don't think so. I think its progressively worsened over time at work." PX 27, p. 24. Although he noted that Petitioner had not worked since 2009, he testified that "...this didn't happen in an isolated situation at home. This almost certainly happened at work." ... "I would think those doors would be a big part of the problem, lifting and pushing, and apparently she's shifting boxes and so on and doing repetitive carrying. These are traumatic injuries. This is not something that happens from ... sitting still." PX 27, p. 24-25.

The next surgery was July 12, 2011, for the left shoulder, being a subacromial decompression, mini open rotator cuff repair, arthroscopic labral repair and arthroscopic biceps tenotomy with open biceps tenodesis for a left shoulder rotator cuff repair, chronic impingement, interior labral tear, type II slap lesion and biceps anchor instability (Pet's. Ex. 13). He again related the left shoulder condition to her job duties stating that she had these chronic conditions relating to his first visit with Petitioner when she complained of upper extremity pain. PX 27, p. 25.

The next surgery was May 14, 2013, and Petitioner underwent a left wrist arthroscopy with triangular fiber cartilage complex debridement, and arthroscopy of the left elbow with removal of intraarticular loose bodies, and an arthroscopic repair of chronic lateral epicondylitis of the left elbow at Amsurg Surgery Center (Pet's Ex. 14). Dr. Komanduri testified, " I think these are overuse injuries from repetitive pushing, lifting, carrying that occurred at work. Again, this patient had essentially, and in total, had severe pain and swelling in the entire arm—both arms, dating back to 2009. We progressively resolved all of her conditions, and I suspect that they are all causally connected to work." PX 27, p. 27.

Petitioner testified and the records reveal that on September 6, 2013 Petitioner fell down stairs at home where she leaned to the left to protect her right side in falling and suffered a recurrent tear of the left shoulder for which a second left shoulder surgery was performed October 8, 2013 at Presence St. Joseph Medical Center (Pet's. Ex. 15). Dr. Komanduri testified that a portion of the tear repaired in the left shoulder in July 2011 did not restore so a revision was necessary. PX 27, p. 28. In September 2014, Petitioner underwent her last surgery which was a middle trigger finger release which Dr. Komanduri testified was not work related. PX 27, p. 28. He placed Petitioner at MMI for her work related conditions on May 1, 2014. PX 27, p. 34. He further opined that Petitioner could not return to her job as a corrections officer due to the totality of her health conditions as of 2014.

Petitioner's Exhibit 25 is the Section 12 Exam by an Occupational Specialist, Dr. Jeffrey Coe. The report is dated July 2, 2012, before all treatment was concluded. It set forth the history which included work as a correctional officer requiring repetitive and forceful use of both upper extremities, and it included the history that she was assigned various duties during her employ including cell house work, sanitation work, adjustment committee, gate house and tower duty. Petitioner reported that all of her assigned duties were "stressful to her upper extremities" and that the use of the Folger-Adams keys were "difficult for her to grip and turn." Petitioner reported the gradual onset of symptoms starting with locking of her right thumb and that with continued work activities she reported the onset of upper extremity pain, tingling and pressure in both shoulders. The doctor noted no past significant injuries or symptoms from her shoulders, arms, or hands prior to her work for the State of Illinois, and no hand intensive home activities or history of diabetes, thyroid disease, or collagen and vascular diseases. There was evidence of Petitioner being borderline or "uncontrolled" diabetic. After performing an exam with significant deficits and reciting all surgeries to date, Dr. Coe found that the repetitive strain injuries were a factor in causing development of a right trigger thumb, right carpal tunnel syndrome, right lateral epicondylitis, right ulnar nerve entrapment at the elbow and bilateral shoulder labral and supraspinatus tears. Dr. Coe opined there was a causal relationship between the repetitive strain upper extremity injuries and overuse of these extremities suffered at work to April 13, 2009. He opined that Petitioner's injuries caused permanent partial disability to both hands, arms, and to the person as whole and requiring permanent work restrictions at the sedentary demand level with all activities below shoulder height. In addition, he noted she would be unable to use firearms or assist fellow officers in correctional work. PX 25.

Respondent offered the deposition of Dr. Michael Vender, Respondent's Exhibit 2 which included Section 12 Exams. Petitioner presented for an independent medical evaluation with Dr. Vender on May 14, 2014. (Rx2, 4). Petitioner reported the onset of symptoms in both upper extremities going back to 2007. He noted she had been off work since 2009. At the time of the IME, Petitioner reported significant ongoing complaints in both upper extremities and lower extremities with ongoing treatment. Petitioner expressed frustration with her ongoing musculoskeletal complaints several times during the exam. Petitioner reported continued pain in both shoulders, both wrists, both elbows, diffuse left hand pain and right middle finger locking. With regard to her job duties, Petitioner reported she was a correctional officer and performed various activities including pulling carts, carrying products and opening and closing of gates. The ongoing assumption at the deposition was that Petitioner opened and closed heavy hinged gates two times per minute. He noted Petitioner was 5 foot 6 and weighed 269 pounds. He noted Petitioner was diabetic. Dr. Vender assumed most of the job activities were sedentary to light and understood the gate Petitioner operated was a sliding gate. He did not know the weight of the gates and assumed she would only be pulling a gate towards her.

With regard to Petitioner's trigger fingers, cubital tunnel, carpal tunnel, epicondylitis and rotator cuff tears, Dr. Vender opined that Petitioner's marked musculoskeletal problems, especially of a diffuse nature, are more indicative of a systemic predisposition to the development of musculoskeletal diseases. (Rx2). Further, on the

aggregate, the Petitioner's conditions could not be explained by the performing of work activities, especially the type of activities described by Petitioner. He testified that he did not consider opening and closing the gates as described by Petitioner to be a high risk factor for the development of Petitioner's multiple conditions. He further noted that Petitioner described various activities performed at work and he considered all activities to be of sedentary or light nature. Dr. Vender specifically testified that lateral epicondylitis required forceful gripping with the elbow extended for significant duration. With regard to medical epicondylitis, repeated forearm pronation, heavy lifting and resisted wrist flexion is required. For ulnar nerve or cubital tunnel, forceful hyperflexion of the elbow is required. For trigger fingers forceful gripping associated with palm pressure irritating the A1 pulley area is required. For carpal tunnel, forceful activities on a regular and persistent basis with gripping is required. Dr. Vender opined that Petitioner's whole presentation was unusual, she had continued symptoms despite several surgeries and that as such it was difficult to correlate her subjective complaints with objective findings. Further, the doctor stated the Petitioner reached MMI. Lastly, the doctor stated he believed the Petitioner would be able to perform her previous work activities as a correctional officer.

On cross, Dr. Vender agreed that work activities and diabetes can be contributing factors to the development of carpal tunnel. However, he testified that if there is no risk factor posed by the job duties then the job duties are not going to contribute to the problem even if there are other things now predisposing the patient. RX 2, p. 28.

Lastly, during a Section 12 exam on November 1, 2016 with Dr. Nho, the Petitioner presented with subjective complaints of bilateral shoulder soreness, with the right shoulder worse than the left. (Rx3). Objectively, the Petitioner had mild limitations in range of motion, pain with provocative maneuver, and reasonable strength. Id. The diagnosis was status post bilateral rotator cuff repair with appropriate soreness. Id. With regard to causal connection to a work injury, Dr. Nho stated that "I do not believe that the alleged work injury had led to both of her shoulder ailments but rather I believe that these are likely usual wear and tear of both her shoulder leading to rotator cuff degeneration." (Rx3) Dr. Nho went further and stated that "the medical treatment to date has been excessive with regards to this alleged work injury. I do not believe the shoulder is related to original injury on April 13, 2009." Dr. Nho's report does not reference any description of Petitioner's job duties recorded or provided by Petitioner.

At trial, Petitioner testified that she has been off work since 2009 and has gained weight due to inactivity. Petitioner testified that she participated in Respondent's alternative employment program in spring 2016. She applied and qualified for various clerk jobs and switch board positions in Cook County but did pursue those jobs as she wanted to work in Will County. Petitioner is currently on SSDI. Petitioner did not retire from Respondent. She testified that her right middle finger currently locks up and she cannot make a fist or grip with her right hand. She uses ice, ibuprofen and Norco for continued pain and swelling and needs the medication to perform daily activities.

CONCLUSIONS OF LAW

The above findings of fact are incorporated into the following conclusions of law.

In Support of the Arbitrator's Decision regarding "C" (Accident arising out of in the course of employment and "F" (Causal Connection), the Arbitrator makes the following findings and conclusions:

After considering the evidence as a whole, the Arbitrator finds that Petitioner failed to establish that she sustained a compensable accident as claimed. Specifically, the arbitrator finds that there is insufficient evidence to establish that Petitioner's multiple claimed injuries including trigger fingers, cubital tunnel, carpal tunnel,

epicondylitis and rotator cuff tears are linked to her duties as a correctional officer for Respondent. In so concluding, the Arbitrator notes Petitioner's testimony about her duties starting in 1996 and finds that those duties varied over the next 13 years. Petitioner's testimony and the medical records indicate that between 1996 and 2009, Petitioner worked in or at the gates, cell houses, administrative, towers and writs. Petitioner's frequent use of keys, both regular and Folger-Adams, and the frequency of the maneuvers performed to open the gates during a shift while working some of these positions, are not lost on the Arbitrator. However, in assessing the issues of repetitive trauma and causal connection the Arbitrator places greater weight on the testimony of Dr. Vender than on the testimony of Petitioner and the vague opinions offered by Dr. Komanduri.

In this matter, Dr. Vender's testimony and medical opinion regarding a lack of causal connection between Petitioner's job duties and her multiple conditions is more detailed and persuasive. Dr. Vender understood Petitioner's job duties as a correctional officer and relied on Petitioner's proffered description of her duties, in particular the gates position, in assessing causal connection. He testified to the necessary physical maneuvers required for each condition and concluded that Petitioner's job duties did not require her to perform the necessary maneuvers with the required frequency, force or repetitiveness to result in her multiple conditions. Conversely, Dr. Komanduri offered a general summation of his opinion that Petitioner's conditions were causally related to her job stating, "From my perspective, many, if not all, of those activities could have contributed to hand pain and elbow pain and shoulder pain." Dr. Komanduri's opinion was further and simply based on the fact that Petitioner had the complaints to all of the body parts involved when he first saw her in 2009 and that "... This is not something that happens from ... sitting still." The Arbitrator finds that Dr. Komanduri's opinion is general and thus flawed.

Based on all of the foregoing and the record in its entirety, the Arbitrator finds that Petitioner did not sustain a repetitive trauma type injury that arose out of and in the course of her employment with Respondent manifesting on April 13, 2009 as claimed. Accordingly, all other issues are rendered moot and all requested compensation and benefits are denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SHAWN DANIELS,
Petitioner,

vs. No: 12 WC 36183

M-CLASS MINING,
Respondent

ORDER

This matter comes before the Commission on Petitioner's petition for penalties pursuant to §19(k) and §19(l), and fees pursuant to §16, of the Act. A hearing was held before Commissioner Simpson on November 3, 2017 in Mt. Vernon, the parties were represented by counsel, and a record was taken.

The Commission approved a settlement of the instant claim on April 8, 2016. The settlement provided Petitioner be paid a total of $270,000.00, representing loss of "approximately" 60% of the person-as-a-whole, loss of "approximately" 29% of the left arm, and loss of 7.5% of the left hand. The contract also provides that "Respondent has or will pay all related, reasonable and necessary medical expenses incurred by the petitioner that are causally related to the alleged accident of **6/11/2012** that were incurred and that were submitted to the Respondent or its insurer." (emphasis in original).

The record indicates that Petitioner engaged in self-initiated professional vocational rehabilitation services provided by England & Associates. Those services resulted in Petitioner being offered a job in which he earned less than he did in his previous occupation. Respondent agreed to the new employment. It is undisputed that Petitioner submitted the bills for vocational rehabilitation prior to the settlement. The crux of the instant dispute is whether the vocational rehabilitation services are incorporated in the settlement provision that Respondent is required to pay all medical bills submitted to it or its insurer prior to the settlement, and whether its non-payment of those bills exposes Respondent to penalties and fees under the Act.

Respondent argues that it is not responsible for vocational rehabilitation bills because they are not medical bills, as specified in the settlement. In addition, it claims it paid $279,016.75 in medical bills prior to the settlement. Petitioner seems to argue that vocational rehabilitation services are subsumed into medical expenses because both medical expenses and vocational rehabilitation are included in Section 8(a). Petitioner also asserts that "courts should not decide contract matters 'in a vacuum looking only to the four corners of the document,'" citing an Appellate Court case.

With all due respect to Petitioner, the Commission is not a court and we are specifically precluded by the Act from considering matters not in the record before us. From the settlement document, we do not know whether the "meeting of the minds" included Respondent being responsible for payment of the vocational rehabilitation services Petitioner incurred. In our opinion Respondent has a legitimate dispute on whether vocational rehabilitation is included within its obligation to pay medical expenses. Therefore, we cannot find that Respondent has acted unreasonably or in a vexatious manner in not paying those expenses and accordingly denies Petitioner's petition.

The Commission notes that if the parties cannot mutually agree on the meaning of their contract, the matter can be taken to Circuit Court, either through direct appeal of this order or through enforcement of a judgement after the settlement/Commission decision is certified pursuant to §19(g). Circuit Courts have better resources than the Commission with which to determine the intent of the parties and/or to enforce an interpretation of the contract.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Petitioner's petition for penalties pursuant to §19(k), §19(l), and fees pursuant to §16 of the Act is denied.

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

DATED: APR 5 - 2018

Deborah L. Simpson

Deborah L. Simpson

David L. Gore

David L. Gore

Stephen J. Mathis

Stephen J. Mathis

DLS/dw
R-11/3/17
46

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROBERT E. BUTTS,
Petitioner,

vs. No: 14 WC 584

SALEM MANUFACTURED & MODULAR HOMES, LTD.,
Respondent

ORDER

This matter comes before the Commission on Petitioner's petition for penalties pursuant to §19(k) and §19(l), and fees pursuant to §16, of the Act. A hearing was held before Commissioner Simpson on January 10, 2018 in Collinsville, the parties were represented by counsel, and a record was taken.

The Commission approved a settlement of the instant claim on February 24, 2017. The settlement provided Petitioner be paid a total of $51,075.00, representing loss of "approximately" 30% of the person-as-a-whole. The contract also provides that "Respondent has or will pay all related, reasonable and necessary medical expenses incurred by the petitioner that are causally related to the alleged accident of **6/14/2011** that were incurred and that were submitted to the Respondent or its carrier prior to the date of this settlement." (emphasis in original).

The record indicates that Petitioner engaged in self-initiated professional vocational rehabilitation services provided by England & Associates. Those services resulted in Petitioner being offered a job, which he accepted. Petitioner presented cover letters it allegedly sent Respondent with the vocational rehabilitation bills. Respondent argues that it could not locate the bills in its file. The crux of the instant dispute is whether the vocational rehabilitation services are incorporated in the settlement provision that Respondent is required to pay all medical bills submitted to it or its insurer prior to the settlement, and whether its non-payment of those bills exposes Respondent to penalties and fees under the Act.

Respondent argues that it is not responsible for vocational rehabilitation bills because they are not medical bills, as specified in the settlement. Petitioner seems to argue that vocational rehabilitation services are subsumed into medical expenses because both medical expenses and vocational rehabilitation are included in Section 8(a). Petitioner also asserts that "courts should not decide contract matters 'in a vacuum looking only to the four corners of the document,'" citing an Appellate Court case.

With all due respect to Petitioner, the Commission is not a court and we are specifically precluded by the Act from considering matters not in the record before us. From the settlement document, we do not know whether the "meeting of the minds" included Respondent being responsible for payment of the vocational rehabilitation services Petitioner incurred. In our opinion Respondent has a legitimate dispute on whether vocational rehabilitation is included within its obligation to pay medical expenses. Therefore, we cannot find that Respondent has acted unreasonably or in a vexatious manner in not paying those expenses and accordingly denies Petitioner's petition.

The Commission notes that if the parties cannot mutually agree on the meaning of their contract, the matter can be taken to Circuit Court, either through direct appeal of this order or through enforcement of a judgement after the settlement/Commission decision is certified pursuant to §19(g). Unlike the Commission, which is limited to the specific powers granted under its Act, Circuit Courts have greater resources, and the authority, with which to determine the intent of the parties and/or to enforce an interpretation of the contract.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Petitioner's petition for penalties pursuant to §19(k), §19(l), and fees pursuant to §16 of the Act is denied.

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

DATED: APR 5 - 2018

Deborah L. Simpson

Deborah L. Simpson

David L. Gore

David L. Gore

Stephen J. Mathis

Stephen J. Mathis

DLS/dw
R-11/3/17
46

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Stephen Harris,

Petitioner,

18IWCC0206

vs.

NO: 16 WC 05763

Northwestern University,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective medical care, and the nature and extent of the disability and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Petitioner, a 46-year-old animal care technician, filed an Application for Adjustment of Claim alleging repetitive trauma injuries to both hands manifesting on September 22, 2012. To treat his work-related injury, Petitioner underwent two bilateral carpal tunnel release surgeries. Respondent disputed the medical necessity of a third round of bilateral carpal tunnel releases, and Petitioner sought an award of the requested treatment and medical expenses pursuant to §8(a) and §19(b). In the alternative, Petitioner sought an award of permanent partial disability benefits.

The Arbitrator denied Petitioner's request for a third carpal tunnel surgery, finding that Petitioner failed to prove that the prospective treatment was medically necessary. The Arbitrator awarded permanent partial disability benefits representing the loss of use of 15% of each hand. After considering all the evidence, we affirm the Decision of the Arbitrator on the issue of prospective medical care for the reasons set forth by the Arbitrator. We hereby modify the Decision of the Arbitrator on the issue of the nature and extent of the injury.

18IWCC0206

In considering permanent partial disability, the Arbitrator weighed the §8.1(b) factors: 1) There is no impairment rating in evidence; 2) Petitioner is currently working full duty in his pre-injury job and based on Petitioner's testimony the job duties are repetitive and hand-intensive; 3) Petitioner was 46-years-old at the time of the injury and the Arbitrator noted he has relatively fewer years of work-life expectancy than a younger individual; 4) Petitioner's earning capacity has not been affected; and 5) The evidence of disability corroborated by the treatment records shows that two rounds of surgeries failed to improve Petitioner's work-related condition.

Pursuant to the 2011 amendments to the Act, a claimant must present clear and convincing evidence to support any award above 15% of a hand for carpal tunnel syndrome due to repetitive trauma. We find that despite two rounds of bilateral surgeries to address his carpal tunnel syndrome, Petitioner consistently reports high pain levels. He underwent additional treatment in the form of a right wrist injection by Dr. Vender and a left wrist injection by Dr. Xia, but reportedly received no benefit. Petitioner's scars are noted to be "thick and prominent" and Petitioner consistently reports that they interfere with his day-to-day functions, although he is working full duty. After considering all the evidence of permanent partial disability, we modify the Arbitrator's award and find that Petitioner is entitled to 20% loss of use of his dominant right hand and 15% loss of use of his left hand.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,231.00, subject to §8(a) and the medical fee schedule of §8.2 of the Act, for treatment related to Petitioner's carpal tunnel syndrome and incurred on or before October 4, 2016.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $455.99 per week for a period of 66.5 weeks, as provided in §8(e)9 of the Act, because the injuries sustained caused 15% loss of use of the left hand and 20% loss of use of the right hand.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $31,700.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED:
DLS/plv
o-3/22/18
46

APR 5 - 2018

Deborah L. Simpson

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

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

18IWCC0206

HARRIS, STEPHEN S
Employee/Petitioner

Case# **16WC005763**

NORTHWESTERN UNIVERSITY
Employer/Respondent

On 10/13/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.22% 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:

2512 THE ROMAKER LAW FIRM
CHARLES P ROMAKER
211 W WACKER DR SUITE 1450
CHICAGO, IL 60606

1109 GAROFALO SCHREIBER STORM
MATTHEW J NOVAK
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

18IWCC0206

18IWCC0206

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Stephen S. Harris
Employee/Petitioner

v.

Northwestern University
Employer/Respondent

Case # 16 WC 5763

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Glaub**, Arbitrator of the Commission, in the city of **Chicago**, on **7/26/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Nature and extent of disability if further medical treatment not awarded.**

FINDINGS

On the date of accident, **9/8/2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$759.99**; the average weekly wage was **$39,519.48**.

On the date of accident, Petitioner was **46** years of age, ***married*** with **3** dependent children.

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

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

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

ORDER

The arbitrator finds that the petitioner's carpal tunnel syndrome is causally related to his September 8, 2012.

The petitioner is awarded and the respondent is order to pay reasonable and necessary medical expenses in the amount of $1,231.00, subject to Section 8(a) and the medical fee schedule of Section 8.2 of the Act, for treatment related to his carpal tunnel syndrome and incurred on or before October 4, 2016.

The petitioner's request for authorization of his third bilateral carpel tunnel release surgeries is denied as the proposed surgeries are not medically necessary.

The respondent shall pay the petitioner permanent partial disability benefits of $455.99 per week for 57 weeks because the injuries sustained caused 15% loss of use of the left hand and 15% loss of use of the right hand as provided in Section 8(e)9 of the Act. Any accrued benefits are to be paid in a lump sum.

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

10/13/17
Date

ICArbDec19(b)

OCT 13 2017

Stephen Harris v. Northwestern University

No. 16 WC 5763

FINDINGS OF FACT

The petitioner has worked as an animal care technician for the respondent since 1996 or 1997. In this position his job responsibilities included changing out animal cages for mice and feeding primates, rabbits, dogs, pigs and gerbils. Feeding would involve opening and closing cage doors and putting the feed into the cage. The petitioner estimated that, at most, he handled 2,700 mouse cages on one day. On weekends he would come and do health checks where he would check out approximately 3,000 to 4,000 cages in the weekend.

In September of 2012 the petitioner began to experience numbness and tingling in both of his hands and sought medical treatment with Dr. Ellis Nam on September 8, 2012. He provided a history of bilateral hand numbness, right possibly worse than left, for approximately one year. He also complained of pain over his second MCP joint to his right hand over the past several months, but did not recall any acute trauma. Physical examination revealed signs consistent with bilateral probable carpal tunnel syndrome and possible right MCP joint sprain of the second digit of the right hand. At a follow up with Dr. Nam on September 29, 2012, it was recommended that the petitioner undergo an EMG study of the bilateral upper extremities to rule out carpal tunnel versus cubital tunnel. On October 6, 2012 the petitioner saw Dr. Nam, who reviewed an EMG study from October 1, 2012 that demonstrated evidence of mild bilateral carpal tunnel syndrome. Dr. Nam performed a Cortisone injection into the right carpal tunnel on this date. When the petitioner followed up with Dr. Nam on October 13, 2012 it was recommended he undergo surgical intervention for his carpal tunnel syndrome.

The petitioner also sought medical treatment with Dr. Michel Malek for both his carpal tunnel syndrome and an unrelated back condition. The earliest dated medical record from Dr. Malek is September 10, 2012. There are various diagnoses contained in this record pertaining to the petitioner's lumbar spine, but there is a recommendation for evaluation of the bilateral hands.

The petitioner followed up with Dr. Malek on October 8, 2012 following an EMG/NCV study of the upper extremities. Dr. Malek noted this showed moderate bilateral carpal tunnel syndrome with possible cervical radiculopathy. With respect to the carpal tunnel syndrome Dr. Malek provided bilateral wrist splints then recommended continued physical therapy. It was noted that Dr. Nam did an injection to the wrist for the carpal tunnel syndrome. Eventually, conservative medical treatment failed and Dr. Malek performed bilateral carpal tunnel release surgeries, the first occurring on February 8, 2013 and the second occurring on March 15, 2013. The procedures performed on both surgeries were open carpal tunnel release and external neurolysis. Postoperatively the petitioner stated he was doing well following his bilateral carpal tunnel releases and underwent physical therapy beginning around May of 2013.

The petitioner underwent an IME with Dr. Thomas Wiedrich on May 1, 2013. The petitioner was seen for his bilateral hands and it was noted that he had had recent bilateral carpal tunnel releases in February and March of 2013. He states that he was not sure that the surgeries had helped him as he had still had pain in his arm and he notices some numbness and stiffness when he wakes up in the morning. It was also noted he had not been enrolled in physical therapy, and thought his doctor was going to prescribe some. Dr. Wiedrich noted the petitioner was status post bilateral carpal tunnel releases and he had not reached maximum medical

improvement but would do so in six to eight weeks. The petitioner could return to work with restrictions and noted that there was no impairment rating at the time, but typically after a carpal tunnel release surgery there is no permanent impairment unless a significant surgical complication occurred. Dr. Wiedrich recommended additional physical therapy.

A July 24, 2013 report from Dr. Malek states that the petitioner had returned to work and was doing excellent prior to his return to work, but after three or four hours of repetitive work his back and hands began to bother him significantly. Dr. Malek stated the petitioner had no pressure on his nerves and that the problem was nerve damage itself. Dr. Malek recommended medications as his physical examination did not show a focal deficit.

The petitioner sought medical treatment at Northwestern Medicine on May 22, 2013. He complained of bilateral hand numbness and pain left greater than the right. The petitioner stated that his left hand was worse than it was before his surgery, and it was noted that he had had carpal tunnel releases on the right and the left. It was noted that he had recently returned to work light duty, but prior to going back to work he had some pain in both hands and tingling of the fingers that had recently worsened. It was also noted he had started physical therapy and ha two sessions. The petitioner was given restrictions and he was referred to Dr. Michael Vender for further evaluation.

The petitioner was seen by Dr. Vender on May 31, 2013. He complained of bilateral hand pain and numbness and tingling in all of the hands and digits of each hand. It was noted that the petitioner had a prior carpal tunnel release in February, 2013 and again in March of 2013 for the right and left hands respectively. Since that time he stated he overall felt worse and his symptoms were very similar to prior to the carpal tunnel releases, though he thought the numbness may be worse. He stated he ha more significant pain mostly in the surgical areas. Dr. Vender noted that the petitioner underwent electrodiagnostic studies on May 31, 2013 with Lakeshore Neurology and an EMG report. The radiologist's impression was moderate left sided residual carpal tunnel syndrome and mild to moderate residual right carpal tunnel syndrome. Dr. Vender stated that it was not unusual to experience some degree of abnormality even after a successful carpal tunnel release and recommended additional time for healing.

At a follow up appointment with Dr. Vender on June 28, 2013, the petitioner continued to experience pain with numbness and tingling in his hands that he though could be worse than his preoperative condition. He stated that during certain activities his hands would go numb and feel heavy. Dr. Vender sated that it was reasonable to proceed with a repeat carpal tunnel release surgery. On July 30, 2013 Dr. Vender performed a repeat carpal tunnel release with flexor synovectomy, neurolysis of the median nerve, flexor tenolysis, flexor tendons to index and flexor pollicis longus. On September 10, 2013 Dr. Vender performed a repeat right carpal tunnel release with synovectomy, neurolysis of the median nerve, tenolysis of flexor digitorum profundus and superficialis of the middle, ring and small fingers.

Postoperatively the petitioner was progressing more slowly than with a routine carpal tunnel release, though Dr. Vender stated this was consistent with a revision surgery involving more extensive release and neurolysis. Post-operatively the petitioner underwent significant postoperative physical therapy through Dr. Vender's office. On November 13, 2013 Dr. Vender noted that the petitioner had done very well in physical therapy. The petitioner's strength was good but he was concerned about returning to work. There was a discussion about the need to attempt to return to work though that could cause some change in symptoms. Dr. Vender recommended that he return to normal work activities though he had a limit on the number of cages he could clean per day. On December 18, 2013 the petitioner stated he was concerned about his ongoing complaints. Dr. Vender noted he was reaching a point of maximum medical improvement and expected the petitioner to continue to improve over time. It was noted that he could continue to have some degree of residual complaints and that his hands

may never feel the same as he previously perceived them. That being said, Dr. Vender did not anticipate a significant impairment or need for restriction.

The petitioner followed up with Dr. Vender on March 12, 2014 with concerns regarding residual discomfort in the palm and the nature of the scars from his carpal tunnel surgeries. Dr. Vender noted the discomfort was not unexpected after undergoing two surgeries, though it was possible that he continued to improve with time. Dr. Vender indicated he would not try to revise the scar in palm of the left side and the right sided palm scar was not a problem. Consideration could be given to revising the portion of the scar in the dorsal forearms, though recurrent thickening or keloid scar formation could occur. Dr. Vender would not recommend it until at least after a year following his prior surgery. At another follow up visit on July 30, 2014 it was noted that a prior steroid injection into the left first extensor compartment did not help. The petitioner related multiple complaints of both hands and noted that at times his fingers will twitch and there is a significant feeling of weakness. There was some tenderness of both first extensor compartments but definitely not indicative of DeQuervain's disease. The petitioner continue to discuss the possibility of scar revisions in the distal volar forearm.

Dr. Vender generated a letter dated January 12, 2015 that, among other things, noted the petitioner had undergone bilateral carpal tunnel revision surgeries and had experienced an excellent clinical response. While the petitioner had some degree of complaints after the surgery, these were not necessarily indicative of an ongoing nerve problem. The petitioner focused for many months on the nature of his scar without any neurological complaints. Later he presented with complaints still referable to his scars but also with other non-specific complaints, and for a long time he did not have any indications of an ongoing neurological problem. Therefore, there was no reason to suspect that he was redeveloping neurological problems. Dr. Vender stated the petitioner would never be completely free of symptoms based upon the nature of his ongoing complaints but those complaints were not of clinical significance. Dr. Vender believed that further surgery would be contra indicated for the petitioner.

The petitioner also sought medical treatment with Dr. Renlin Xia from October 24, 2014 through May 17, 2017. Dr. Xia's medical records mostly involve treatment for the petitioner's lower back condition, which is not the subject of this case. In regards of the bilateral hand conditions it was noted that the petitioner was treating with a hand surgeon for these conditions.

The petitioner then saw Dr. Jeffrey Wienzweig on October 30, 2014 for bilateral carpal tunnel syndrome on referral from Dr. Xia. It was noted the petitioner had bilateral carpal tunnel release recently performed by Dr. Vender approximately one year prior with minimal release and that he was scheduled to undergo an additional release with Dr. Vender. Dr. Wienzweig wanted to obtain additional medical records and diagnostics studies and follow up with the petitioner regarding medical treatment. In the interim, the petitioner continued working his full duty job.

On November 5, 2014 a repeat EMG study was performed of the bilateral upper extremities at Norwegian American Hospital. The interpretation was moderate carpal tunnel syndrome of the right and mild carpal tunnel syndrome on the left with underlying axonal sensory neuropathy.

Dr. Wienzweig again saw the petitioner on November 25, 2014 for further evaluation of his carpal tunnel syndrome, left greater than right with axonal neuropathy. Dr. Wienzweig explained at length that this would be his third carpal tunnel release procedure and there was no guaranty that there would be any improvement of his symptoms due to significant injury to the median nerves at this point. It was noted the petitioner would also need neurolysis as well as the carpal tunnel release. In the interim the petitioner continued to work full duty while awaiting authorization for the carpal tunnel release.

A Utilization Review report was prepared by Prium on July 27, 2016 and was directed to Dr. Wienzweig. It noted medical records had been reviewed and noted that Dr. Wienzweig's registered nurse called the utilization reviewer to discuss the clinical details and the guidelines. The reviewer, Dr. David Trotter, determined that Dr. Wienzweig's proposed third bilateral carpal tunnel release surgery was not medically necessary. In his opinion, the clinical information did not establish the medical necessity of the proposed surgeries. Dr. Trotter noted there was no documentation of sensory examination or carpal tunnel provocative testing nor was there documentation of a positive diagnostic injection for the more recent treatment.

The petitioner was seen by Dr. John Fernandez for an independent medical examination on August 25, 2016. The petitioner related his history of symptoms while working for the respondent as an animal care technician. He was currently complaining of bilateral hand and wrist complaints that were somewhat globally distributed and not very focal. He described numbness in the hands, but it was more consistent with pain complaints rather than true neurologic symptoms. Dr. Fernandez noted he was very specific with him and took time trying to distinguish his complain of neurological symptoms such as numbness or tingling away from pain complaints. The pain complaints were again somewhat vague and global along the volar and dorsal wrist. He also complains of weakness relating this and rated his complaints of pain at 8/10 at rest and 9/10 with moderate to heavier activities. Despite all that he continued to work essentially in a full capacity. After review of medical records and a job description and conduction of an examination, Dr. Fernandez indicated he would not recommend any further carpal tunnel surgery. The petitioner had already had two surgical procedures and a third surgical procedure for carpal tunnel release is not medically indicated. There would be significant risk with little function to return. Dr. Fernandez noted there was no irritability or percussion or compression over the median nerve at the wrist and a 2-point discrimination test was normal with no atrophy of the thenar muscles. Although EMG studies may show abnormalities in the median nerve, this did not mean there was active disease present. He did not have significant subjective complaints supporting a diagnosis of active median nerve neuropathy. Dr. Fernandez stated the petitioner could continue working full duty despite his subjective complaints of pain. There would be further medical treatment for work up for arthritis to his wrist, and this would be separate from his workers' compensation claim. While the petitioner had some keloid formation for scarring at the risk, there were no deficits involving the median nerve itself. Other than the scars he has the petitioner had only subjective complaints of pain or discomfort, which appeared to be emanating from his wrist joints themselves as seen in the radiographic findings. X-rays of both hands and wrists revealed degenerative changes and possible widening of the scapholunate interval indicative of possible carpal instability or carpal degeneration. There do not appear to be any neurologic losses from an objective basis on physical examination and his symptoms did not correlate with the EMG findings.

The petitioner testified that he continued to experience numbness, sharp pains, and swelling in his hands when he wakes up. He would experience dropping things and possibly experiencing anxiety. He also continued to experience on and off tingling in his fingers and thumbs. When further questioned, the petitioner stated that he experiences tingling and numbness in all of his fingers in both hands. The petitioner testified that he wants to undergo the third surgery recommended by Dr. Wienzweig due to his pain. The petitioner has had two surgeries and has continued to work his full duty job in the same position for the respondent since he was hired. He testified that, of his four prior surgeries (two on the left and two on the right) for carpal tunnel syndrome, none provided any meaningful relief and possibly made his hands worse.

CONCLUSIONS OF LAW

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

The medical records are replete with information establishing the petitioner suffers from bilateral carpal tunnel syndrome and has undergone two surgeries in an attempt to cure or alleviate the effects of this medical condition. The petitioner has received care from multiple doctors including specialists in the treatment of hand and wrist related conditions. While the Arbitrator notes that medical records do not contain a specific statement causally relating the petitioner's bilateral carpal tunnel syndrome to the performance of his job duties for the respondent other than Dr. Cullen's note of May 29, 2014 that petitioner had "Bilateral CTS: Work related overuse". The Arbitrator also notes that there is no medical opinion that petitioner's carpal tunnel syndrome is unrelated to the performance of his job duties. That Arbitrator notes that the petitioner provided histories to his physicians of repetitively using his hands in the performance of his job duties for the respondent. The petitioner testified that he may have to handle upwards of 2,700 mouse cages every day and perform wellness checks on between 3,000 to 4,000 cages on the weekends, which involves opening and closing cage doors and potentially moving cages for smaller animals. The petitioner testified that he has been employed for the respondent since 1996 or 1997.

Based on the above, the Arbitrator finds that the petitioner's bilateral carpal tunnel syndrome is causally related to his repetitive work duties for the respondent, Northwestern University.

K. Is the petitioner entitled to prospective medical care?

The petitioner is seeking authorization and payment for a proposed carpal tunnel release for both hands. This would be the third such surgery performed on both of his hands.

In support of the claim of medical necessity for the third bilateral carpal tunnel release surgeries, the petitioner relies upon the opinions of Dr. Weinzweig. However, in Dr. Weinzweig's report of November 25, 2014 he states "there is no guarantee that there will be improvement of his symptoms due to significant injury to the median nerves at this point." (Px 11). The petitioner's second treating physician, Dr. Vender, noted that it was not unusual for a patient to show permanent changes on electrodiagnostic studies, but they do not necessarily have any clinical significance. To this extent, a diagnosis of carpal tunnel syndrome needed to be correlated with a clinical presentation. Dr. Vender noted that the petitioner had an excellent clinical presentation after his repeat carpal tunnel release surgeries, and while he may always have some degree of complaints they were not necessarily indicative of an ongoing nerve problem. Dr. Vender believed the petitioner's ongoing complaints were not of clinical significance and further surgery for the petitioner for this condition would be contra-indicated. (Px 8). Dr. Fernandez examined the petitioner and opined that a third carpal tunnel release for both hands would not be medically indicated. He stated there would be significant added risk with little functional return. Dr. Fernandez also noted that there were no physical examination findings or subjective complaints supportive of a diagnosis of active median nerve neuropathy. (Rx 4). Finally, Dr. Trotter in his UR report opined that the proposed third carpal tunnel release surgery for both hands was not medically necessary, which is consistent with the opinions of Dr. Vender and Dr. Fernandez. (Rx 3).

While it is noted the petitioner continues to tender subjective symptoms including pain, numbness and tingling in both of his hands, Dr. Vender noted that it would not be unusual for some residual electrical diagnostic evidence and other symptoms to be present following the second carpal tunnel release. Even Dr.

Malek, the surgeon performing the first carpal tunnel release, noted the petitioner may have a degree of permanent nerve damage. Dr. Fernandez did not find any evidence of active carpal tunnel symptoms and opined that a third carpal tunnel release surgery for both hands would be unnecessary and not medically indicated. Even Dr. Weinzweig, the petitioner's treating physician, stated that there would be no guarantee of improvement of his symptoms due to significant injury to the median nerves. Though a neurolysis was also proposed in addition to the carpal tunnel release surgery, the Arbitrator notes that both prior surgeries involved neurolysis and provided no benefit. The petitioner had testified that neither of the prior two bilateral carpal tunnel release surgeries provided any significant relief to his symptoms Dr. Weinzweig does not appear to be proposing anything different than what was performed in the four prior surgeries and which offered no relief according to the petitioner. As a result, the evidence in its totality suggests that the third surgery will also not offer any benefit to the petitioner, and as such it cannot be said that the third proposed carpal tunnel release surgeries are medically necessary to cure the petitioner's symptoms. It appears unlikely that the third carpal tunnel release surgery would improve the petitioner's symptoms at all. Finally, the arbitrator notes that the respondent's denial of the third surgery is based (in part) upon a utilization review report consistent with Section 8.7 of the Act.

Based upon all of the above, the Arbitrator finds the petitioner failed to prove he is entitled to prospective medical care in the form of the surgeries proposed by Dr. Weinzweig.

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

At issue appears to be treatment for the petitioner's carpal tunnel syndrome condition after his discharge from care by Dr. Vender, and it includes the medical bills of Dr. Wienzweig. Based on the foregoing evidence, the Arbitrator awards medical expenses and orders the respondent to pay medical bills incurred on or before October 4, 2016, the date of the final treatment in the medical bill of Dr. Weinzweig.

Based upon all of the above, the Arbitrator finds that the treatment of Dr. Weinzweig was medically necessary and that the respondent is responsible for those medical charges (which are listed at $1,231.00) for dates of treatment listed on the medical bill as October 28, 2014 through October 4, 2016 (Px 12) pursuant to the Illinois Medical Fee Schedule. The parties agreed that the balance of the medical bills submitted into evidence had already been paid. (T 5).

O. Other: Nature and Extent of Disability

The parties stipulated at hearing that, if the Arbitrator did not award further medical treatment in the form of a third carpal tunnel release surgery for both hands, the Arbitrator would render an award for permanent partial disability benefits. Since the third carpal tunnel release surgery for both hands is being denied as detailed above, the following is the Arbitrator's permanency award.

Section 8.1(b) of the Illinois Workers' Compensation Act provides that, for accidental injuries occurring after September 1, 2011, permanent partial disability is established using the following criteria:

1. The reported level of impairment using an AMA impairment rating; The parties did not introduce an impairment rating consistent with the AMA Guides to the Evaluation of Permanent Impairment as contemplated

in 8.1(a) of the Act. As such, the Arbitrator gives this factor no weight in determining permanent partial disability.

2. The occupation of the injured employee; In terms of the occupation of the injured employee, the Arbitrator notes that the petitioner is an animal care technician and is currently working full duty in that position. Based on the petitioner's testimony, the Arbitrator notes that this is a repetitive job and appears to involve intensive use of hands in the course of performing the job duties. As such, the Arbitrator gives this factor greater weight

3. The age of the employee at the time of the injury; The third factor, the age of the employee at the time of the injury, provides that the petitioner was forty-six years old at the time of his accidental injury. This means that the petitioner is now over half way through his expected work-life expectancy and has less years of work ahead of him as compared to other individuals in the labor market. As such, the Arbitrator gives this factor the appropriate weight.

4. The employee's future earning capacity; The fourth factor is the employee's future earning capacity. At trial the petitioner testified that he has suffered no loss of earning capacity as a result of his work related injury. The petitioner has testified that he continued to work full duty in the same position for the respondent following both of his surgeries. As such, the Arbitrator gives this factor lesser weight.

5. Evidence of disability corroborated by the treating records;
The fifth factor is evidence of disability corroborated by the treating medical records. The medical records establish that the petitioner did not have a good result from his two carpel tunnel release surgeries. He has subjective complaints of pain, numbness and tingling in both of his hands and all of his fingers. Electrodiagnostic studies showed the petitioner did have bilateral carpal tunnel syndrome, but both Dr. Vender and Dr. Fernandez stated that a positive EMG is not necessarily indicative of an active disease process. Moreover, Dr. Fernandez stated that the petitioner's subjective complaints were not consistent with active and ongoing carpal tunnel syndrome. Therefore, the Arbitrator gives this factor greater weight.

No single enumerated factor is the sole determiner of disability when determining permanent partial disability.

Based on all of the above evidence and weighing the factors described above, the Arbitrator awards 15% loss of use of the right hand and 15% loss of use of the left hand under Section 8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RICHARD BALESTRI,

Petitioner,

18IWCC0207

vs.

10 WC 45853

CITY OF CHICAGO,

Respondent.

DECISION AND OPINION ON PETITION FOR REVIEW PURSUANT TO §§19(h)/8(a)

This matter comes before the Commission on Petitioner's Petition for Review Pursuant to §§19(h)/8(a). Hearings were held in Chicago on June 22, 2017 and July 25, 2017 before Commissioner Simpson. The parties were represented by counsel and a record was taken.

Findings of Fact & Conclusions of Law

1. Petitioner testified that his claim was adjudicated and on October 10, 2012, he was awarded permanent partial disability benefits representing loss of 50% of the right leg and 30% of his left arm. He continued to treat for his left arm after the arbitration decision. He saw Dr. Stogin who performed tests and eventually performed revision left ulnar transposition with compression of the nerve on March 25, 2015. He had postop physical therapy and pain management at the Chicago Pain Center.

2. Petitioner also testified that the pain in his left elbow was about the same as it was after Dr. Sonnenberg performed the initial surgery, but it was worse than it was prior to that surgery. He has trouble driving, picking up/working with tools, and his grip is weakened. He returned to work after Dr. Sonnenberg's surgery, but retired in June 2012. His current condition is worse than it was when he returned to work after that surgery.

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3. Besides physical therapy for his wrist after the 2015 surgery, he also had physical therapy for his hips and left side of his low back. He had right-hip surgery in June 2010. After the surgery there was a differential in the length of his legs. He started noticing pain in his left hip in physical therapy and his gait was altered. It was also difficult to perform some physical therapy because of pain in his back. He had treatment for his back after his retirement with Dr. Fetzer at Rush. She administered four or five epidural steroid injections. She also administered injections in his left hip and pelvis.

4. Currently, he had constant pain in his back, shooting down his legs. He treated for his left hip with Dr. Berger, Dr. Nelson had initially performed the right-hip surgery. He started treating with Dr. Berger on 6/24/13. He performed left hip replacement surgery on 10/18/13. Dr. Berger felt that his left hip pain might be related to his back and he referred Petitioner to Dr. Fetzer.

5. Petitioner testified he did not have left hip pain until after his right hip surgery. Now it was painful to walk, sit, sleep, or lie down. He had seen his primary care provider a couple of times for his back/groin pain. He also saw Dr. Gross for a section 12 examination at his lawyer's request and Dr. Troy at Respondent's request.

6. On cross examination, Petitioner testified he was 6'3" and 320 lbs. He had first ulnar-nerve surgery prior to arbitration. He returned to work as a truck driver without restrictions after that surgery. There was no mention of his left hip at the arbitration hearing. He had claimed a back injury at arbitration, but the Arbitrator found only his right hip and left arm conditions were related to his accident. He agreed that his back injections were administered in 2014, four years after the incident in which he alleged he hurt his back. He has no appointments scheduled for treatment of his back prospectively.

7. Petitioner also agreed that an MRI showed stenosis in his back and x-rays showed severe osteoarthritis/degenerative disc disease in his left hip. He acknowledged that that condition "could be" degenerative by nature. He was "pretty sure" that he testified that he had no back pain prior to his accident. He did not recall filing a workers' compensation claim against Respondent in 1995 alleging an injury to his low back. Nor did he recall receiving a settlement for that claim. The Commission notes that on May 14, 1996, Petitioner's claim, 95 WC 53825, was settled for $2,052.15 representing loss of 1% of the person-as-a-whole for an alleged injury to his low back.

8. On redirect, Petitioner testified that on May 3, 2010, he weighed about 282 lbs, and he gained weight after the accident and after both hip surgeries. When he returned to work, he was restricted to what he could lift. His back symptoms changed after the accident with constant shooting pain in his back tingling down to his legs. He did not recall losing any time from work in 1995 because of a back injury. He had no treatment for his back between 1995 and the date of the accident and worked every day during that period.

9. On re-cross, Petitioner testified "it could be" that he weighed 348 lbs by 2014. No doctor has told him that his weight contributed to his low back pain.

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10. In the Arbitration decision, the Arbitrator noted that on May 3, 2010, Petitioner sustained injuries when he slipped off the running board of his truck and fell on his right hip. Total hip replacement was performed on July 21, 2010. Petitioner testified that he noticed pain in his left forearm and numbness in some fingers when he awoke from anesthesia. An EMG showed left median and ulnar polyneuropathy and carpal tunnel syndrome. Dr. Sonnenberg opined that Petitioner's left arm/hand symptoms were the result of brachial stretch in the axilla, "most likely related to his hospitalization for his hip replacement surgery."

11. In the Arbitration decision it was noted that on September 13, 2011, Dr. Sonnenberg performed anterior transposition and neurolysis of the left median nerve. Petitioner returned to work on November 16, 2011. Petitioner was seen by Respondent's section 12 medical examiner, Dr. Fernandez, on July 26, 2012. He diagnosed residual ulnar neuropathy, which was caused by positioning during the hip surgery. While he opined that Petitioner was at maximum medical improvement and could return to work at full duty, he left open the possibility that Petitioner might need a revision ulnar nerve decompression. The Arbitrator found Petitioner's conditions of ill-being of his right hip and left arm were causally connected to his work accident. There appears to be no mention of any alleged back injury in the arbitration decision.

12. The medical records presented at the instant hearing indicated that on June 24, 2013, Petitioner presented to Dr. Berger with 4/10 pain in the left hip and groin. He had right hip replacement in 2010. X-rays showed the right hip prosthesis was in good position and it also showed severe osteoarthritis in the left hip. Dr. Berger noted that Petitioner had failed conservative treatment and was a candidate for total hip replacement. On October 18, 2013, Dr. Berger performed minimally invasive left hip replacement surgery for osteoarthritis.

13. Petitioner still complained of persistent pain in the left hip radiating into the thigh six months postop. X-rays showed no evidence of complications. Dr. Berger aspirated the hip and sent it to the lab for a "cell count." Dr. Berger thought that some of his symptoms could be from his lumbar spine, which showed degenerative changes. Dr. Berger referred him to Dr. Feltzer.

14. On April 3, 2014, Petitioner presented to Dr. Feltzer in the spine clinic. He complained of 6/10 pain, and the hip "was cleared from contribution to his pain etiology." Lumbar x-rays showed moderate disc desiccation at L4-5 and facet spondylosis at L4-5 and L5-S1. He also had grade 1 spondylolisthesis at L4-5. Dr. Feltzer diagnosed trochanteric bursitis, spondylolisthesis at L4-5, and L4 radiculopathy. She noted that Petitioner had not had a lumbar MRI and ordered one. She thought he was a candidate for a lumbar ESI, pending the MRI. The MRI showed broad-based disc bulges L4-S1, with severe foraminal stenosis. Dr. Feltzer administered an injection for the trochanteric bursitis, and administered more injections over the following weeks.

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15. On December 23, 2014, Petitioner presented to Dr. Stogin for another opinion regarding problems with his left arm. He had a hip replacement several years earlier, after which he developed apparent left ulnar neuropathy. He had decompression surgery. He did not have clear improvement postop. Petitioner indicated he was to have a transposition, but the exam suggested the ulnar nerve remained posterior to the medial condyle. After his examination, Dr. Stogin diagnosed probable cubital tunnel syndrome. Initially, Petitioner would bring in the operative report. Petitioner understood that it was very possible that they would not be able to return his arm to normal.

16. Dr. Stogin noted that the operative report indicated Dr. Sonnenberg performed an anterior transposition of the ulnar nerve to a sub-muscular position. Dr. Stogin was skeptical of "predictable improvement," but Petitioner wanted "to try to turn over every stone." He ordered an EMG. The EMG suggested ulnar neuropathy that could not be localized. There was also a question of some possible median neuropathy, but Petitioner had no symptoms on the radial side of the hand. Dr. Stogin reiterated that he suspected there was nothing he could do surgically, but he ordered an ultrasound "to turn over one last stone."

17. On March 25, 2015, Dr. Stogin performed revision of left ulnar nerve transposition with decompression for persistent ulnar neuropathy after anterior transposition of the ulnar nerve with compression of the ulnar nerve at the proximal edge of the left ulnar nerve at the elbow.

18. Petitioner showed limited improvement postop. On May 14, 2015, Dr. Stogin reiterated that the surgery was performed "as a last resort in the hopes that he might have some improvement." Petitioner reported he may have had less pain in his arm since surgery but he still had numbness in fingers. He would see Petitioner again in October. There are no additional records from Dr. Stogin.

19. On June 29, 2016, Dr. Gross performed a section 12 medical examination at the request of Petitioner's lawyer. Petitioner injured his left elbow/wrist/hand and right hip as a result of a work accident in 2010. He had right hip surgery after which he had continued pain and weakness in the right hip. He also developed low back pain, which became gradually worse. In early 2013, he developed left hip problems and had left hip replacement surgery on October 18, 2013. He retired from his work as a truck driver because bouncing caused low back pain and leg weakness made it difficult to get into and out of the truck. He also had two left elbow surgeries.

20. Currently, Petitioner complained of constant sharp shooting pain through the left mid-arm, intermittent pain, reduced range of motion in the left elbow and arm weakness, swelling and constant sharp pain in the left hand/wrist, bilateral hip pain, and constant low back pain. His back constrains him from bending or lifting.

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21. After his examination, Dr. Gross' diagnoses were residuals of left ulnar nerve injury, residuals of low back injury, residuals of right & left hip injuries, and pre-existing bilateral hip arthritis. He indicated that the 2010 accident significantly aggravated the right hip arthritis.

22. Dr. Gross noted that Petitioner reported no low back pain prior to his accident, but developed such pain shortly after the accident. The condition was sufficiently symptomatic for an MRI to be performed on June 3, 2010. His low back pain was initially "somewhat overshadowed" by his right hip pain. However, after the hip replacement, his back was aggravated by physical therapy. In addition, "the combination of altered body mechanics due to the low back pain and favoring the right lower extremity caused symptoms to develop in the left hip."

23. Dr. Gross also noted that Petitioner had another lumbar MRI in 2014, which appeared to show his condition had worsened. He further opined that Petitioner suffered a back injury that has been aggravated by physical therapy for his left arm and right hip, as well as altered body mechanics. Unfortunately, the arm surgeries did not improve his condition. He will need periodic prospective treatment for his back, hips, and left arm. All of these conditions were causally related to his accident on May 3, 2010.

24. On December 5, 2016, Dr. Troy performed an Section 12 medical examination of Petitioner at Respondent's request. Petitioner was 6'3" and 365 lbs. Dr. Troy noted that Petitioner "presented with a history of injury to his left hip and his low back." He reported that on May 3, 2010 he slipped off his truck while getting out, twisted his right hip, landed on a step, and fell to the ground. He was not sure whether he hit his back and did not recall hitting his left hip, at that time. He was off work until November or December 2011 at which time he worked full duty. He worked until about June 2012, at which time he retired.

25. Dr. Troy answered interrogatories. He opined that Petitioner left hip arthroplasty was secondary to "non-Workers' Compensation advanced" degenerative joint disease of the left hip. That diagnosis was not "a direct result of the injury that occurred on May 3, 2010." He noted that Petitioner was able to work "uneventfully" after his right hip arthroplasty from November 2011 to June 2012. Dr. Troy also diagnosed long-standing degenerative disc disease of the lumbar spine, greatest at L4-5.

26. Dr. Troy also noted that Petitioner had a 1.4 cm leg-length discrepancy. "This leg length discrepancy, along with his morbid obesity, caused an exacerbation of his pre-existing, longstanding, degenerative process to his lumbar spine. All of this is non-Workers' Compensation-related." The treatment Petitioner received to date was appropriate, irrespective of causation of his condition. Dr. Troy disagreed with the opinions of Dr. Gross about the causal connection between Petitioner's right hip and lumbar condition and his work accident on May 3, 2010.

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Petitioner argues he is entitled to compensation for the second elbow surgery, the left hip arthroplasty, and his low back condition. He seeks additional compensation of 258.4 weeks of permanent partial disability benefits representing an additional loss of 30% of the left arm (cubital tunnel syndrome), loss of 15% of the person-as-a-whole (lumbar spine), and 50% of the right leg (left hip). Respondent argues that Petitioner did not prove a causal connection between his left hip condition and subsequent arthroplasty, or his current lumbar condition. It notes that none of Petitioner's treating doctors ever related Petitioner current left hip and lumbar conditions related back to the May 3, 2010 accident, and Petitioner had to rely on his "paid consultant," Dr. Gross.

The Commission concludes that Petitioner's continuing left-arm problems are still related to his original injury. The Arbitrator found that his left arm condition was caused by his positioning at the time of his right hip surgery, an opinion with which Respondent's Section 12 medical examiner, Dr. Fernandez, apparently concurred. The record indicates that Petitioner's left arm never really got better even after his first surgery. In addition, in 2012 Dr. Fernandez even noted the possible need for revision ulnar surgery in his Section 12 report.

However, the Commission also finds that Petitioner did not sustain his burden of proving that his current conditions of ill-being of his lumbar spine and left hip are causally related to his work accident on May 3, 2010, but rather result from the natural progression of his degenerative diseases.

The medical record establishes that Petitioner had significant pre-existing degenerative disease in both his left hip and lumbar spine. His back issues spanned at least from 1995, when he filed a workers' compensation claim for a back condition for which he received a small settlement, a claim and settlement that he could not recall at arbitration. Similarly, the records show that Petitioner had severe degenerative osteoarthritis in his left hip. In addition, Petitioner did not seek treatment for his left hip until June 2013, three years after his right hip arthroplasty.

While Dr. Gross opined a scenario that conceivably could causally relate Petitioner's lumbar and left hip conditions to the original 2010 accident/injury, that is not sufficient in itself to establish causation. A Commission finding of a causal connection to his lumbar and left conditions would require improper speculation on the part of the Commission. Therefore, Petitioner's Petition Pursuant to Section 19(h) is granted with regard to his left arm condition of ill-being and denied regarding his left hip and lumbar conditions of ill-being.

The Commission notes that Petitioner has ongoing problems with his left arm. Dr. Stogin, the surgeon who performed the latest surgery on his arm, acknowledged that he likely would not return Petitioner's arm to its "normal" condition with surgery. Currently, he has pain, weakness, difficulty driving, and holding and using tools. Nevertheless, the Commission also notes that Petitioner is retired and there is no loss of potential income from the ongoing difficulties with his left arm. The Commission finds that an additional award of loss of 15% of the left arm is appropriate in this proceeding under Section 19(h).

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In addition, while Petitioner included Section 8(a) in the description of his motion, he does not seek any medical expenses in his brief. Petitioner is entitled for payment of any outstanding medical bills associated with treatment of his left elbow condition. Finally, Petitioner also filed a Petition for Penalties and Fees. However, it does not argue the issue in its brief. The Commission denies Petitioner's Petition for Penalties and Fees.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition for Review Under Section 19(h) is granted, but only with regards to the condition of ill-being of his left arm.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner an additional sum of $664.72 per week for a period of 37.95 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the additional loss of the use of 15% of his left arm.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay any outstanding medical expenses associated with treatment of his left elbow condition, under §8(a) of the Act pursuant to the applicable medical fee schedule.

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

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

DATED: APR 5 - 2018

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

DLS/dw
O-3/22/18
46

STATE OF ILLINOIS)
) SS.
COUNTY OF Cook)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Johnny Patterson,
Petitioner,

vs.

NO: 15WC 41612

18IWCC0208

Oak Park Police Department,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 22, 2017, is hereby affirmed and adopted.

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

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

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

DATED: APR 5 – 2018
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Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PATTERSON, JOHNNY
Employee/Petitioner

Case# **15WC041612**

OAK PARK POLICE DEPARTMENT
Employer/Respondent

18IWCC0208

On 2/22/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.67% 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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18IWCC0208

J. Patterson V. Oak Park Police Dept. , 15 WC 041612

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

Johnny Patternson
Employee/Petitioner

v.

Oak Park Police Department
Employer/Respondent

Case # 15 WC 041612

18IWCC0208

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 **December 7, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

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

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

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

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

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

In the year preceding the injury, Petitioner earned **$90,402.00**; the average weekly wage was **$1,738.50**.

On the date of accident, Petitioner was **58** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**. The Parties agreed that Petitioner was paid PEDA benefits From May 3, 2015-May 3, 2016 and that Respondent was entitled to credit for TTD paid during that time, if an award is made.

Respondent is entitled to a credit under Section 8(j) of the Act for all claimed medical bills that it paid.

ORDER

Respondent shall pay Petitioner the claimed reasonable and necessary medical expenses in accordance with §§8(a) and 8.2 of the Act, as is set forth below.

Respondent shall pay Petitioner **TTD benefits of $1,159.01/week for 18 weeks, commencing 5/3/2016 through 9/6/2016, pursuant to §8(b) of the Act**, as is set forth below.

Respondent shall pay Petitioner **disfigurement benefits of $735.37/week for 65 weeks, as provided in §8(c) of the Act.**

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

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

Signature of Arbitrator

February 22, 2016
Date

ICArbDec19(b)

FEB 22 2017

FINDINGS OF FACT

18IWCC0208

Petitioner was employed by Respondent as a police officer on May 3, 2015. He had worked for Respondent as a police officer for over 25 years. Every year, he undergoes training; and they go over Respondent's rules and regulations, as well as any updates. The Oak Park Police Department Rules and Regulations provide: "A member carries at all times the responsibility for the safety of the community and discharges that responsibility by an immediate and intelligent response to any emergency." (PX10) Petitioner testified that Respondent's policy is that an officer is not supposed to allow a crime to happen without taking action, whether the officer is on duty or off duty. If a police officer witnesses a crime, he or she cannot just stand there and allow it to happen; you have to announce your office and then use force if necessary to prevent the crime or stay alive. Prior to May 3, 2015, Petitioner did not have any injuries to his right arm or right calf.

Petitioner worked the 12-hour "day watch" shift, patrolling from 6:00 AM to 6:00 PM. Petitioner was scheduled to work on May 3, 2015. Petitioner was on his way from his home in Chicago to Respondent's facility. Respondent's General Orders require that officers not wear identifiable uniforms or badges when not on duty. Petitioner leaves his uniform shirts and vest in his locker at work. He was wearing his patrolman's pants and his gun belt, as well as a Cubs jersey. He would not be officially on duty until he punched in at the station. Petitioner parked his car in the alley behind his house, located at 326 West 103rd Street, and walked to his garage to retrieve a protein shake to drink for breakfast on the way to work. As he walked back to his car, Petitioner observed someone coming down the alley with a gun pointed at his face. Petitioner announced that he was a police officer. A second assailant reached out and attempted to grab Petitioner, but Petitioner pulled away, at which time the man yelled out "shoot him, shoot him." Petitioner put his hand over his face as the first man began firing his gun, shooting Petitioner in the right forearm. The gunman was at the trunk of Petitioner's car; Petitioner was at the driver's side door. As Petitioner reached for his gun, the assailant shot him on the left side of his body. Petitioner was shot in the right calf as he began to fire back. Petitioner fired four shots. The gunman fled down the alley as Petitioner fired; at one point, Petitioner heard the gunman say, "He shot me, man, he shot me."

After the assailants left, Petitioner felt his leg go out from under him, and he fell. Petitioner grabbed his phone, walked to the garage, and called the Chicago Police to let them know he'd been involved in a shooting. He also called Respondent to let them know what had happened. He had a bullet wound in his right forearm, had been grazed on his left side, and had suffered another bullet wound in his right calf.

The Chicago Fire Department crew noted that Petitioner's calf and arm were bleeding and painful, caused by gunshot wounds as well as a graze wound to his flank. They took this history of injury: "Pt was in his garage leaving for work and 2 individuals started running at him with a gun shooting possibly a robbery, he returned fire and he was struck in the rt calf entrance no exit, rt forearm entrance and exit, and a graze wound to the left flank." The paramedics controlled Petitioner's bleeding and transported him to Christ Hospital. (PX3)

Petitioner was treated in the trauma unit at Christ Hospital. It was noted that Petitioner had been shot in the arm and the leg outside by his garage. On examination, the doctor noted a gunshot wound to the right lower mid leg, antero-lateral, and a second wound posterior medial and slightly more proximal; a graze wound about 3 cm superior to the left iliac crest at the posterior axillary line; and a gunshot wound in the ulnar aspect of the distal right arm and a second wound at the ulnar aspect just distal to the elbow. Imaging did not disclose any bone fractures. Petitioner complained of pain in his right calf after multiple gunshot wounds. Petitioner was diagnosed with open arm, leg, and flanks wounds, as well as acute pain due to trauma. Petitioner was unable to

ambulate with a walker due to the pain; he was admitted to the SSU for pain control and scheduled for a physical therapy evaluation for ambulation. (PX3)

Petitioner remained hospitalized overnight. On May 4, 2016, Petitioner underwent a physical therapy evaluation. The therapist noted that Petitioner had a tense, guarded posture, with right leg pain between 3/10 and 5/10. Petitioner was unable to tolerate weightbearing on his right lower extremity, and was unable to use his right upper extremity with a walker to assist with ambulation. He was assigned a wheelchair and given discharge recommendations of 24-hour assistance and physical therapy at home to be performed 2 to 4 times per week. Petitioner was discharged at about 10:30 pm on May 4, 2015. (PX3)

On May 8, 2015, Petitioner followed up at Advocate Christ Medical Center, treating through the trauma center. Petitioner reported paresthesia in the fifth digit of his right hand, with delayed flexion. Petitioner's right upper extremity was positive for swelling and erythema. Petitioner stated that his right lower extremity was without pain, swelling, or erythema at that time. It was observed that this wound was healing. Petitioner was assessed with multiple gunshot wounds and an infection in his right upper extremity; he was prescribed Keflex for the infection and Norco for the pain, and was continued on HHPT. (PX4)

On May 15, 2015, Petitioner returned to Advocate Christ Medical Center for follow-up treatment. He gave the doctor his history of injury: he was a 58-year-old police officer who sustained multiple gunshot wounds to his right upper extremity, right lower extremity, and left flank during an attempted car jacking. It was noted that Petitioner's right upper extremity gunshot wound, which had been infected, was no longer showing signs of infection after treatment with Keflex. Petitioner reported paresthesia in the fifth digit of his right hand and poor motor response. He complained of pain in his right lower extremity calf region. (PX4, P0210.) It was noted that Petitioner had increased swelling laterally and erythema to his gunshot wound holes, with pain on palpation and a sensation of tightness. Petitioner was assessed with neuropathy to his right upper extremity fifth digit and an abscess in his right lower extremity. Petitioner was kept off work until reevaluation in two weeks. (PX4)

On May 29, 2015, Petitioner visited the clinic complaining of pain and swelling in his right lower extremity. It was noted that Petitioner's leg was less swollen than it had been two weeks prior, and Petitioner reported less pain with palpation relative to that earlier visit. Petitioner was instructed to continue icing and elevating his right leg, and to apply an ACE wrap or compression sock to help reduce the swelling. (PX4)

On June 9, 2015, Petitioner followed up at Advocate Christ Medical Center. It was noted that Petitioner was ambulating with a cane. Petitioner complained of increasing pain in his lateral left leg gunshot wound; the doctor noted that the wound was becoming larger, with erythema and a "purulent discharge." The right leg gunshot wound was noted to be slightly more swollen than the left, positive for erythema and discharge, malodorous, yellow, and serous. The doctor noted the presence of a subcutaneous abscess. (PX4)

Petitioner was issued a Trauma Disability Form stating: "The aforementioned patient has been under my care due to a traumatic injury sustained on 5/3/15." Petitioner was kept on "No duty," to be reevaluated on June 12, 2015. (PX4)

On June 12, 2015, Petitioner returned for treatment of the infected wound in his right leg. It was noted that Petitioner edema bilaterally in his lower extremity, with superficial infection of the right lateral gunshot wound. Petitioner was given local anesthesia and the necrotic tissue around the infected wound was debrided. (PX4)

On July 14, 2015, Petitioner returned to Advocate Christ Medical Center. He was improving, and ambulating well with a walker. Petitioner reported that his right lower extremity gunshot wound felt improved, and that it was smaller than before. He reported numbness and tingling in his right fifth digit, but otherwise reported no sensory deficits. The doctor noted a mild foul odor coming from the wound, and instructed Petitioner to clean it with soap and water. (PX4)

From July 14, 2015 until May 24, 2016, Petitioner was engaged in physical therapy. (PX4.)

On May 27, 2016, Petitioner was released to return to work at full duty by Christ Medical Center. (PX4) Respondent sent Petitioner for return to work clearance at its occupational health service, Loyola University Medical Center, where he was taken off work and referred to a work-hardening program. Dr. Phillip McAndrew charted that he was mostly concerned about Petitioner's stamina after being off work for more than a year; he stated that work hardening would help him improve that stamina, and that an FCE would help define his physical abilities. (PX7)

Petitioner underwent work hardening at ATI Physical Therapy from August 19, 2016 until September 1, 2016. (PX8) On September 6, 2016, Petitioner was released back to work full-duty by Loyola University Medical Center. Petitioner returned to work full duty at that time.

Petitioner was paid his full salary from May 3, 2015 until May 3, 2016, pursuant to PEDA. The payments stopped right at the beginning of May 2016. Petitioner received no sick pay while he was undergoing work hardening. During the period in which he was receiving pay, Respondent was "charging" Petitioner sick time and putting his available sick time into the negative.

Toward the end of 2015, Petitioner earned income by working as a range instructor, assisting with the paperwork portion of the job. The work was intermittent. The work did not require physical activity. In all, Petitioner earned approximately $1,500 for this work between May 4, 2015 and September 6, 2016. The income may have been less than $1,500, and would not be much more.

Petitioner testified that he no longer feels any ill effects from his gunshot wounds. He has scars on his leg and his arm from the injuries, which were displayed to the Arbitrator. There is an entrance wound on the ulnar side of the forearm about an inch in diameter; an exit wound on the medial side of the elbow with a keloid appearance about an inch in diameter; a medial wound near the top of the calf, about an inch in diameter; and a large lateral wound on the back of the calf about the size of a baseball, with discoloration and visible tissue loss.

Petitioner has returned to full duty work as a police officer and is able to perform his job.

Chief Anthony L. Ambrose testified at the request of Respondent. He has been on the Oak Park Police Department for 33 years. On May 3, 2015, he was Deputy Chief –Support Services Bureau. He was made Police Chief on August 30, 2016. At 5:15am, when the shooting occurred, Petitioner was not on duty. Petitioner was scheduled to begin his shift at 6:00am. Respondent's officers are not permitted to wear their uniform or badge when off duty. Respondent's General Orders do not address when an officer is required to take action during an occurrence when they are off duty. Such action is not required. The Chief believes that Respondent's Rules and Regulations require that an off duty officer take action if he becomes aware of criminal activity in Oak Park. On cross examination, Ambrose stated that Oak Park does not require its officers to be on duty 24/7. He did agree that 725 ILCS 5/107-16 (PX 9) applies to police officers. He thought that Petitioner was sworn in the state and employed in Oak Park. Ambrose believes that Petitioner was acting as an individual,

defending his property, at the time of the shooting. Return to work issues regarding Petitioner were handled by the HR and Legal Departments at Respondent.

CONCLUSIONS OF LAW

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

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATED TO:

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

The Arbitrator finds that that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on May 3, 2015, based upon Petitioner's credible testimony and his statutory duty as a sworn police officer in Illinois (725 ILCS 5/107-16).

Police officers are unique among employees, in that they can be suddenly called upon to act in the course and scope of their employment at any time and place, regardless of whether they are "on duty". "While the usual on-call employee is subject to the possibility of a specific summons emanating directly from his employer, the policeman may be at any moment 'called' into duty by events taking place in his presence, whether or not he is technically off duty." 1 A. Larson, Workmen's Compensation Law § 16.17, at 4-208.44 – 4-208.48 (1990); *City of Springfield v. Industrial Comm'n*, 244 Ill.App.3d 408, 410-11 (4th Dist. 1993). Thus, when a police officer acts to prevent the commission of a crime, it is always considered to be an act in the furtherance of his duties as a police officer regardless of the time or place:

> The nature of a policemen's [sic] job is that he be fit and armed at all times, whether on or off duty, and subject to respond to any call to enforce the laws and preserve the peace. It is true that his being considered 'on duty' at all hours of the day or night does not result in all of his acts being deemed to have been taken in performance of his duties as a police officer. However, *since he is always obligated to attempt to prevent the commission of crime in his presence, any action taken by him toward that end, even in his official off-duty hours, falls within the performance of his duties as a police officer.*

Banks v. City of Chicago, 11 Ill.App.3d 543, 549-50 (1st Dist. 1973) (citation omitted) (emphasis added). Thus, when Petitioner acted to prevent the commission of a crime in his presence on May 3, 2015, he acted in the course and scope of his employment as a matter of law.

This case is analogous to *Keller v. Industrial Commission*. In *Keller*, a deputy sheriff was driving his personal car from home to work at the sheriff's office. 125 Ill.App.3d 486, 486 (5th Dist. 1984) The road was covered with ice and snow. *Id.* at 487. En route, the deputy spied a man driving recklessly and skidding on the ice. The deputy pulled off the road so that he could turn around and pursue the driver to issue him a ticket. *Id.* at 487-88. He was then injured in an automobile collision. *Id.* at 486. The Commission found that the deputy was not acting in the course and scope of his employment. The appellate court reversed: "Here, from the moment [the petitioner] sought to perform his proper duties, he was acting in the course of his employment." *Id.* at 489. Likewise, in the present case, from the moment Petitioner sought to prevent the commission of a

crime in his presence. By announcing that he was a police officer and taking action against the assailants, he was acting in the course of his employment.

Further, the injury arose out of Petitioner's employment. "For an injury to 'arise out of' the employment its origin must be in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Caterpillar Tractor Co. v. Indus. Comm'n*, 129 Ill. 2d 52, 58, 541 N.E.2d 665, 667 (1989) "[I]f the injury results from a hazard to which the employee would have been equally exposed apart from the employment, or a risk personal to the employee, it is not compensable"—but "[i]f an employee is exposed to a risk common to the general public to a greater degree than other persons, the accidental injury is also said to arise out of his employment." *Id.*

While it may be true that Petitioner's risk of being targeted by criminals near his place of residence was no greater than that faced by the general public, Petitioner's risk of being shot during that encounter was far greater due to his professional obligation to stop a crime from being committed in his presence. Petitioner testified that, per Respondent's policy, an officer is not supposed to allow a crime to happen without taking action, whether the officer is on duty or off duty. Petitioner's understanding of his obligations mirrors the obligations of Illinois police officers set forth by statute:

> It is the duty of every sheriff, coroner, and every marshal, policeman, or other officer of an incorporated city, town, or village, having the power of a sheriff, when a criminal offense or breach of the peace is committed or attempted in his or her presence, forthwith to apprehend the offender and bring him or her before a judge, to be dealt with according to law; to suppress all riots and unlawful assemblies, and to keep the peace, and without delay to serve and execute all warrants and other process to him or her lawfully directed.

725 ILCS 5/107-16. This duty has been construed broadly: Illinois courts hold that a policeman "is always obligated to attempt to prevent the commission of crime in his presence." *Banks v. City of Chicago*, 11 Ill.App.3d at 549-50 The duty to prevent commission of a crime is only found not to apply when the officer's conduct is "entirely in pursuit of personal goals." *Garner v. City of Chicago*, 319 Ill.App.3d 255, 262 (2001)

Certainly, Petitioner was not acting entirely in the pursuit of personal goals when he acted to prevent the commission of a crime on May 3, 2015; *Garner v. City of Chicago* compels this conclusion. In *Garner*, a police officer was off-duty and meeting in his own, privately owned vehicle with a woman with whom he was carrying on an extramarital affair. 319 Ill.App.3d at 259. The officer's vehicle was approached by a man with an automatic handgun. 319 Ill.App.3d at 259. The police officer exited his vehicle carrying a gun of his own; a struggle ensued, and the police officer was mortally wounded by multiple gunshots. *Id.* The police officer's surviving family members sued for benefits, alleging that he was killed in the act of duty. *Id.* The court noted that there was no dispute as to the fact that the shooter was brandishing a weapon on a public street prior to the struggle; citing *Banks*, the court therefore found that in attempting to disarm the man, the decedent police officer was acting in the furtherance of his duty pursuant to 725 ILCS 5/107-16. Here, similarly, there is no dispute as to the fact that Petitioner was approached by a man brandishing a handgun in a public alley; thus, in attempting to apprehend the man, Petitioner was acting in the furtherance of his duty pursuant to 725 ILCS 5/107-16. Additionally, an off-duty police officer may be subject to a greater risk of injury by criminals, due to his status as a police officer and carrying his service weapon. The criminal may recognize the police officer, or take more harmful action because the officer has a weapon. In such situations, a police officer's risk of injury is greater than that of the public at large due to his/her occupation.

Although Respondent contends that Petitioner's duty to apprehend criminals extends only to the territory of the municipality which employs him, the courts have found that a police officer's authority to act actually extends throughout his or her entire police district:

> A police officer has authority to act not only within the corporate limits of his or her municipality but throughout his or her police district, which consists of "[t]he territory which is embraced within the corporate limits of adjoining municipalities within any county in this State." Moreover, this court has indicated that an officer may make an arrest outside of his jurisdiction, as long as the arrest is made in a municipality within the same county as the officer's jurisdiction.

Harroun v. Addison Police Pension Bd., 372 Ill.App.3d 260, 264–65 (2d Dist. 2007) (citations omitted). In this case, Petitioner is a police officer of the Village of Oak Park, and he acted to prevent the commission of a crime in the City of Chicago. Both Oak Park and the City of Chicago are within Cook County, both within the same police district and they share a border at various points (albeit not at 10300 South).

In short: Petitioner was subject to Illinois law imposing a duty to apprehend those committing a criminal offense in his presence, and he was within his own police district when he carried out that duty. Petitioner was obligated to act to prevent the commission of a crime on the morning of May 3, 2015. The fact that he was the victim of the crime in the alley behind his house does not make his risk of injury a personal risk, such that the injuries do not arise out of his employment as a police officer and does not take his injuries out of the course of his employment when he chooses to follow 725 ILCS 5/107-16.

At the moment that Petitioner announced his office and took action pursuant to 725 ILCS 5/107-16, injuries sustained arise out of and in the course of his employment by Respondent as a police officer.

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

Petitioner's current condition of ill-being (status post gunshot wound to the right arm with residual scarring, status post gunshot wound to the right leg with development of infection with scarring and tissue loss, as observed and described by the Arbitrator) is causally related to the injury, based upon Petitioner's testimony and the medical records.

ISSUE J: What medical bills are in dispute?

Petitioner's claimed medical bills were itemized on an attachment to the Request for Hearing form and submitted with the corresponding medical records (Petitioner's Exhibits 2 – 8). Respondent is self-insured for group health benefits. The submitted bills are found to be reasonable and necessary to cure or relieve the effects of the injuries and are awarded, pursuant to §§8(a) and 8.2 of the Act. Respondent is entitled to a credit for all bills paid.

ISSUE K: What temporary benefits are in dispute?

Respondent paid Petitioner a full year of PEDA benefits, from May 3, 2015 until May 3, 2016. Petitioner returned to work on September 6, 2016. Petitioner therefore claims that he is entitled to an award of TTD benefits from May 3, 2016 until September 6, 2016.

The Parties agreed that they would resolve issues regarding sick pay and vacation time that Petitioner was charged from May 3, 2015 until May 27, 2016.

Respondent argues that Petitioner is not due TTD because Petitioner's injuries of May 3, 2015 did not arise out of and in the course of his employment by Respondent. Based upon the Arbitrator's ruling regarding Issue C, above, Petitioner is owed all outstanding TTD benefits.

In this case, Petitioner's work as a range instructor does not preclude an award of benefits. He clearly could not have returned to work as a police officer until he completed PT and work hardening. Petitioner assisted with paperwork and classroom instruction towards the end of 2015. Petitioner testified that this work was occasional and intermittent; he was only able to work 2 or 3 classes per year. All told, Petitioner earned only $1,500 for this work between May 4, 2015 and September 6, 2016. See: *Zenith Company v. Industrial Commission*, 91 Ill.2d 278 (1982)

In all, Petitioner was off of work for 70 and 1/7 weeks (from May 3, 2015 to September 6, 2016); he was unpaid for 18 of those weeks (from May 3, 2016 to September 6, 2016). A combination of Respondent's HR Department, Legal Department and the occupational physicians at Loyola kept Petitioner off work from May 27, 2016 to September 6, 2016. Petitioner was not at MMI until he cleared the required therapy and successfully completed the FCE recommended by Respondent's physicians. He is entitled to an award of TTD for this time period. See: *Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Commission*, 236 Ill.2d 132 (2010)

L. What is the nature and extent of Petitioner's injuries?

Petitioner honestly testified that he did not experience any residual complaints from his injuries. He did sustain significant scarring from the gunshot wounds, as was observed by the Arbitrator and described in the Record. The Arbitrator finds that the injuries sustained caused serious and permanent disfigurement to the right arm and right leg to the extent of 65 weeks of disfigurement, in accordance with §8(c) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sherrie Rosen,
Petitioner,

vs.

NO: 11WC 8901

18IWCC0209

E.C.H.O.,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 28, 2017, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $6,800.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 5 - 2018
o040318
MJB/jrc
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ROSEN, SHERRIE
Employee/Petitioner

Case# **11WC008901**

11WC008902
11WC008903

E.C.H.O.
Employer/Respondent

18IWCC0209

On 2/28/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.67% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2221 VRDOLYAK LAW GROUP LLC
MICHAEL P CASEY
741 N DEARBORN ST 3RD FL
CHICAGO, IL 60654

1120 BRADY CONNOLLY & MASUDA PC
STEVEN L MILLER
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CHICAGO, IL 60603-1016

18IWCC0209

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

SHERRIE ROSEN,
Employee/Petitioner

v.

E.C.H.O.,
Employer/Respondent.

Case # **11** WC **8901**

Consolidated cases: **11 WC 8902**
11 WC 8903

18IWCC0209

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **MARIA S. BOCANEGRA**, Arbitrator of the Commission, in the city of **CHICAGO**, on **9/20/16 and 12/15/16**. 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 _____

18IWCC0209

FINDINGS

On **11/16/10**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$66,167.60**; the average weekly wage was **$1,654.72**.

On the date of accident, Petitioner was **59** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$0** for TTD, **$0.00** for TPD and **$0.00** for other benefits, for a total credit of **$0**. Respondent is entitled to a credit under Section 8(j) of the Act for medical group insurance benefit payments made.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$0** for **0 weeks**, as provided in Section 8(b) of the Act.

Respondent shall pay such reasonable and necessary medical services as provided in Section 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, including but not limited to those identified in Rx4, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, included but not limited to those payments identified in Px16a-b, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$669.64/week** for **10 weeks**, because the injuries sustained caused the **2%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

2-28-2017
Date

FEB 28 2017

18IWCC0209

BACKGROUND

Sherrie Rosen ("Petitioner") alleged injuries arising out of and in the course of her employment on 9/28/10, 11/16/10 and 1/20/11 with E.C.H.O. ("Respondent"). Ax1-3. On 9/20/16 and 12/15/16, the parties proceeded to arbitration. As to all claims, the following issues were in dispute: causal connection, liability for unpaid medical bills, temporary total disability and nature and extent of the injuries. The following is a recitation of the facts adduced at trial, along with conclusions of law.

FINDINGS OF FACT

A. Date of accident September 28, 2010 claim number 11 WC 8902

Petitioner and Respondent stipulated to an accident of 9/28/10, arising out of an in the course of her employment with Respondent. Ax2. Prior to this date, Petitioner said she did in fact have problems with her chest and breasts. Specifically, Petitioner had breast cancer for which she underwent a double mastectomy on 10/1/01. She eventually underwent surgery for tissue expansion followed by surgery for breast implants in 2002 or 2003. Between the time of her implantation surgery and her first work accident, Petitioner had no problems with her implants or her breast area. She also had no prior cervical/neck or middle back problems.

Petitioner worked as a teacher for Respondent, where she worked with handicapped adult children suffering from multiple handicapping conditions. Her duties included dealing with physical activities, getting students off of buses, undressing them, escorting students, feeding, cleaning up after breakfast, providing bathroom assistance, assisting with diaper change, conducting morning activities, dressing students to go home and helping lift students in and out of chairs or off of a floor as needed.

On 9/28/10, Petitioner suffered injuries to her chest area when a student punched her very hard in the chest between her breasts. The male student was 6'3 and weighed approximately 275 pounds. She noticed pain in her arm, wrist and chest. She then saw a nurse and completed an incident report. Px1. For this injury, she treated with Ingalls for neck, left wrist, left hip, mid back and low back. Px3:54-59. Petitioner underwent physical therapy at Ingalls through the end of October. Px2. There, Dr. Akhtar recommended she continue to see Dr. Dreyfus, who specialized in both orthopedics and plastic surgery. She was placed on light duty.

On 11/2/10, Petitioner followed up at Ingalls Occupational. She was diagnosed with chest contusion and low back pain. She was released to full duty and ordered to follow up. She underwent a chest x-ray which was normal. Px3, Px5. She said she lost time because of her pain in her chest, arm and back. Eventually, Petitioner was approved to see Dr. Dreyfus and on 8/7/12, underwent bilateral replacement of both breast implants at Ingalls relative to her first work accident. Px3. Pre-op diagnosis was traumatic injury with deformity and contracture of bilateral breasts. She continued to follow up with Dr. Dreyfus and was given a prescription for therapy. During this time, she felt some pain radiating from her chest area down her arms, along with tingly finger tips. When she bent down, she experienced pain under her breast area. She last saw Dr. Dreyfus in 2013 and at that time had no restrictions or future medical recommendations.

B. Date of accident November 16, 2010 claim number 11 WC 8901

The parties stipulated to an accident of 11/16/10, arising out of an in the course of Petitioner's employment with Respondent. Ax1. Petitioner testified that on this date she attempted to scooch an agitated male student back into a table. While trying to lift and scoot the chair, she injured her chest, neck and back.

She felt like she pulled her muscles. She again reported the incident and completed an incident report. Px4. She was seen at Ingalls Urgent Care and was eventually referred for physical therapy with ATI Physical Therapy. On 11/17/10, Petitioner presented to Ingalls with back pain and left groin pain. Px3:40-41. X-ray of the cervical spine showed moderate degenerative changes from C2-C7. Px3, Px5. X-ray of the lumbar spine showed mild to moderate multi-level degenerative changes, greatest at L5-S1.

Petitioner testified she recalled seeing Dr. Izquierdo on 11/30/10, who examined her breasts at the request of Respondent relative to her first work accident. On 12/6/10, Petitioner saw Dr. Bernstein at the request of Respondent for her neck and back. Following her second work accident, Petitioner continued to work. Petitioner testified that during this time, she was referred to physical therapy with ATI and was still awaiting approval to see Dr. Dreyfus.

C. Date of accident January 7, 2011 claim number 11 WC 8903

The parties stipulated to an accident of 1/7/11, arising out of an in the course of Petitioner's employment with Respondent. Ax3. On that date, Petitioner injured her upper back, neck and shoulder while lifting an adult student, who was experiencing a seizure and needed aid in lifting to a safe position. She reported the incident the same date and sought medical treatment. Px6.

On 1/9/11, Petitioner presented to Ingalls Memorial Hospital with back pain and a thoracic strain. Px3. She related she worked with handicapped children and had done some heavy lifting over the past few days. It was noted to have possibly occurred from repeated lifting of handicapped adults. Exam of the back showed paraspinal tenderness. X-ray of the thoracic spine showed shallow scoliosis without acute findings. Px5. Petitioner was prescribed ibuprofen and Tylenol and discharged. From 1/10/11-1/13/11, Petitioner saw Dr. Bremen, D.C., of Brementowne Chiropractic. Px14. He diagnosed cervicalgia, degeneration, spondylosis, spasms, segmental dysfunction and thoracicalgia. He referred her back to her primary doctor and noted a possible referral for pain management.

On 1/17/11, Petitioner saw Dr. Robinson, who ordered an MRI of the lumbar spine. Px9. A total bone scan showed minimal arthritic changes in the right knee but otherwise unremarkable scan. Px5. Dr. Robinson released Petitioner to sedentary work only with a 10 pound lifting restriction. Px9. He diagnosed Petitioner with lumbago on the right, thoracic or lumbosacral neuritis or radiculitis, T8-9 bulge on the left and degeneration of lumbar or lumbosacral intervertebral disc. *Id.* On 1/26/11, MRI of the lumbar spine showed degenerative changes greatest at L4-L5, protrusion at L5-S1. Px5.

On 2/8/11, Dr. Robinson saw Petitioner and his diagnosis was unchanged. The doctor added myofascial pain, facet dysfunction and a right L4-5 HNP of unclear significance. Petitioner remained on sedentary work duty. Petitioner was prescribed Flexeril and physical therapy 2-3 times per week for 4 weeks. Px9. Therapy took place at ATI Physical Therapy. Px10. Petitioner stated that during this time, she continued to teach.

On 2/13/12, Petitioner related to Ingalls that she was at work leaning over a table for a long period of time and went to stand up and complained of pain in the mid lower back radiating bilaterally. Petitioner said her pain started at 1pm that afternoon. She was diagnosed with lumbar strain, prescribed Vicodin, ibuprofen, heat/massage, light duty and discharged home.

Today, Petitioner notices that since her implants were replaced, it has caused thin skin, resulting in scarring and puckering. She notices her scars are longer and tighter than before. Regarding appearance, she testified Dr. Dreyfus tried to achieve symmetry but she did not think they are the same. Petitioner said she experiences chest pain and has a hard time lofting and pulling. When bending, she has pain in the rib area near the breasts. She has difficulty bowling and carrying a bowling ball and fishing in casting and reeling. She also has pain in her shoulders, neck and lower back, which she says were injured during the second and third accidents. Petitioner takes Tylenol and Ibuprofen as needed and retired one year prior to her hearing. Petitioner stated that following her breast surgery, she returned to her same job but noticed she was not able to do all of the things as before. She said her lifting of students changed because she did not have physical strength to do that and she relied on assistance. At home, she notices difficulty with vacuuming, lifting items and pushing/pulling.

On cross, Petitioner admitted to other work comp claims unrelated to this in which she sought some treatment. She agreed that for her neck and back injuries, Ingalls diagnosed sprain/strains. Following her second work accident, Ingalls released her to full duty. Petitioner confirmed she never received injections for her neck or back. Petitioner further agreed that she last saw Dr. Dreyfus for her breasts in May 2013. She has not current treatment recommendations from Dr. Dreyfus. Petitioner also confirmed she has not seen a chiropractor since her low back and neck injury. Petitioner agreed that her PT was for gaining movement from reconstructive breast surgery and not for her neck and back.

Regarding her teacher pay, she confirmed she can elect to be paid thru the year or pay can be increased at the end of a school year. She confirmed there are either 21 or 26 pay periods. She elected to be paid throughout the calendar year. She received her regular paycheck, which included sick time on them, and did not go without any pay. Petitioner confirmed she used sick time and received full pay on 10/1/10, 10/6, 10/20, 11/1-11/3, 11/12, and 11/17-11/18/10. Petitioner also missed 1/10/11-1/17/11 as a result of her being off work from her work accident. She received her full pay by using sick days and did not receive TTD. She also missed 8/6/12-8/19/12 for her breast surgery but used no sick time as she was out of school on summer break and she was also free to work anywhere during this time. In all, Petitioner agreed she was off of work for approximately 23 days for all work accidents and was paid for this time off using sick time and 2 personal days.

CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment

The Arbitrator observed the demeanor of the Petitioner during examination and cross-examination. The Arbitrator considered the testimony of this witness in light of all of the other evidence in the record. The Arbitrator finds that Petitioner was a credible witness.

ISSUE (F) Is Petitioner's current condition of ill-being causally connected to the injury?

A. Date of accident September 28, 2010 claim number 11 WC 8902

With regard to the accident date of 9/28/2010 the Arbitrator finds that the weight of credible evidence demonstrates that Petitioner had no immediate past problems with her chest, bilateral breast implants, neck, low back that caused her to seek medical treatment. The weight of credible evidence demonstrates that Petitioner's work accident of being punched in the chest caused, in part, her breast implants to become damaged or deformed, ultimately requiring treatment and surgical replacement of the implants. She credibly described an

acute and immediate onset of pain in the chest, neck, low back, left arm and left wrist with noticeable redness and soreness in the chest. Her recollection and description is consistent with her timely and equally credible medical treatment records.

Dr. Dreyfus described the traumatic event of 9/28/2010 is the cause of the condition for which he treated her. Similarly, Respondent's Section 12 examiner, Dr. Izquierdo opined in his medical report that the condition of Petitioner's breasts which he examined was causally related to the traumatic event of 9/28/2010. Petitioner continued to seek treatment for her breasts through 2013, having undergone reconstructive/implant surgery in 2012. Based on the foregoing as well as the record as a whole, the Arbitrator finds that the weight of credible evidence demonstrates that Petitioner's current condition of ill being with regard to the bilateral breasts, chest, neck, left arm and left wrist, under a chain of events theory, are causally related to the work accident of 9/28/2010.

B. Date of accident November 16, 2010 claim number 11 WC 8901

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. With regard to the accident date of 11/16/2010 the Arbitrator finds that the weight of credible evidence demonstrates that Petitioner was pushing a chair with a student who was very agitated and rocking back and forth seated in the chair into it into the table so that the student would be safe and not injure himself or those around him. The chair did not slide on the floor and Petitioner had to pick it up to move the chair with the student seated in it into the table. Petitioner felt an immediate pain in her chest, neck and back as if she had pulled muscles. That history is given to the initial medical providers. She had no problems with these body parts before the date of the accident. The Arbitrator finds that based upon the weight of credible evidence that Petitioner's current condition of ill being with regard to the neck back and chest is causally related to the accident of 11/16/2010.

C. Date of accident January 7, 2011 claim number 11 WC 8903

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. With regard to the accident date of 1/7/2011 the Arbitrator finds that the weight of credible evidence demonstrates that on that date Petitioner was lifting a student who was experiencing a seizure disorder. While attempting to lift the student she felt an immediate onset of pain in her neck, back, lower back, upper back and shoulders. Medical records confirm Petitioner injured herself lifting.

Petitioner sought timely treatment and was diagnosed with sprain/strains. The Arbitrator finds that based upon the weight of credible evidence Petitioner's current condition with regard to her neck, back, lower back upper back and shoulders are causally related to the accident of 1/7/2011.

ISSUE (J) Were the medical services that were provided to Petitioner reasonable and necessary?

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having found in favor of Petitioner on the foregoing issue of causation, the Arbitrator finds that Petitioner's medical treatment for all three dates of accident were reasonable and necessary to treat her bilateral breast condition, chest contusions, lumbar and cervical sprain/strains. This treatment was conservative and necessary in nature in order to address each of her work injuries. Respondent shall pay such reasonable and

necessary medical services as provided in Section 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, including but not limited to those identified in Rx4, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, included but not limited to those payments identified in Px16a-b, as provided in Section 8(j) of the Act.

ISSUE (K) What temporary benefits are in dispute?

A. Date of accident September 28, 2010 claim number 11 WC 8902

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having found in favor of Petitioner on the issue of accident and causal connection, the Arbitrator concludes that Petitioner is entitled to temporary total disability (TTD) for the time that she was off of work due to her chest, bilateral breast, back and neck injuries sustained as a result of this injury. Ax2. The weight of credible evidence demonstrates that Petitioner was off 10/1/10; 10/6/10; 10/20/10; 11/01/10 through 11/3/10; and 8/6/12 through 8/19/12 representing 2-6/7th weeks as a result of the injury sustained in this work accident.

Respondent seeks a credit for the sick time paid during this time. The Arbitrator finds that Respondent is not entitled to credit for the sick days which Petitioner used while she was off on these dates. Respondent failed to meet its burden for credit under 8(j) in that it failed to present evidence that Petitioner such leave in lieu of TTD compensation. In support thereof, the Arbitrator relies on Tee-Pak, Inc. v. Indus. Comm'n, 141 Ill. App. 3d 520, 490 N.E.2d 170 (1986), which found that the employer was not entitled to a credit under Section 8(j) where it failed to show claimant's salary payments received were limited to occupationally related disabilities, noting that "the employer receives no credit for benefits which would have been paid irrespective of the occurrence of a workers' compensation accident." *Id.* at 529. *Tee-Pak* found that there was evidence from which the Commission could infer that the employer intended its employees to collect both TTD benefits and salary payments for the same period of time. Consistent with *Tee-Pak*, the Commission has found an employer is not entitled to credit under Section 8(j) where there is no evidence presented that an employer intended its employees to receive benefits *in lieu of* TTD payments, as those benefits would have been paid irrespective of the occurrence of a workers' compensation accident. See, 12 IWCC 1082 (sick pay), 08 IWCC 0900 (sick pay), 1999 IIC 0623 (vacation pay). In contrast, in *Elgin Bd. Of Edu. School Dist. U-46 v. Ill. Workers' Comp. Comm'n*, 409 Ill. App. 3d 943, 949 N.E.2d 198 (1st Dist. 2011), the employer presented evidence that the claimant received a letter indicating that employees had the option of using earned sick leave in order to receive full pay for an absence resulting from a work injury, that human resources would automatically charge sick leave when an employee was absent because of a work related injury unless directed otherwise and that once sick leave was exhausted, the employee would be placed on temporary total disability benefits. The employer argued, and the appellate court agreed, it was entitled to a credit under 8(j)(2) for wages paid to claimant in lieu of TTD benefits. Here, because no such evidence was presented, no credit is awarded.

Thus, for **11 WC 8902**, Respondent shall pay Petitioner temporary total disability benefits of **$1,103.14/week** for **2-6/7th weeks**, commencing 10/1/10; 10/6/10; 10/20/10; 11/01/10 through 11/3/10; and 8/6/12 through 8/19/12, as provided in Section 8(b) of the Act. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 10/1/10; 10/6/10; 10/20/10; 11/01/10 through 11/3/10; and 8/6/12 through 8/19/12, and shall pay the remainder of the award, if any, in weekly payments.

B. Date of accident November 16, 2010 claim number 11 WC 8901

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. With regard to the accident of 11/16/2010 the Arbitrator finds that the weight of credible evidence demonstrates that Petitioner was off 11/17/10 and 11/18/10 as a result of the work injury. Under the Act, no TTD is due. Thus, for **11 WC 8901**, Respondent shall pay Petitioner temporary total disability benefits of **$0** for **0 weeks**, as provided in Section 8(b) of the Act.

C. Date of accident January 7, 2011 claim number 11 WC 8903

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. With regard to the accident date of 1/7/11 the Arbitrator finds that the weight of credible evidence demonstrates that Petitioner was off 1/10/11 through 1/17/11 representing 1 week as a result of the work injury. This time off of work was pursuant to her treating doctor's orders. Thus, for **11 WC 8903**, Respondent shall pay Petitioner temporary total disability benefits of **$1,103.14/week** for **1-1/7th weeks**, commencing **1/10/11** through **1/17/11**, as provided in Section 8(b) of the Act. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **1/10/11** through **1/17/11**, and shall pay the remainder of the award, if any, in weekly payments. No credit for sick leave pay is awarded as previously noted, *supra*.

ISSUE (L) What is the nature and extent of the injury?

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. All of the consolidated claims occurred on date prior to September 1, 2011 and therefore are not subject to the terms of Section 8.1b of the Workers Compensation Act.

Petitioner testified at hearing that she continues to experience pain in the chest, weakness in her arms, limited range of motion in her shoulder and neck which limits her ability to lift and pull. She experiences pain in the rib cage under the breasts which she did not have before the accident. Bending over causes this pain. Petitioner also noted asymmetry in her breasts. She no longer bowls because of pain on the right side; she bowled once a week before the September 28, 2010 accident and has attempted to bowl one time subsequent to that accident and the pain was such that she could not continue. Her activities using a fishing rod and reel doing casting are limited because of pain in the neck shoulder and back. She required assistance of coworkers to do lifting and assisting in dressing and undressing the students which she did prior to the September 28, 2010 accident without assistance. The Arbitrator notes that Petitioner's testimony on this issue did not specify or attribute any one particular limitation to any one particular accident or accidents. Rather, most of Petitioner's complaints and/or limitations, on the whole, however, appear or suggest to be connected to Petitioner's breast injury and surgery, neck pains and back pains. Petitioner agreed that she had no treatment for any of these injuries since 2013 and had no future recommended treatment. She further agreed that as to her neck and back injuries, Ingalls diagnosed her with sprain/strains. Petitioner has since retired.

A. Date of accident September 28, 2010 claim number 11 WC 8902

In light of the foregoing, for case **11 WC 8902**, the Arbitrator finds based upon the weight of credible evidence the accident resulted in permanent partial disability to the extent of **10%** loss man as a whole.

Respondent shall pay Petitioner permanent partial disability benefits of **$669.64/week** for **50 weeks**, because the injuries sustained caused the **10%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

B. Date of accident November 16, 2010 claim number 11 WC 8901

In light of the foregoing, for case **11 WC 8901**, the Arbitrator finds based upon the weight of credible evidence the accident resulted in permanent partial disability to the extent of **2%** loss man as a whole. Respondent shall pay Petitioner permanent partial disability benefits of **$669.64/week** for **10 weeks**, because the injuries sustained caused the **2%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

C. Date of accident January 7, 2011 claim number 11 WC 8903

In light of the foregoing, for case **11 WC 8903**, the Arbitrator finds based upon the weight of credible evidence the accident resulted in permanent partial disability to the extent of **3.5%** loss man as a whole. Respondent shall pay Petitioner permanent partial disability benefits of **$669.64/week** for **17.5 weeks**, because the injuries sustained caused the **3.5%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Signature of Arbitrator

2-28-2017
Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sherrie Rosen,
Petitioner,

vs. NO: 11WC 8902

E.C.H.O.,
Respondent.

18IWCC0210

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 28, 2017, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $36,700.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

APR 5 - 2018

DATED:
o040318
MJB/jrc
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ROSEN, SHERRIE
Employee/Petitioner

Case# **11WC008902**

11WC008901
11WC008903

E.C.H.O.
Employer/Respondent

18IWCC0210

On 2/28/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.67% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2221 VRDOLYAK LAW GROUP LLC
MICHAEL P CASEY
741 N DEARBORN ST 3RD FL
CHICAGO, IL 60654

1120 BRADY CONNOLLY & MASUDA PC
STEVEN L MILLER
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603-1016

18IWCC0210

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

SHERRIE ROSEN,
Employee/Petitioner

v.

E.C.H.O.,
Employer/Respondent.

Case # **11** WC **8902**

Consolidated cases: **11 WC 8901**
11 WC 8903

18IWCC0210

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **MARIA S. BOCANEGRA**, Arbitrator of the Commission, in the city of **CHICAGO**, on **9/20/16 and 12/15/16** . 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 _____

18IWCC0210

FINDINGS

On **9/28/10**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$66,167.60**; the average weekly wage was **$1,654.72**.

On the date of accident, Petitioner was **59** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$0** for TTD, **$0.00** for TPD and **$0.00** for other benefits, for a total credit of **$0**. Respondent is entitled to a credit under Section 8(j) of the Act for medical group insurance benefit payments made.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$1,103.14/week** for **2-6/7th weeks**, commencing 10/1/10; 10/6/10; 10/20/10; 11/01/10 through 11/3/10; and 8/6/12 through 8/19/12, as provided in Section 8(b) of the Act. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 10/1/10; 10/6/10; 10/20/10; 11/01/10 through 11/3/10; and 8/6/12 through 8/19/12, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay such reasonable and necessary medical services as provided in Section 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, including but not limited to those identified in Rx4, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, included but not limited to those payments identified in Px16a-b, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$669.64/week** for **50 weeks**, because the injuries sustained caused the **10%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

2-28-2017
Date

FEB 28 2017

BACKGROUND

Sherrie Rosen ("Petitioner") alleged injuries arising out of and in the course of her employment on 9/28/10, 11/16/10 and 1/20/11 with E.C.H.O. ("Respondent"). Ax1-3. On 9/20/16 and 12/15/16, the parties proceeded to arbitration. As to all claims, the following issues were in dispute: causal connection, liability for unpaid medical bills, temporary total disability and nature and extent of the injuries. The following is a recitation of the facts adduced at trial, along with conclusions of law.

FINDINGS OF FACT

A. Date of accident September 28, 2010 claim number 11 WC 8902

Petitioner and Respondent stipulated to an accident of 9/28/10, arising out of an in the course of her employment with Respondent. Ax2. Prior to this date, Petitioner said she did in fact have problems with her chest and breasts. Specifically, Petitioner had breast cancer for which she underwent a double mastectomy on 10/1/01. She eventually underwent surgery for tissue expansion followed by surgery for breast implants in 2002 or 2003. Between the time of her implantation surgery and her first work accident, Petitioner had no problems with her implants or her breast area. She also had no prior cervical/neck or middle back problems.

Petitioner worked as a teacher for Respondent, where she worked with handicapped adult children suffering from multiple handicapping conditions. Her duties included dealing with physical activities, getting students off of buses, undressing them, escorting students, feeding, cleaning up after breakfast, providing bathroom assistance, assisting with diaper change, conducting morning activities, dressing students to go home and helping lift students in and out of chairs or off of a floor as needed.

On 9/28/10, Petitioner suffered injuries to her chest area when a student punched her very hard in the chest between her breasts. The male student was 6'3 and weighed approximately 275 pounds. She noticed pain in her arm, wrist and chest. She then saw a nurse and completed an incident report. Px1. For this injury, she treated with Ingalls for neck, left wrist, left hip, mid back and low back. Px3:54-59. Petitioner underwent physical therapy at Ingalls through the end of October. Px2. There, Dr. Akhtar recommended she continue to see Dr. Dreyfus, who specialized in both orthopedics and plastic surgery. She was placed on light duty.

On 11/2/10, Petitioner followed up at Ingalls Occupational. She was diagnosed with chest contusion and low back pain. She was released to full duty and ordered to follow up. She underwent a chest x-ray which was normal. Px3, Px5. She said she lost time because of her pain in her chest, arm and back. Eventually, Petitioner was approved to see Dr. Dreyfus and on 8/7/12, underwent bilateral replacement of both breast implants at Ingalls relative to her first work accident. Px3. Pre-op diagnosis was traumatic injury with deformity and contracture of bilateral breasts. She continued to follow up with Dr. Dreyfus and was given a prescription for therapy. During this time, she felt some pain radiating from her chest area down her arms, along with tingly finger tips. When she bent down, she experienced pain under her breast area. She last saw Dr. Dreyfus in 2013 and at that time had no restrictions or future medical recommendations.

B. Date of accident November 16, 2010 claim number 11 WC 8901

The parties stipulated to an accident of 11/16/10, arising out of an in the course of Petitioner's employment with Respondent. Ax1. Petitioner testified that on this date she attempted to scooch an agitated male student back into a table. While trying to lift and scoot the chair, she injured her chest, neck and back.

She felt like she pulled her muscles. She again reported the incident and completed an incident report. Px4. She was seen at Ingalls Urgent Care and was eventually referred for physical therapy with ATI Physical Therapy. On 11/17/10, Petitioner presented to Ingalls with back pain and left groin pain. Px3:40-41. X-ray of the cervical spine showed moderate degenerative changes from C2-C7. Px3, Px5. X-ray of the lumbar spine showed mild to moderate multi-level degenerative changes, greatest at L5-S1.

Petitioner testified she recalled seeing Dr. Izquierdo on 11/30/10, who examined her breasts at the request of Respondent relative to her first work accident. On 12/6/10, Petitioner saw Dr. Bernstein at the request of Respondent for her neck and back. Following her second work accident, Petitioner continued to work. Petitioner testified that during this time, she was referred to physical therapy with ATI and was still awaiting approval to see Dr. Dreyfus.

C. Date of accident January 7, 2011 claim number 11 WC 8903

The parties stipulated to an accident of 1/7/11, arising out of an in the course of Petitioner's employment with Respondent. Ax3. On that date, Petitioner injured her upper back, neck and shoulder while lifting an adult student, who was experiencing a seizure and needed aid in lifting to a safe position. She reported the incident the same date and sought medical treatment. Px6.

On 1/9/11, Petitioner presented to Ingalls Memorial Hospital with back pain and a thoracic strain. Px3. She related she worked with handicapped children and had done some heavy lifting over the past few days. It was noted to have possibly occurred from repeated lifting of handicapped adults. Exam of the back showed paraspinal tenderness. X-ray of the thoracic spine showed shallow scoliosis without acute findings. Px5. Petitioner was prescribed ibuprofen and Tylenol and discharged. From 1/10/11-1/13/11, Petitioner saw Dr. Bremen, D.C., of Brementowne Chiropractic. Px14. He diagnosed cervicalgia, degeneration, spondylosis, spasms, segmental dysfunction and thoracicalgia. He referred her back to her primary doctor and noted a possible referral for pain management.

On 1/17/11, Petitioner saw Dr. Robinson, who ordered an MRI of the lumbar spine. Px9. A total bone scan showed minimal arthritic changes in the right knee but otherwise unremarkable scan. Px5. Dr. Robinson released Petitioner to sedentary work only with a 10 pound lifting restriction. Px9. He diagnosed Petitioner with lumbago on the right, thoracic or lumbosacral neuritis or radiculitis, T8-9 bulge on the left and degeneration of lumbar or lumbosacral intervertebral disc. *Id.* On 1/26/11, MRI of the lumbar spine showed degenerative changes greatest at L4-L5, protrusion at L5-S1. Px5.

On 2/8/11, Dr. Robinson saw Petitioner and his diagnosis was unchanged. The doctor added myofascial pain, facet dysfunction and a right L4-5 HNP of unclear significance. Petitioner remained on sedentary work duty. Petitioner was prescribed Flexeril and physical therapy 2-3 times per week for 4 weeks. Px9. Therapy took place at ATI Physical Therapy. Px10. Petitioner stated that during this time, she continued to teach.

On 2/13/12, Petitioner related to Ingalls that she was at work leaning over a table for a long period of time and went to stand up and complained of pain in the mid lower back radiating bilaterally. Petitioner said her pain started at 1pm that afternoon. She was diagnosed with lumbar strain, prescribed Vicodin, ibuprofen, heat/massage, light duty and discharged home.

Today, Petitioner notices that since her implants were replaced, it has caused thin skin, resulting in scarring and puckering. She notices her scars are longer and tighter than before. Regarding appearance, she testified Dr. Dreyfus tried to achieve symmetry but she did not think they are the same. Petitioner said she experiences chest pain and has a hard time lofting and pulling. When bending, she has pain in the rib area near the breasts. She has difficulty bowling and carrying a bowling ball and fishing in casting and reeling. She also has pain in her shoulders, neck and lower back, which she says were injured during the second and third accidents. Petitioner takes Tylenol and Ibuprofen as needed and retired one year prior to her hearing. Petitioner stated that following her breast surgery, she returned to her same job but noticed she was not able to do all of the things as before. She said her lifting of students changed because she did not have physical strength to do that and she relied on assistance. At home, she notices difficulty with vacuuming, lifting items and pushing/pulling.

On cross, Petitioner admitted to other work comp claims unrelated to this in which she sought some treatment. She agreed that for her neck and back injuries, Ingalls diagnosed sprain/strains. Following her second work accident, Ingalls released her to full duty. Petitioner confirmed she never received injections for her neck or back. Petitioner further agreed that she last saw Dr. Dreyfus for her breasts in May 2013. She has not current treatment recommendations from Dr. Dreyfus. Petitioner also confirmed she has not seen a chiropractor since her low back and neck injury. Petitioner agreed that her PT was for gaining movement from reconstructive breast surgery and not for her neck and back.

Regarding her teacher pay, she confirmed she can elect to be paid thru the year or pay can be increased at the end of a school year. She confirmed there are either 21 or 26 pay periods. She elected to be paid throughout the calendar year. She received her regular paycheck, which included sick time on them, and did not go without any pay. Petitioner confirmed she used sick time and received full pay on 10/1/10, 10/6, 10/20, 11/1-11/3, 11/12, and 11/17-11/18/10. Petitioner also missed 1/10/11-1/17/11 as a result of her being off work from her work accident. She received her full pay by using sick days and did not receive TTD. She also missed 8/6/12-8/19/12 for her breast surgery but used no sick time as she was out of school on summer break and she was also free to work anywhere during this time. In all, Petitioner agreed she was off of work for approximately 23 days for all work accidents and was paid for this time off using sick time and 2 personal days.

CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment

The Arbitrator observed the demeanor of the Petitioner during examination and cross-examination. The Arbitrator considered the testimony of this witness in light of all of the other evidence in the record. The Arbitrator finds that Petitioner was a credible witness.

ISSUE (F) Is Petitioner's current condition of ill-being causally connected to the injury?

A. Date of accident September 28, 2010 claim number 11 WC 8902

With regard to the accident date of 9/28/2010 the Arbitrator finds that the weight of credible evidence demonstrates that Petitioner had no immediate past problems with her chest, bilateral breast implants, neck, low back that caused her to seek medical treatment. The weight of credible evidence demonstrates that Petitioner's work accident of being punched in the chest caused, in part, her breast implants to become damaged or deformed, ultimately requiring treatment and surgical replacement of the implants. She credibly described an

acute and immediate onset of pain in the chest, neck, low back, left arm and left wrist with noticeable redness and soreness in the chest. Her recollection and description is consistent with her timely and equally credible medical treatment records.

Dr. Dreyfus described the traumatic event of 9/28/2010 is the cause of the condition for which he treated her. Similarly, Respondent's Section 12 examiner, Dr. Izquierdo opined in his medical report that the condition of Petitioner's breasts which he examined was causally related to the traumatic event of 9/28/2010. Petitioner continued to seek treatment for her breasts through 2013, having undergone reconstructive/implant surgery in 2012. Based on the foregoing as well as the record as a whole, the Arbitrator finds that the weight of credible evidence demonstrates that Petitioner's current condition of ill being with regard to the bilateral breasts, chest, neck, left arm and left wrist, under a chain of events theory, are causally related to the work accident of 9/28/2010.

B. Date of accident November 16, 2010 claim number 11 WC 8901

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. With regard to the accident date of 11/16/2010 the Arbitrator finds that the weight of credible evidence demonstrates that Petitioner was pushing a chair with a student who was very agitated and rocking back and forth seated in the chair into it into the table so that the student would be safe and not injure himself or those around him. The chair did not slide on the floor and Petitioner had to pick it up to move the chair with the student seated in it into the table. Petitioner felt an immediate pain in her chest, neck and back as if she had pulled muscles. That history is given to the initial medical providers. She had no problems with these body parts before the date of the accident. The Arbitrator finds that based upon the weight of credible evidence that Petitioner's current condition of ill being with regard to the neck back and chest is causally related to the accident of 11/16/2010.

C. Date of accident January 7, 2011 claim number 11 WC 8903

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. With regard to the accident date of 1/7/2011 the Arbitrator finds that the weight of credible evidence demonstrates that on that date Petitioner was lifting a student who was experiencing a seizure disorder. While attempting to lift the student she felt an immediate onset of pain in her neck, back, lower back, upper back and shoulders. Medical records confirm Petitioner injured herself lifting.

Petitioner sought timely treatment and was diagnosed with sprain/strains. The Arbitrator finds that based upon the weight of credible evidence Petitioner's current condition with regard to her neck, back, lower back upper back and shoulders are causally related to the accident of 1/7/2011.

ISSUE (J) Were the medical services that were provided to Petitioner reasonable and necessary?

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having found in favor of Petitioner on the foregoing issue of causation, the Arbitrator finds that Petitioner's medical treatment for all three dates of accident were reasonable and necessary to treat her bilateral breast condition, chest contusions, lumbar and cervical sprain/strains. This treatment was conservative and necessary in nature in order to address each of her work injuries. Respondent shall pay such reasonable and

necessary medical services as provided in Section 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, including but not limited to those identified in Rx4, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, included but not limited to those payments identified in Px16a-b, as provided in Section 8(j) of the Act.

ISSUE (K) What temporary benefits are in dispute?

A. Date of accident September 28, 2010 claim number 11 WC 8902

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having found in favor of Petitioner on the issue of accident and causal connection, the Arbitrator concludes that Petitioner is entitled to temporary total disability (TTD) for the time that she was off of work due to her chest, bilateral breast, back and neck injuries sustained as a result of this injury. Ax2. The weight of credible evidence demonstrates that Petitioner was off 10/1/10; 10/6/10; 10/20/10; 11/01/10 through 11/3/10; and 8/6/12 through 8/19/12 representing 2-6/7th weeks as a result of the injury sustained in this work accident.

Respondent seeks a credit for the sick time paid during this time. The Arbitrator finds that Respondent is not entitled to credit for the sick days which Petitioner used while she was off on these dates. Respondent failed to meet its burden for credit under 8(j) in that it failed to present evidence that Petitioner such leave in lieu of TTD compensation. In support thereof, the Arbitrator relies on Tee-Pak, Inc. v. Indus. Comm'n, 141 Ill. App. 3d 520, 490 N.E.2d 170 (1986), which found that the employer was not entitled to a credit under Section 8(j) where it failed to show claimant's salary payments received were limited to occupationally related disabilities, noting that "the employer receives no credit for benefits which would have been paid irrespective of the occurrence of a workers' compensation accident." *Id.* at 529. *Tee-Pak* found that there was evidence from which the Commission could infer that the employer intended its employees to collect both TTD benefits and salary payments for the same period of time. Consistent with *Tee-Pak*, the Commission has found an employer is not entitled to credit under Section 8(j) where there is no evidence presented that an employer intended its employees to receive benefits *in lieu of* TTD payments, as those benefits would have been paid irrespective of the occurrence of a workers' compensation accident. See, 12 IWCC 1082 (sick pay), 08 IWCC 0900 (sick pay), 1999 IIC 0623 (vacation pay). In contrast, in *Elgin Bd. Of Edu. School Dist. U-46 v. Ill. Workers' Comp. Comm'n*, 409 Ill. App. 3d 943, 949 N.E.2d 198 (1st Dist. 2011), the employer presented evidence that the claimant received a letter indicating that employees had the option of using earned sick leave in order to receive full pay for an absence resulting from a work injury, that human resources would automatically charge sick leave when an employee was absent because of a work related injury unless directed otherwise and that once sick leave was exhausted, the employee would be placed on temporary total disability benefits. The employer argued, and the appellate court agreed, it was entitled to a credit under 8(j)(2) for wages paid to claimant in lieu of TTD benefits. Here, because no such evidence was presented, no credit is awarded.

Thus, for **11 WC 8902**, Respondent shall pay Petitioner temporary total disability benefits of **$1,103.14/week** for **2-6/7th weeks**, commencing 10/1/10; 10/6/10; 10/20/10; 11/01/10 through 11/3/10; and 8/6/12 through 8/19/12, as provided in Section 8(b) of the Act. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 10/1/10; 10/6/10; 10/20/10; 11/01/10 through 11/3/10; and 8/6/12 through 8/19/12, and shall pay the remainder of the award, if any, in weekly payments.

B. Date of accident November 16, 2010 claim number 11 WC 8901

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. With regard to the accident of 11/16/2010 the Arbitrator finds that the weight of credible evidence demonstrates that Petitioner was off 11/17/10 and 11/18/10 as a result of the work injury. Under the Act, no TTD is due. Thus, for **11 WC 8901**, Respondent shall pay Petitioner temporary total disability benefits of **$0** for **0 weeks**, as provided in Section 8(b) of the Act.

C. Date of accident January 7, 2011 claim number 11 WC 8903

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. With regard to the accident date of 1/7/11 the Arbitrator finds that the weight of credible evidence demonstrates that Petitioner was off 1/10/11 through 1/17/11 representing 1 week as a result of the work injury. This time off of work was pursuant to her treating doctor's orders. Thus, for **11 WC 8903**, Respondent shall pay Petitioner temporary total disability benefits of **$1,103.14/week** for **1-1/7th weeks**, commencing **1/10/11** through **1/17/11**, as provided in Section 8(b) of the Act. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **1/10/11** through **1/17/11**, and shall pay the remainder of the award, if any, in weekly payments. No credit for sick leave pay is awarded as previously noted, *supra*.

ISSUE (L) What is the nature and extent of the injury?

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. All of the consolidated claims occurred on date prior to September 1, 2011 and therefore are not subject to the terms of Section 8.1b of the Workers Compensation Act.

Petitioner testified at hearing that she continues to experience pain in the chest, weakness in her arms, limited range of motion in her shoulder and neck which limits her ability to lift and pull. She experiences pain in the rib cage under the breasts which she did not have before the accident. Bending over causes this pain. Petitioner also noted asymmetry in her breasts. She no longer bowls because of pain on the right side; she bowled once a week before the September 28, 2010 accident and has attempted to bowl one time subsequent to that accident and the pain was such that she could not continue. Her activities using a fishing rod and reel doing casting are limited because of pain in the neck shoulder and back. She required assistance of coworkers to do lifting and assisting in dressing and undressing the students which she did prior to the September 28, 2010 accident without assistance. The Arbitrator notes that Petitioner's testimony on this issue did not specify or attribute any one particular limitation to any one particular accident or accidents. Rather, most of Petitioner's complaints and/or limitations, on the whole, however, appear or suggest to be connected to Petitioner's breast injury and surgery, neck pains and back pains. Petitioner agreed that she had no treatment for any of these injuries since 2013 and had no future recommended treatment. She further agreed that as to her neck and back injuries, Ingalls diagnosed her with sprain/strains. Petitioner has since retired.

A. Date of accident September 28, 2010 claim number 11 WC 8902

In light of the foregoing, for case **11 WC 8902**, the Arbitrator finds based upon the weight of credible evidence the accident resulted in permanent partial disability to the extent of **10%** loss man as a whole.

18IWCC0210

Respondent shall pay Petitioner permanent partial disability benefits of **$669.64/week** for **50 weeks**, because the injuries sustained caused the **10%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

B. Date of accident November 16, 2010 claim number 11 WC 8901

In light of the foregoing, for case **11 WC 8901**, the Arbitrator finds based upon the weight of credible evidence the accident resulted in permanent partial disability to the extent of **2%** loss man as a whole. Respondent shall pay Petitioner permanent partial disability benefits of **$669.64/week** for **10 weeks**, because the injuries sustained caused the **2%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

C. Date of accident January 7, 2011 claim number 11 WC 8903

In light of the foregoing, for case **11 WC 8903**, the Arbitrator finds based upon the weight of credible evidence the accident resulted in permanent partial disability to the extent of **3.5%** loss man as a whole. Respondent shall pay Petitioner permanent partial disability benefits of **$669.64/week** for **17.5 weeks**, because the injuries sustained caused the **3.5%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Signature of Arbitrator

2-28-2017
Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sherrie Rosen,
Petitioner,

vs.

NO: 11WC 8903

E.C.H.O.,
Respondent.

18IWCC0211

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 28, 2017, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $13,100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

APR 5 – 2018

DATED:
o040318
MJB/jrc
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ROSEN, SHERRIE
Employee/Petitioner

Case# **11WC008903**

11WC008901
11WC008902

E.C.H.O.
Employer/Respondent

18IWCC0211

On 2/28/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.67% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2221 VRDOLYAK LAW GROUP LLC
MICHAEL P CASEY
741 N DEARBORN ST 3RD FL
CHICAGO, IL 60654

1120 BRADY CONNOLLY & MASUDA PC
STEVEN L MILLER
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603-1016

18IWCC0211

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

SHERRIE ROSEN,
Employee/Petitioner

v.

E.C.H.O.,
Employer/Respondent.

Case # **11** WC **8903**

Consolidated cases: **11 WC 8901**
11 WC 8902

18IWCC0211

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **MARIA S. BOCANEGRA**, Arbitrator of the Commission, in the city of **CHICAGO**, on **9/20/16 and 12/15/16** . 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 ____

18IWCC0211

FINDINGS

On **1/7/11**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$66,167.60**; the average weekly wage was **$1,654.72**.

On the date of accident, Petitioner was **59** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$0** for TTD, **$0.00** for TPD and **$0.00** for other benefits, for a total credit of **$0**. Respondent is entitled to a credit under Section 8(j) of the Act for medical group insurance benefit payments made.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$1,103.14/week** for **1-1/7th weeks**, commencing **1/10/11** through **1/17/11**, as provided in Section 8(b) of the Act. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **1/10/11** through **1/17/11**, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay such reasonable and necessary medical services as provided in Section 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, including but not limited to those identified in Rx4, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, included but not limited to those payments identified in Px16a-b, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$669.64/week** for **17.5 weeks**, because the injuries sustained caused the **3.5%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

2-28-2017
Date

FEB 28 2017

18IWCC0211

BACKGROUND

Sherrie Rosen ("Petitioner") alleged injuries arising out of and in the course of her employment on 9/28/10, 11/16/10 and 1/20/11 with E.C.H.O. ("Respondent"). Ax1-3. On 9/20/16 and 12/15/16, the parties proceeded to arbitration. As to all claims, the following issues were in dispute: causal connection, liability for unpaid medical bills, temporary total disability and nature and extent of the injuries. The following is a recitation of the facts adduced at trial, along with conclusions of law.

FINDINGS OF FACT

A. Date of accident September 28, 2010 claim number 11 WC 8902

Petitioner and Respondent stipulated to an accident of 9/28/10, arising out of an in the course of her employment with Respondent. Ax2. Prior to this date, Petitioner said she did in fact have problems with her chest and breasts. Specifically, Petitioner had breast cancer for which she underwent a double mastectomy on 10/1/01. She eventually underwent surgery for tissue expansion followed by surgery for breast implants in 2002 or 2003. Between the time of her implantation surgery and her first work accident, Petitioner had no problems with her implants or her breast area. She also had no prior cervical/neck or middle back problems.

Petitioner worked as a teacher for Respondent, where she worked with handicapped adult children suffering from multiple handicapping conditions. Her duties included dealing with physical activities, getting students off of buses, undressing them, escorting students, feeding, cleaning up after breakfast, providing bathroom assistance, assisting with diaper change, conducting morning activities, dressing students to go home and helping lift students in and out of chairs or off of a floor as needed.

On 9/28/10, Petitioner suffered injuries to her chest area when a student punched her very hard in the chest between her breasts. The male student was 6'3 and weighed approximately 275 pounds. She noticed pain in her arm, wrist and chest. She then saw a nurse and completed an incident report. Px1. For this injury, she treated with Ingalls for neck, left wrist, left hip, mid back and low back. Px3:54-59. Petitioner underwent physical therapy at Ingalls through the end of October. Px2. There, Dr. Akhtar recommended she continue to see Dr. Dreyfus, who specialized in both orthopedics and plastic surgery. She was placed on light duty.

On 11/2/10, Petitioner followed up at Ingalls Occupational. She was diagnosed with chest contusion and low back pain. She was released to full duty and ordered to follow up. She underwent a chest x-ray which was normal. Px3, Px5. She said she lost time because of her pain in her chest, arm and back. Eventually, Petitioner was approved to see Dr. Dreyfus and on 8/7/12, underwent bilateral replacement of both breast implants at Ingalls relative to her first work accident. Px3. Pre-op diagnosis was traumatic injury with deformity and contracture of bilateral breasts. She continued to follow up with Dr. Dreyfus and was given a prescription for therapy. During this time, she felt some pain radiating from her chest area down her arms, along with tingly finger tips. When she bent down, she experienced pain under her breast area. She last saw Dr. Dreyfus in 2013 and at that time had no restrictions or future medical recommendations.

B. Date of accident November 16, 2010 claim number 11 WC 8901

The parties stipulated to an accident of 11/16/10, arising out of an in the course of Petitioner's employment with Respondent. Ax1. Petitioner testified that on this date she attempted to scooch an agitated male student back into a table. While trying to lift and scoot the chair, she injured her chest, neck and back.

She felt like she pulled her muscles. She again reported the incident and completed an incident report. Px4. She was seen at Ingalls Urgent Care and was eventually referred for physical therapy with ATI Physical Therapy. On 11/17/10, Petitioner presented to Ingalls with back pain and left groin pain. Px3:40-41. X-ray of the cervical spine showed moderate degenerative changes from C2-C7. Px3, Px5. X-ray of the lumbar spine showed mild to moderate multi-level degenerative changes, greatest at L5-S1.

Petitioner testified she recalled seeing Dr. Izquierdo on 11/30/10, who examined her breasts at the request of Respondent relative to her first work accident. On 12/6/10, Petitioner saw Dr. Bernstein at the request of Respondent for her neck and back. Following her second work accident, Petitioner continued to work. Petitioner testified that during this time, she was referred to physical therapy with ATI and was still awaiting approval to see Dr. Dreyfus.

C. Date of accident January 7, 2011 claim number 11 WC 8903

The parties stipulated to an accident of 1/7/11, arising out of an in the course of Petitioner's employment with Respondent. Ax3. On that date, Petitioner injured her upper back, neck and shoulder while lifting an adult student, who was experiencing a seizure and needed aid in lifting to a safe position. She reported the incident the same date and sought medical treatment. Px6.

On 1/9/11, Petitioner presented to Ingalls Memorial Hospital with back pain and a thoracic strain. Px3. She related she worked with handicapped children and had done some heavy lifting over the past few days. It was noted to have possibly occurred from repeated lifting of handicapped adults. Exam of the back showed paraspinal tenderness. X-ray of the thoracic spine showed shallow scoliosis without acute findings. Px5. Petitioner was prescribed ibuprofen and Tylenol and discharged. From 1/10/11-1/13/11, Petitioner saw Dr. Bremen, D.C., of Brementowne Chiropractic. Px14. He diagnosed cervicalgia, degeneration, spondylosis, spasms, segmental dysfunction and thoracicalgia. He referred her back to her primary doctor and noted a possible referral for pain management.

On 1/17/11, Petitioner saw Dr. Robinson, who ordered an MRI of the lumbar spine. Px9. A total bone scan showed minimal arthritic changes in the right knee but otherwise unremarkable scan. Px5. Dr. Robinson released Petitioner to sedentary work only with a 10 pound lifting restriction. Px9. He diagnosed Petitioner with lumbago on the right, thoracic or lumbosacral neuritis or radiculitis, T8-9 bulge on the left and degeneration of lumbar or lumbosacral intervertebral disc. *Id.* On 1/26/11, MRI of the lumbar spine showed degenerative changes greatest at L4-L5, protrusion at L5-S1. Px5.

On 2/8/11, Dr. Robinson saw Petitioner and his diagnosis was unchanged. The doctor added myofascial pain, facet dysfunction and a right L4-5 HNP of unclear significance. Petitioner remained on sedentary work duty. Petitioner was prescribed Flexeril and physical therapy 2-3 times per week for 4 weeks. Px9. Therapy took place at ATI Physical Therapy. Px10. Petitioner stated that during this time, she continued to teach.

On 2/13/12, Petitioner related to Ingalls that she was at work leaning over a table for a long period of time and went to stand up and complained of pain in the mid lower back radiating bilaterally. Petitioner said her pain started at 1pm that afternoon. She was diagnosed with lumbar strain, prescribed Vicodin, ibuprofen, heat/massage, light duty and discharged home.

Today, Petitioner notices that since her implants were replaced, it has caused thin skin, resulting in scarring and puckering. She notices her scars are longer and tighter than before. Regarding appearance, she testified Dr. Dreyfus tried to achieve symmetry but she did not think they are the same. Petitioner said she experiences chest pain and has a hard time lofting and pulling. When bending, she has pain in the rib area near the breasts. She has difficulty bowling and carrying a bowling ball and fishing in casting and reeling. She also has pain in her shoulders, neck and lower back, which she says were injured during the second and third accidents. Petitioner takes Tylenol and Ibuprofen as needed and retired one year prior to her hearing. Petitioner stated that following her breast surgery, she returned to her same job but noticed she was not able to do all of the things as before. She said her lifting of students changed because she did not have physical strength to do that and she relied on assistance. At home, she notices difficulty with vacuuming, lifting items and pushing/pulling.

On cross, Petitioner admitted to other work comp claims unrelated to this in which she sought some treatment. She agreed that for her neck and back injuries, Ingalls diagnosed sprain/strains. Following her second work accident, Ingalls released her to full duty. Petitioner confirmed she never received injections for her neck or back. Petitioner further agreed that she last saw Dr. Dreyfus for her breasts in May 2013. She has not current treatment recommendations from Dr. Dreyfus. Petitioner also confirmed she has not seen a chiropractor since her low back and neck injury. Petitioner agreed that her PT was for gaining movement from reconstructive breast surgery and not for her neck and back.

Regarding her teacher pay, she confirmed she can elect to be paid thru the year or pay can be increased at the end of a school year. She confirmed there are either 21 or 26 pay periods. She elected to be paid throughout the calendar year. She received her regular paycheck, which included sick time on them, and did not go without any pay. Petitioner confirmed she used sick time and received full pay on 10/1/10, 10/6, 10/20, 11/1-11/3, 11/12, and 11/17-11/18/10. Petitioner also missed 1/10/11-1/17/11 as a result of her being off work from her work accident. She received her full pay by using sick days and did not receive TTD. She also missed 8/6/12-8/19/12 for her breast surgery but used no sick time as she was out of school on summer break and she was also free to work anywhere during this time. In all, Petitioner agreed she was off of work for approximately 23 days for all work accidents and was paid for this time off using sick time and 2 personal days.

CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment

The Arbitrator observed the demeanor of the Petitioner during examination and cross-examination. The Arbitrator considered the testimony of this witness in light of all of the other evidence in the record. The Arbitrator finds that Petitioner was a credible witness.

ISSUE (F) Is Petitioner's current condition of ill-being causally connected to the injury?

A. Date of accident September 28, 2010 claim number 11 WC 8902

With regard to the accident date of 9/28/2010 the Arbitrator finds that the weight of credible evidence demonstrates that Petitioner had no immediate past problems with her chest, bilateral breast implants, neck, low back that caused her to seek medical treatment. The weight of credible evidence demonstrates that Petitioner's work accident of being punched in the chest caused, in part, her breast implants to become damaged or deformed, ultimately requiring treatment and surgical replacement of the implants. She credibly described an

acute and immediate onset of pain in the chest, neck, low back, left arm and left wrist with noticeable redness and soreness in the chest. Her recollection and description is consistent with her timely and equally credible medical treatment records.

Dr. Dreyfus described the traumatic event of 9/28/2010 is the cause of the condition for which he treated her. Similarly, Respondent's Section 12 examiner, Dr. Izquierdo opined in his medical report that the condition of Petitioner's breasts which he examined was causally related to the traumatic event of 9/28/2010. Petitioner continued to seek treatment for her breasts through 2013, having undergone reconstructive/implant surgery in 2012. Based on the foregoing as well as the record as a whole, the Arbitrator finds that the weight of credible evidence demonstrates that Petitioner's current condition of ill being with regard to the bilateral breasts, chest, neck, left arm and left wrist, under a chain of events theory, are causally related to the work accident of 9/28/2010.

B. Date of accident November 16, 2010 claim number 11 WC 8901

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. With regard to the accident date of 11/16/2010 the Arbitrator finds that the weight of credible evidence demonstrates that Petitioner was pushing a chair with a student who was very agitated and rocking back and forth seated in the chair into it into the table so that the student would be safe and not injure himself or those around him. The chair did not slide on the floor and Petitioner had to pick it up to move the chair with the student seated in it into the table. Petitioner felt an immediate pain in her chest, neck and back as if she had pulled muscles. That history is given to the initial medical providers. She had no problems with these body parts before the date of the accident. The Arbitrator finds that based upon the weight of credible evidence that Petitioner's current condition of ill being with regard to the neck back and chest is causally related to the accident of 11/16/2010.

C. Date of accident January 7, 2011 claim number 11 WC 8903

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. With regard to the accident date of 1/7/2011 the Arbitrator finds that the weight of credible evidence demonstrates that on that date Petitioner was lifting a student who was experiencing a seizure disorder. While attempting to lift the student she felt an immediate onset of pain in her neck, back, lower back, upper back and shoulders. Medical records confirm Petitioner injured herself lifting.

Petitioner sought timely treatment and was diagnosed with sprain/strains. The Arbitrator finds that based upon the weight of credible evidence Petitioner's current condition with regard to her neck, back, lower back upper back and shoulders are causally related to the accident of 1/7/2011.

ISSUE (J) Were the medical services that were provided to Petitioner reasonable and necessary?

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having found in favor of Petitioner on the foregoing issue of causation, the Arbitrator finds that Petitioner's medical treatment for all three dates of accident were reasonable and necessary to treat her bilateral breast condition, chest contusions, lumbar and cervical sprain/strains. This treatment was conservative and necessary in nature in order to address each of her work injuries. Respondent shall pay such reasonable and

necessary medical services as provided in Section 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, including but not limited to those identified in Rx4, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, included but not limited to those payments identified in Px16a-b, as provided in Section 8(j) of the Act.

ISSUE (K) What temporary benefits are in dispute?

A. Date of accident September 28, 2010 claim number 11 WC 8902

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having found in favor of Petitioner on the issue of accident and causal connection, the Arbitrator concludes that Petitioner is entitled to temporary total disability (TTD) for the time that she was off of work due to her chest, bilateral breast, back and neck injuries sustained as a result of this injury. Ax2. The weight of credible evidence demonstrates that Petitioner was off 10/1/10; 10/6/10; 10/20/10; 11/01/10 through 11/3/10; and 8/6/12 through 8/19/12 representing 2-6/7th weeks as a result of the injury sustained in this work accident.

Respondent seeks a credit for the sick time paid during this time. The Arbitrator finds that Respondent is not entitled to credit for the sick days which Petitioner used while she was off on these dates. Respondent failed to meet its burden for credit under 8(j) in that it failed to present evidence that Petitioner such leave in lieu of TTD compensation. In support thereof, the Arbitrator relies on Tee-Pak, Inc. v. Indus. Comm'n, 141 Ill. App. 3d 520, 490 N.E.2d 170 (1986), which found that the employer was not entitled to a credit under Section 8(j) where it failed to show claimant's salary payments received were limited to occupationally related disabilities, noting that "the employer receives no credit for benefits which would have been paid irrespective of the occurrence of a workers' compensation accident." *Id.* at 529. *Tee-Pak* found that there was evidence from which the Commission could infer that the employer intended its employees to collect both TTD benefits and salary payments for the same period of time. Consistent with *Tee-Pak*, the Commission has found an employer is not entitled to credit under Section 8(j) where there is no evidence presented that an employer intended its employees to receive benefits *in lieu of* TTD payments, as those benefits would have been paid irrespective of the occurrence of a workers' compensation accident. See, 12 IWCC 1082 (sick pay), 08 IWCC 0900 (sick pay), 1999 IIC 0623 (vacation pay). In contrast, in *Elgin Bd. Of Edu. School Dist. U-46 v. Ill. Workers' Comp. Comm'n*, 409 Ill. App. 3d 943, 949 N.E.2d 198 (1st Dist. 2011), the employer presented evidence that the claimant received a letter indicating that employees had the option of using earned sick leave in order to receive full pay for an absence resulting from a work injury, that human resources would automatically charge sick leave when an employee was absent because of a work related injury unless directed otherwise and that once sick leave was exhausted, the employee would be placed on temporary total disability benefits. The employer argued, and the appellate court agreed, it was entitled to a credit under 8(j)(2) for wages paid to claimant in lieu of TTD benefits. Here, because no such evidence was presented, no credit is awarded.

Thus, for **11 WC 8902**, Respondent shall pay Petitioner temporary total disability benefits of **$1,103.14/week** for **2-6/7th weeks**, commencing 10/1/10; 10/6/10; 10/20/10; 11/01/10 through 11/3/10; and 8/6/12 through 8/19/12, as provided in Section 8(b) of the Act. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 10/1/10; 10/6/10; 10/20/10; 11/01/10 through 11/3/10; and 8/6/12 through 8/19/12, and shall pay the remainder of the award, if any, in weekly payments.

B. Date of accident November 16, 2010 claim number 11 WC 8901

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. With regard to the accident of 11/16/2010 the Arbitrator finds that the weight of credible evidence demonstrates that Petitioner was off 11/17/10 and 11/18/10 as a result of the work injury. Under the Act, no TTD is due. Thus, for **11 WC 8901**, Respondent shall pay Petitioner temporary total disability benefits of **$0** for **0 weeks**, as provided in Section 8(b) of the Act.

C. Date of accident January 7, 2011 claim number 11 WC 8903

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. With regard to the accident date of 1/7/11 the Arbitrator finds that the weight of credible evidence demonstrates that Petitioner was off 1/10/11 through 1/17/11 representing 1 week as a result of the work injury. This time off of work was pursuant to her treating doctor's orders. Thus, for **11 WC 8903**, Respondent shall pay Petitioner temporary total disability benefits of **$1,103.14/week** for **1-1/7th weeks**, commencing **1/10/11** through **1/17/11**, as provided in Section 8(b) of the Act. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **1/10/11** through **1/17/11**, and shall pay the remainder of the award, if any, in weekly payments. No credit for sick leave pay is awarded as previously noted, *supra*.

ISSUE (L) What is the nature and extent of the injury?

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. All of the consolidated claims occurred on date prior to September 1, 2011 and therefore are not subject to the terms of Section 8.1b of the Workers Compensation Act.

Petitioner testified at hearing that she continues to experience pain in the chest, weakness in her arms, limited range of motion in her shoulder and neck which limits her ability to lift and pull. She experiences pain in the rib cage under the breasts which she did not have before the accident. Bending over causes this pain. Petitioner also noted asymmetry in her breasts. She no longer bowls because of pain on the right side; she bowled once a week before the September 28, 2010 accident and has attempted to bowl one time subsequent to that accident and the pain was such that she could not continue. Her activities using a fishing rod and reel doing casting are limited because of pain in the neck shoulder and back. She required assistance of coworkers to do lifting and assisting in dressing and undressing the students which she did prior to the September 28, 2010 accident without assistance. The Arbitrator notes that Petitioner's testimony on this issue did not specify or attribute any one particular limitation to any one particular accident or accidents. Rather, most of Petitioner's complaints and/or limitations, on the whole, however, appear or suggest to be connected to Petitioner's breast injury and surgery, neck pains and back pains. Petitioner agreed that she had no treatment for any of these injuries since 2013 and had no future recommended treatment. She further agreed that as to her neck and back injuries, Ingalls diagnosed her with sprain/strains. Petitioner has since retired.

A. Date of accident September 28, 2010 claim number 11 WC 8902

In light of the foregoing, for case **11 WC 8902**, the Arbitrator finds based upon the weight of credible evidence the accident resulted in permanent partial disability to the extent of **10%** loss man as a whole.

Respondent shall pay Petitioner permanent partial disability benefits of **$669.64/week** for **50 weeks**, because the injuries sustained caused the **10%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

B. Date of accident November 16, 2010 claim number 11 WC 8901

In light of the foregoing, for case **11 WC 8901**, the Arbitrator finds based upon the weight of credible evidence the accident resulted in permanent partial disability to the extent of **2%** loss man as a whole. Respondent shall pay Petitioner permanent partial disability benefits of **$669.64/week** for **10 weeks**, because the injuries sustained caused the **2%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

C. Date of accident January 7, 2011 claim number 11 WC 8903

In light of the foregoing, for case **11 WC 8903**, the Arbitrator finds based upon the weight of credible evidence the accident resulted in permanent partial disability to the extent of **3.5%** loss man as a whole. Respondent shall pay Petitioner permanent partial disability benefits of **$669.64/week** for **17.5 weeks**, because the injuries sustained caused the **3.5%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Signature of Arbitrator

2-28-2017
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

NICHOLAS ZINGARELLI,

Petitioner,

vs.

NO: 14 WC 28048

CHICAGO PARK DISTRICT,

18IWCC0212

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) and §8(a) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, notice, causal connection, medical expenses and permanent disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Commission notes four instances of transposed consolidated case numbers in the Arbitrator's Decision. The cover page and the introductory paragraph, line three, on page four reference the subject case's consolidation with two other cases, "09 WC 20972 and 12 WC 12664". The Commission records confirm, however, the subject case is consolidated with case numbers "09 WC 30972" and 12 WC 12664. Therefore, the Commission strikes "09 WC 20972" on the cover page and in line three of the introductory paragraph on page four and substitutes "09 WC 30972" to correct the transposed numbers.

On page one of the Arbitration Decision and in the heading on page four, the subject case is listed and consolidated with case numbers "09 WC 29072 and 12 WC 12664." The Commission

18IWCC0212

strikes "09 WC 29072" on page one and in the heading on page four and substitutes "09 WC 30972" to correct those transposed numbers.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on March 8, 2017, is hereby modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,440.00 for medical expenses under §8(a) and in accord with the fee schedule provided in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION Respondent shall authorize and pay for prospective medical care as prescribed and recommended by D. John J. Fernandez, as well as reasonable and necessary follow-up rehabilitative care.

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

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

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

No county, city, town, township, incorporated village, school district, body politic or municipal corporation is required to file a bond to secure the payment of the award and the costs of the proceedings in the court to authorize the court to issue such summons. *820 ILCS 305/19(f)(2).* Based upon the named Respondent herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 5 – 2018
KWL/bsd
O: 02/20/18
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

ZINGARELLI, NICHOLAS
Employee/Petitioner

Case# **14WC028048**

09WC020972
12WC012664

CHICAGO PARK DISTRICT
Employer/Respondent

18IWCC0212

On 3/8/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.83% 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:

0140 PETER D CORTI LAW GROUP PC
MARK A DePAOLO
180 N LASALLE ST SUITE 2910
CHICAGO, IL 60601

1946 CHICAGO PARK DISTRICT LAW DEPT
LEON W PAWLYKOWYCZ
541 N FAIRBANKS COURT 3RD FL
CHICAGO, IL 60611

18IWCC0212

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Nicholas Zingarelli
Employee/Petitioner

v.

Chicago Park District
Employer/Respondent

Case # **14WC 28048**

Consolidated cases: **09WC 29072, 12WC 12664**

18IWCC0212

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **June 30, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **July 30, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$57,397.08**; the average weekly wage was **$1,103.79**.

On the date of accident, Petitioner was **59** years of age, ***married*** with **0** dependent children.

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of $1,440.00, as provided in §8(a) of the Act and in accord with the fee scheduled provided in §8.2 of the Act.

Respondent shall authorize and pay for prospective medical care as prescribed and recommended by Dr. John J. Fernandez, as well as reasonable and necessary follow-up rehabilitative care.

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

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

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

Signature of Arbitrator

March 3, 2017
Date

MAR 8 - 2017

Nicholas Zingarelli v. Chicago Park District
14 WC 2848, consolidated 09WC 29072 & 12 WC 12664

INTRODUCTION

This matter proceeded to hearing before Arbitrator Steven Fruth on Petitioner's Motion for Hearing pursuant to §8(a) and §19(b) of the Act. This matter, 14 WC 28048, is consolidated with 09 WC 20972 and 12 WC 12664. The parties stipulated that only the issues pending in 14 WC 28048 would be decided at the present trial.

The disputed issues were: ***C:*** Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?; ***E:*** Was timely notice of the accident given to Respondent?; ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; ***K:*** Is Petitioner entitled to prospective medical care?

After the close of proofs Petitioner's counsel withdrew his Petition for Penalties and Attorneys' fees.

FINDINGS OF FACT

Petitioner Nicholas Zingarelli is a 59 year old rigger employed by Respondent Chicago Park District for the past 35 years. His job duties included construction and dismantling of Park District playgrounds, construction and dismantling of bleachers and temporary seating for special events, moving of furniture and equipment, and setting up athletic fields. His self-described job duties are in agreement with Respondent's Job Description of Rigger (RX #5).

Petitioner described his hands as his biggest and most basic tool. He used power and vibratory tools, such as a jackhammer or a reciprocating saw, on a daily basis, as much as 4-6 hours per day. Petitioner also testified to repetitive and forceful grasping activities as part of his job tasks, such as the lifting and moving of heavy concrete pieces, the use of manual wrenches, large pliers, and hammer drills. From 1988 to 1995, Petitioner constructed over 225 playgrounds for Respondent.

Petitioner had to break concrete in order to build and install playground structures. For big concrete jobs Petitioner had some help. He used a 90 pound hammer drill in breaking the concrete. Petitioner used a wheel barrow to remove concrete chunks. He also used a wrecking bar to pick up the concrete chunks.

Petitioner also used a reciprocating saw when working on swings. He also used hand tools such as socket wrenches, regular manual wrenches, and Crescent wrenches. Petitioner also uses large pliers in removing swings or repairing swings.

Petitioner was also responsible for the recovering of gymnasium bucks, horses, rings and athletic equipment and for repairs to rope, ball, furniture, canvas awnings, nets, screens, curtains, gymnasium mats, boxing ring mats, wrestling mats and covers, and steel lockers in locker rooms.

Petitioner also laid out and marked all types of athletic fields, such as track and archery fields for special events. He also erected and dismantled temporary seats, parallels and tops for portable stages and platforms. He also moved all recreational equipment, apparatus, and stage recovery from and to various parks. He also moves office and park furniture. He also moved pianos throughout park system. He also set up and dismantled for special events, such as model airplane meets, archery, and sand modeling. He also installed baseball bases and football goals. After 1995, Petitioner's job generally was maintaining playgrounds.

Petitioner testified that he had work-related back injuries in 2008 and in 2012. Petitioner was on light duty restrictions as a result of the back injuries. He testified that he has been doing sedentary work, including data entry of work orders, for Respondent from March 12, 2012 to the present. The keyboarding activities have now been difficult for him.

During his years of constructing playgrounds, Petitioner began having problems with his hands. His hands would "stiffen up." He dropped tools and other objects. He had to switch his tasks between hands. His hands would lock up on tools. He has pain, tingling and, sometimes, total numbness in his hands.

Petitioner testified that he had himself removed from re-doing the playgrounds and fixing them because he couldn't use his hands. He testified that he asked to be removed from maintenance because he couldn't use the power tools. Petitioner testified that over the years he has complaints with regard to his hands. Petitioner testified that he had to use his left hand while doing his playground duties. Petitioner testified that he felt pain and tingling while doing his playground duties. Petitioner testified that he felt numbness a number of years ago.

Petitioner saw Dr. John Fernandez in May and July of 2014 (PX #1). At that time, he was doing the keyboarding job because of the severe symptoms in both hands. He had previously been treated by Dr. Fernandez for a significant work injury to his

right hand which resulted in a right middle finger carbon fiber knuckle implant in 2005. On May 29, 2014 Petitioner complained of residual pain in his right middle finger and numbness and tingling in the right hand overall. He complained that he had been dropping things.

Dr. Fernandez diagnosed carpal tunnel syndrome and recommended an EMG, which was not approved until March 2015. Dr. Fernandez addressed a letter requesting authorization for the EMG on July 30, 2014 (PX #1). Dr. Fernandez stated that Petitioner's bilateral symptoms of numbness and tingling was likely from carpal tunnel syndrome. He noted that Petitioner's work had required frequent and moderate-to-heavy use of his hands. He noted that the bilateral carpal tunnel syndrome was related to Petitioner's work.

The March 31, 2015 EMG was abnormal, showing mild to moderate right median nerve neuropathy due to entrapment in the wrist. There was no evidence of ulnar entrapment neuropathy or cervical radiculopathy. Petitioner disclosed that he had a thyroid problem and that he had had pain and numbness in both hands since being rear-ended in his work truck about 11 years before.

Petitioner returned to Dr. Fernandez on April 23, 2015. Petitioner testified that he was told that he had carpal tunnel syndrome in both hands, right greater than left. Dr. Fernandez noted right moderate to severe carpal tunnel syndrome with demyelination. Dr. Fernandez recommended carpal tunnel release surgery along with revision of the middle finger implant. At that time Petitioner wished to undergo the surgery.

Petitioner was examined pursuant to §12 of the Act by Dr. M. Bryan Neal on September 17, 2015 (RX #2). In addition, Dr. Neal reviewed Petitioner's medical records and the job description for Petitioner's job. Dr. Neal took a medical history from Petitioner and conducted a clinical exam. Dr. Neal diagnosed right carpal tunnel syndrome with confirmatory electrodiagnostics. He also diagnosed left carpal tunnel syndrome without confirmatory electrodiagnostics. Dr. Neal diagnosed chronic hypothyroidism, low back pain attendant to lumbar fusion, and right long finger MP joint pain attendant to implant.

Dr. Neal opined that Petitioner's right carpal tunnel syndrome was not causally related to Petitioner's reported work accident on July 30, 2014. He did not state what he thought caused Petitioner's carpal tunnel syndrome. Dr. Neal particularly took note that there was no reported discreet trauma or accident. Dr. Neal also took note of Petitioner's pre-existing hypothyroidism as a risk factor for carpal tunnel syndrome, citing to sources on Orthopedic Knowledge Online, a resource provided by the American

Academy of Orthopaedic Surgeons. Dr. Neal did note Dr. Fernandez's long relationship with Petitioner. Dr. Neal noted that Petitioner could benefit from splinting and corticosteroid injections, but also acknowledged that surgery would be appropriate if conservative care failed.

Dr. Neal was unable to determine any degree of Petitioner's impairment. Dr. Neal did find that Petitioner was unable to perform his regular work activities due to his underlying lumbar spine condition but that the carpal tunnel syndrome was not limiting Petitioner's office work activities. He did opine that Petitioner was not at MMI regarding his carpal tunnel syndrome.

At the request Petitioner's counsel Dr. Fernandez prepared a narrative report review of Petitioner's case dated March 17, 2016 (PX #1). The doctor reviewed Petitioner's clinical course and the IME report of Dr. Neal. Dr. Fernandez acknowledged points raised by Dr. Neal that carpal tunnel is common and is often idiopathic. Dr. Fernandez discounted Dr. Neal's emphasis on Petitioner's hypothyroidism. In the end Dr. Fernandez opined that, even considering other risk factors Petitioner had, Petitioner's right carpal tunnel syndrome was work related.

Dr. Neal prepared a supplemental report April 25, 2016 (RX #3). This report was prepared in response to Dr. Fernandez's March 17 letter. Dr. Neal noted that he and Dr. Fernandez agreed on Petitioner's diagnosis. Nevertheless, Dr. Neal rebutted Dr. Fernandez's opinions. Dr. Neal distinguished between the development of carpal tunnel syndrome and the onset of manifestation of symptoms. He noted Dr. Fernandez's history of treating Petitioner earlier right middle finger and not recording any complaints or signs of carpal tunnel over that course of care. Dr. Neal also commented that records from Petitioner's primary physician, Dr. Bruce Bernheim, could have provided helpful information with regard to Petitioner's carpal tunnel signs and symptoms.

In the end, Dr. Neal, despite acknowledging that Dr. Fernandez is a well-recognized hand surgeon, continued to disagree with Dr. Fernandez's causation opinion and held to his opinion of no causal relation.

Petitioner testified that he wants the carpal tunnel release surgery.

On cross-examination Petitioner described the problems with his hands as ongoing for many years. He has been on restricted duty since 2014. Petitioner further testified that he suffers from hypothyroidism for at least the past 5 years and that he takes medication every day for this condition.

Dr. Fernandez gave his evidence deposition on May 20, 2016 (PX #2). Dr. Fernandez refreshed his memory with review of records. He reviewed his care of Petitioner over the years. He confirmed his diagnosis of carpal tunnel syndrome. He clarified that Petitioner had predisposing factors for carpal tunnel syndrome, including hypothyroidism. Dr. Fernandez acknowledged that Petitioner did not have a specific accident or a specific event that caused his carpal tunnel syndrome. But, he noted Petitioner's 30-year work history of repetitive forceful gripping and use of power tools.

Dr. Fernandez further testified that carpal tunnel syndrome is a cumulative disorder. It is never one specific thing. There are always several contributing traits including genetic predisposition. He noted that Petitioner's type of physical work was a significant risk factor and/or contributory factor, and that was the reason why he felt the injury was work related.

Dr. Fernandez further testified that the risk factor of thyroid disease cannot be quantified. There is no known proportional association of severity of thyroid disease being related to the severity of carpal tunnel syndrome. He opined that one does not necessarily develop carpal tunnel with severe thyroid disease. One may have severe thyroid disease and not have carpal tunnel syndrome.

In the end, Dr. Fernandez continued with his opinions that Petitioner carpal tunnel syndrome is related to his work activities and that Petitioner needs carpal tunnel release to relieve his symptoms.

CONCLUSIONS OF LAW

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

The Arbitrator finds that Petitioner proved that he sustained accidental injuries on July 30, 2014 that arose out of and in the course of his employment by Respondent. In so finding, the Arbitrator notes the credible testimony of Petitioner regarding his 35 years of job activities with Respondent. The description of strenuous and repetitive job activities described by Petitioner is unrebutted and in accord with his job description (RX #5).

E: Was timely notice of the accident given to Respondent?

This issue was not genuinely disputed.

The Arbitrator finds that Petitioner gave Respondent notice of his accident within the time limits provided by the Act. The Arbitrator notes that the Application for

Adjustment of Claim was filed August 20, 2014, stating that Petitioner injured both hands while working July 30, 2014. Filing an Application for Adjustment within 45 days of the claimed injury satisfy the notice requirement set for in §6(c) of the Act.

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

The Arbitrator finds that Petitioner's condition of ill-being (bilateral carpal tunnel syndrome) is causally connected to Petitioner's job duties and activities described by Petitioner.

The Arbitrator considered the opinions of Drs. John Fernandez and Bryan Neal. Drs. Fernandez and Neal have offered conflicting causation opinions. Dr. Fernandez is Petitioner's treating physician. Dr. Neal was retained by Respondent to rebut Dr. Fernandez's opinions.

Deference is often given to the opinions of treating physicians in light of their goal to cure or relieve the effects of their patient's injuries. However, opinions of treating physicians may lack persuasive power for a variety of reasons, including well-reasoned and persuasive contrary opinions. Here, Dr. Fernandez opined that Petitioner's work activities caused or aggravated Petitioner's bilateral carpal tunnel syndrome. Dr. Neal agreed that Petitioner has bilateral carpal tunnel syndrome but opined that work activities did not cause or contribute to the carpal tunnel syndrome.

The Arbitrator finds Dr. Fernandez's causation opinion more persuasive than the opinion of Dr. Neal. Dr. Fernandez is a widely accepted expert in the area of orthopedic care of hand and wrist injuries. Dr. Neal acknowledged as much. Dr. Fernandez had the advantage of care for Petitioner over a span of years whereas Dr. Neal relied on a dry review of records and only one clinical encounter. Dr. Fernandez had the advantage of a broader overview that Dr. Neal lacked. Dr. Neal Opined that Petitioner's carpal tunnel syndrome was not related to Petitioner's work activities. Without saying directly, Dr. Neal seemed to imply that the carpal tunnel was related to Petitioner's hypothyroidism. Without an opinion of the cause of Petitioner's carpal tunnel, Dr. Neal's opinion ruling out work-related activities is speculative.

In addition, Dr. Neal's opinions tended to be strident and argumentative. The expositions in his written reports resemble the work of an advocate rather than the sober consideration of open-minded examiner. Dr. Neal revealed a bias of such degree as to totally undermine any persuasive value of his opinions.

Therefore, the Arbitrator accepts and adopts the opinions of Dr. Fernandez that Petitioner's work activities were a contributing cause of his carpal tunnel syndrome.

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?

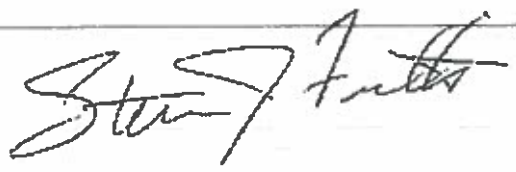
For reason stated above regarding causation of Petitioner's current condition of ill-being, the Arbitrator finds that Petitioner proved that medical care evidence by billing records in Petitioner's Exhibit #3 was reasonable and necessary to cure or relieve the effects of his work related injury. Respondent shall pay to Petitioner the sum of $1,440.00 for reasonable and necessary medical care as evidenced by Petitioner's Exhibit #3, in accord with the fee schedule provided by §8.2 of the Act.

The Arbitrator notes that Respondent's dispute of the reasonableness and necessity of the unpaid bills was based on Respondent's dispute of notice, accident, and causation.

K: Is Petitioner entitled to prospective medical care?

Based upon all of the above, and after weighing the opinions of Drs. Fernandez and Dr. Neal, and for the same reasons stated above, the Arbitrator finds that the opinions of Dr. Fernandez are the more reasonable and persuasive than those of Dr. Neal.

Therefore, the Arbitrator orders Respondent to authorize and pay for the surgery recommended and prescribed by Dr. John Fernandez, namely carpal tunnel release, and all reasonable and necessary post-operative medical care and therapy.



March 3, 2017

Steven J. Fruth, Arbitrator

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

VERN PHILLIPS, IV,
Petitioner,
vs.

NO: 12 WC 27863

18IWCC0213

NICA, INC.,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, notice, causal connection, average weekly wage, medical, prospective medical, and temporary total disability (TTD), and being advised of the facts and applicable law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 10, 2017 is hereby affirmed and adopted.

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

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

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

DATED: APR 6 - 2018

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

MJB/tdm
O: 2-6-10
052

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

PHILLIPS IV, VERN
Employee/Petitioner

Case# **12WC027863**

15WC008532

NICA INC
Employer/Respondent

18IWCC0213

On 7/10/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4599 SHUCHAT COOK & WERNER
CLARE R BERHLE
1221 LOCUST ST 2ND FL
ST LOUIS, MO 63103

0210 GANAN & SHAPIRO PC
ELAINE T NEWQUIST
210 W ILLINOIS ST
CHICAGO, IL 60654

18IWCC0213

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)/8(a)

VERN PHILLIPS, IV
Employee/Petitioner

v.

NICA, INC.
Employer/Respondent

Case # **12** WC **27863**

Consolidated cases: **15 WC 08532**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Collinsville**, on **October 25, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0213

FINDINGS

On the date of accident, **February 22, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$N/A**; the average weekly wage was **$N/A**.

On the date of accident, Petitioner was **41** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$1,850.00** for other benefits, for a total credit of **$1,850.00**.

ORDER

The Arbitrator finds that the Petitioner failed to prove that he sustained accidental injuries arising out of and in the course of his employment with the Respondent on February 22, 2012. The Petitioner has also failed to prove that his current condition is causally related to an alleged February 22, 2012 accident.

No benefits are awarded.

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

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

Signature of Arbitrator

July 3, 2017
Date

JUL 10 2017

STATEMENT OF FACTS

Petitioner testified he was employed with Respondent as a carpet installer and had been so employed at times for about 20 years for companies under the control of Robert and/or Brian Drake. Brian Drake is the owner of Respondent, Bob is a consultant and Chris is the comptroller (see Rx6, 7 and 8).

Petitioner's work often involved removing/installing carpet at out of state military housing units. He testified he would work 12 hour days when working, often for weeks at a time, and then be off until the next job came up, which could also be for weeks at a time. If off for more than a week or so, he and other Respondent employees would collect unemployment until the next job started. He testified that he was paid $185.00 per day plus $12.50 per day for meals. There were times he would also perform shorter local jobs or warehouse work for 2 or 3 days at a time. Petitioner agreed he knew Respondent would only provide him work when they had work and that there would be periods of time when he would not be working for them and collecting unemployment. He agreed he would very occasionally work a side job involving carpet. He testified that there were periods when he worked 10 to 12 days straight, in a month, and others when he only worked a day or two. This was generally consistent with the testimony of Chris Drake in the Missouri portion of the 2/22/12 claim. (Rx7).

Petitioner alleges an initial 2/22/12 low back injury, the subject of consolidated case 12 WC 27863. (Arbx3). On 2/22/12, Petitioner testified he was working at the federal courthouse in St. Louis. He was unloading boxes of carpet tile two foot by two foot and weighing 40 to 50 pounds, bending to pick them up and throw them from the truck up onto the loading dock. When he jumped back up onto the loading dock he felt something in his lower back. He thought it was a muscle strain, had pain for two or three days and then it went away. He did not report the incident to Respondent, did not seek any medical treatment and did not take any time off. After he recovered from that event and before the accident in March of 2012, he testified that his back was not giving him any trouble and he was able to do his regular activities.

Petitioner also alleges a second work injury "on or about" 3/12/12, the subject of consolidated case 15 WC 8532, involving his low back while working for Respondent in South Dakota. (Arbx3). Petitioner testified that he was the leader of a crew that would tear out and replace the carpet. As the crew leader, he had to be on the jobsite to clear the other workers to enter the military facilities. The job included some strenuous activities to pull up the carpet, carry carpet and a 300 to 400 pound turbo stripper up or down stairs, and kneeling and bending. Part of his job was to unload rolls of carpet (85 to 90 pounds) from a semi into a Conex storage box. He testified the carpet rolls were very large and had to be stacked in the Conex. Petitioner testified that on 3/12/12, he was working with a co worker, Larry Davies, to put carpet rolls in the Conex. He indicated he had to move the carpet rolls in the Conex into positions they would roll out of by bracing himself with his foot or feet on the Conex wall and his back against the carpet roll to push it. He testified: "When I jumped out of the Conex box I went to my knees and above my butt cheek and my lower back I felt a lot of pain." He continued working but said he had difficulty bending to cut and tear out old carpet, as well as his other duties. At lunch time he purchased some Aleve, testifying he took 15 to 20 per day for two to three days. He testified his low back continued to hurt and he started passing blood in his stool.

CONCLUSIONS OF LAW

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

Petitioner alleges he was injured while working at a federal courthouse in St. Louis, Missouri on 2/22/12 when he jumped onto a loading dock after unloading boxes of carpet squares. He testified he had low back pain, without any other symptoms, and that this lasted a few days and then went away. The Arbitrator notes this history comports with Petitioner's testimony under oath in the Missouri compensation case pursued for the same date of accident (Rx6).

The Arbitrator notes that the Application for Adjustment of Claim with regard to this case indicates the Petitioner was injured when he was pulling carpet. (Arbx3). This differs from his testimony regarding the alleged incident.

The Arbitrator notes that the Petitioner's testimony was oftentimes inconsistent and that he was generally a poor historian. Unlike the claim in 15 WC 8532, the Petitioner testified he did not report this injury, had no lost time, did not seek treatment and the pain resolved after a few days and he continued working. There are no contemporaneous documentations which would support that an accident occurred on this date in lieu of Petitioner's testimony.

Based on the above, the Arbitrator finds that the preponderance of the evidence supports the finding that the Petitioner failed to prove a compensable 2/22/12 accident.

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

Based on the Arbitrator's finding that the Petitioner failed to prove a 2/22/12 accident, this issue is moot.

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

Based on the Arbitrator's finding that the Petitioner failed to prove a 2/22/12 accident, this issue is moot.

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

Based on the Arbitrator's finding that the Petitioner failed to prove a 2/22/12 accident, this issue is moot.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's finding that the Petitioner failed to prove a 2/22/12 accident, this issue is moot.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's finding that the Petitioner failed to prove a 2/22/12 accident, this issue is moot.

WITH RESPECT TO ISSUE (L), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's finding that the Petitioner failed to prove a 2/22/12 accident, this issue is moot.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

VERN PHILLIPS, IV,

Petitioner,

vs. NO: 15 WC 8532

18IWCC0214

NICA, INC.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, notice, causal connection, average weekly wage, medical, prospective medical, and temporary total disability (TTD), and being advised of the facts and applicable law, reverses the Decision of the Arbitrator and finds that Petitioner, Vern Phillips, sustained a work-related injury on March 12, 2012 and that his current condition of ill-being relative to his lumbar spine is causally related to his accident. The Commission further finds that Petitioner failed to prove that his cervical condition is causally related to the accident and failed to prove that he is entitled to TTD benefits.

The Commission further finds that Petitioner is entitled to the discogram as recommended by Dr. Kennedy. The Commission awards Petitioner all reasonable and related medical expenses related to the March 12, 2012 accident. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Commission affirms the Arbitrator's denial of claim 12 WC 27863 for which a separate decision has been issued.

18IWCC0214

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all of the testimony, exhibits, pleadings and arguments submitted by the parties.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission makes the following findings:

1. Vern Phillips testified that he has worked for the Respondent for 20 plus years installing carpet. He primarily installed carpet at Air Force bases. T.13. He described his job as physical in nature. The rolls of carpet weighed about 90 pounds. T.15. With help, he will carry a turbo stripper that weighs 400 pounds. He traveled mostly out-of-state and worked 12-hour days. T.16. He was paid $185.00 per day plus $12.50 for meal pay. T.48.

2. Vern Phillips sustained an accident on February 22, 2012 while working in St. Louis. He filed a workers' compensation claim in Missouri and Illinois. Phillips testified that he felt something in his low back when he jumped up on the loading dock while working on February 22, 2012. His pain went away in a couple days, and he did not seek any medical treatment and did not miss any time away from work.

3. On March 12, 2012, Phillips was working at the military base in South Dakota. His co-worker, Larry Davies, was unloading a roll of carpet with a forklift. As his co-worker was moving the roll to the Conex box to store the carpet, Petitioner jumped out of the Conex box and felt pain in his lower back. He continued to work with difficulty. T.20. He started to take Aleve and would take 15 to 20 Aleve a day after the accident. T.21. He noticed that his back continued to hurt and he had blood in his stool. *Id.* He informed Brenda, the secretary, of his injury. T.22. Petitioner stated that Brian Drake knew of the injury and arranged for him to fly home. T.23. Before he flew home, he sought medical treatment at the ER. T.24.

4. On cross-examination, Phillips stated that he felt pain in his back on February 22, 2012 when he jumped onto the loading dock. T.66. This claim is currently pending in Missouri. T.67. Regarding the March 2012 accident, Phillips stated that he felt pain when he had his back against the roll of carpet and pushed his legs against the wall. *Id.* He reported the accident the next morning. He did not seek medical treatment until 4 days later, when his replacement arrived. T.69.

5. Mike Johns worked with Petitioner on March 12, 2012. Johns stated that Phillips has been a family friend for over 5 years. Johns testified that Petitioner began complaining of low back and neck pain shortly after they started the job in South Dakota. He further testified that Petitioner complained that the pain made him sick to his stomach. T.108.

He was not sure if Petitioner told him what happened. T.109. On cross-examination, Johns stated that Petitioner helped him get the job. *Id.*

6. Phillips presented to Rapid City Regional Health ER on March 16, 2012 for back pain and diarrhea. He complained of frequent diarrhea for the past 3 days. He reported diffuse abdominal cramping and discomfort, right greater than left. He had diarrhea every half hour that appeared to be red. He also complained of low back pain that started 5 days ago and he was uncertain if it was work related as he installed carpet. His pain increased with range of motion. He denied any numbness or paresthesias into his legs. Examination of the back revealed no midline tenderness. He was discharged in fair condition. The assessment was diarrhea and back pain unspecified. PX.1.

7. Phillips testified that he also informed Chris Drake, the owner, of the March 12, 2012 accident. He stated that Chris wanted him to submit the medical through his group health insurance and Chris would pay the deductible. T.41. He noted that Brian, Chris' brother, thought the matter should be a workers' compensation issue. *Id.* Petitioner told Chris that he did not think it would be necessary to turn this accident into a workers' compensation issue. T.42.

8. Phillips was paid $1,850.00 when he returned home and was then told to start collecting unemployment. T.43. He then hired an attorney. T.47. Petitioner last worked for Respondent in March 2012. T.12.

9. Discovery depositions of Chris Drake and Robert Drake were taken October 3, 2014 pursuant to Missouri law and pertained to Petitioner's Missouri Workers' Compensation case, claim 12-056851. Respondent offered the depositions in the case at bar as Respondent's exhibit 7 and 8. Petitioner objected to the admission of the depositions arguing that they were discovery depositions and the best evidence was the live testimony of the witnesses, as they were party opponents. Petitioner's counsel further argued that their depositions did not allow the Arbitrator to judge the credibility of the witnesses. The Arbitrator overruled the objections and admitted the deposition transcripts into evidence. T.112.

10. Phillips was seen by Dr. Mark Klucka of Saint Anthony's Physician Group on March 27, 2012 for GI bleeding, abdominal pain, and back pain. It was noted that he was installing carpet in South Dakota and started to feel sick. He did have some abdominal pain in the right mid abdomen that sometimes radiated around his back. His stool was now normal. He complained of chronic low back pain that was quite severe at times. The impression was chronic back pain. A lumbar spine x-ray was recommended. PX.2.

11. Phillips testified that Dr. Klucka told him that he had degenerative changes in the lumbar spine and there were no signs of a new injury. T.74.

18IWCC0214

12. Phillips underwent an x-ray of the lumbar spine on March 30, 2012 that revealed mild degenerative changes and no acute bony abnormality. There was some slight facet arthropathic changes on the left at L5-SI. There were mild degenerative spondylosis changes with minimal anterior spurring seen at several of the levels. PX.2.

13. Phillips was seen by Dr. Thomas Brummett on April 30, 2012 for right sided low back pain that had been fairly severe for 6 months. He was working at the time when his symptoms began. He had pain in the right low back and in the mid lower thoracic area. It did not travel to his legs. His pain was better in the morning and then somewhat debilitating when he tried to get out of bed. Examination revealed a negative straight leg raise, tenderness to palpation in the midline low thoracic level, and tenderness to palpation at L5-SI. He was positive for back pain. The impression was radiating right low back pain of undetermined etiology. Dr. Brummett favored the source being from the low thoracic disc level rather than L5-SI. He recommended at MRI. PX.2.

14. Phillips underwent an MRI of the lumbar spine without contrast at Imagining Center of Alton on June 8, 2012. The MRI revealed mild multilevel degenerative changes without significant central spinal canal or neural foraminal stenosis. There was a mild diffuse disc bulge with no significant central spinal canal or foraminal stenosis at L2-L3 and L4-L5. PX.3.

15. Phillips was seen by Dr. Brummett on June 25, 2012. Dr. Brummett noted that Petitioner had some very minimal degenerative changes that were essentially normal for his age. He had some mild bilateral facet hypertrophy at L5-SI. He stated that Petitioner's pain was either muscle generated pain from his work as a carpet installer or may be some facet generation of his symptoms. He recommended an MBN block of the nerve supplying L5-SI facet joint bilaterally, which would tell whether the bottom facet was involved in the pain generation. If it was involved, then a steroid injection would be recommended. If it was not involved, then it was muscle generated pain and there was no specific treatment. PX.3.

16. Phillips underwent a right L3, L4, and L5 MBN block with Marcaine on July 2, 2012. PX.3.

17. Phillips followed-up with Dr. Brummett on July 10, 2012. Petitioner noted that the MBN block helped the pain a great deal. He only had episodes of pain for which Dr. Brummett did not think an intra articular facet injection was necessary. He was to follow-up in one month. PX.3.

18. Phillips underwent a right L4-SI facet injection on July 30, 2012. PX.3.

19. Petitioner followed-up with Dr. Brummett on July 30, 2012. Dr. Brummett noted Petitioner was basically pain free last month. His right low back pain was now

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bothering him a great deal. Petitioner now reported that his pain was work-related and he was seeing an attorney. Dr. Brummett provided an injection and told him that he did not see workers' compensation patients. PX.3.

20. According to the Missouri Department of Labor and Industrial Relations Claim for Compensation dated August 2, 2012, Phillips alleged an accident while working on February 22, 2012. RX.2.

21. Phillips was seen by Dr. Robert Ayres on August 30, 2012 for back pain. It was noted that the onset was 3 months ago. The problem was stable but occurred persistently. PX.4.

22. Phillips was seen by Dr. Syed Ali of Tri-City Neurology on November 15, 2012 for back pain with a 9-month onset. His pain was severe and persistent. It was noted this was a work injury. He was working and carrying carpet and leaned over to pick-up carpet from the truck and felt low back pain. The MRI was not available. Examination was positive for severe back pain. He had lower extremity weakness. His symptoms had been present for 9 months. The assessment was radiculitis, thoracic or lumbar. An EMG was recommended. PX.5.

23. Phillips underwent a nerve conduction velocity study on December 12, 2012. The findings were consistent with right-sided lumbar radiculopathy. PX.5.

24. Phillips was seen by Dr. Syed Ali on April 2, 2013 for moderate low back pain. The pain radiated to the back and right buttocks. His pain was burning, discomforting, numbness, sharp, shooting, stabbing, and throbbing. His symptoms were aggravated by ascending stairs, changing positions, descending stairs, lifting and pushing. Examination revealed back pain. He had moderate pain with motion. The assessment was radiculitis, thoracic or lumbar. PX.5.

25. Phillips was seen by Dr. David Kennedy on October 3, 2013. It was noted that Petitioner was moving multiple rolls of carpet on February 12, 2012 when he experienced severe pain in the lower lumbar area. It became progressively more severe and he was seen in the ER on March 16, 2012 for lower lumbar pain. He subsequently underwent injections without much relief. Examination revealed that the lumbar range of motion was severely reduced in forward flexion. He had a negative straight leg raise. The assessment was ongoing disabling lumbar pain with radicular features corroborated by the EMG. He recommended a discogram at L4-L5 and an MRI of the cervical spine. Dr. Kennedy attributed his lumbar and lower extremity complaints directly to his work-related injury as described and was a prevailing factor in his need for treatment. Dr. Kennedy noted that Petitioner reported that the cervical issues have been a problem since the original injury though not well documented in other records. However, based upon the history, Dr. Kennedy found the neck related. PX.9.

26. Dr. David Kennedy's evidence deposition was taken April 9, 2014. Dr. Kennedy is a board-certified neurosurgeon. He saw Petitioner on October 3, 2013 at the request of Petitioner's counsel. He noted that Petitioner's lumbar spine was severely reduced in forward flexion while his motor and sensory examination was normal. There was no evidence of sciatica. He had significant muscle spasms. He reviewed an MRI from June 8, 2012 that revealed an annular tear at L4-L5. The tear was consistent with his symptoms and mechanism of injury. PX.9. pg.11. The EMG revealed right sided lumbar radiculopathy, which was consistent with his history of symptoms and the mechanism of injury. PX.9. pg.12. Dr. Kennedy recommended a discogram and a cervical MRI. PX.9. pg.14. He opined that Petitioner's symptoms were related to his work accident based upon the history presented to him. PX.9. pg.15. He was not at MMI and could not work.

27. On cross-examination, Dr. Kennedy noted that the medical records do not indicate radicular symptom during the March 16, 2012 ER visit. He noted that Dr. Brummett's April 30, 2012 record indicated that Petitioner had severe right low back pain for 6 months. He noted that Dr. Brummett indicated Petitioner was pain free on July 30, 2012. PX.9. pg.32. He noted that the MRI did not reveal any cord compression. He does not know the age of the annular tears. PX.9. pg.41.

28. Phillips was seen by Dr. Ali on February 18, 2014 with continued back pain. His problem was stable but occurred persistently. He had moderate lumbar pain and moderately reduced range of motion. The assessment was radiculitis, thoracic or lumbar and brachial neuritis or radiculitis, both work related. PX.5.

29. Phillips underwent a nerve conduction velocity study on October 30, 2014 that was consistent with right carpal tunnel syndrome. PX.5.

30. Phillips underwent an MRI without contrast on October 30, 2014. The MRI revealed significant neural foraminal stenosis at C5-C6 and relatively mild spondylosis. PX.5.

31. Phillips continued to follow-up with Dr. Ali with no change indicated in his condition.

32. Phillips was seen by Dr. Kristina Naseer on referral from Dr. Ali on July 29, 2015 for pain in his low back, right side. He had explosive onset of pain in his low back travelling to the center of the back while unloading carpet. He had tenderness to palpation across the right sacroiliac joint and pain across the right lumbar paraspinous muscle. The impression was lumbar myofascial pain and right sacroiliitis. PX.7.

33. Phillips underwent an MRI of the lumbar spine on February 4, 2016 that revealed mild lumbar spondylosis. PX.5.

34. Dr. Frank Petkovich performed a Section 12 examination on March 21, 2016. Examination revealed subjectively limited range of motion with forward flexion at 50 degrees. He could not palpate any muscle spasms throughout his lumbar spine. There was no tenderness over the right or left sacroiliac joint. Dr. Petkovich opined Petitioner had some decreased range of motion and some tenderness on the right side that was consistent with his mild degenerative lumbar disc conditions. He diagnosed Petitioner with a degenerative lumbar disc condition at L4-L5 and L5-SI, mild right carpal tunnel syndrome, and degenerative cervical disc condition. His strains should have resolved within 6 weeks of the accident. His accident may have caused some exacerbation of his mild pre-existing degenerative lumbar disc conditions that were present prior to the accident, but they did not cause any aggravation or acceleration. The cervical condition was not related. He was not in need of any further treatment. He could work. Petitioner sustained muscular lumbar strain at the time of the incident. He did not have an annular tear present at L4-L5, there was a small degenerative annular fissure at L4-L5 and it had absolutely nothing to do with the accidents. His complaints were grossly out of proportion to his objective physical findings. He needed to be weaned off the medication. RX.9.

35. Phillips was seen by Dr. Ali on August 2, 2016 with moderate low back pain that was consistent and worsening. It was in his low back and legs. The assessment was radiculopathy in the lumbar region.

36. Phillips underwent an MRI of the lumbar spine on September 28, 2016 that revealed degenerative disc disease and facet arthropathy without high grade central canal or neural foraminal stenosis at any level in the lumbar spine. PX.5.

37. Phillips testified that a pain pump has been recommended, which he has not received. T.35. Petitioner stated that his bleeding has stopped. He still has back pain and his arm goes numb on the right side when he drives, which is from the permanent nerve damage. T.49. The right side of his neck hurts from time-to-time. He cannot lift anything with his right arm. T.50. His back will swell up. He has a hard time performing household functions and cannot lift his grandson. T.52. He cannot bend to put on his tennis shoes. T.53. He cannot work because of the pain. T.54.

The Commission is not bound by the Arbitrator's findings, and may properly determine the credibility of witnesses, weigh their testimony and assess the weight to be given to the evidence. *R.A. Cullinan & Sons v. Industrial Comm'n*, 216 Ill. App. 3d 1048, 1054, 575 N.E.2d 1240, 159 Ill. Dec. 180 (1991). It is the province of the Commission to weigh the evidence and draw reasonable inferences therefrom. *Niles Police Department v. Industrial Comm'n*, 83 Ill. 2d 528, 533-34, 416 N.E.2d 243, 245, 48 Ill. Dec. 212 (1981). Interpretation of medical testimony is particularly within the province of the Commission. *A. O. Smith Corp. v. Industrial Comm'n*, 51 Ill. 2d 533, 536-37, 283 N.E.2d 875, 877 (1972).

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The Commission finds that the Arbitrator erred in admitting the discovery depositions of Chris Drake and Robert Drake. Pursuant to Illinois Supreme Court Rule 212 (eff. January 1, 2011),

> (a) Purposes for Which Discovery Depositions May Be Used. Discovery depositions taken under the provisions of this rule may be used only:
>
> (1) for the purpose of impeaching the testimony of the deponent as a witness in the same manner and to the same extent as any inconsistent statement made by a witness;
>
> (2) as an admission made by a party or by an officer or agent of a party in the same manner and to the same extent as any other admission made by that person;
>
> (3) if otherwise admissible as an exception to the hearsay rule;
>
> (4) for any purpose for which an affidavit may be used; or
>
> (5) upon reasonable notice to all parties, as evidence at trial or hearing against a party who appeared at the deposition or was given proper notice thereof, if the court finds that the deponent is not a controlled expert witness, the deponent's evidence deposition has not been taken, and the deponent is unable to attend or testify because of death or infirmity, and if the court, based on its sound discretion, further finds such evidence at trial or hearing will do substantial justice between or among the parties.

No showing has been made demonstrating that Chris Drake or Robert Drake were unavailable to testify at trial in the case at bar or that their discovery depositions are otherwise admissible pursuant to Illinois Supreme Court Rule 212. During oral argument, Respondent's counsel stated that they were unable to locate Chris or Robert Drake. The Commission finds that Respondent's efforts to secure their testimony do not satisfy the requirements as stated in Illinois Supreme Court Rule 212. Accordingly, the Commission finds that the Arbitrator erroneously admitted into evidence these discovery depositions. Therefore, the Commission strikes the discovery depositions of Chris Drake and Robert Drake from the record, found as Respondent's exhibit's 7 and 8.

The Commission reverses the Arbitrator's decision and finds that Vern Phillips established that he sustained an accident and injury to his low back only on March 12, 2010 that arose out of and in the course of his employment. The Petitioner testified that he was working when he felt pain in his back after jumping out of the Conex box. His testimony was supported by that of Mike Johns. While Mike Johns was uncertain whether Petitioner informed him of what happened, he

did confirm that Phillips started to complain of neck and back pain shortly after they started the South Dakota job. The Petitioner's testimony is further supported by the March 16, 2012 Rapid City Regional Health ER record which indicated that Petitioner had back pain that began 5 days ago. The Petitioner further testified that he reported the incident and Respondent made arraignments to fly him home. The Respondent offered no evidence of any kind to rebut Petitioner's testimony.

The Commission also finds that Petitioner failed to prove that he sustained an injury to his neck on March 12, 2012. The first indication of a neck injury does not appear in the medical records until several months after the accident. At that point, Petitioner had been examined by several doctors on multiple occasions and there was no indication of a neck issue. To find the neck condition related to the accident would require the Commission to engage in speculation, and it declines to do so.

The Commission therefore finds that Phillips established that he sustained a work-related accident involving his low back on March 12, 2012.

The Commission finds that Petitioner established that his current low back condition is causally related to the March 12, 2012 accident. It is well established that "a chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability *may be sufficient* circumstantial evidence to prove a causal nexus between the accident and the employee's injury." *International Harvester v. Industrial Comm'n*, 93 Ill. 2d 59, 63-64, 442 N.E.2d 908, 66 Ill. Dec. 347 (1982).

The evidence establishes that Petitioner worked without restriction prior to March 12, 2012. He then sustained a work accident on March 12, 2012 and began to experience low back issues. There are no medical records documenting that he was receiving medical treatment prior to March 12, 2012 or that he was experiencing low back pain. Rather, all of the medical records consistently document ongoing low back issues after the March 12, 2012 accident.

In that regard, the Commission is not persuaded by Dr. Petkovich's opinion. Dr. Petkovich opines that the accident caused an exacerbation of Petitioner's alleged pre-existing condition and should have healed within 6 weeks of the accident. Despite his opinion, Dr. Petkovich's examination revealed decreased range of motion and some tenderness. Dr. Petkovich indicated this was due to Petitioner's degenerative lumbar spine condition. Dr. Petkovich's opinion, however, is not supported by the evidence. There are no records establishing that Petitioner had any low back issues prior to the accident and there is no credible evidence that his condition had healed within 6 weeks after the accident. Rather, the medical records document consistent complaints following the accident that continued through the date of hearing.

The Commission finds the opinion of Dr. Kennedy relative to the condition of Petitioner's low back persuasive. Dr. Kennedy noted that the MRI revealed an annular tear at L4-L5 and that the EMG revealed lumbar radiculopathy. He noted that the symptoms were consistent with the

mechanism of injury. As previously stated, the record lacks any evidence supporting that Petitioner's condition was pre-existing. Thus, the Commission finds the opinion of Dr. Kennedy relative to the lumbar spine persuasive.

Therefore, the Commission finds that Petitioner established that his low back condition is causally related to his March 12, 2012 accident.

Pursuant to Section 8(a) of the Act, a claimant is entitled to recover reasonable medical expenses, the incurrence of which are causally related to an accident arising out of and in the scope of his employment and which are necessary to diagnose, relieve, or cure the effects of the claimant's injury. *University of Illinois v. Industrial Comm'n*, 232 Ill. App. 3d 154, 164, 596 N.E.2d 823, 173 Ill. Dec. 199 (1992). Whether a medical expense is either reasonable or necessary is a question of fact to be resolved by the Commission, and its determination will not be overturned on review unless it is against the manifest weight of the evidence. *F&B Manufacturing Co. v. Industrial Comm'n*, 325 Ill. App. 3d 527, 534, 758 N.E.2d 18, 259 Ill. Dec. 173 (2001).

Having found that Petitioner's lumbar spine condition is causally related to his accident, the Commission finds that Petitioner is entitled to all reasonable and necessary medical expenses related to his low back as a result of the March 12, 2012 accident. Further, the Commission finds that Petitioner is entitled to a lumbar discogram as recommended by Dr. Kennedy.

The Commission declines to award Petitioner TTD benefits. The Commission has reviewed the record and finds no credible medical evidence supporting that Petitioner could not work. While Dr. Kennedy testified in his evidence deposition that Petitioner could not work, his medical records were silent as to Petitioner's work status. The Commission is not persuaded by Dr. Kennedy's deposition testimony relative to Petitioner's work status.

Further, there is no evidence of record that demonstrates that the Petitioner ever produced an off work slip and provided same to the Respondent or its counsel. For this additional reason, the Commission refuses to award TTD to the Petitioner.

The Commission affirms the Arbitrator's finding that Petitioner's AWW is $1,296.64.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on July 10, 2017, is hereby reversed for the reasons stated above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent authorize and pay for prospective medical treatment as recommended by Dr. David Kennedy.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner $22,473.25 under §8(a) of the Act and subject to the medical fee schedule.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $20,700.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 6 - 2018
MJB/tdm
O: 2-6-18
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

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

PHILLIPS IV, VERN
Employee/Petitioner

Case# **15WC008532**

12WC027863

NICA INC
Employer/Respondent

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On 7/10/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4599 SHUCHAT COOK & WARNER
CLARE R BEHRLE
1221 LOCUST ST 2ND FL
ST LOUIS, MO 63103

0210 GANAN & SHAPIRO PC
ELAINE T NEWQUIST
210 W ILLINOIS ST
CHICAGO, IL 60654

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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)/8(a)

VERN PHILLIPS, IV
Employee/Petitioner

v.

NICA, INC.
Employer/Respondent

Case # 15 WC 08532

Consolidated cases: 12 WC 27863

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Collinsville**, on **October 25, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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FINDINGS

On the date of accident, **March 12, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned **$28,344.16**; the average weekly wage was **$1,296.64**.

On the date of accident, Petitioner was **41** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$1,850.00** for other benefits, for a total credit of **$1,850.00**.

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

ORDER

The Arbitrator finds that the Petitioner has failed to prove that he sustained a March 12, 2012 accident which arose out of and in the course of his employment with the Respondent via the preponderance of the evidence. As a result, no benefits are awarded.

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

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

Signature of Arbitrator

July 3, 2017
Date

JUL 10 2017

STATEMENT OF FACTS

Petitioner testified he was employed with Respondent as a carpet installer and had been so employed at times for about 20 years for companies under the control of Robert and/or Brian Drake. Brian Drake is the owner of Respondent, Bob is a consultant and Chris is the comptroller (see Rx6, 7 and 8).

Petitioner's work often involved removing/installing carpet at out of state military housing units. He testified he would work 12 hour days when working, often for weeks at a time, and then be off until the next job came up, which could also be for weeks at a time. If off for more than a week or so, he and other Respondent employees would collect unemployment until the next job started. He testified that he was paid $185.00 per day plus $12.50 per day for meals. There were times he would also perform shorter local jobs or warehouse work for 2 or 3 days at a time. Petitioner agreed he knew Respondent would only provide him work when they had work and that there would be periods of time when he would not be working for them and collecting unemployment. He agreed he would very occasionally work a side job involving carpet. He testified that there were periods when he worked 10 to 12 days straight, in a month, and others when he only worked a day or two. This was generally consistent with the testimony of Chris Drake in the Missouri portion of the 2/22/12 claim. (Rx7).

Petitioner alleges an initial 2/22/12 low back injury, the subject of consolidated case 12 WC 27863. (Arbx3). On 2/22/12, Petitioner testified he was working at the federal courthouse in St. Louis. He was unloading boxes of carpet tile two foot by two foot and weighing 40 to 50 pounds, bending to pick them up and throw them from the truck up onto the loading dock. When he jumped back up onto the loading dock he felt something in his lower back. He thought it was a muscle strain, had pain for two or three days and then it went away. He did not report the incident to Respondent, did not seek any medical treatment and did not take any time off. After he recovered from that event and before the accident in March of 2012, he testified that his back was not giving him any trouble and he was able to do his regular activities.

Petitioner also alleges a second work injury "on or about" 3/12/12, the subject of consolidated case 15 WC 8532, involving his low back while working for Respondent in South Dakota. (Arbx3). Petitioner testified that he was the leader of a crew that would tear out and replace the carpet. As the crew leader, he had to be on the jobsite to clear the other workers to enter the military facilities. The job included some strenuous activities to pull up the carpet, carry carpet and a 300 to 400 pound turbo stripper up or down stairs, and kneeling and bending. Part of his job was to unload rolls of carpet (85 to 90 pounds) from a semi into a Conex storage box. He testified the carpet rolls were very large and had to be stacked in the Conex. Petitioner testified that on 3/12/12, he was working with a co worker, Larry Davies, to put carpet rolls in the Conex. He indicated he had to move the carpet rolls in the Conex into positions they would roll out of by bracing himself with his foot or feet on the Conex wall and his back against the carpet roll to push it. He testified: "When I jumped out of the Conex box I went to my knees and above my butt cheek and my lower back I felt a lot of pain." He continued working but said he had difficulty bending to cut and tear out old carpet, as well as his other duties. At lunch time he purchased some Aleve, testifying he took 15 to 20 per day for two to three days. He testified his low back continued to hurt and he started passing blood in his stool.

Petitioner testified he contacted company secretary, Brenda Mueller, the morning after the incident, reporting the incident and his back and abdominal pain. He testified that Brian Drake then called him about what had happened, and indicated he would make arrangements to fly him home to Illinois. However, because the crew needed the crew leader to enter the military facility, Drake asked him to stay on the job until a replacement, Brian Rushing, could get to the jobsite. Petitioner testified that as soon as Rushing arrived three days later, he took the company truck to the closest emergency room in South Dakota. He testified that he remained in South Dakota for another 2-3 days or so because Drake was paying for his flight home and obtained a cheaper rate by waiting.

The 3/16/12 ER records from Rapid City Regional Hospital indicated Petitioner reported that his low back and stomach were hurting, was directed to stop taking the Aleve, was given other medication and directed to follow up with an Illinois physician. The Hospital's records reflect a history of sharp abdominal and back pain with diarrhea. The Emergency Nursing Record notes a two day history of symptoms, including black and red stools.

This note also states the Petitioner reported his back pain had improved. The attending physician's chart notes frequent diarrhea for three days with right greater than left abdominal cramping. The Petitioner also complained of a 5 day history of low back pain, and "he is uncertain if it related to his work as a construction worker laying carpet." He denied any numbness or paresthesias into his legs. There was noted concern for infectious diarrhea, but if the diarrhea "relates to his back pain which seems to be related to range of motion position onset with the mechanics of his job is uncertain may just be a back strain but with a diarrhea for the fall but this would be indicated if not improving." Petitioner was discharged with diagnoses of "diarrhea" and "back pain-unspecified." (Px1).

Petitioner testified he told them about his lower back pain as well as his passing blood. He was advised to stop taking the Aleve and he was given medication to help with his stomach pain and back pain and was advised to follow up with a doctor once he returned home. Asked about the lack of a history of a specific injury, Petitioner testified, "he didn't ask." He agreed he did not report any neck or right arm pain.

After returning to Illinois, Petitioner testified he went to Chris Drake's office, and that Drake knew he had been injured at work. Asked how Chris Drake knew he had been injured at work, Petitioner testified: "From flying home. He knew that I flew home from South Dakota." Petitioner again indicated that Chris "knew" he hurt his back at work on cross exam, and then testified he specifically told both Brian and Chris Drake he hurt his back at work.

He and Chris had 4 or 5 discussions. They discussed his medical bills, Petitioner testifying that Chris wanted him to put the bills through his group insurance, offering to pay the deductibles, and that they didn't discuss turning it in to workers compensation. However, in the 3rd or 4th conversation, Chris told him that his brother, Brian Drake, thought the matter should be turned into workers' compensation. Petitioner was getting injections at the time, so he figured both he and Drake would wait and see if that helped before turning it in to workers compensation. However, Petitioner testified group insurance did not pay any of his medical bills. For a period of time he received some ongoing checks from Respondent totaling $1,850.00 ("What he did was he was continuing to give me my salary but I didn't have to do anything for it while I was getting medical treatment") until he was advised they were stopping and he should take unemployment. He did receive unemployment for approximately eight months following that. Since he was advised to go on unemployment Petitioner retained an attorney and has not had any other further conversations with any of the Drakes.

Chris Drake testified, via discovery deposition in the Missouri workers' compensation claim, that he was employed by Respondent, which was owned by his brother Brian, as the controller. (Rx7) He became aware Petitioner was not turning in hours while away on a job, somewhere "north", in March, 2012. He testified he asked why and was told by an unnamed supervisor that Petitioner had been urinating blood and was in the hospital. After Petitioner returned to Illinois he recalled a couple of conversations about Petitioner being off work sick and having doctor's appointments, and that Petitioner requested advances on his pay. He did not remember how the Petitioner got home. Chris Drake testified he provided pay advances to Petitioner, and also recalled Petitioner applied for and collected unemployment benefits. He denied having any conversation about him turning anything in to workers' compensation. He testified he was never told by Petitioner that he was injured at work, and the first time he learned of a workers' compensation claim was when he received a letter from Petitioner's lawyer in July or August of 2012. He would ask Petitioner when he was returning to work, and Petitioner would say he had lots of medical appointments and hoped to get back soon. Chris Drake testified he would have conversations with Petitioner about health insurance but none about whether he injured his back. He denied being told by Petitioner he needed medical insurance coverage for his back or that he was seeking medical care for his back. He testified Respondent's policy for work injuries, per a handbook, is that "there's a

report to be filled out and then we send them to the hospital." Had Petitioner reported a work injury, he would have done both. (Rx7).

Michael Johns testified on behalf of the Petitioner. A friend and co-worker, who agreed Petitioner helped him get his job with Respondent, Johns testified that he presently is not working but is in school and pursuing a culinary degree. In March of 2012 he was working as a general laborer for Respondent in South Dakota with the Petitioner. He became aware that Petitioner was having physical problems and Petitioner complained to him of low back, neck and stomach problems. He observed that Petitioner was not able to do the physical work. For instance, any time Petitioner lowered himself to the floor it seemed to cause extreme pain. Petitioner was not able to finish the job.

Robert Drake's discovery deposition from the Missouri Workers' Compensation case was also entered into evidence (Rx8). He testified he is the father of Brian Drake, who owns the Respondent company, and that his position in 2012 was as a consultant for the company. He testified he had no knowledge of a job in South Dakota and never spoke to Petitioner about a work injury. He recalled that at one time the Petitioner came in and requested a job performing local work, as the company had a number of local jobs at that time, but that he questioned Petitioner about being ill, and that and having problems this his kidneys.

Petitioner testified that when he returned to Illinois, he sought treatment with Dr. Klucka, advising him that he had been passing blood and he had lower back pain. Dr. Klucka's records reflect Petitioner was initially seen on 3/27/12 for GI bleeding, abdominal and back pain. While working in South Dakota he "began feeling kind of sick to his stomach," took Alka Seltzer, Pepto Bismol and Aleve, after which he began having melenic stools. He "did have some abdominal pain in the right mid abdomen that sometimes radiates around to the back." He "also complains of some back pain" and one episode of paresthesias in the right upper extremity, but "mostly he complains of chronic low back pain", which at times was quite severe. Physical and neurologic exams were all normal. Dr. Klucka diagnosed melenic stools and gastrointestinal bleeding, possible gastroenteritis, inflammatory or neoplastic disease, and chronic back pain. Lumbar and sacral x-rays, blood work, stool cultures, colonoscopy, EGD and CBC labs were prescribed. (Px2).

On cross exam, as to the indication of "chronic" back pain, Petitioner said he only reported pain since the work accident. The only things he reported were back pain and blood in his stool. Petitioner testified both that he didn't discuss his back pain with Dr. Klucka because he was there for abdominal issues, but also agreed Klucka took a lumbar x-ray and told him he had lumbar degeneration and no evidence of acute injury.

At some point after returning to Illinois, Petitioner testified he began experiencing "like a phone was ringing" in his legs and numbness in his right arm, dropping stuff out of his right hand. He did not pinpoint exactly when this began.

3/30/12 lumbar x-rays indicated a history of four months of low back pain which goes down the right leg. Films reflected mild degenerative changes with minimal spurring at several levels and was diagnosed, with slight facet arthropathic changes at left L5/S1. 4/4/12 colonoscopy was negative other than for internal hemorrhoid tissue. 4/13/12 abdominal CT scan was unremarkable, as was a 4/20/12 Upper GI exam other than mild duodenitis. He was advised to discontinue NSAIDs. (Px2).

He next sought treatment with Dr. Brummett on 4/30/12, which he testified was based on the recommendation of his mother in law. The report notes Petitioner reported: "The patient … works as a carpet layer & has been having problems with right low back pain that's fairly severe for 6 months now. He does heavy lifting in the normal course of his occupation. In that regard, he was working at the time & carrying large rolls of carpet when

his pain symptoms started." The pain was primarily in the right low back, but also in the mid lower thoracic area and had symptoms radiating into his legs. He was taking Hydrocodone and reported taking a large amount of over-the-counter NSAIDs. Physical and neurological exam was normal other than tenderness to palpation at the lower thoracic and L5/S1 levels. Exam was negative for neck pain. Dr. Brummett indicated an unknown etiology for the back pain and requested an MRI, but believed the problem was likely originated with disc disease at the lower thoracic level as opposed to L5/S1, and believed thoracic epidurals at that level would be indicated. (Px3).

Petitioner testified he told Dr. Brummett about his more recent work injury, but the report does not reflect this. He did not recall telling Dr. Brummett he had a 6 month history of low back pain, but agreed he did not complain of leg symptoms. He agreed Dr. Brummett did not restrict him from working.

Dr. Brummett on 6/25/12 indicated the 6/8/12 MRI showed very minimal degenerative disc disease, "essentially normal for his age," with mild bilateral facet hypertrophy at L5-S1. The MRI report noted no spinal or foraminal stenosis was seen. He believed Petitioner's pain was either muscular pain from his work as a carpet layer or could be coming from the facets. He recommended a bilateral facet nerve block at L5/S1. If it helped, that would indicate facet involvement and further injections would be indicated; if it didn't, he noted he had no specific treatment to offer. Dr. Brummett also was going to discontinue Norco given the lack of significant findings and start Celebrex. (Px3).

On cross exam, Petitioner acknowledged that Dr. Brummett told him the MRI basically showed degenerative findings, and that he had been working hard all his life, but was normal for his age.

Dr. Brummett then performed the nerve blocks on the right from L3 to L5 to evaluate facet involvement. On 7/10/12, Petitioner reported the injections helped significantly and he was only having "episodes" of pain, so Dr. Brummett cancelled a planned facet steroid injection. Petitioner then returned to Dr. Brummett on 7/30/12 due to significant right low back pain, and facet steroid injections were performed at L4 to S1. Dr. Brummett stated Petitioner "now, however, says his pain is work related and he's seeing a workman's compensation attorney", and since he did not treat work injuries, discharged him from care. (Px3).

Petitioner testified the injections did help, but only for a week or two, reporting this on 7/30/12. He also testified Dr. Brummett dropped him as a patient "when I told him it was a work comp case", but that he had still performed injections on 7/30/12, which he testified helped his low back for about a week.

Petitioner did not have a primary care doctor and needed one for insurance purposes to see a neurologist, so he started seeing Dr. Ayers. On 8/30/12, Petitioner visited Dr. Ayers with a report of 3 month history of low back pain and left scapular pain, and Ayers prescribed medication and referred Petitioner for a neurosurgical evaluation. Petitioner also noted bilateral hand numbness and tingling, and Dr. Ayers diagnosis included carpal tunnel syndrome (CTS). (Px4).

Petitioner testified that Dr. Ayers referred him to Dr. Naseer at Tri-City Neurology. Petitioner denied indicating left shoulder area pain, as everything had always been right sided. He agreed Dr. Ayers did not restrict his work duties.

Petitioner presented to Dr. Ali at Tri City Neurology on 11/15/12 with a 9 month history of severe low back pain with an onset 9 months ago. The duration varied, and Petitioner noted it was now radiating into both legs from a work injury where he had been carrying carpet. When he leaned over to pick up carpet from his truck he felt low back pain, and he continued to carry carpet up to freight elevator. He says he then went to South Dakota and was

unable to pull carpet, contacted his employer and was told to take that day off, and the next day he went to the ER due to passing blood, which Petitioner indicated was due to taking Aleve. He flew home one week later and had not been back to work since. Dr. Ali ordered EMG and nerve conduction testing. (Px5).

12/12/12 EMG/NCV of the lower extremities reflected findings consistent with right sided lumbar radiculopathy. (Px6).

On 1/8/13, Petitioner reported persistent low back pain into the legs, and Dr. Ali diagnosed radiculitis and continued to treat him with medications. Petitioner denied neck symptoms. On 4/2/13, Dr. Ali noted persistent pain complaints to the lower back, right buttock and legs. Symptoms were aggravated by such activities as stair climbing, changing positions, standing twisting and walking. His symptoms were relieved by pain medication and rest. He was continued on medication and activity as tolerated. On 2/18/14, Petitioner reported low back and neck pain, and Dr. Ali diagnosed radiculitis, thoracic or lumbar and brachial neuritis or radiculitis, work related. He continued to treat him with medication. Dr. Ali noted the Petitioner was compliant with his current therapy but was not responding. He changed his medication from Hydrocodone to Percocet and started Valium. (Px5).

On 6/10/14, Petitioner saw Dr. Ali complaining of persistent, moderately severe pain in the lower back and legs. He had moderate pain complaints to the neck. On examination the doctor noted muscle spasms, musculoskeletal tenderness and weakness. Although Petitioner was compliant with current therapy he wasn't responding to his treatment. He was having some difficulty with ambulation and needed some assistance with activities of daily living. (Px5).

Petitioner had physical therapy at the request of Dr. Reynolds, who became his primary provider after Dr. Ayers became ill, at Anderson Hospital, with diagnoses of lumbago and back spasms, on 7/22/14, but it appears he may not have returned after that and was discharged on 8/5/14. (Px6).

A 10/2/14 evaluation showed that Petitioner's complaints continued, and Dr. Ali ordered an MRI of the cervical spine and motor and EMG testing. 10/30/14 EMG/NCV of the upper extremities noted findings consistent with right CTS. Cervical MRI from the same date indicated significant neuroforaminal stenosis, left greater than right, at C5/6 with relatively mild spondylosis. (Px6).

At Petitioner's 2/5/15 visit, Dr. Ali noted the EMG/NCV findings, and that the cervical MRI showed significant neural forminal stenosis at C5/6 and mild spondylosis. Dr. Ali continued him on medications. (Px5; Px6).

Petitioner saw family nurse practitioner Lee Ann Taradino on 2/18/15, noting severe right low back pain radiating into the buttocks, with a history of 2012 injury as a carpet layer. He reported no improvement with prior injection. Taradino's diagnosis was lumbago, and Gabapentin was prescribed. On 4/9/15, Petitioner complained of chronic low back pain radiating into the buttocks. She increased his dosage of Gabapentin. (Px8).

On 5/28/15, Dr. Ali noted Petitioner's problem was worsening and his low back pain had increased. Petitioner was interested in injections to address his low back pain. Dr. Ali stated he would refer Petitioner to pain management. (Px5). Dr. Naseer's 7/29/15 report notes Petitioner was referred by Dr. Ali and provided the following history: he "used to load and unload carpet. He was working one day and as he was loading and unloading carpet, toward the end of the day, he was unable to continue to work secondary to severity of pain. Had explosive onset of pain in his low back travelling to the center of the back." He was working in South Dakota at the time and sought emergency room care. Current complaints were central low back pain that traveled to his right buttock and occasionally his right leg, noting it to be at a 10/10 level. Lumbar MRI was

reviewed. Neurological exam was normal. The diagnosis was lumbar myofascial pain and right sacroilitis. Noting Petitioner has had 3.5 years of pain but that injections helped for 1 to 1.5 years, Dr. Naseer recommended a right SI joint injection along with lumbar trigger point injections, mainly on the right side of the low back. Therapy was also recommended. (Px7).

The records reflect that Petitioner continued to see Dr. Ali, three times between 8/25/15 and 5/5/16. His complaints continued and the doctor did not feel Petitioner was responding to current treatment. (Px5)

According to the radiologist, a 2/4/16 lumbar MRI from Anderson Hospital, prescribed by Dr. Ali, reflected an L5/S1 bulge with an annular fissure. Otherwise, there were disc bulges and degeneration at multiple levels with mild canal and mild bilateral foraminal stenosis. There was a 3 mm retrolisthesis of L2 on L3 and L3 on L4. A cervical MRI taken on that date showed unchanged moderate cervical spondylosis. (Px5). The Arbitrator did not see any specific indication in Dr. Ali's records of prescribing these tests.

On 8/2/16, Dr. Ali noted that Petitioners low back problem was persistent and worsening, with symptoms including spasms and tenderness. On that date, Petitioner heard a pop in his low back and had increased low back pain. Dr. Ali ordered an MRI. The 9/28/16 lumbar MRI revealed a small right L5/S1 with mild right and no significant left foraminal stenosis, as well as degenerative disc disease and facet arthropathy without high grade central canal or neural formainal stenosis at any lumbar level. (Px5).

Petitioner testified that Dr. Ali has taken over his pain medication prescriptions. He continues to see Dr. Ali on a regular basis. He testified that Dr. Ali advised him that he has permanent pain or nerve damage and wants to send him to pain management for consideration of a pain pump. Dr. Ali also advised him to seek disability. He is the only doctor who has held him off work, and Petitioner agreed he did not initially restrict him from doing so, and may not have recommended disability until 2015. He has applied for disability and is awaiting a hearing. As Petitioner lost his group insurance he has qualified for state aid and had to establish a primary doctor for the state insurance, so he does see NP Tardino, who prescribes medications such as Gabapentin.

Dr. Kennedy, a board certified neurosurgeon, examined the Petitioner at his attorney's request on 10/3/13, and his evidence deposition was taken on 4/9/14. (Px9). Dr. Kennedy testified that Petitioner reported a 2/22/12 work injury where he was "moving carpet and things like that", with a sudden onset of severe low back pain radiating into both legs and numbness radiating into the right arm. He then "sort of lived with that for a while" until going to work in South Dakota, at which time his pain became much more severe and he went to a local emergency room. He reviewed Petitioner's medical records. Petitioner's exam demonstrated severely reduced forward flexion, but normal sensory and neurologic findings without sciatica on either side. Dr. Kennedy's review of the 6/8/12 lumbar MRI films indicated multi-level degenerative changes, with an annular tear at L4-5, which he noted was not reflected in the radiologist's report. Dr. Kennedy explained such an annular tear can occur with heavy lifting, such as the Petitioner reported to him, and can result in pain complaints. Noting the 12/12/12 EMG/NCV was consistent with right sided lumbar radiculopathy, Dr. Kennedy testified it was not specific as to the nerve roots involved, but that it likely involved the lower L4/5 or L5/S1 levels, or both. Dr. Kennedy testified that the EMG/NCV findings are consistent with Petitioner's history of symptoms and the mechanism of injury that Petitioner described. Dr. Kennedy did agree on cross examination that the only abnormal finding he noted on exam was severely reduced forward flexion, along with muscle spasms, and that the neurological exam was essentially normal. (Px9).

It was Dr. Kennedy's impression that Petitioner had ongoing disabling lumbar pain with radicular features which were corroborated by the EMG findings. He testified that these findings suggested some degree of nerve irritation or structural problem either compressing or irritating the nerves in the lower back. Asked about the

significance of Petitioner not indicating radicular complaints when he initially sought emergency care or treatment, then reporting such symptoms at a later date, Dr. Kennedy testified that often times those symptoms will develop over time and especially in a setting with an annular tear. The disc contents can leak out and cause an evolving series of symptoms that are consistent with or at least radicular in nature. On cross examination, he opined that the longest time period he would still relate such symptoms to the injury would be three months, and that such symptoms would likely begin in days or weeks if related. (Px9).

Dr. Kennedy recommended a lumbar discogram to try to pinpoint the structure(s) that were causing Petitioner's pain. He also recommended a cervical MRI. Following the discogram, he would be better able to tell what additional treatment might be necessary. (Px9).

It was Dr. Kennedy's opinion that Petitioner's lumbar and lower extremity complaints were directly related to the work injury and were the prevailing factor in his need for treatment. This was significantly based on the history of onset provided by Petitioner of the work accident. As to his symptoms in the upper extremities, although they had not been well documented in the medical encounters, Dr. Kennedy felt that based upon the Petitioner's history it was work related and should be evaluated. Dr. Kennedy was asked a hypothetical question which described Petitioner's two work injuries, the first one occurring in St. Louis in February 2012 and the second in South Dakota that following March. It was Dr. Kennedy's opinion that his diagnosis was related to the work activities described in the hypothetical. Dr. Kennedy testified that taking an excessive amount of Aleve medication can cause abdominal cramping and diarrhea. At the time Dr. Kennedy evaluated Petitioner he did not believe he was at maximum medical improvement nor did he feel he could work. With the symptoms that Petitioner told him about and the objective finding noted on the MRI and EMG testing Dr. Kennedy indicated there is no way he could do his work as a carpet layer as he could barely bend forward. If he tried those activities it would make him worse. It was his opinion that the treatment Petitioner had received up to that time was appropriate, reasonable, necessary and causally related to his work injury. (Px9)

On cross examination, Dr. Kennedy admitted the only history of work injury he received from Petitioner pertained to a 2/22/12 incident while working in South Dakota. He agreed that there were inconsistencies in Petitioner's medical records, including a claimed 2/22/12 injury in St. Louis; a lack of mention of lower or upper extremity problems in his Missouri workers compensation filing; a report of primarily abdominal pain, radiating into the low back when seeking emergency room care in South Dakota, as well as no indication of any cervical or right arm complaints at that time; a 5 day history of symptom onset at that same ER visit (he opined that Petitioner's report of uncertainty of whether his complaints related to his job duties at that visit was "equivocal" as to whether it was inconsistent with what Petitioner told him); no specific work event causing his symptoms noted in the South Dakota ER records; D.. Klucka's report of feeling sick in South Dakota, with abdominal pain radiating into the low back, with only one episode of right arm numbness, and denial of leg complaints; the history provided to Dr. Brummett of right low back pain since November, 2011, also without indication of leg, right arm or neck complaints; Petitioner's report to Dr. Ayers of low back pain since May, 2012, without mention a work injury (Px9).

Dr. Kennedy agreed his admitted his causation opinion was based on the history provided to him by Petitioner. He admitted that the types of degenerative changes in the lumbar spine were typical of Petitioner's stated age and his smoking history, and that given the extent of those degenerative changes "nearly any activity" could have made those changes symptomatic. However, he did testify that Petitioner's work activities could have aggravated the degenerative lumbar condition. He admitted there was no history of injury to the cervical spine. He had imposed no work restrictions on Petitioner. (Px9).

Petitioner testified that he agreed he reported the history noted by Kennedy, but denied telling him he had symptoms into the bilateral legs, as it was always the right side. He testified that it was "a little after" the accident that his right arm would start to go numb when he drove.

Dr. Petkovich examined Petitioner at request of Respondent and reviewed all of the treating records. His exam was basically normal although he did find evidence of mild right carpal tunnel syndrome. He felt Petitioner had degenerative changes in the lumbar and cervical spine, without any acute findings. If an incident at work occurred on March 12, 2012, as claimed, at most Petitioner suffered a muscular lumbar strain that would have resolved within six weeks of occurrence. The cervical findings were not connected to any work injury. He did not feel Petitioner required any ongoing medical care, and none of the prescription medications he remains on. He would not impose any work restrictions on Petitioner.

Board certified orthopedic surgeon Dr. Petkovich examined the Petitioner on behalf of the Respondent on 3/21/16. (Rx9) Dr. Petkovich did not agree with Dr. Kennedy's assessment that there is an annular tear at the L4/5, level instead finding a mild fissure consistent with the degenerative process. Petitioner had preexisting degenerative changes in the lumbar and cervical spines. It was Dr. Petkovich's opinion that Petitioner sustained a lumbar strain on both 2/22/12 and 3/12/12, both of which should have resolved within 6 weeks from the time of their onset. It was his opinion that both incidents may have caused some exacerbation of mild preexisting degenerative lumbar conditions but did not cause any aggravation or acceleration of the pre-existing conditions. Dr. Petkovich's review of the 6/8/12 and 2/4/16 lumbar MRIs indicated some mild degenerative disc disease at the L4/5 level with a small degenerative annular fissure at the L4/L5 level. His diagnosis was cervical disc disease, which was an incidental finding having nothing to do with his two injuries nor did he believe that his cervical problems were aggravated or accelerated by the two incidents. He also diagnosed right carpal tunnel syndrome but also found this to be an incidental finding not related to the two incidents. Dr. Petkovich did not recommend any further medical treatment for his lumbar spine, including medications. The doctor thought Petitioner should be encouraged to be taken off of the Oxycodone, Diazepam and Gabapentin and he could return to work without restrictions. (Rx9).

Following his review of Dr. Petkovich's report, as well as the 2/4/16 lumbar/cervical and 10/30/14 cervical MRIs, on 6/13/16 Dr. Kennedy indicated nothing in that report changed his opinions in this case. (Px10).

Petitioner testified his initial bleeding issues have resolved. He has continued pain in his low back above his right butt cheek that awakens him, his right arm goes numb when he drives or sleeps on his right side, and the right side of his neck hurts occasionally. He testified his symptoms have all been on the right side. He has difficulty lifting with his right arm, and with prolonged sitting and walking. He doesn't believe he can work any job right now, noting it is hard to avoid being pain focused. Petitioner testified that he continues to see both NP Tardino, as his primary provider to allow him continued insurance coverage through the state, and that he receives Gabapentin for his back, and general medical care for any other health issues, through her. He testified to a standing prescription for a pain pump from Dr. Ali, though, again, the Arbitrator does not see this indicated in Dr. Ali's records. The Petitioner testified that Dr. Ali told him that a surgery could leave him paralyzed. This is not indicated in Dr. Ali's records that the Arbitrator could discern.

Petitioner has not worked for anyone since this injury occurred. He has mowed lawns for his landlord in exchange for rent, as he was in arrears. None of the doctors Petitioner saw in the course of treatment have directly addressed work restrictions. However, he was not working at the time so Petitioner indicated they did not discuss it. He does not feel he could return to his regular work as a floor installer. He does not feel he can do other physical work even if it requires less physical duties than the regular floor laying job. He presently

takes Oxycoden, Valium and Gabapentin. He would like to be assessed for the "pain pump" so he can stop taking so much medication.

Petitioner testified he did receive $1,850.00 from Respondent. He indicated this was ongoing pay; the Respondent indicates this to be advances paid at Petitioner's request. He also applied for and collected unemployment for eight to ten months.

Petitioner submitted the medical expenses he claims are related to the alleged 3/12/12 accident as Petitioner's Exhibit 11.

CONCLUSIONS OF LAW

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

In a difficult determination, the Arbitrator finds that the Petitioner has failed to prove, by the preponderance of the evidence, that he sustained accidental injuries arising out and in the course of his employment on 3/12/12.

The evidence appears quite clear that something occurred while Petitioner was on the job on or about 3/12/12. However, the evidence is equally unclear whether that something involved a work related back injury. Part of the difficulty in reviewing this claim is that the Petitioner's testimony was very confusing. Oftentimes, he answered questions without truly listening to what was being asked, resulting in some disjointed testimony.

It is unclear to the Arbitrator if the Petitioner is claiming that he hurt his back pushing the carpet rolls within the Conex, or rather that he hurt his back jumping out of the Conex. His testimony indicates that what really drove him to seek assistance was blood in his stool, which he relates to taking large amount of over the counter pain medication. The initial ER visit in South Dakota noted sharp abdominal pain that radiated to the back, but no report of any specific injury or incident. The 3/16/12 report notes a 5 day history of pain, which would go back to 3/11/12, not 3/12/12. The report notes Petitioner installs carpet and is unsure if his condition is related to work. It is unclear if this relates to the abdomen, the back or both. He agreed he had no leg, neck or arm symptoms at that time, and did not report any.

Chris Drake testified that the Petitioner never specifically indicated he had a work accident, and his understanding is that the Petitioner had blood in his urine. He testified he first learned Petitioner was making a workers compensation claim when he got a letter from an attorney. While the Petitioner ultimately testified that he specifically told Brian and Chris Drake that he hurt his back on the job, several prior questions in this regard were answered by Petitioner with the claim that the two "knew" he had been hurt, as opposed to testifying that he told them. In the Petitioner's favor, it does seem odd that there was no testimony presented from Brian Drake.
Dr. Klucka's records note chronic back pain with no specified injury. While Petitioner testified that he was seeing Klucka for GI symptoms and not his back, he agreed that Dr. Klucka took a lumbar x-ray, and advised him that he saw degenerative changes and nothing acute. Thus, its clear they did in fact discuss his back.

Petitioner testified that his leg and arm numbness just bean at some point after he returned to Illinois, but he could not pinpoint when.

When Petitioner saw Dr. Brummett on 4/30/12, his report notes a 6 month history of low back pain, and that Petitioner was working and carrying carpet rolls when his symptoms began. That is not what he testified he was doing when his symptoms began – he testified he was pushing the carpet rolls in the Conex and had pain when he jumped out of the box. At that point the Petitioner indicated to Brummett that he was taking Hydrocodone. He had not treated for his back since the 3/16 ER visit, so it is unclear where he received such a prescription. Dr. Brummett also informed Petitioner that an MRI showed minimal degenerative change.

When Petitioner saw Dr. Ayers on 8/30/12, he noted a 3 month history of back pain, which is obviously subsequent to when his pain began.

The history that was provided to Dr. Kennedy by Petitioner appears to have comingled aspects of the 2/22/12 and 3/12/12 accidents into one incident. The cross examination of Dr. Kennedy points out a significant number of inconsistencies, as noted above.

Overall, it does appear likely that the Petitioner developed pain while performing some aspect of his job for Respondent. However, the evidence does not support a specific incident occurring on a specific date, 3/12/12, and a specific incident is what the Petitioner has alleged. The evidence makes it entirely possible the Petitioner had been having back problems going back to 2011, and that the ball started rolling as to him seeking treatment only when he started to have abdominal problems.

There are just too many inconsistencies regarding the Petitioner's testimony as a historian and his medical records to find in his favor in this case. The Arbitrator again notes that the failure to produce Brian Drake for testimony made this a very close case, as he would be able to testify to what Petitioner reported after the alleged accident. Petitioner was sent home by Respondent at their cost and he was paid salary advances. This would tend to show the Arbitrator that they may have done this because a work accident was reported. However, there is also evidence which indicates the group carrier did not pay Petitioner's medical bills, which Petitioner said Chris Drake said they would do to avoid turning it in to workers compensation, and while Petitioner testified that he received his salary for several weeks before going on unemployment, $1,850 does not appear to cover several weeks of his salary. There is also evidence in this case that advances were given to other employees when there was no work available.

As noted, there are factors in this case which lead the Arbitrator in the direction that the Petitioner may well have reported an accident, and the Respondent tried to keep it out of the workers compensation system by initially trying to cover the medical and lost time themselves. The Arbitrator believes that the inconsistencies and the lack of initial reporting of a specific 3/12/12 incident or onset to the medical providers results in the preponderance of the evidence reflecting a failure to prove a 3/12/12 accident.

The Arbitrator also specifically notes that the records provide no evidence whatsoever of a neck or arm injury occurring at the time Petitioner claims his low back was injured, so there is really no solid evidence connecting such symptoms to his job. Additionally, the Arbitrator notes that the Petitioner's testimony was somewhat odd in a way that he appeared to be on some kind of medication or drug at the hearing. This, the indication to Dr. Brummett in April 2012 that he was taking Hydrocodone where the Arbitrator saw no indication of a prior prescription for same, lead to questions as to whether there may be a narcotic medication issue going on in this case as well.

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

Based on the Arbitrator's findings with regard to the issue of accident, this issue is moot.

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

Based on the Arbitrator's findings with regard to the issue of accident, this issue is moot.

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

Petitioner alleges an average weekly wage of $1296.64. Respondent alleges one of $545.08. Section 10 of the Act provides the basis of computing compensation. Section 10 states, "[t]he compensation shall be computed on the basis of the "Average weekly wage" which shall mean the actual earnings of the employee in the employment in which he was working at the time of the injury during the period of 52 weeks ending with the last day of the employee's last full pay period immediately preceding the date of injury, illness or disablement excluding overtime, and bonus divided by 52; but if the injured employee lost 5 or more calendar days during such period, whether or not in the same week, then the earnings for the remainder of such 52 weeks shall be divided by the number of weeks and parts thereof remaining after the time so lost has been deducted."

Petitioner worked for Respondent for several years before his injuries. Petitioner testified that the majority of their jobs were out of town working on government bases. When they were on a job they worked twelve hours a day, without days off until the job was completed. He was paid $185.00 a day and $12.50 a day for meals or $87.50 a week. When they came home they had time off and were told to apply for unemployment. Respondent Ex. 1 is a "Payroll Transaction Detail" of the Petitioner's wages covering the period of 2/22/11 through 2/22/12. Of the 365 days, earning $27,411.00, Petitioner worked 148 days. Section 10 mandates if the injured employee lost 5 or more calendar days during such period, whether or not in the same week, then the earnings for the remainder of such 52 weeks shall be divided by the number of weeks and parts thereof remaining after the time so lost has been deducted." In the present case, the Petitioner worked 21.14 weeks in the year preceding his injury. $27,411.00 divided by 21.14 results in an average weekly wage of $1,296.64.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's findings with regard to the issue of accident, this issue is moot.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's findings with regard to the issue of accident, this issue is moot.

WITH RESPECT TO ISSUE (L), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's findings with regard to the issue of accident, this issue is moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF CHAMPAIGN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Stella Hock,

Petitioner,

vs. NO: 12WC 20117

Manpower and North American Lighting, Inc.,

Respondent.

18IWCC0215

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 11, 2017, is hereby affirmed and adopted.

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

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

18IWCC0215

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $19,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 6 - 2018
o020618
KWL/jrc
042

Kevin W. Lamborn

Michael J. Brennan

DISSENT

To the extent that the majority opinion, in affirming and adopting the Arbitrator's award, inadequately addresses the severity of Petitioner's injuries and their relationship to her undisputed accident, I respectfully dissent.

Petitioner consistently reported an injury at work on 5/17/12 wherein she was struck by a motorized vehicle causing her to twist or torque her body in such a way so as to result in right knee and lower back pain. Admittedly, the specific details of the incident and her symptoms varied slightly among the histories recorded by the various caregivers in this case, but those differences can only be interpreted as relatively minor. More importantly, the record is totally devoid of any references to any back and/or right leg complaints immediately prior to the accident in question, much less treatment and time off work for same. Indeed, the evidence shows that Petitioner was asymptomatic during the period leading up to the incident and clearly had symptoms relative to her back and right leg within one to two days thereafter.

Furthermore, I believe that the opinions of Dr. Harms and Dr. Trombly, to the effect that Petitioner's current back and right leg conditions were causally related to the accident on 5/17/12, were far more persuasive than those offered by Respondent's hired guns, Drs. Wojciehoski and Graf. Indeed, both physicians seemed more than willing to question Petitioner's version of events and the validity of her complaints for the slightest of reasons.

As a result, I would reverse the Arbitrator and find that Petitioner proved by a preponderance of the credible evidence that her current conditions of ill-being relative to her lower back and right leg were causally related to the accident on 5/17/12, and award benefits accordingly, including additional TTD and medical expenses. In addition, given the serious nature of Petitioner's injuries and the treatment relative thereto, including three lumbar surgeries, I believe the Arbitrator's permanency award was woefully inadequate, and would find that Petitioner suffered the permanent partial loss of use of 15% of the right leg pursuant to §8(e)12 for an unoperated meniscal tear and 50% loss of use of a person-as-whole pursuant to §8(d)2 of the Act regarding Petitioner's lower back condition.

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HOCK, STELLA
Employee/Petitioner

Case# **12WC020117**

MANPOWER AND NORTH AMERICAN LIGHTING INC
Employer/Respondent

18IWCC0215

On 5/11/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.01% 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:

0787 MEYERS & FLOWERS LLC
JOHN N HARP III
3 N SECOND ST SUITE 300
ST CHARLES, IL 60174

2904 HENNESSY & ROACH PC
PAUL N BERARD
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

STATE OF ILLINOIS)

)SS.

COUNTY OF Champaign)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Stella Hock
Employee/Petitioner

v.

Manpower and North American Lighting, Inc.
Employer/Respondent

Case # **12 WC 20117**

Consolidated cases: **N/A**

18IWCC0215

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Urbana**, on **March 8, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **5/17/2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$2,289.64**; the average weekly wage was **$443.91**.

On the date of accident, Petitioner was **41** years of age, *single* with **1** dependent child.

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

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

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

Respondent is entitled to a credit of **$0.00** for any medical bills paid by its group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Petitioner failed to prove that her current condition of ill-being is causally related to her accident. Petitioner did prove she sustained a right knee sprain and contusion and low back strain with radiculopathy as a result of the accident; however, she failed to prove causation for those conditions after August 27, 2012.

Respondent shall pay the Petitioner permanent partial disability benefits of **$266.35/week** for **5.375 weeks**, because the injuries sustained caused **2.5% loss of the right leg,** as provided in Section 8(e) of the Act and **$266.35/week** for **15 weeks**, because the injuries sustained also caused **3% loss of a person as a whole** pursuant to Section 8(d)2 of the Act.

Respondent shall pay temporary total disability benefits of **$295.94/week** for **8 4/7 weeks** commencing **5/18/12** through **7/16/12**, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of **$11,203.80**, pursuant to the medical fee schedule, as provided in Section 8(a) and 8.2 of the Act. Respondent shall receive credit for any of the awarded bills that have been previously paid by it.

Respondent shall pay Petitioner compensation that has accrued between **5/17/12** and **3/8/17** and shall pay the remainder of the award, if any, in weekly installments.

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

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

Signature of Arbitrator

May 5, 2017
Date

MAY 11 2017

FINDINGS OF FACTS and CONCLUSIONS OF LAW

Petitioner was involved in an undisputed work accident on May 17, 2012 while working for Respondent Manpower at North American Lighting, Inc. The disputed issues are causal connection, medical expenses, temporary total disability, and the nature and extent of Petitioner's injury.

The Arbitrator finds:

According to the medical records, Petitioner underwent an employment-related medical examination and was deemed "accepted for employment" on April 12, 2012. (PX 2)

Petitioner was involved in an accident at work on May 17, 2012 while employed by Respondent Manpower.

Petitioner completed an undated NAL Accident Report shortly after the accident and indicated she had been involved in an accident date on "April 16, 2012" when "Amy came around the aisle, lost control and her carts ran into mine and pinned my leg in cart and table." As a result of the injury Petitioner listed a scrape-bruise-scratch as well as pain and swelling on her knee. She denied the need for first aid. (PX 1; RX 3)[1]

On May 17, 2012, Petitioner presented to Paris Community Hospital at 2:55 P.M. and reported having both her legs pinned by a cart earlier that day at about 5:00 A.M. The care provider is listed as Dr. Phipps. According to the Occupational Health Encounter Form, Petitioner's posterior thighs were very sore, she couldn't sit because of pain, and it was difficult to walk. Petitioner appeared uncomfortable with bruising and swelling of both thighs being visibly apparent. Petitioner underwent a venous duplex ultrasound of her lower extremities on May 17, 2012 per Dr. Phipps. It was negative. (PX 5) She was diagnosed with a right knee contusion and told to use Tylenol, Motrin, and ice and instructed to stay off work until the next day (May 18, 2012) at which time she could return to work, but with restrictions of no standing or walking. Petitioner was further advised that she could return to work without restrictions on May 21, 2012. The Paris Community Hospital Report of Work Ability dated the same dated indicated that Petitioner presented with bilateral leg pain and stated a "cart smashed into her work station pinning her legs under a table." (PX 3; RX 6)

On "May 12, 2012"[2] Petitioner signed a Manpower Associate's Report of Injury for an accident date of "May 17, 2012." She indicated that she was working as a re-work operator and "Amy lost control of her cart and crashed into mine and me while standing and reworking parts." Petitioner planned on seeking medical treatment at the Family Medical Center with Dr. Phipps. (PX 3)

[1] While PX 1 is undated, Petitioner testified, without rebuttal, that she filled it out after the accident.

[2] While the date is "5/12/12" that has to be an error as it would pre-date the accident. In light of the fact accident is undisputed the Arbitrator has placed the report in chronological order based upon Petitioner's testimony and not the date on the form.

On May 21, 2012, Petitioner presented to Dr. James Shroba at Advantage Chiropractic in Oak Brook, Illinois, for right knee and low back pain. Petitioner completed an accident injury report indicating a co-worker lost control of her cart and hit her, pushing her up against/under a table and cart. She completed a pain drawing showing lower back, right thigh, right knee, left calf, and bilateral foot tingling. Dr. Shroba recommended a treatment plan including chiropractic spinal manipulation and neuromuscular therapy, stripping massage, ultrasound, interferential and fomentation/cryotherapy four times a week for two weeks followed by three times a week for two weeks. He anticipated full functional recovery in six to eight weeks. (PX 4)

Petitioner sought additional chiropractic care with Dr. Shoba on May 22nd, 23rd, 25th, 29th, 31st, June 1st, 2nd, 12th, 13th, 19th, 21st, July 2nd, and 5th. Dr. Shroba excused Petitioner from work during the following periods: May 21, 2012 through June 4, 2012; June 1, 2012 through June 11, 2012; June 8, 2012 through June 18, 2012; June 15, 2012 – June 25, 2012; June 21, 2012 through July 2, 2012; July 2, 2012 through July 9, 2012; and July 6, 2012 through July 16, 2012. (PX 4)

Per Dr. Shoba, Petitioner underwent a lumbar spine x-ray on June 12, 2012 showing "postural alteration." A right knee x-ray dated May 21, 2012 was unremarkable. (PX 4)

In a note dated June 14, 2012 Dr. Shroba wrote that Petitioner was currently unable to drive for prolonged periods (15 – 30 minutes) due to lower extremity pain and numbness. (PX 4)

Dr. Shroba's notes indicate that as of June 19, 2012 Petitioner's sleeping was improved and she reported some pain behind her right knee that day. She reported being scheduled for an IME the next day. (PX 4)

Dr. Randal Wojciehoski performed a Section 12 examination on June 20, 2012, at the request of Respondent. A written report followed on June 29, 2012. In his report the doctor indicated that Petitioner was working at 5:00 in the morning on May 17, 2012 when another co-worker "crushed her lower leg" and Petitioner twisted her back. She reported the incident and went home. Upon wakening later that day she called Manpower and went to the Paris Hospital where she was seen in Occupational Medicine, diagnosed with a contusion and told she could return to work the next day. Petitioner told the doctor she was not happy with the treatment and she went to Chicago to see her family doctor[3] who referred her to a chiropractor who treated patients lacking insurance. Petitioner's complaints included significant right knee pain and some left knee pain. She expressed the hope that the doctor would order an MRI. Petitioner reported difficulty walking due to right knee pain and radiating pain from her lower leg into her buttocks. She also complained of severe back pain and paresthesia in her lower extremity along with knee pain radiating up to her back. As for her past medical history, Petitioner reported she had been in excellent health. He also noted that her chiropractor felt she could not drive for long periods of times so Petitioner was living in Chicago with her ex-husband and getting treatment. She was refusing to take any prescription medication.

Dr. Wojciehoski noted that Petitioner cried during the examination. He felt she was histrionic and had clear evidence of symptom magnification. Waddell signs were "grossly positive" and non-physiologic. Light touch caused some back pain, rotation of the shoulders and

[3] No records from a family doctor in Chicago for this time period were admitted into evidence.

axial loading of her spine exacerbated her pain, all of which was nonphysiologic. When the doctor tried to examine her right knee, she began to cry. He could find no evidence of obvious pathology and no joint line tenderness or effusion was noted. Varus and valgus stress tests were normal. Lachman test was negative. He was unable to perform McMurray testing. Petitioner's left knee revealed full range of motion. Subjective complaints were appreciated. No effusion was noted. Straight leg raising was inconsistent in the supine and seated positions. The supine position exacerbated her low back pain without evidence of radicular symptoms. Of interest, the same examination reproduced tightness in the hamstrings. Dr. Wojciehoski felt all of the foregoing was suggestive of symptom magnification.

Dr. Wojciehoski concluded that Petitioner had sustained a minor contusion of the right knee without consequence. Petitioner also reported neck and back pain, but Dr. Wojciehoski opined these subjective symptoms were unrelated to the work accident. He felt all of her pain complaints were out of proportion to his physical findings. Dr. Wojciehoski found that no further treatment was necessary and that Petitioner had reached maximum medical improvement as of May 21, 2012 and could return to work without any restrictions. (RX 2, dep. ex. 2)

Petitioner returned to see Dr. Shroba on June 21, 2012 reporting that she had undergone the IME and the results were pending. Petitioner was reporting some increased pain from the exam and long drive. (PX 4)

As of July 5, 2012 Dr. Shroba noted that Petitioner was reporting some "giving out" in her right leg which caused her to "tweak" her low back on July 4, 2012. (PX 4)

In a note dated July 6, 2012, Dr. Shroba excused Petitioner from work until July 16, 2012. He did not see her during this time as no exam notes are included in PX 4. (PX 4)

Petitioner underwent no treatment between July 5, 2012 and August 15, 2012. She did not return to work.

On August 16, 2012 Petitioner presented to the Family Medical Center in Paris, Illinois to establish care. Petitioner was examined by CNP Louwanna Wallace. Petitioner's complaints included knee and back pain. Petitioner reported that her back pain began in May after she was involved in a work accident where she was "hit in the side by a cart of some sort." Since then, she had been experiencing pain in her lower back and right buttock which radiated into her right leg and right groin. Petitioner explained that her pain traveled down to her toes with some intermittent numbness in her toes and feet. She denied any pain in her left leg. Petitioner also reported intense right knee pain stemming from the accident and that her knee would give out on her at times. Petitioner reported being currently unemployed as she had been unable to work since her injury. She denied tobacco, alcohol or drug use. On exam she was tender to palpation in her lower back area, more in the area of the right sacroiliac joint. Her right knee lacked any indication of swelling or deformity but she was very tender to palpation along both the lateral and medial aspects of her knee. She could extend her knee and bear weight with difficulty. She was diagnosed with right knee pain and low back pain with right-sided radiculopathy. MRIs of the low back and right knee were ordered. She was prescribed Diclofenac and Vicodin and told to use moist heat on her back at frequent intervals and to avoid any activity that would worsen her pain. (PX 3)

On August 21, 2012, Petitioner underwent a MRI of the lumbar spine and lower extremity. The radiologist's impression was stenosis at the lumbosacral level of the lumbar spine. She also underwent an MRI of her right knee. A flap tear of the posterior medial meniscus and mucoid degenerative of the anterior cruciate ligament was noted. (PX 3; PX 5)

Petitioner returned to see CNP Wallace on August 23, 2012 regarding female medical issues. During the visit they reviewed and discussed Petitioner's MRI results. Petitioner was to be referred to an orthopedist for her knee and a neurologist for her back. According to the Progress Notes Nursing Assessment form, completed by CNP Wallace, Petitioner was being referred to an orthopedist for her knee and a neurosurgeon for her back, "knee pain X 3mos, torn meniscus back pain for more than 1 yr., has had PT, epidural inj." The note further stated that Petitioner preferred to go to Chicago for referrals as she had family there. (PX 3)

On the referral of CNP Wallace, Petitioner presented to Dr. Platt's office in the Department of Orthopedics at Carle on August 27, 2012 regarding her right knee. Petitioner's address was listed as Chrisman, Illinois. Petitioner related her history of having been "struck by a co-worker's bins" in May of 2012 when the co-worker lost control and it "rammed" into Petitioner hitting her on the left side, hitting her left knee and then knocking her to where she got her right knee stuck underneath the table. Petitioner extricated herself, had immediate pain, went home, and appeared to the Emergency Room and then got "involved with occupational medicine." Petitioner had undergone physical therapy and was now experiencing pain worse than the day it happened. She also mentioned having some spinal stenosis on an MRI and a SLAP posterior medial meniscus tear but not a lot. The doctor wrote, "It is not real impressive." Petitioner was noted to have pain in her back, thigh, and knee which was especially aggravated when doing things like pushing on the gas pedal. She was not working. On exam, flexing and extending her knee caused some pain. Her quadriceps were a little atrophied and not as strong as they could be. She was to see the Spine Center that afternoon. His assessment was sciatica, spinal stenosis and a knee strain. He felt she should use a pull-on knee support a couple of hours a day and try topical baby oil and essence of peppermint (Petitioner was not tolerant of a lot of medicine and lived a healthy and natural lifestyle). He didn't think the knee was her main issue as the tear was small. Dr. Platt felt surgery could repair the tear but it wouldn't fix all of her pain. He felt she needed to get her back under control first, describing her as "a workup in progress." She was to return after her back was addressed or if her symptoms worsened or failed to improve. (PX 6; PX 7; PX 8)

That same day (August 27, 2012) Petitioner sought care with the Spine Institute at Carle Health for her back pain and right leg pain, upon the referral of Ms. Wallace, the nurse practitioner. She was examined by Dr. James Harms and CNP Glenett Barrett. Petitioner reported being "run into by another employee" and since then she had been having back and right leg pain, including right groin pain, buttock pain, radiating pain down the lateral leg into her big and second toes and numbness in her right foot. She was reportedly worse with activities such as driving, sitting, lying and standing and better when in a recliner. On examination, no gross deformities were noted. Tapping on her back was not particularly uncomfortable. She was just barely able to bend forward and backwards and she could not toe walk, heel walk, squat or rise. Straight leg raise on the left was negative and on the right it increased her right knee and buttock pain. Her hips were not tested because of "her having a meniscal tear on the right." Dr.

Harms reviewed her MRI. He felt she had a prematurely aging disc in her back (degenerative disc disease) which could account for back pain and leg symptoms. She also had evidence of foraminal stenosis which could account for her leg symptoms as could her meniscal tear. (PX 7; PX 8)

Dr. Harms felt it appropriate to try and ascertain what was coming from her back and what was coming from her knee. He recommended a L5 nerve root block for diagnostic purposes. (PX 7)

On September 4, 2012, Dr. Samantha Tipirneni performed a right-sided L5 selective nerve root block. According to the Surgical Report Petitioner reported that she also had ongoing issues with a meniscal tear of her right knee but "they" do not know whether her pain was coming from the pinched nerve in the back or the right knee. She had seen Dr. Harms and Glenett Barrett who reviewed her MRI of the spine and felt it was her right foraminal stenosis at L5-S1 that could be giving her issues. Accordingly, she was undergoing the L5 nerve root block. On exam straight leg raising was positive on the right and negative on the left. Petitioner was also noted to, possibly, have a rudimentary rib and rudimentary disc at S1-2 level. (PX 3, PX 7)

On September 6, 2012 Petitioner contacted CNP Wallace's office requesting a muscle relaxer after having undergone her injection. (PX 3)

On September 14, 2012 Petitioner was seen at the Paris Community Hospital emergency room regarding abdominal pain in the right lower quadrant that had begun three days earlier and radiated to the right side of her back. She was diagnosed with abdominal pain, given medication and told to follow up with her private doctor. She underwent a CT of the abdomen and pelvis without contrast. There are no comparison studies cited. The impression was that of abundant feces throughout the colon. (PX 5)

Petitioner presented to CNP Wallace's office on September 18, 2012 for removal of a mole. No other concerns were noted. (PX 3)

On September 26, 2012, Petitioner presented to Dr. Harms for follow up after her September 4th nerve root block. Petitioner reported 50% improvement; however, she wasn't comfortable with the way things were going. She brought her MRI with her and the doctor reviewed it noting it showed degenerative disc disease and some narrowing of the foramen at L5-S1 on the symptomatic side. Dr. Harms' impression was degenerative disc disease in the lumbar spine with some narrowing of the hole where the nerve exits the spine in a patient who had a superimposed back strain. He gave her various options including living with it or undergoing surgery which he noted, "she was seriously considering." (PX 3, PX 7; PX 8)

A pre-op History and Physical Note was generated on October 29, 2012. According to it Petitioner was experiencing leg pain, numbness and weakness, secondary to an injury. She had reportedly been taking pain medications, as needed, and had tried a nerve block which provided minimal relief. Petitioner also reported hand numbness and tingling along with neck pain and she had been falling more lately. By her history she had gone to the emergency room two days

earlier and had x-rays performed which were normal[4]. She remained sore and concerned that she may have damaged her knee more significantly as she has a meniscus tear and was using a cane at home. (PX 7; PX 8)

A lumbar spine x-ray taken on October 29, 2012 was read as showing mild degenerative findings at the lumbosacral junction. A transitional vertebra was also suspected. (PX 7)

On November 13, 2012, Dr. Harms performed a laminotomy at L5-S1 bilaterally, a posterior lateral fusion at L5-S1 bilaterally, trans-lumbar interbody fusion at L5-S1, with right iliac bone graft, screw and rod fixation type GSO L5-S1 bilaterally and placement of epidural catheter for post-op analgesia. (PX 7)

Petitioner was hospitalized in conjunction with her surgery from November 13th through the 18th. On 11/14/12 at 3:28 A.M. a progress note Petitioner was complaining of left leg numbness and being unable to lift her left leg. Her blood pressure was low and she was being encouraged to use her pain pump. At 6:31 A.M. Petitioner was able to dangle her legs over the bed but could not stand up due to left leg numbness. She could wiggle her toes on both feet. At 8:12 A.M. Petitioner was noted to still be experiencing some difficulty with her left leg. Anesthesia was contacted regarding changing her epidural so they could get her up in a chair. At 9:29 A.M. Petitioner was comfortable and in no acute distress. Her Infusion was then changed in an effort to address the weakness and numbness on the left side. On 11/15/12 at 8:34 A.M. nursing staff recorded that Petitioner's left leg was still somewhat weak and sore and she still had more pain in her back than she would like but she didn't like to take oral medication because of migraine headaches. She had been up in a chair the day before but not walking much. As of 11/16/12 at 6:56 A.M. Petitioner was reporting too much pain to walk very far but improvement in her leg numbness since the epidural had been removed. The Case Management nurse met with Petitioner on November 17th to discuss discharge. Petitioner was noted to be very tearful as she didn't feel she could return to her home as "it is in the middle of nowhere and she would be all alone." She was going to stay at her brother's home in Indiana but he would be unable to pick her up until Sunday. She would need a walker upon discharge. At 5:37 P.M. Petitioner was found on her knees sitting in front of "bsc." She was crying and calling out. Attempted to help self back to bed. Petitioner could not explain the events of what had happened and why she was on her knees. Nursing notes were silent as to any other left leg complaints after 11/16/12.

A physical therapist met with Petitioner on 11/18/12 at 10:03 A.M. She documented her conversation with Petitioner about a possible AFO for Petitioner's left tibialis anterior weakness. She further noted that Petitioner had not previously complained of any weakness with dorsiflexing her ankle in previous therapy sessions with that therapist. She had no foot drop or shuffling of gait noted with gait and stair training. Petitioner would subconsciously dorsiflex her bilateral ankles when doing bed mobility that day. When the therapist asked Petitioner to actively dorsiflex her left ankle, Petitioner could not. However, when the therapist dorsiflexed her ankle and asked Petitioner to hold it she could do so. When Petitioner was asked to do so again on her own, she could. Petitioner complained of pain in the anterolateral aspect of her left leg when dorsiflexing her foot stating it was harder to get it to do what she wanted. No AFO was recommended at the time due to Petitioner's lack of unsteadiness with gait and stair training. If

[4] No report of such a visit is contained in the records.

she continued to notice weakness Petitioner was told to contact her doctor. (PX 8, p. 30) At 10:54 A.M. the nurse noted Petitioner was standing and walking with no deficits in her right lower extremity. She had been seen by the therapist regarding her left knee/leg/foot issue. (PX 8, p. 31)

A Discharge Summary was completed by N.P. Barrett on November 21, 2012. According to it Petitioner had suffered from leg pain that was unresponsive to non-operative therapy resulting in surgery by Dr. Harms. Petitioner had problems with pain management post-operatively noting that Petitioner suffered from headaches with oral pain medication. As a result, she was given fentanyl patches to help with drugs in her pca and an epidural. She was noted to complain of numbness in her left leg which was helped by discontinuing the epidural. He also noted that Petitioner was still reporting some weakness and numbness in her left leg which she did not remember having pre-operatively. (PX 8, pp. 36 – 38)

On December 10, 2012 Petitioner was seen by NP Barrett for her first follow-up visit after her laminotomy and fusion for degenerative disc disease and stenosis that had become symptomatic during working hours after she was "hit by another employee." She was noted to be doing fairly well with the left leg numbness experienced before surgery, as it was now gone. She still noted a problem with her right meniscus but her back felt better. Petitioner reported being unable to take any pain pills, not sleeping very well but doing some walking. Her incision was noted to be nicely healed. She was wearing her brace and it fit her fairly well. Petitioner did voice some right hip pain from her graft site and that the brace was hitting her right there. They agreed to have her stop wearing the brace until her hip stopped hurting so much. Petitioner reported that there was a question about her pre-existing problems before she was hurt at work. "Certainly she did not overnight get degenerative disc disease and stenosis. Those are gradual processes. However, one can live with those without having any symptoms. It takes stress to sometimes make them symptomatic." Petitioner was advised to continue walking and to start the physical therapy for her knee if she wished. Certain restrictions were given regarding bending, twisting and lifting. She was to return in six weeks. An x-ray taken that day showed good placement of the instrumentation at L5 and S1. (PX 8)

Petitioner did not follow up with Dr. Harms as instructed.

On January 8, 2013, Petitioner initiated care with Dr. Varkey at Loyola General Medicine Clinic as a new patient. She reported residing in "Southern Illinois" until recently when she decided to move closer to her children. By history, Petitioner was reportedly healthy and normal until May of 2012 when she had a work accident. Petitioner reported damaging her spine and knee in the accident but workers' compensation would not recognize that it was related to the accident. Since then she had lost her job and filed for Public Aid and moved to the Chicago area as she felt she needed to get away from her small town to fix her situation. She wished to see an orthopedic specialist at Loyola to address her torn meniscus now that she had undergone spine surgery. Petitioner was also noted to have "little balls" in her feet causing pain. Dr. Varkey noted that Petitioner needed to start physical therapy when cleared by the neurosurgeon. (PX 9)

Petitioner was examined by Dr. Belich (at Loyola) on January 17, 2013. By history she was standing at work on May 18, 2012 when a "machine struck her on the left knee and she apparently twisted her right knee." She denied hearing a pop or tear. She also injured her back at

the same time for which she had undergone a two level fusion in Champaign on November14, 2012. Petitioner reported ongoing issues with back pain and pain in her right leg. She was unable to localize the back pain and denied any episodes of instability. She reported the pain was worse with sitting, driving and squatting. No specific catching or locking was noted. Petitioner's physical exam was negative except for some slight tenderness in the popliteal space, hamstring spasm, and she was five degrees short of full extension. The doctor noted that the Drawer test at 90 was difficult due to complaints of back pain. Dr. Belich reviewed the MRI from August and felt Petitioner had a right knee sprain. He further told Petitioner that he disagreed with the reading of the MRI as he did not see any evidence of a meniscal tear and nothing on her exam that day suggested one. He recommended that she finish her back therapy and then undergo some knee therapy for three months and, possibly, a knee injection. He indicated he would be glad to see her again if needed. (PX 9)

Petitioner was examined by Dr. Amin (Loyola) on January 25, 2013 regarding her persistent back and lower extremity pain. Again, she gave a history of her "May 15, 2012" accident stating she was standing in a forward flexion position and a cart hit her causing her to "twist" her entire body followed by severe back pain and the inability to move. Petitioner's back pain radiated along the entire aspect of her right lower extremity, including her foot with numbness. At the same time she reportedly tore her right medial meniscus. She explained that an MRI of her low back showed degenerative changes and a herniated disc for which she underwent one injection with no relief, followed by a two level fusion. Petitioner was now noticing a "different kind" of pain in her low back and persistent right lower extremity pain with constant back pain described as "6-10/10." When stepping on the gas pedal Petitioner would notice right lateral leg pain into her foot and right posterior thigh numbness. Aggravating factors included walking and sitting. Petitioner denied any improvement in her right lower extremity pain after surgery. She denied taking any pain medication and became tearful when speaking about how her post-operative pain was preventing her from walking and doing activities she previously enjoyed. Dr. Amin ordered a CT myelogram and x-rays. She denied the need for any pain medications. (PX 9)

Petitioner followed up with Dr. Amin on February 19, 2013. Dr. Amin noted that the CT myelogram performed on February 4, 2013 showed a mal-positioned right L5 pedicle screw with lateral breach causing compression on the exiting right L4 nerve root and a possible injury to her vessels. The S1 screws were noted to be long and perhaps causing some injury to vessels. The doctor ordered a CT angiogram of Petitioner's abdomen and pelvis to evaluate for pseduoaneurysm or vascular injury. He explained to Petitioner that she might need revision surgery and that some of her right leg pain might be due to compression of the L4 nerve root. He did not know if all her leg pain could be resolved by repositioning the screw since the compression had been present on the right L4 nerve root for quite some time. (PX 9)

The CT myelogram of the abdomen and pelvis was performed and Dr. Amin found in inconclusive regarding vascular injury due to the hardware artifact from the right L5 pedicle screw. A venogram did not reveal any evidence of penetration of the screw into the lumen of the Bessel; however it was abutting the lumen. (PX 9)

Petitioner telephoned Dr. Harms' office on February 22, 2013 reporting she had undergone surgery with the doctor a couple of months earlier and had a "misplaced" bolt/screw and needed to know what kind it was. Petitioner advised that she was having surgery to correct it in Chicago and they said they didn't use the same hardware as Dr. Harms. Surgery was scheduled for March 5th. (PX 8)

Dr. Harms dictated a note after speaking with Petitioner by telephone on February 22, 2013. Petitioner advised the doctor she was having problems with a screw too close to a nerve and she was having symptoms in her legs. Dr. Harms contacted Dr. Amin and advised the office of the type of screw. Dr. Harms apologized that she was having trouble and wished she was closer so he could handle it rather than someone else. He advised her that he would follow up with her in a few weeks to see how she was doing. (PX8)

Petitioner was admitted to Loyola on March 4, 2013 for back revision surgery. A lower extremity EMG was performed on March 4th and interpreted as normal. On March 5, 2013, Dr. Amin of Loyola Medicine performed surgery consisting of removal of the old L5-S1 pedicle screw fixation and rods, placement of new bilateral L5-S1 screws with rods and use of morselized allograft for L5-S1 posterolateral arthrodesis. Both a vascular surgeon and general surgeon were present during surgery in case they were needed. During surgery significant scar tissue was noted. Post-surgical findings were noted on Petitioner's March 6, 2013 abdominal CT. There was no evidence of any acute hemorrhage, active extravasation or arterial injury. Petitioner was discharged on March 9, 2013. (PX 9)

Dr. Harms spoke with Petitioner by telephone on March 21, 2013. He noted that she reported her symptoms were dramatically improved along with her numbness and pain. Petitioner still reported knee pain and attributed that to a problem with her knee. Her back was sore because of the surgery and she has trouble taking pain medications which has been a bit of a problem. Petitioner reported not doing much in the way of walking or anything and having gained some weight. Petitioner also mentioned that she had lost her house and had to move in with her ex-husband. She said that she was calling her situation "work related" but the company had fired her and said otherwise. She also said that the records indicated it was degenerative. Dr. Harms noted that he went back and looked at her original note and told her he had put in her note that she considered it work-related because there was an incident at work where this happened. Petitioner said her attorney had asked for a deposition but the doctor did not know when it was scheduled. According to the note,

> If the attorney can show the patient was asymptomatic ahead of time, there was significant trauma to her lumbar spine, she had immediate onset of symptoms afterwards, that the symptoms were consistent from the time of the incident until the time in question, if there is no other explanation for her symptoms, then that makes a strong case for having it be work related. No one had asked me previously whether it was work related or not." (PX 8)

Dr. Harms concluded his conversation with Petitioner by advising her that if she moved back to the area he would be happy to help in any way that he could. (PX 8)

Dr. Amin re-examined Petitioner on March 31, 2013. She reported resolution of her right buttock and lower extremity pain as well as improved back pain. She also reported that her back pain had returned after being home a few days and then having to drive two hours to the clinic. Dr. Amin further noted that "[Petitioner] states her dog knocked over her oral pain medication and she has been out of medication since that time." She appeared very emotional in the clinic and expressed that "she wants her life back." On exam she was motor and sensory intact with a well healed incision. His impression was that her right lower extremity pain had resolved with the surgery and she had slight improvement in her low back pain. She was advised to avoid long distance driving and the importance of physical therapy was stressed. Petitioner was advised to avoid any lifting greater than ten pounds and to return in four weeks. (RX 4, dep. ex. 2)

Petitioner returned to see Dr. Amin on April 26, 2013 reporting that in the previous four weeks her right leg pain had returned and her most significant pain was located in the right lower back with radiation to her right buttock. She described radiation of her pain circumferentially down the right lower extremity to her calf. Petitioner reported the inability to perform prolonged sitting or standing and rated her pain at "4-10/10." She had subjective right leg weakness as well as burning, numbness and urinary urgency. Liquid Hydrocodone was giving her two hours of pain relief but she didn't want to take any pain medication during the day as she didn't want to "mask [her] pain and not know that something is wrong." She also reported poor sleep and that her pain was radiating up her entire spine to her neck with knots in that region. Petitioner was apparently homeless and upset that workers' compensation was not providing her with disability income. She thought she would likely lose her Medicaid in June as her son was turning eighteen. Her exam failed to show any evidence of abnormal movement of the screws and no evidence of hardware failure. The doctor felt her right leg pain "could be a result of persistent injury to the right nerve root from the initial misplaced pedicle screw. This may or may not improve." He stated that the purpose of the revision surgery was to reposition the screw and avoid vascular insult. He ordered six weeks of formal physical therapy and a psychiatric evaluation. He also prescribed Lyrica for her neuropathic pain, along with Hydrocodone. Petitioner was to return in six weeks. (RX 4, dep. ex. 2)

Petitioner was seen in therapy at Loyola on April 29, 2013. She reported right lower back pain and buttock pain into the anterior thigh and posterior calf. She further reported intense right lower back pain and buttock pain with lifting her "left leg." The office note records the mechanism of injury as "pinned against wall at work with machinery." Petitioner had problems with muscle performance, joint mobility, range of motion, gait and balance and skilled therapy two times a week for eight weeks was recommended. (PX 9)

Petitioner participated in physical therapy in May and June of 2013 as recommended. The therapist's notes indicate Petitioner continued to complain of problems in the area of her right iliac crest and sacrum/coccyx. According to the May 23, 2013 notation Petitioner was very apprehensive about people touching her and she was afraid to go to public places due to the possibility of people bumping into her. She was also uneasy about having a donor bone in her body. Increased pain in her right groin was noted with ball squeeze. As of May 28, 2013 Petitioner was feeling overall 60% better since starting the physical therapy. She tolerated all

exercises without any complaints. On May 30, 2013 Petitioner reported falling down the stairs two days earlier and that her entire body was hurting and she could hardly move. She did not want to perform any exercises and was unable to tolerate any provocative testing. Her left ankle was visibly swollen. Petitioner's last physical therapy visit was on June 13, 2013 at which time Petitioner reported she was moving to San Antonio Texas. She requested that she not do any exercises or treatments and had cancelled further therapy visits due to cost/reported insurance limitation. She stated her pain was a "4/10" but could become a "9/10" with activity. Petitioner stated the rehabilitation for her back had improved her symptoms 75% but she still had unchanged symptoms in her groin, sacrum and legs. Petitioner reported having radicular symptoms into her right foot and lower leg as well as numbness in her right thigh and buttock after about 10 minutes of sitting. She was educated on piriformis stretching during which time she felt a "pop" in her right groin which required her to rest for a minute to relieve her pain. Petitioner still suffered from loss in range of motion, difficulty with sitting and standing and pain upon using stairs. Petitioner was noted to have had an increase in her pain symptoms upon testing and decreased flexibility and range of motion when compared to her initial evaluation. (PX 9)

Petitioner presented to the emergency room on May 13, 2013 reporting a 1-2 day history of left-sided chest pain that was constant and aching. She denied any recent illness but described mild shortness of breath and radiation of her pain to the left side of her neck. She had been relatively inactive after her recent back surgery but was now able to walk 1 -2 miles per day. She denied taking any current pain medications and denied any lower extremity pain or swelling. She was given IV fluids, aspirin and Toradol for pain management and diagnosed with atypical chest pain. Due to family history an EKG was recommended. The plan was for admission to general medicine for further evaluation and treatment. (RX 4, dep. ex. 2)

Petitioner was examined by Dr. Marfia on May 13, 2013 regarding her chest pain symptoms per the ER visit earlier that day. (RX 4, dep. ex. 2)

Petitioner was examined by Dr. Brent Rieger on June 5, 2013 as a new patient. He noted that Petitioner was happy and healthy until May of 2012 when she had a work accident in which her spine and knee were damaged and workers' compensation would not recognize that it was related to the accident. Since then she had lost her job and filed for public aid, and moved "here" since she felt the need to move away from her small town to fix her situation. Petitioner told the doctor she had undergone surgery to her back to repair a misplaced screw and, despite that, she still had continued pain she described as consistently in her low back, right buttock and right groin area. She described a feeling of tightness but denied any radiating pain, weakness, numbness or incontinence. Petitioner admitted to a heightened anxiety and did not think being followed by a psychologist was helping. She was currently taking Norco. The doctor noted that Petitioner was quite emotional and wanted to fix her pain but wasn't eager to take medications. He recommended physical therapy, formal physical medicine and an evaluation for rehabilitation. She was also provided a referral to a different psych provider. (RX 4, dep. ex. 2)

Petitioner returned to see Dr. Amin on June 6, 2013. At that time she was seen by the nurse practitioner staff. Overall she reported improvement in her low back pain but continued right groin and right buttock pain. She described a pop and clicking noise in her right groin and stated that, occasionally, her groin pain radiated to her right anterior thigh. She also reported

falling three times post-operatively due to her symptoms and that she recently fell down the stairs and sprained her ankle. She also reported continued urinary urgency and incontinence with sneezing. Petitioner was noted to be experiencing financial and insurance issues and during the visit informed the staff that she was not satisfied with Dr. Amin's care and wished that he not examine her that day. The examiner wrote, "of note she does not express dissatisfaction with the surgical repair he performed on her. She reports that she also recently fired her psychiatrist and walked out of his office." On physical exam she was motor and sensory intact with normal reflexes. Faber test was positive on the right. X-rays of the lumbar spine showed no abnormal movement and the screws were in good position without evidence of hardware failure. She was advised to continue physical therapy and obtain an FCE to determine her current physical status and possible return to employment. Petitioner was to return in three weeks. (RX 4, dep. ex. 2)

Dr. Amin issued an addendum to the foregoing note documenting that he was present during the visit and that Petitioner "thanked him for relieving her low back pain. However, she expressed her dissatisfaction with my care. She states that I destroyed her spirits. She explains to me that I did this multiple times and once even during the first clinic visit before surgery." Dr. Amin specifically noted that this was the first time during their relationship that Petitioner expressed any dissatisfaction. (RX 4, dep. ex. 2)

Petitioner filed her Application for Adjustment of Claim herein against Manpower on June 11, 2013. (AX 2)

Dr. Ringer re-examined Petitioner on July 18, 2013 for an allergic reaction as she was having difficulty breathing as well as hives. She had apparently used a friend's epi pen which helped her breathing. She was diagnosed with an allergic reaction. (RX 4, dep. ex. 2)

Dr. Klisiewicz ordered a pelvic x-ray which was taken on August 23, 2013. (PX 20)

On August 25, 2013 Petitioner was seen by Dr. Klisiewicz who issued a physical medicine and rehab report regarding Petitioner.[5] Petitioner told him her injuries had never been "tendered to." She complained of right groin and hip, right buttock and right knee pain as well as numbness and pins and needles of the entire right leg. She also reported right neck and right scapular pain and that her leg would give out and that she had fallen several times. Petitioner reported difficulty with driving using her right foot and rated her pain at "9/10." The doctor noted that she had driven 100 miles that day. She was taking Norco and reported Lyrica had not been approved in the past. Her sleep was disrupted and she was not working. She had gained weight, experienced chest pain and an irregular heart rate, had urinary incontinence, constipation, weakness, numbness, and cold intolerance. She had a positive straight leg raise on the right and was motor and sensory intact. She had a non-antalgic gait but notable difficulty with balance and was unable to maintain her balance with her eyes closed. She reported pain with lumbar flexion and right hip and groin pain with lumbar extension. On palpation of her right inguinal ligament and femoral/ilioinguinal nerve Petitioner noted tenderness. The doctor's theory was that when Petitioner was injured she sustained a significant pelvic obliquity, has compromise of the neurovasculature under the right inguinal ligament, and sustained a sprain of the pelvic ring ligaments. His differential diagnoses were pelvic floor dysfunction with possible pudendal nerve

[5] A copy of this office note is not found in Petitioner's exhibits; rather, a summary of the visit is contained in RX 4, dep. ex. 2.

dysfunction, right femoral neuropathy, or right ilioinguinal neuritis. He also felt she might have a lumbosacral radiculopathy but he noted the hip weakness and groin pain would not be explained by radiculopathy and degenerative disc disease at L5-S1. He further wrote, "I am uncertain of the etiology of the whole right side sensation change at this time but on exam she does not have signs of a cervical myelopathy." He wished to get an MRI of Petitioner's pelvis to further evaluate and he ordered pelvic manual therapy and noted she might possibly benefit from regenerative injections/prolotherapy of the right SI joint and pelvic ligaments. He also proposed Lyrica twice a day and a magnesium/calcium supplement. (RX 4, dep. ex. 2)

On August 29, 2013 Petitioner underwent an MRI of her pelvis and hip per Dr. Klisiewicz. (PX 20) the impression noted a linear sulcus of increased signal adjacent to the anterosuperior labrum of the right hip which "could" represent a tear. An MR arthrogram was suggested if further evaluation was desired. (RX 4, dep. Ex. 2)[6]

Dr. Wojciehoski performed a second IME on October 1, 2013. In his written report of October 9, 2013 the doctor noted Petitioner's history of having been working on an assembly line when "a worker ran into her, crushing her lower leg and causing her to twist her back." Petitioner advised the doctor that since her previous visit with him she had undergone two back surgeries. She was also financially destitute as a result of the accident and had low her home and was homeless. She also reported undergoing knee surgery. Petitioner's complaints included both knee and back pain. She described difficulty getting around. According to Petitioner her osteopathic physician was recommending prolotherapy. She had ongoing difficulty driving, back pain, neck pain, headaches, leg pain, hip pain, loss of balance, and intermittent vertigo. With regard to her back exam, she had limited forward excursion to approximately thirty degrees. Paraspinal cervical tenderness was appreciated. Her right knee had full range of motion but some soft tissue tenderness. No instability or effusion was noted.

Dr. Wojciehoski opined that Petitioner was currently suffering from mechanical low back pain, degenerative disc disease and degenerative knee arthritis. Dr. Wojciehoski affirmed his prior opinion that Petitioner only sustained a minor contusion and, at most, a knee strain as a result of her work accident in May 2012. He felt her back complaints were degenerative in nature and unrelated. He also stated that Petitioner's degenerative knee arthritis and meniscal tear were completely unrelated to the work injury as the mechanism of injury was inconsistent with a meniscal tear. Dr. Wojciehoski opined that Petitioner's treatment has been directed at a pre-existing personal health condition and completely unrelated to her workplace injury. Finally, Dr. Wojciehoski reaffirmed his opinion that Petitioner had reached MMI from her work-related injury by May 21, 2012. (RX 2, dep. ex. 3)

Having undergone no treatment since August 25, 2013, and having last seen Dr. Amin in June of 2013, Petitioner then followed up with Dr. Amin's office on October 3, 2013 with unchanged pain and occasional right groin pain radiating to her right anterior thigh. She reported having fallen due to her pain and described a fire, burning and numbness sensation in her low back with ongoing urinary urgency and incontinence with sneezing. Dr. Amin wrote, "she reports today that she never previously told us that she had numbness in the perineum region." She was seeing Dr. Klisiewicz and would be undergoing a pelvic MRI. Her post-operative films

[6] The actual MRI report is not a part of the record.

looked good and he told Petitioner that her pelvic MRI showed a tear in the right hip. He advised her to follow up with Dr. Klisiewicz and return to see him in six months. (RX 4, dep. ex. 2)

Dr. Klisiewicz re-examined Petitioner on October 10, 2013. She had not started therapy as she had been taking care of her grandmother. She reported a clicking in her right hip and buttock as well as give away with her right leg. According to Petitioner, her pain would move around and was a "10/10." She could not say how helpful the Norco was. She denied any balance problems but reported ongoing constipation and bladder incontinence. She had right groin and buttock pain with Faber and Gaenslen testing. She had tenderness to light palpation over the right PSIS/SI joint. The right hip and pelvis MRI was noted to show a possible tear of the anterosuperior labrum of the right hip. The doctor noted that Petitioner was claiming she injured her right knee and lower neck/shoulder during the injury but that would be addressed at the next visit. She received an SI joint injection without complication. He wished to proceed with a MR arthrogram of her right hip for further evaluation. She was told to proceed with therapy and he gave her a refill of her Norco. He also ordered an EMG/NCV. (RX 4, dep. ex. 2)

On October 21, 2013 Petitioner attempted to undergo another right hip and pelvis MRI so that it could be compared to the earlier one taken in August. During the procedure it was noted that contrast mainly filled a bursa overlying the proximal right femur. Only a tiny amount of intra-articular contrast could be injected. Dr. Klisiewicz was left a voice message regarding the procedure. (PX 9)

Petitioner presented to Loyola's physical therapy department on October 29, 2013 reporting she had been involved in a work-related accident about seventeen months earlier for which she had undergone back surgery on November 15, 2012 and "I knew something was wrong from the surgery, but the doctor [said] there was nothing wrong." She then went to a doctor at Loyola Medical Center who told her "screws and bolts were in the wrong place. They were in the iliac vein" and she had a second surgery in March of 2013 to correct the first surgery. Petitioner reported undergoing therapy but it was unsuccessful in resolving her pain. She then saw Dr. Sebastian who recommended pelvic floor therapy. In addition to her pain she reported hearing a "clicking" in her left hip and her leg would "give out" causing her to fall. Petitioner appeared very frustrated and labile during the session and denied being able to do anything due to her pain. As for the mechanism of injury – "Patient had gotten hit and torqued to the right as a bench with all her power tools (over 500 lbs.) had trapped her against the wall." She states that she went to [the] supervisor who told her to see employer recommended doctor. They took an ultrasound of her knee to r/o a blood clot which was negative. The next day, the patient was in so much pain that she had her children pick her up to take her for a second opinion. Her employer would not pay for services and she had to wait for Medicaid approval. After Medicaid approved, patient was able to seek consult in Urbana where it was deemed she needed back surgery. Recent diagnostics performed secondary to a questionable labral tear on the right hip had been done. According to Petitioner a minimal tear was found; however, the report with Dr. Sebastian[7] stated "increased signal adjacent to the anterosuperior labrum of the right hip which could represent tear." Petitioner reported pain in her tailbone, hip and entire right leg that she described as "something is going to bulge out." She also reported numbness down her right leg. Wearing wedged shoes reportedly relieved her right groin pain as did lying on her right side. Petitioner

[7] Dr. Sebastian Klisiewicz

had a slow and guarded cadence with forward flexed posture and wide based gait. She reported that when she hears a "click" in her hip she feels like her right leg is giving way causing her to fall. Extensive therapy was recommended to address various issues raised to the therapist. (PX 9)

Dr. Klisiewicz re-examined Petitioner on October 30, 2013 at which point Petitioner told him "she was at a breaking point secondary to severe pain [and is] unable to enjoy any of her life." She had undergone therapy the day before and the injection didn't help. She "returned" with neck, back and right leg pain that started in June of 2012 after a work accident in which she was "run over by a forklift (with the load) and was pinned between [the] wall and table, claimed her pelvis rotated to the [left]. Went to ER, had an u/s of the leg and was told she 'was fine.' She awoke the next day with right leg pain and swelling. Was told she had spinal damage [for which she had subsequently undergone two surgeries, one of which was a revision due to mal-positioned right L5 pedicle screw, pseudoarthrosis, mechanical low back pain and right lower leg radiculopathy.]" Petitioner claimed her other injuries "were never tended to" and she related pain to her right groin, hip leg, buttock and knee. She reported numbness and pins/needles in her entire right leg along with right neck and right scapula pain. The worst pain was reportedly in her right groin and buttock. Petitioner further reported that her legs had given out and she had fallen several times and she was walking "tilted." Her pain was described as constant and worse with driving. When sitting she would get a "digging sensation in her groin." She noticed improvement in her pain with "zero gravity" and floating in water. Petitioner also reported difficulty sleeping and was now "at the breaking point" due to severe pain. She reported being unable to enjoy her life and had written a letter about "leaving, goodbye" to her children but hadn't given it to them. She denied any current suicidal plans. She reported being very depressed and wondered if she was going crazy. She had been using Hydrocodone 30 mls. three times a day. Petitioner's right superior and medial cluneal nerves were swollen and tender to palpation. Dr. Klisiewicz's theory was that when she was injured she sustained a significant pelvic obliquity and had compromise of the neurovasculature under the right inguinal ligament resulting in a sprain of the pelvic ring ligaments (right sacroiliac joint sprain/pain) His differential diagnosis was pelvic floor dysfunction with possible pudendal nerve dysfunction, right femoral neuropathy and/or right ilioinguinal neuritis. While she may have had a lumbosacral radiculopathy at L5-S1 in the past her current symptoms were not consistent with an L5-S1 radiculopathy. The doctor was still uncertain as to the etiology of Petitioner's "whole right side" sensation change and she had no signs of a cervical myelopathy on exam. He did feel she "might" have a right labral tear component to her symptoms. He found Petitioner to be very depressed and emotionally liable. She agreed to a perineural nerve injection and he ordered ("we'll re-try") a right hip MR arthrogram for evaluation of a labral tear. She was to continue pelvic manual therapy and the doctor felt she would benefit from seeing a psychiatrist or starting anti-depressants, the latter of which she was encouraged to discuss with her primary care physician (which the doctor did that day). (PX 9; RX 4, dep. ex. 2)

Petitioner attended physical therapy on November 5, 2013 and was very tearful and labile. She reported being unable to live with her pain anymore and the therapist noted Petitioner continued to have significant frustration and stress secondary to events leading up to the current situation. Petitioner reported being alone and having no one to help her. Her children were away in college and she didn't wish to burden them. She had not filled out her bladder log as she had been instructed to, secondary to drinking "nutriblast drinks" that helped her with bowel issues.

Dr. Sebastian[8] was contacted regarding Petitioner's emotional issues as he had received an email from her described as a "cry for help." She did not wish to be admitted because she didn't want to be drugged up and she would refuse any medication. The therapist noted Petitioner was having significant emotional attachment to events leading to her current situation. She was extremely hypersensitive to touch in the area of her right lateral iliac crest and groin and she had difficulty with any type of functional movement requiring increased time to perform. (PX 9)

Petitioner returned to see Dr. Klisiewicz on November 19, 2013 regarding neck, back and right leg pain. She was given a right hip IA injection. She was again encouraged to see a psychiatrist or psychologist. An EMG was to be done later in the week. (PX 9)

A November 23, 2013 EMG was performed by Dr. Klisiewicz was read as abnormal as there was a "suggestion" of a right obturator neuropathy. There was no evidence of a right lumbosacral radiculopathy. She also reported that the recent hip injection did not change her groin pain; however, her buttock pain was better. It was also noted that she had experienced a breakthrough with therapy per the therapist. No new complaints were otherwise noted. She had some tenderness to palpation of the right femoral nerve just below the inguinal ligament as well as pain with hip internal rotation on the right. She was noted to be hypersensitive to light ouch in the medial right leg and reported less sensation on the lateral leg. Therapy was to be continued along with Norco and psychological care. (PX 9; RX 4, dep. ex. 2)

Petitioner returned to see Dr. Klisiewizc on December 5, 2013 reporting her pain was better controlled and she was "able to enjoy herself more." She reported her hip was a little better following her recent injection and continued therapy. She was taking Hydrocodone and Diazepam which was helping her sleep. She was to continue the medication and therapy. (RX 4, dep. ex. 2)

Petitioner contacted Dr. Harms' office on December 6, 2013 and left a message in which she didn't know if the doctor remembered her but she'd had some screws misplaced and "well anyway during my time with you were there any indication symptoms me describing something that could be a right hip torn labarum [sic]…I guess that's is what was the main issue was and is now what I am dealing with and just overlooked.. if possible and off the record or on which ever I do have a few questions I would like to ask you and honestly you are the only one who can answear [sic] if you wouldn't mind." (PX 8)

That same day Dr. Harms dictated a note regarding the message. He noted that he had reviewed her August 27, 2012 note in which she reported back pain going down her right leg with some right groin pain and buttock pain and that her pain radiated down to the big toe and second toe and she had some numbness in her right foot. "I told her that the main problem appeared to be the back, but the groin pain usually does not come from the lumbar spine. That suggests that she may have had a hip problem at that time as well." Petitioner also wondered how her screws got misplaced and the doctor told her he had used surgeon's judgment as to where the screws would go and he did not pick up on any malpositioning of the screws at the time of the surgery. Dr. Harms believed Petitioner might have an independent hip problem and she should call if she needed further assistance. (PX 8)

[8] Dr. Sebastian Klisiewicz

Petitioner returned to Dr. Klisiewicz's office on December 5, 2013 regarding her medications. She claimed her pharmacy did not fill the 30 day supply of the Hydrocodone. She also reported the current dose, along with Diazepam, seemed to be working as it helped her sleep, controlled her pain a little better, and was able to enjoy herself a little more. She also reported that her hip seemed a little better. The doctor agreed with the medication plan but didn't want her driving while on such large doses of opiates. She was to return in two weeks. (PX 9)

Petitioner then had a consultation with Dr. Craig McAsey on December 10, 2013 in regard to her right hip and thigh pain. The doctor noted that Petitioner was injured at work in May of 2012 when "struck by a number of carts and moving boxes when she sustained a twisting injury to her lower extremities." Despite surgery and revision surgery she reported never having any relief of her pain which she described as being in her buttock and deep within the mid portion of her groin radiating to the inner aspect of her thigh and lower level of her knee. She reported difficulty with prolonged walking and pain at night when lying down and navigating stairs. She reported occasional paresthesias in the right lower extremity. She was not taking any anti-inflammatory medications at this time per the request of her neurosurgeon due to her spinal fusion. She was currently taking Valium and Hydrocodone for her pain. On exam she had a relatively non-antalgic gait with pain and difficulty turning. Dr. McAsey's assessment was enthesopathy of the right hip with history of a lumbar spinal stenosis status post revision fusion surgery. He noted that she appeared to have some aggravating factor as far as her right hip that is contributing to her overall condition and felt she might have a labral tear. He recommended a MR hip arthrogram to further address that. (RX 4, dep. ex. 2)

Dr. Klisiewicz again saw Petitioner on December 10, 2013.She was reporting right groin pain worse with driving, stepping, and stairs and it would shoot down her thigh and occasionally into her lumbar spine. She had been in too much pain to watch her son's debate competition and had not taken her pain medication for three days as she had to drive a lot and was not able to function well while on medications. She was continuing physical therapy and was given a femoral nerve block. (RX 4, dep. ex. 2)

Dr. Rieger re-examined Petitioner on December 13, 2013 at which point Petitioner was reporting her pain was much better controlled and that she was taking the medication on a regular basis but a little less during the day. She expressed frustration and continued follow-up with Dr. Klisiewicz. Her depressive symptoms were discussed and Petitioner was noted to become emotional stating she was frustrated more than anything else. He wrote, "denies even thinking of hurting herself but admits to telling Dr. [Klisiewicz] she wished she could cut her leg off." She was felt to have chronic pain for which an orthopedic second opinion was recommended. (RX 4, dep. ex. 2)

Petitioner had another visit with Dr. Klisiewicz on December 23, 2013. Petitioner reported that the earlier injection had helped with her pain and she was able to tolerate driving better as she could now go about ten minutes before having pain whereas before it was immediate. Petitioner reported going to Florida for the winter and being gone about three months. Stairs were still painful but more manageable. She was not eating well and trying not to sue pain medications. She received another injection and was told to continue with pelvic manual

therapy. She was told to continue the Hydrocodone and to discuss her issues with Janice, the rehab social worker. Dr. Klisiewicz wished to see her when she got back from Florida. (PX 9)

Petitioner filed an Amended Application for Adjustment of Claim herein naming North American Lighting, Inc. as a party respondent on February 5, 2014. (AX 2)

Petitioner underwent no treatment between December 23, 2013 and May 22, 2014.

On May 23, 2014 Petitioner again presented to Dr. Rieger with continued hip and pelvis pain. She was still under Dr. Klisiewicz's care and "was working on a lot of things." She admitted to anxiety and mood symptoms. Her diagnosis remained unchanged. (RX 4, dep. ex. 2)

Dr. Klisiewicz examined Petitioner on May 29, 2014. Petitioner reported having been in Texas and Arizona, noting her symptoms had improved while there and that she had been more active. She was taking her medications and still was unable to stand, sit or drive for more than one hour. The doctor recommended she find a pelvic specialist in Arizona and that she continue with therapy and pain interventions, followed by an FCE. The plan was for her to continue care in Arizona. (RX 4, dep. ex. 2)

Dr. Klisiewicz authored a note on May 29, 2014 stating Petitioner should be excused from work beginning May 29, 2014. He wrote that she was unable to work as she could not stand or sit and was unable to drive due to all the pain and leg weakness. He felt she should continue treatments with therapy and other pain interventions at this time followed by a functional capacity evaluation to determine her work status/capacity. Petitioner was going to be continued the therapy at another facility so a return to work date could not be determined. (PX 9)

Petitioner was also examined by Dr. Amin on May 29, 2014. She reported aqua therapy had been helpful in Arizona and she would like to permanently move there. X-rays showed no instability and the fusion was intact. She appeared to be doing much better but still had intermittent low back discomfort. The doctor was deferring to Dr. Klisiewicz regarding Petitioner's return to work status. (RX 4, dep. ex. 2)

Petitioner was examined by Dr. Timothy Russell on June 4, 2014 for a complaint of chest pain noted while flying back from Arizona. She appeared anxious and very symptomatic and a call was made to EMS for a transport to Hinsdale Hospital for further testing. (RX 4, dep. ex. 2)

Petitioner was seen at the Advocate Christ Medical Center ER on July 17, 2014 regarding lower extremity pain. Petitioner reported right knee pain and back pain after a fall as she was at a shopping center and, as she started to push a cart, she felt a sharp pain and pop to her right knee. She took two steps and again felt a sharp pain which caused her to fall to the floor. She denied any head trauma but felt the pain shoot up her right leg and into her back. She had been ambulatory since then. Petitioner's right knee had mild effusion and tenderness laterally. Pain was elicited with anterior drawer testing but no laxity when compared to the left. Petitioner was diagnosed with a sprain. Another entry from that visit stated that Petitioner was putting groceries into her car and felt a sharp pain in her right knee with radiating to her right hip and back, causing her right knee to get weak and give out. (PX 10)

On December 3, 2014, Dr. Wojciehoski authored a records review report summarizing his review of additional records from October 2013 through December 2014. Dr. Wojciehoski reiterated his prior opinions. (RX 2, dep. ex. 4)

On March 9, 2015, Dr. Wojciehoski was deposed. Dr. Wojciehoski testified that he first examined Petitioner approximately 4 weeks after her March 16, 2012, work accident and, at that time, diagnosed Petitioner with a minor right knee contusion. According to the history provided by Petitioner she had been struck by a co-worker in the lower leg and had twisted her back. She reported the accident and went home but was later sent to Occupational Medicine by her employer where she was diagnosed with a knee contusion. Dissatisfied with the care she received from Occupational Medicine she returned to her home outside of Chicago and began treating with her chiropractor. At the time of the exam she complained of bilateral knee pain and was hoping the doctor would order an MRI. Petitioner was having trouble walking and sitting as it bothered her right knee, lower leg and buttocks. She also complained of back pain. (RX 2[9], pp. 1- 13)

Dr. Wojciehoski testified regarding his exam of Petitioner, which was consistent with his earlier report. Dr. Wojciehoski opined that Petitioner had sustained a minor contusion of her right knee that resolved without consequence. Her neck and back complaints were unrelated to the accident. Dr. Wojciehoski testified that Petitioner reached maximum medical improvement (MMI) by May 21, 2012, when she was released back to work full-duty. Dr. Wojciehoski did not believe Petitioner needed any additional treatment at the time of his first IME on June 20, 2012. (RX 2, pp. 13 – 17)

Dr. Wojciehoski testified that he re-examined Petitioner a second time on October 9, 2013. His testimony regarding this visit was consistent with his earlier report. (RX 2, pp. 17 – 20) He testified that his second examination did not alter any of his original opinions. Dr. Wojciehoski opined that Petitioner's need for her two back surgeries was unrelated to her May 16, 2012, work accident. (RX 2, pp. 19 – 20)

Dr. Wojciehoski subsequently had an opportunity to review additional records pertaining to Petitioner. He also looked at radiographic films. He then issued a third report on December 3, 2014 and he testified consistent with that report. At that time he felt Petitioner had subjective complaints of mechanical low back pain, sacroiliac joint pain and right lower extremity pain, all of which were unrelated to her work accident. (RX 2, pp. 20 – 23, 26)

Dr. Wojciehoski opined that Petitioner's need for two back surgeries was a result of her degenerative disc disease and spinal stenosis. Dr. Wojciehoski addressed Dr. Harms' and Dr. Klisiewicz's causation opinions and opined that it would be extremely unlikely that either of their two theories would be the cause of Petitioner's need for her two back surgeries. Dr. Wojciehoski opined that it is medically and scientifically improbable a simple knee contusion could cause these numerous conditions and need for surgery. Dr. Wojciehoski agreed with Dr. Belich's opinions regarding Petitioner's right knee and, in particular, that any meniscal injury was secondary to degeneration and not an acute injury. Furthermore, he felt Petitioner lacked the physical presentation one normally sees with a meniscal injury. (RX 2, pp. 23 – 26, 44)

[9] RX 2 and PX 13a are identical copies of Dr. Wojciehoski's deposition. Any objections have been ruled on in RX 2.

On cross-examination Dr. Wojciehoski acknowledged that he described Petitioner as being histrionic; however, he was not referring to that as a diagnosed personality disorder. He further explained that the second examination was supervised because he recalled Petitioner complaining that the doctor's movement of her knee caused undue pain and she was emotional. He agreed that at the October 1st exam, Petitioner was complaining of severe back pain and her back exam had inconsistent findings. When he examined her in June of 2012 he felt there was nothing wrong with her back. (RX 2, pp. 26 – 33)

On cross-examination Dr. Wojciehoski was asked further questions about Petitioner's right knee. At the June of 2012 visit he agreed that she began to cry and he was able to perform varus and valgus testing. They were normal. Lachman's test was normal. Dr. Wojciehoski also testified that he did not perform a McMurray's test, which is the classic test for meniscal pathology, because of her histrionic behavior. Thus, he didn't really evaluate her meniscus at that exam. However, the doctor was able to test it in October of 2013 and it was normal. Dr. Wojciehoski agreed that the August 21, 2012 MRI of Petitioner's right knee revealed a posterior horn meniscal flap tear with degenerative changes involving the anterior cruciate. He also testified that meniscal tears occur with violent twisting of the knee followed by effusion and significant obvious physical findings. A tear is usually not caused by a direct blow to the knee. (RX 33 – 38)

Dr. Wojciehoski agreed that Petitioner did sustain an accident on May 17, 2012. Regarding the mechanism of injury the doctor recalled that she told him she was hit by another co-worker and that another report stated something about a "cart." Either way she was struck by a person or a cart in the right knee. He agreed that the accident caused a contusion and that was from a direct blow to the leg. He acknowledged that in his second report he also stated that the accident caused a minor strain from the bump. Dr. Wojciehoski also agreed that to the best of his knowledge, Petitioner was in good health prior to her accident. (RX 2, pp. 38 – 41)

Dr. Wojciehoski testified that if one has degenerative changes in the lumbar spine one can also have some spinal stenosis. He could not recall just what her low back spine films revealed. He did agree that the treatment she had received for her low back was reasonable. Dr. Wojciehoski was asked how spinal stenosis can become aggravated and he testified there is usually trauma with associated neurologic pathology. One could see it with a significant torsion event such as a violent automobile accident. He went on to testify that he simply did not believe that bumping her knee caused Petitioner's back pathology. Dr. Wojciehoski agreed that Petitioner was complaining of back pain in May of 2012 adding that "like all chiropractic visits, everybody has back pain, so there's treatment of knee pain and back pain. (RX 2, pp. 41 – 49, quote at p. 49)

On cross-examination Dr. Wojciehoski was asked to look at Dr. Belich's January 17, 2013 report in which he stated there were no tears on the MRI. Dr. Wojciehoski agreed that there were no tears on the MRI. He did feel the injection and therapy prescribed by Dr. Belich were reasonable. (RX 2, pp. 51 – 52)

Dr. Wojciehoski was asked about his qualifications. He testified that he is a doctor of osteopathic medicine and a doctor of podiatric medicine. He is still licensed in Wisconsin for the

latter. Medical Topics Unlimited is medical-legal consulting. The doctor is qualified to perform lower extremity surgery but not spine surgery. (RX 2, pp. 52 – 60)

On redirect examination Dr. Wojciehoski testified that people can have spinal stenosis manifest itself without any accident or traumatic event. (RX 2, p. 71)

On March 30, 2015 a law firm called Dr. Harms' office inquiring if some time could be scheduled with the doctor to answer some questions and see if a deposition was needed. (PX 8)

Petitioner underwent no treatment between her ER visit on July 17, 2014 and April 9, 2015.

Petitioner presented to the emergency room on April 9, 2015 complaining of a burning right leg pain for the last 2 and ½ weeks. She reported that her problems began in 2012 when she was involved in a work-related accident with injuries to her back and pelvis. She had four screws inserted into her pelvis back and then removed at Loyola. "She's doing fairly well until the last a half weeks." She denied taking any medications for the pain "lasted have week." She had a history of mitral valve prolapse and panic disorder. She also gave a history of a "labrum injury" of the right hip. She's reported radicular pain in her right leg "in the past" since the injury and being on Lyrica in the past. She was allergic to codeine but could take Hydrocodone; however, she couldn't take pills, only liquid medicine. She was requesting Diazepam by name. She appeared in no acute distress. According to the note, "She's had her seizure when touching her arm and leg on the right." Petitioner was diagnosed with back pain and told to follow up with her primary care doctor. (PX 10)

On May 26, 2015 Petitioner presented to the emergency room "at the request of her insurance company" with complaints of chronic back pain and intermittent right leg numbness. Petitioner reported that she had a grandbaby the day before and her family would not let her hold it because she falls so often. She went to see her doctor earlier and was told they could no longer see her for her chronic pain. She then called her insurance company who advised her to go to the emergency room. Petitioner stated she had been having these problems since a fork lift injury in 2012. She reported multiple surgeries but wanted to find out that day why she still had pain. She reported three years of intermittent increased sensation in her right lower extremity and some weakness in her right upper extremity. She reported occasional problems with urination for the last three years. Petitioner was diagnosed with "leg pain" and told to use a walker and follow up with an orthopedic surgeon and a pain specialist. (PX 10)

Petitioner presented to Dr. Jacobs at Advocate Medical Group on May 29, 2015 to establish care and discuss her right-sided numbness and recent ER visit. Petitioner gave a history of chronic low back pain and right-sided paresthesia (both upper and lower) since a work accident in 2012 when a "forklift ran into tables and then the tables hit her and she wound up having multiple back surgeries." She had last seen a surgeon (Dr. Amin) about 1 -1.5 years earlier and then she had insurance issues. She had had several primary care doctors who wouldn't do anything for her. The only medication that worked for her was Diazepam as neither Lyrica nor Gabapentin help. Hydrocodone has helped her low back pain. According to Petitioner standing felt the best and sitting/lying down hurts. She also reported trouble getting up from a sitting position, falling on occasion, and dropping things with her right arm "all the time." She

denied any recent injury or trauma or that she was currently on any medication. She was given a prescription for Naproxen and orders for an EMG and referrals to a neurosurgeon and pain clinic. (PX 11)

On June 1, 2015, Dr. Harms was deposed.[10] Dr. Harms testified that if there was a significant amount of energy absorbed by Petitioner's back during her work accident that could cause her to become symptomatic and need surgery. However, Dr. Harms also testified that he had insufficient information to opine on whether that was the case for Petitioner's accident as he had "insufficient information to provide a definitive opinion. I can give you some idea that may strengthen or weaken the causal connection, but basically no." (RX 4, dep. ex. 2)

Petitioner presented to the office of Dr. Nathan Gilling at Advocate Medical Group on **June 10, 2015** to establish care for the chief complaint of a bump on her left upper arm of one year's duration. Petitioner was also noted to be following up for right-sided numbness and back pain. She had not yet had her EMG completed nor seen a neurosurgeon or pain management. She reported continued chronic numbness in her right upper and lower extremity with associated intermittent episodes of weakness in her right arm. She would drop objects intermittently. Petitioner reported that this had been going on "for years" and she believed it was all related to her prior back surgery where a screw was put in the "wrong place." Petitioner described severe back pain radiating down her right leg and difficulty going from sitting to standing or vice versa. She also had dizziness and episodes of feeling off balance. She had no other concerns. She was controlling her pain with Naproxen and wanting an IV injection of some pain medication that began with a "D" as that had worked well in the past. Petitioner admitted to using "Marijuana Gummy Bears" at home to control her pain. Petitioner reported concern that she had been told in the past that her pain was psychological in nature and that she should see a psychiatrist. She was adamant that she wasn't depressed and simply wanted help with her numbness and pain. A physical examination was conducted with some positive findings and a notation as to poor effort. Petitioner was felt to have lumbar back pain with right leg radiculopathy and pain believed to probably be due to degenerative disc disease and spinal stenosis. Petitioner was to follow up with NeuroSurgery and see Dr. Jido for pain management. An MRI was ordered. She was to undergo an EMG for her right arm radiculopathy, the etiology of which was not clear. Marijuana use was not recommended. Over-the-counter Tylenol and Ibuprofen were. (PX 11)

Petitioner again presented to Dr. Gilling at Advocate Medical Group on July 24, 2015 in follow-up after a Mercy Hospital ER visit in Wisconsin. Petitioner presented with "a broken right ankle." By history she had been on vacation seven days earlier in Wisconsin when she tripped while walking outside a store. She went down two steps, tripped over a hole at the bottom of the steps and rolled her right ankle inward and fell. She went to the ER at Mercy Walworth and had x-rays taken. Earlier that day, she received a call and was told she had a fractured ankle. Her ankle was red and swollen but better than earlier. She was taking Norco and Ibuprofen for the pain and using ice for swelling. She reported difficulty using crutches due to the paresthesias in her right arms and legs so she had been putting some pressure on her ankle. Petitioner had not bothered to have the EMG or follow-up with Dr. Jido/Pain or NeuroSurgery as she had been told she couldn't get in until September. She denied any other concerns. A right ankle x-ray was ordered. After the x-ray was taken Petitioner was contacted and told she had a

[10] Neither party submitted Dr. Harms' deposition as an exhibit; however, the deposition was summarized in RX 4, dep. ex.2.

subtle nondisplaced lateral malleolus fracture. She was told to proceed to ER for splint placement and return to see the doctor in one week. (PX 11)

Petitioner was seen at the emergency room at Advocate Health Center on July 24, 2015 with an inversion injury to her right ankle after stepping on uneven pavement one week earlier. Another note from the ER visit indicates she was "walking down steps." She had been seen at the emergency room and underwent x-rays that were read as normal and diagnosed with a sprain. However, she later received a call back from the doctor advising her a hairline fracture was noted. Repeat x-rays were taken. She had evidence of a nondisplaced lateral malleolar fracture for which she was given a cast boot and appropriate instructions for further care. (PX 10)

Petitioner was examined by Dr. Trombly on July 30, 2015 reporting she was a line supervisor in an electrical supply company and was working in June of 2012 when she was "struck by a forklift." Petitioner walked away and went to the hospital where her right knee was evaluated and the next day she woke up and couldn't move her legs because of the pain. She also told the doctor that normally she would have jumped out of bed and done twenty push-ups. She could not return to work, tried physical therapy, and ultimately had surgery but when she woke up from surgery she could not move her legs until she had an "adjustment." In March of 2013 she had an adjustment of the L5 screws because of impingement on "IVC" without perforation. Petitioner felt her right upper extremity had been progressively worsening over time and by six months after March of 2013 she was having tingling and weakness in her right arm and hand and dropping objects with her right hand. Petitioner was having trouble combing her hair and opening jars with her right hand. She reported having 12 migraine headaches a month and diplopia 4-5 times per day. Dr. Trombly recommended CTs of her cervical and lumbar spines and head, the latter being ordered in regard to her headaches and diplopia. He felt Petitioner had severe L5 foraminal stenosis exacerbated by L5-S1 fusion requiring a CT of the lumbar spine and revision foraminotomy. She also had symptoms of a right brachial plexus injury exacerbated by a nine hour surgery possible positioning palsy and possible cervical spondylosis for which she needed a CT of the cervical spine. (PX 11)

On August 3, 2015, Petitioner presented to Advocate Christ Medical Center with right upper extremity pain, weakness and paresthesia. She underwent an EMG. The doctor's impression was right cervical C7 radiculopathy. Petitioner also underwent a CT of the lumbar spine without contrast. The radiologist's impression was post-op changes and multi-level degenerative disc disease. A CT of Petitioner's head (ordered due to headaches and right arm paresthesia) showed nothing acute. A cervical spine CT showed multi-level degenerative disc disease. Detail in the canal was limited. (PX 10, PX 11)

Petitioner returned to see Dr. Trombly on August 5, 2015. He noted that Petitioner had been in an accident in 2012 with transient quadriparesis and persistent Lhermitte's phenomenon. She had recently undergone an EMG showing a right C7 radiculopathy and symptoms of pain and weakness in her right upper extremity for which she noted she dropped objects and couldn't carry her 8 lb. grandchild. A recent CT of the neck showed a 8 mm. canal with foraminal stenosis at C3-4 and C5-6, overall stenosis worse at C3-4. Petitioner was also noted to have persistent back pain and paresthesias in her legs, right worse than the left with a recent CT confirming persistent foraminal stenosis worse on the right at L5-S1 but also present on the left after a prior L5-S1 fusion. Petitioner had an obvious weak right ankle and foot and was losing

strength. On exam Petitioner had a weak right deltoid and triceps. He felt she had cervical spondylosis with myelopathy and EMG confirmation of a right C7 radiculopathy. He also felt she had lumbar stenosis at L5 with compression confirmed on CT and persistent right leg pain and paresthesia with weak right foot requiring an L5 laminectomy. The doctor wished to see the old MRIs and prescribed Hydrocodone and a cervical collar. (PX 11)

Petitioner presented to Dr. Gilling at Advocate Medical Group on August 11, 2015 for the purpose of establishing care and following up on her right malleolus fracture and right-sided radiculopathy. Petitioner reported being recently seen by a neurosurgeon and undergoing CTs of her neck, low back and head. Petitioner was also shown an EMG which indicated a C7 radiculopathy on the right. She was scheduled to have a cervical and lumbar MRI on the 17th and then follow up with the neurosurgeon as she was considering surgery. Petitioner reported Lyrica and Norco were helping control her pain. She had ongoing numbness and radicular pain in her right leg and pain in her right ankle. She denied any other problems. Petitioner was examined and diagnosed with cervical degenerative disc disease and a C7 radiculopathy. She also had lumbar degenerative disc disease, paresthesia of the right arm, paresthesia of the right leg and a lateral malleolar fracture. She was to follow up with the treatment she advised the doctor she was currently undergoing. She was also told to continue wearing the Cam boot and to use Ibuprofen and Norco for pain relief. (PX 11)

On August 13, 2015, Petitioner underwent an MRI of the cervical spine. The radiologist's impression was mild degenerative change/disc disease which is resulting in mild to moderate bilateral neural foraminal narrowing at C3-C5. Petitioner also underwent a lumbar spine MRI. The radiologist's impression was laminectomy and posterior fusion at L5-S1 with probable post-surgical edema in the resection bed. Minimal degenerative change which is not significantly narrowing the central spinal canal and resulting in no more than mild bilateral neural foraminal narrowing. (PX 10; PX 11)

On August 17, 2015 Petitioner presented to Advocate Medical Group to establish care and receive medical clearance for lumbar surgery. She had undergone an ECG and labs earlier in the week which were reportedly normal. Petitioner reported continued weakness in her right leg and arm and that Lyrica seemed to control the right leg pain. However, Petitioner was sick of living with her pain and was willing to undergo back surgery to try and get rid of it. She denied any other problems at the time. On exam Petitioner had an antalgic gait on the right with limping and was noted to be wearing a Cam boot on her right foot. Her right hip and left hip were normal. Her left knee was normal. No findings regarding her right knee were made. She was given clearance for surgery. (PX 11)

Petitioner, along with her daughter, presented to Dr. Trombly on August 17, 2015. According to the office note, "MVC 2012, June 2012." She had undergone a lumbar decompression in November of 2012 followed by revision surgery in March of 2013. Petitioner had pain in her back and right leg between June and November of 2012. When she "woke up from surgery 'something was wrong' and she manipulated herself and then she felt her whole right side. Over next few months her back pain and leg pain persisted, and she was found to have a L5 screw impinging on her iliac vein. She had a recent fall on July 24th resulting in a right ankle fracture. Petitioner reported being unable to dorsiflex her right ankle since the November surgery. Dr. Trombly looked at her recent MRI of her low back and neck as well as a CT of her

lumbar spine. His diagnosis was foraminal stenosis in the neck and lumbar region with post-operative right foot drop worsening over time. Due to her recent exacerbation of pain and progressive loss of function in her right foot she needed an x-ray and urgent surgical treatment to prevent further foot drop. He recommended an L4-S1 laminectomy in the near future. (PX 11)

Petitioner underwent a lumbar spine x-ray at Advocate Christ Medical Center on August 20, 2015. In comparison to films taken on July 17, 2014 Petitioner had evidence of post-operative and degenerative changes of the lower spine. Mild dextroscoliosis of the thoracolumbar spine was present. Hardware and alignment from the prior fusion were intact and stable. (PX 11)

On August 21, 2015 Petitioner left the following voice message with Dr. Harms' office:

> Not sure if you remember me but due to the embedded screw you put into my vein I suffered and now am going on the 3rd back operation in the same spot. Also thanks for ring [sic] my life I'm homeless because you memory seem to fade during the testimony you gave. Karma is Bitch have a wonderful life knowing toy[sic] ruined mine amd [sic] my families you took a healthy mother away and broke her more. (PX 8)

On August 24, 2015, Dr. Trombly performed a lumbar 3, lumbar 4, lumbar 5, sacral 1 laminectomy, medial facetectomy and foraminotomy and L4-5 posterolateral arthrodesis using local vertebral autograft and cancellous allograft and demineralized bone matrix. (PX 11)

Petitioner was admitted to the hospital on August 26, 2015 with a complaint of back pain. She had undergone surgery and been admitted to the ICU due to an episode of hypotension and bradycardia. Her headache was suspected to be related to a dural leak post-operatively and she was managed with pain medication while admitted. (RX 4, dep. ex. 2)

On August 28, 2015, Dr. Trombly performed an application of skull fixation and right-sided cervical foraminotomy at C4-C5, C5-C6, C6-C7, and C7-T1. Cervical spine x-rays revealed cross table lateral image of the cervical spine with marker at C4. (PX 11)

On September 3, 2015 Petitioner presented to the emergency room with a chief complaint of lower back pain for the past seven days and neck pain for the preceding four days. She also developed a recent redness and swelling of her eyes associated with tongue swelling and difficulty swallowing. She had been discharged from the hospital post-surgery three days earlier. She denied any pain medication other than Percocet. It was felt she possibly had an allergic reaction to an unknown source. Dr. Trombly was contacted and she was admitted for continued observation. (RX 4, dep. ex. 2)

Petitioner followed up with Dr. Trombly on October 27, 2015 and he noted she "now [had] swelling and pain in right ankle but good range of motion. Improved strength in right deltoid and right hand, limited range of motion compared with left." No active facial swelling was appreciated and she was ambulating independently although right groin pain was noted. She

was to continue therapy as tolerated and he ordered a CT of her right ankle as he felt her current ankle pain might be from her fracture and not a persistent spinal problem." (RX 4, dep. ex. 2)

Petitioner attended therapy at Advocate Christ Medical Center on November 2, 2015. According to the report of that date she had begun therapy on August 25, 2015. It was noted that prior to her work injury she worked as an electrical engineer. She reported no change in her symptoms and the therapist noted that "[Petitioner] states she is willing to participate in therapy as long as not affecting her neck." She walked to the clinic that day without a cane (five blocks). Petitioner rated her pain as "9/10" at both the beginning and end of the session. Her rehab potential was described as "fair." (RX 4, dep. ex. 2)

Petitioner attended therapy on November 13, 2015. Petitioner reported that the problem was that she kept falling and it was difficult for her to continue moving on. She reported hip flexor region pain and stated "people won't listen to me, I can't deal with falling all the time. They keep saying you will be better and I'm getting worse, I'm getting lumps in my joints, my whole face just explodes." Her pain was noted to be "8/10." She was emotional during the session and cried throughout as she appeared frustrated that doctors don't listen to their symptoms. (RX 4, dep. ex. 2)

On December 1, 2015, Dr. Trombly was deposed. (PX 12) Dr. Trombly is a board certified neurosurgeon. He testified that he initially examined Petitioner on July 30, 2015. He did not know who referred her to him as he never looks into that with his patients. She provided a history of having been struck by a forklift in 2012. She had a knee injury and difficulty moving her legs despite conservative treatment, including physical therapy. Between June and November of 2012 she experienced a progression in her pain resulting in a spinal fusion in 2012. Dr. Trombly testified that she had a very unusual history in that she recounted having problems moving her leg after her surgery as well as after her injury. That improved to some degree and then she had to have revision surgery due to supposed mal-positioned instrumentation; however, she denied that the second surgery helped her from a functional point of view. According to Dr. Trombly Petitioner told him she initially needed the fusion due to persistent symptoms of pain. He acknowledged the note didn't really contain any specifics but it was the pain in her back and right leg and difficulty walking and performing normal activities. According to Petitioner, she was struck by a forklift. (PX 12, pp. 1 -11)

Dr. Trombly acknowledged that he never saw or reviewed any of Petitioner's earlier records. He could not answer whether her symptoms in 2015 were consistent with what she told him. She did acknowledge that she had persistent back pain and significant weakness in her right foot that was quite "obvious." Dr. Trombly testified that the diagnostic films he ordered in August of 2015 correlated with her clinical symptoms of chronic back pain and right footdrop. Her lumbar spine MRI showed a disc bulge on the right at L5-S1 and a facet hypertrophy bilaterally at L5-S1 and L4-L5. Dr. Trombly was asked if he believed the mechanism of injury of being struck at work was the cause of her lumbar stenosis and lumbar radiculopathy to which he replied:

> Based on her story, I do definitely believe that, yes. I mean, for someone to be working and then be out of work for five months to go on to spinal fusion and then

never to really recover to me is a believable and an all-to-common scenario. (PX 12, pp. 15 – 16)

Dr. Trombly testified that in his opinion it did not matter whether Petitioner was hit by a forklift or a cart. He testified that the most important factor in his opinion was Petitioner not having any prior history of back treatment and then her work injury causing right radiculopathy in her lower extremity that necessitated surgery. However, Dr. Trombly testified he had not reviewed Petitioner's prior records, except for, perhaps, some operative reports and radiograph findings. (PX 12, p. 17) He testified that it would be a "long sorted, you know, process to review all that stuff that wouldn't really help me make a medical decision." (PX 12, p. 18) He further testified that if Petitioner had a clean bill of health pre-employment and then developed back pain after she was struck it is more likely than not that her condition was caused or aggravated by the work injury. (PX 12, pp. 18 – 19)

Dr. Trombly testified that he had just seen Petitioner on October 27th and she was doing well and recovering from both lumbar and cervical surgery with objective improvement in her right arm, leg, and foot and the doctor was confident she would continue to improve. When asked if she had any current work restriction, the doctor testified that it has been almost four months and would kind of depend on what she could tolerate and what her work entails. If she was a clerical worker she could go back to work without any restrictions; however, her job sounded a little more strenuous so it might be prudent to wait another month or two. (PX 12, pp. 19 – 20) He did not anticipate any need for permanent restrictions. (PX 12, p. 21) He testified that she will be more susceptible to arthritis especially since she's had three spine surgeries and there's the possibility of adjacent level segmentation. In the future she may need additional surgery but it's hard to predict. (PX 12, pp. 21 – 23)

Dr. Trombly was asked about the first surgery and the note that the screw was placed incorrectly to which he replied, "Well, again, that was what the second surgeon told her, and then he bragged about how he was going to fix it, and then he did something, but it really didn't help her. So the screw technically was placed somewhat ventral or protruding out through the front of the vertebral body and was seen to be impinging on the vena cava but not piercing it. … That's not an uncommon thing to happen and it didn't really cause any vascular injury or heavy bleeding. It's certainly not the reason she didn't get better. (PX 12, pp. 23 – 24) Dr. Trombly did not believe what had occurred was a violation of the standard of care and he agreed that a surgeon has some discretion in the placement of the screw. He felt Petitioner failed to improve because she had persistent foraminal disease that had nothing to do with the placement of the screws. (PX 12, p. 25)

Dr. Trombly further testified that Dr. Amin shorted the screw in 2013 but did not fix the problem which was the persistent nerve root compression from the facet hypertrophy, from the disc herniation, and the foraminal stenosis. Dr. Amin's goal appeared to be to take the screw away from the vena cava. He didn't believe that Dr. Amin's surgery was a violation of the standard of care either although he wasn't sure how someone would think fixing a screw would fix radiculopathy. (PX 12, pp. 25 – 27)

Dr. Trombly testified that Petitioner presented to him with a radiculopathy dating back to 2012 and that's all he looked into because he doesn't have time to go into the legal aspects of

these issues. He testified, "You know, it would be hard for me to do that, and so from a medical point of view, I was able to tell her why she needed more surgery, why I think we can help her, and why she never got the help in the first place, which was because the doctor is focusing on the vena cava rather than the nerve roots, etc. You know, so I don't really need to go and look at all those old records to tell her what's staring me in the face, someone whose leg doesn't work and her foot barely moves." (PX 12, p. 28)

Dr. Trombly testified that an emergency medicine specialist shouldn't be performing spine surgery or commenting on the appropriateness of spine surgery. He was of the opinion that Petitioner's care had been reasonable and necessary as she was having significant clinical problems between June and November of 2012. Both prior surgeries were reasonable just not successful. His surgery was successful because her radiculopathy is gone. (PX 12, pp. 28 – 30)

On cross-examination Dr. Trombly testified that it was his understanding that Petitioner was working as some sort of a mechanical person in a supervisory role and she got struck by something – a forklift or a cart. It had objects on it with mass and momentum thereby providing a significant impact and then she had significant problems thereafter. She described a period of time when she couldn't even move her legs and that persisted for several months. So, she got struck and never recovered. He recalled that she was struck by a forklift, walked away and went to the hospital and her right knee was evaluated (which, to the doctor, suggested a radiculopathy). He also testified that a big part of her problem by the time he saw her in 2015 was her neck with pain and significant weakness in her right arm which he didn't feel necessarily went back to her 2012 accident. Dr. Trombly recalled that when he saw Petitioner in August of 2015 she told him she had pain after her accident in November of 2012 and then she woke up from that surgery in November of 2012 knowing "something was wrong." Initially she had significant weakness as she was waking from anesthesia and then she had persistent pain and they found that the screw was impinging on the vena cava. The doctor acknowledged that the foregoing was based upon what Petitioner told him and not by reviewing any actual histories she provided to other providers. (PX 12, pp. 30 – 36)

Dr. Trombly was not aware that Petitioner was initially only diagnosed with a knee contusion but it would be irrelevant to his medical understanding of the case which is that her right leg symptoms persisted enough for some surgeon to perform surgery in November. The doctor was then asked about the fact she was released back to work four days after the accident and then worked approximately four months full duty without obtaining any follow-up treatment, would that change your opinion as to whether or not she sustained a more serious injury during this work accident and he replied, "It's not – it's not lost on me that if I spent more time reviewing the medical records I might come up with a different legal understanding of what caused her problems." (PX 12, p. 36)

Dr. Trombly testified that he was unaware of any other opinions from prior surgeons pertaining to Petitioner's care. (PX 12, p. 37)

Dr. Trombly testified that he did perform cervical spine surgery on Petitioner; however, he did not believe Petitioner's cervical spine surgery was related to her lumbar condition or her work accident. He testified that her initial symptoms were back pain, leg pain and weakness. (PX 12, pp. 16, 38) He further believed any records documenting Petitioner displaying symptom

magnification were all absurd. He did not know what a Waddell test was. (PX 12, pp. 38 - 40) Dr. Trombly was adamant that Petitioner had a radiculopathy that was created by her work-related injury and didn't improve for five months thereafter, resulting in a need for surgery. He didn't think there were any medical records showing she had chronic pain in her back and leg with foot weakness prior to her work accident. When asked if the fact she might have reported one accident history to him and a different one to other providers changes his opinion, Dr. Trombly testified "Again, no, it doesn't. I believe what she told me, and I believe all my patients when they come and tell me. I don't believe any patients exhibit symptom magnification or secondary gain or all this nonsense that doctors use to sweep patients under the rug." When asked if a patient's change in history over time causes him any concern, and he replied that in Petitioner's case, if the accident didn't occur, it would change his opinion. However, he did not consider it part of his job to make a medical decision for her and he believed her when she said she was at work and got struck. The force was irrelevant. The fact she may have never mentioned being struck by a forklift until about a year and a half after the accident might cause him some concern. However, "she did [say] she went to the hospital right away and I presume there's records related to that." (PX 12, pp. 37 – 47)

On redirect examination Dr. Trombly testified that prior to his surgery Petitioner had weakness in her right foot on dorsiflexion. She had chronic right ankle pain and was wearing a boot. Someone had diagnosed some sort of ankle fracture. Dr. Trombly testified that the weakness in her ankle could have been the cause of her fall and need for additional care in 2014 adding "That's the whole problem here – persistent radiculopathy eventually leads to weakness, falling." It's also all related." (PX 12, p. 48) Dr. Trombly also testified that degenerative disc disease, as Petitioner had, was aggravated by her trauma. (PX 12, p. 48)

Petitioner met with Dr. Gilling on December 12, 2015 due to itching and a runny nose. She complained of "itching" and "hives" for the last four years and told the doctor that since her accident and subsequent surgery she has had itching and recurrent hives occurring randomly on her face, arms, legs and back. She explained that the itching and swelling would last several hours and then resolve. The doctor ordered a mammogram and lipid panel. Petitioner denied feeling down or depressed but was intermittently crying and expressed feeling angry and sad about her disease process. She refused to speak with Psychology stating it was a waste of time. She was adamant she was not depressed. She had been using the Benadryl for her itching and swelling but it made her tired and sleepy. Petitioner reported that she continued to feel electrical currents when in a room or using her cell phone. She denied any visual or auditory hallucinations. Petitioner told the doctor that she would make an appointment with a psychologist if she felt she needed additional help. Petitioner also reported a concern with dribbling urine when going from sitting to standing or with coughing which had been an issue for her over the last four years since her accident and subsequent surgery. Petitioner told the doctor she believed it all stemmed from the mistake made with her back surgery four years earlier. Her last pelvic exam had been years ago and she agreed to schedule one. On exam her neck was normal in appearance, supple and without evidence of any masses. Her scar was well healed without any signs of infection. Neurologically, no sensory deficits, coordination deficits or problems with gait were noted. Muscle strength and tone were normal. Emotional/psychiatric observations were again noted with Dr. Gilling stating she was "focused and preoccupied with prior injury 4 years ago." She had no tenderness on palpation of the fingers or signs of joint swelling or instability. Muscle strength and tone were normal. Her social history included use of

marijuana. Treatment recommendations for her chronic urticarial and stress incontinence were discussed. The doctor was concerned for possible depression or personality disorder. She adamantly refused any follow-up. The doctor noted his plan included an appointment with Dr. Zitter for further assistance. She was to return in one week. (PX 11)

Petitioner was last seen at Advocate Medical Group on December 18, 2015, presumably by Dr. Gilling.[11] Petitioner was there for a "chief complaint of pelvic exam and hives." The record is incomplete so what transpired is unknown. (PX 11)

On June 1, 2016, Petitioner underwent a Section 12 examination performed by Dr. Carl Graf of the Illinois Spine Institute. Dr. Graf issued a 52 page report which included a detailed summary of Petitioner's medical records post-accident. He opined that Petitioner sustained a knee contusion on May 17, 2012, and was returned to work without restrictions. Dr. Graf opined that he was unable to attribute Petitioner's lumbar disc degeneration, low back pain and radiating leg pain as being related to her knee contusion. Dr. Graf opined that there was no evidence of an acute injury, disc herniation, nerve root compression or otherwise on her imaging studies. Dr. Graf opined that Petitioner's lumbar spine surgeries and cervical spine surgery bore no relation to her claimed work accident. Dr. Graf did not believe Petitioner needed any work restrictions. Dr. Graf opined Petitioner's subjective pain complaints could not be objectively substantiated. Dr. Graf did not recommend any additional treatment, regardless of causation. (RX 4)

On November 2, 2016, Dr. Graf was deposed. (RX 4) Dr. Graf is a board certified orthopedic surgeon. Only a small part of his practice involves independent medical examinations. Dr. Graf testified that in conjunction with his examination he reviewed her medical records regarding her alleged injuries and summarized them in his report. He related the history, physical examination, and summary of the records and depositions as contained in his written report (dep. ex. 2 therein). His physical examination of Petitioner on June 1, 2016 revealed a normal gait with no difficulty stepping up on her tiptoes or her heels. She could tandem gait although she noted back and leg pain. She performed a 1/6 squat which he considered a "minimal" squat and raised from it with pain being noted. With regard to her cervical spine exam, Petitioner noted hypersensitivity in the lateral aspect of her arm at her whole right side, including her face and lips. With regard to her lumbar spine she had forward flexion to the level of the knees with back discomfort and extension to 15 degrees. Her left lower extremity had full 5/5 strength. With her right lower extremity she was unable to break the strength of the doctor's single index finger in any motor group. Her left lower extremity neurologic exam was normal. On the right she had normal reflexes though decreased sensation and hypersensitivity throughout her entire leg, incorporating all nerve root distributions. Straight leg raise testing was positive on the right and negative on the left.

Dr. Graf testified that Petitioner's right hip exam demonstrated very limited internal and external rotation with severe complaints of pain. She also had pain complaints in the right groin over the right SI joint. She also displayed a number of nonorganic pain signs including pain out of proportion to the evaluation, non-anatomic motor loss throughout the entire right lower extremity, non-anatomic sensory loss throughout the entire right side of the body, non-anatomic

[11] Page 3 of the three page office visit is missing so the visit's notes are incomplete, incl. who examined Petitioner.

distribution of upper extremity hypersensitivity and numbness, and non-anatomic distribution of lower extremity hypersensitivity and numbness. (RX 4, pp. 1 -11) Dr. Graf summarized his findings as showing a number of inconsistencies as she had regional distributions of numbness, loss of sensation and weakness but no corresponding specific nerve root distributions. (RX 4, pp. 11 -12) Based upon his exam, he felt Petitioner had subjective complaints of pain which he could not objectively substantiate. (RX 4, p. 13)

Dr. Graf further testified that as a result of the work accident he felt Petitioner suffered a knee contusion. He felt there was no discernible evidence that she suffered any acute lower back injury. Dr. Graf testified that Petitioner's initial lumbar spine of August 21, 2012 was of particular note because of the lack of any significant findings. There was no lumbar disc herniation, no nerve root compression and only some mild degenerative changes at L5-S1. He did not feel her three lumbar spine surgeries and cervical spine surgery were related to her work accident. When asked if Petitioner's first lumbar spine surgery was medically necessary and should have been performed, he responded "That's a very good question. You know, there's minimal degeneration at that level, at L5-S1, and no nerve root compression, no disc herniation. It was initially noted by her care provider that a lumbar fusion would be done at the 'last resort.' That was subsequently performed, and then it appears that she had continued subjective complaints of pain thereafter." (RX 4, p. 13 – 14, quote at p. 14)

Dr. Graf disagreed with Dr. Harms' belief that Petitioner had lumbar stenosis. There was some minimal degeneration but nothing significant. He also disagreed with Dr. Trombly's causation opinion because the doctor simply took Petitioner's story at face value and didn't review the extensive medical records and numerous imaging studies pertaining to Petitioner. (RX 4, pp. 14 – 15)

Dr. Graf testified that when a patient presents with numerous inconsistencies you often begin to question their subjective complaints of pain. In Petitioner's case, she initially had complaints of knee pain and swelling. After care and treatment, she now complains of headaches, neck pain, hip pain, leg pain, intermittent vertigo, loss of balance, and numbness all the way from her face and lips down the entire side of her body – "That can't be substantiated from this type of injury." (RX 4, p. 16)

Dr. Graf was also asked about Dr. Klisiewicz's theory of Petitioner sustaining a significant pelvic obliquity and sprain of the pelvic ring ligaments which the doctor disagreed with noting there is no evidence that such a theory exists. He acknowledged that she had an MRI showing an acute tear of the pelvic ring ligaments but one would see edema on the imaging studies. (RX 4, p. 17) When sked if the radiographic films he reviewed presented any evidence of a real objective problem he replied, "Well, …there's this question of the mal-positioned screw, which there was partial evidence of such." (RX 4, p. 17)

Dr. Graf further testified that if Petitioner had sustained any traumatic injury to her lumbar spine as a result of the accident he would have expected to see evidence of such on the MRI taken three months after the accident. Additionally, the fact that she had a normal EMG has to be measured against her subjective complaints and provides objective evidence negating her subjective complaints and in light of the theory that there was an injury to one of her nerves due to the possibly mal-positioned screw, that would have shown up on the EMG. He further testified

that if Petitioner had sustained any traumatic injury to her low back as a result of the work accident he would have expected her to seek medical treatment for her back earlier than two months post-accident. (RX 4, pp. 17 – 19)

Dr. Graf went on to testify, as stated in his report, that Petitioner had an accident followed by back pain and then, unfortunately underwent a surgery whose need, regardless of causation, was questionable. That was then followed by two other lower spine surgeries. One also, according to the doctor, has to keep in mind that her initial imaging studies showed minimal degeneration which the doctor could not find related to her initial injury given no disc herniation or nerve root compression. Thus, he did not feel the other lumbar spine surgeries which related to that initial surgery would be causally related to her accident. (RX 4, pp. 19 – 20)

On cross-examination Dr. Graf testified that he put all of the medical records in his report that he reviewed other than some irrelevant primary care doctor notes pertaining to a cold or something like that. He acknowledged that he did not review a pre-employment physical performed on Petitioner. He was asked if knowing she had been given a clean bill of health regarding her back would change his opinions and he replied "No." (RX 4, pp. 22 – 23)

Dr. Graff was asked about the fact he would have expected her to have been evaluated earlier than two months after the accident if she had a back problem and he acknowledged that she did see a chiropractor four days after the accident and the chiropractor's records mentioned central back pain. He also testified that when Petitioner saw Dr. Harms or Carle Clinic thereafter she did not have spinal stenosis but she did have mild degenerative disc disease. He also testified that while Dr. Harms noted surgery would be considered if all else failed, Dr. Graf saw little evidence of a workup as far as discograms or "whatnot" which would be considered usual or customary in the evaluation of that type of patient. (RX 4, pp. 23 - 24)

Dr. Graf also acknowledged that his physical exam of Petitioner on June 1, 2016 was positive on the right when performing the straight leg raise test. He testified that the response is "kind of" a subjective one and objective at the same time. A positive finding means that someone is complaining of radiating leg pain as the leg is being stretched and it can indicate a disc herniation or nerve root pressure. She also displayed subjective signs of radiculopathy on the right side and "exquisite complaints of pain when rotating the hips which would suggest hip pathology. Dr. Graf also testified that his exam indicated severe complaints of pain with palpation over the SI joint. (RX 4, pp. 24 – 26)

Dr. Graf was asked about the normal recovery time for a fusion patient and he believed it would be about 12 to 14 weeks with MMI for a one-level fusion expected within six months. Dr. Graf did feel Dr. Amin's surgery was reasonable give the malaligned screw. (RX 4, p. 27)

Dr. Graf was asked if a condition can worsen from spinal stenosis and he replied "It's possible." He also acknowledged it can worsen from a torsion-type accident. However, he added that he didn't see any spinal stenosis in Petitioner and, even if she had it, the surgery for spinal stenosis would be a lumbar decompression, not a fusion. Dr. Graf based his opinion that Petitioner did not have spinal stenosis on the MRI film. When asked if reasonable medical minds might differ on the issue of whether Petitioner had spinal stenosis the doctor replied that it would probably depend on who was looking at the MRI. He feels it is fairly obvious if it is present

because one would see narrowing but it also depends on where it is coming from. With a big disc herniation one can have spinal stenosis but it would be a big disc herniation. Dr. Graf explained that typical spinal stenosis is due to degeneration where one has bulging of a disc pushing back and causing narrowing of the front part of the spinal canal and enlargement of the facet joints. (RX 4, pp. 27 -29)

Dr. Graf acknowledged that he was unaware of any medical treatment received by Petitioner for her spine prior to May 17, 2012. (RX 4, p. 29)

Dr. Graf believed that less than 10% of his practice was made up of medical legal work. (RX 4, p. 30)

Dr. Graf was asked what a "tandem gait" was and he explained it refers to one's balance. He compared it to walking a line for a police officer. In Petitioner's case, that test was normal although she complained of back pain. He also agreed that it would not be normal for someone to have back pain while performing that test. When asked if one had a spinal condition would it be normal for them to have back pain while performing the tandem gait test and the doctor replied, "Not really" as usually one does not complain of back pain with that test so that's why he noted it in his report. (RX 4, pp. 30 – 32)

When asked how a reaction to titanium implants would manifest itself, the doctor testified that such a reaction is extremely rare. He had published a study on implant sensitivity and reactions to implants while at Loyola and so titanium is really neutral. He went on to testify that one can have reactions to cobalt-chrome and nickel (although it, too, is quite rare). If one truly had a reaction to titanium one would see reabsorption of the bone around the implant with loosening but that could be due to other causes such as infection, nonunion, and things like that. (RX 4, pp. 32-33)

The Arbitration Hearing

Petitioner's case proceeded to arbitration on March 8, 2017. The disputed issues were causal connection, temporary total disability benefits, medical expenses and nature and extent of injury. Kim Stewart was present as the representative for Manpower. At the beginning of the proceeding Respondent, National American Lighting, was voluntarily dismissed as a party respondent. Those testifying at the hearing were Petitioner and Ms. Stewart.

Petitioner testified that she currently resides with her ex-husband in Oak Lawn, Illinois. She is not presently employed as she is on disability.

Petitioner testified that she was working at North American Lighting on May 17, 2012 on a temporary basis through Respondent[12]. When asked if anything unusual happened that day, she replied that they were getting off of work and then she "got hit." Petitioner testified that she worked the 5 P.M. to 4 A.M. shift. She was performing her job and wearing headphones and ear plugs and had work boots and a power drill because she was taking some screw off a Ford

[12] All references to "Respondent" during the hearing refers to Manpower.

Mustang head lamp. Her head was down and she couldn't hear anything. The next thing she knew was that she had "shifted" and moved and was not in the same position she had been.

Petitioner did not see the person who hit her because she was working. When asked what struck her, Petitioner replied, "I don't – it's like a cart, and it had like crates behind it that it would trail behind. We had a robot and I guess the robot was coming. I don't know. She tried to explain to me but….." When asked to describe the cart she said it had crates where they would place head lamps for vehicles. Petitioner did not know if Amy, the cart driver, was standing or not because her head was down and she couldn't see her. Petitioner's attorney asked her if Amy was driving a forklift and Petitioner replied that, to her, it looked like "a little forklift" as it was motorized and there were four or five trailers behind it. As Petitioner described it, it's a little "choo choo train" so they can carry more product.

Petitioner further testified that she felt a little jolt "each time" and her table is what actually pushed her. She had a cart she would push around and after it hit she ended up pushed against the table and her cart was pushed against her and her upper body was twisted. Petitioner testified that her legs stayed in place but her upper body twisted "somewhat." Petitioner testified that the table struck her and pushed her like three times every time it hit. The cart (her cart) was pushed into her and so every time it hit her she was pushed more and more against (what she thought was) the conveyor/assembly line.

Petitioner testified that Amy went to find someone but nobody came so she walked over to her supervisor and reported the accident. She completed an accident report at that time. She got off work at 5:00 A.M. and went home. At that time nothing hurt except her leg and hip.

Petitioner believed that she went to the doctor on the 17th. She went to Paris Community and told them her right leg and groin hurt. She was told she could go back to work. She went home and when she woke up she couldn't move. Petitioner testified that she then telephoned her children to come from Chicago and get her so she could seek medical care in Chicago. At that point in time Petitioner felt her right buttock hurt all the way down to the tip of her toe and in her lower back.

Petitioner testified that when she got back in the Chicago area she went to a chiropractor who did manipulation and massage therapy and made it worse. While treating with the chiropractor she complained of her hip and the entire right side of her body down to the tip of her toe. The doctor treated her whole right side, right knee and low back.

Petitioner testified that she then saw Dr. Harms at Carle Clinic and he told her she could get injections for her pain and if they didn't work she would need surgery. Petitioner testified that Dr. Harms performed surgery eventually. When asked what surgery he performed, Petitioner explained that she had "like a sciatica" and some nerve damage and that he just said it would take the pain away in her back because when she twisted she did some damage. When asked if she understood what type of procedure she underwent with Dr. Harms, Petitioner testified that to this day she still doesn't know the name of the procedure she underwent but screws were put in her back. When asked how the surgery went she testified that she had a screw implanted in her iliac vein that left her with severe nerve damage on her right side which led to a second surgery

to remove the screw but they still didn't fix the problem until the third surgery and then she was told she had failed back surgery.

Petitioner agreed that after her treatment at Carle she began treating at Loyola because her children made her and they had better doctors. Petitioner testified that Dr. Amin performed her second surgery and she saw quite a few other doctors at Loyola such as Dr. Klisiewicz and others for other injuries like her leg injury which "nobody can still work on to this day."

Petitioner further testified that at some point she began treating at Christ Advocate Hospital because she started feeling nerve pain in her entire right side and her foot would fall asleep and her doctor at Loyola was moving to Florida so she had to find another doctor closer to home to make transportation back and forth from home easier as her kids had to take her to and from the doctors' visits because she couldn't drive due to the foot drop caused by the nerve damage. Dr. Gilling was her primary care doctor at Advocate. He diagnosed her with failed back syndrome and he recommended she see Dr. Trombly, a neurosurgeon. Petitioner testified that Dr. Trombly performed a fusion around August 24, 2015. She last saw him in December of 2015 at which time he told her not to lift more than a gallon of milk or to lift her grandchildren who she described as "very fat."

Petitioner was asked how she began treating with Dr. Harms and she explained that she "guessed" it came from Paris Community Hospital as there is no major hospital out there so Carle was the closest. She could not recall who actually referred her to him.

Petitioner was asked what, if any, problems she still has with her back and she replied that "every day since the night – also right after my third back surgery three days later because of the nerve damage and drop foot it caused I have also had to have neck surgery as well." As for her problems, she explained she has pins and needles and neuropathy throughout her whole right side which she never had before. When asked if she has had to make changes in her life, Petitioner testified that she has gone from working to being on social security disability and she is homeless and lives with her ex-husband because she has lost everything. Petitioner further testified that her son had to drop out of college to take care of her.

Petitioner also testified that she is prescribed about 12 different prescriptions but she doesn't take any of them as she just seeks meditation and exercises. She also testified to taking a lot of Naproxen and Ibuprofen and "stuff like that" but they don't do anything.

Petitioner testified that due to the fact she is on disability she won't be able to hold her grandchildren and that's a long-term effect of her condition. When asked if the doctor indicated she needed any further medical care, she replied "Yes" indicating she had postponed an appointment because she wanted to get "this over and behind her" and they now have to go in for a fourth back surgery and second neck surgery to put rods in her neck.

Petitioner testified that it takes every ounce of her being to just get up and get dressed. She has no life but used to have a wonderful and beautiful life with four beautiful awesome children and now she doesn't get to enjoy that with them anymore. She can no longer do the active things she once did and the constant pain and worry over falling. Petitioner testified that she has to take Lyrica due to all the nerve damage.

On cross-examination Petitioner denied completing two different accident reports. She only thought she filled out one at her job. When asked if she completed an accident report from Respondent (Manpower) she replied she might have and she thought she did but it was five years ago and she can't remember dates because "when one has nerve damage your nerves go from your feet to your brain." She did identify RX 5 as bearing her handwriting.

Petitioner also agreed that RX 3 bore her handwriting. She agreed that she wrote "Amy's cart hit [my] cart and then pinned [my] leg." When asked if Amy's cart directly hit her, she testified that her head was down so she couldn't say "yes or no" but she didn't believe Amy's cart physically hit her person; rather, she thought it hit her cart. She also testified to being hit from the left side and left hip and then twisted and her right leg got pushed against "whatever" and then she twisted again and twisted again. Petitioner testified that the foregoing was all that she remembered.

Petitioner agreed that she completed a pain drawing on the NAL accident report and that she only circled her knee but it was done within about ten minutes of the accident and that's what hurt at the time. She acknowledged that the report said nothing about twisting but she was "pretty sure" she got twisted three times. She agreed that she was now "pretty sure" but at the time of the report being completed she wasn't sure because she wasn't thinking about "what was going to happen." She also agreed that the bruise, pain and swelling in her knee happened instantly.

Petitioner testified that the second accident report for Respondent Manpower was completed a few hours later after leaving the hospital because she went straight there. She agreed that she indicted she had injured her legs. When asked if she had an opportunity to put any other injuries she may have had at that time, she replied that "it would have been a lie."

Petitioner was asked if she ever told any providers that she was hit by a forklift and she replied, "You know, I never said forklift. I said a cart. It resembles a forklift because they drove it." Petitioner denied ever personally saying she drove a forklift and she denied being hit by a forklift; rather it was a "forklift cart." When asked if she disagreed with entries in her medical records that state she reported being hit by a forklift, Petitioner replied "No." She explained that she may have said that after being asked what was the machine that hit her and she was told a forklift so that's what she told them.

Petitioner acknowledged being examined by Dr. Graf. When asked if she told him she was hit by a forklift she replied that she told him what she told everyone else – that is, her cart got hit by whatever instrument that lady was driving but she didn't know its technical name. However, it was like a small forklift because that's what one of her fellow employees told her it was.

Petitioner agreed that when she filled out the two accident reports she knew it was her cart that hit her. She explained that her cart hit her after somebody hit it. A forklift never "per se hit" her. According to Petitioner she reported what happened – her cart hit her. She did not know if Amy was driving a forklift or a cart because she isn't Amy.

Petitioner also denied telling the Paris Community medical personnel on May 17th that she was hit in the legs. She reported the cart had hit her and she was twisted – that is, her body twisted.

Petitioner was also asked if she sought chiropractic care for a few occasions and then didn't seek any medical care for the rest of the summer to which she responded that she didn't have insurance and she was told she had to prove her injuries. She was trying to get medical care but had to get insurance through Medicaid and it took a while. The chiropractor was treating her because workers' compensation was covering that at the time. Petitioner testified that she didn't follow up at Paris, even though workers' compensation was paying for it, because she moved. Petitioner explained that she moved two days after the accident because she couldn't take care of herself. According to Petitioner she had no one to take care of her and her kids were in school and younger so she had to go back home to be taken care of by her children.

Petitioner could not recall if she ever contacted Respondent to see if it would authorize treatment with another provider. According to Petitioner at some point Respondent told her to prove her accident as it wouldn't pay anything further.

Petitioner was asked if she was aware that Dr. Harms had diagnosed her with degenerative disc disease and she replied that she didn't know what that was. She also didn't know if he had ever provided an opinion on causation but she knew he knew she got hurt at work. She also agreed that the neck surgery isn't from the accident but she feels it was from the drop foot and the fact she walked around "crooked" and with a lot of "damage" so it was a result of her injuries but not a result of the accident.

Petitioner testified that she has continued to seek treatment since December of 2015 and she has had two more surgeries. She sees a doctor every three months.

On redirect examination Petitioner was asked if she ever reported a back injury to Respondent and she testified that about two days after the accident or so she called and said she couldn't make it to work and she didn't know what was wrong with her back. She testified that she was told if she doesn't make it in she will be fired. Petitioner clarified that she didn't say her back was injured; rather, she said something was wrong and she felt like she couldn't move. Petitioner could not recall the name of the lady she spoke to. She also recalled dropping paperwork off to Respondent after leaving the hospital.

Petitioner also testified that she had chiropractic treatment through July and then proceeded to treat with Dr. Harms in August. She also agreed that she initially underwent an epidural injection with Dr. Harms and it didn't work as she had bad side effects. She also testified to bad reactions from "medicine and stuff."

Respondent's witness, Kim Stewart, testified that she is the branch manager at Respondent and familiar with Petitioner and her 2012 work accident. Ms. Stewart testified that the first time she has ever been made aware of Petitioner's allegation of being hit by a motorized cart, or "tugger," was earlier in the arbitration hearing. She testified that she would have been made aware of this information if Petitioner had ever previously reported such. Ms. Stewart

testified that Petitioner was never terminated from Respondent and, instead, Respondent had reached out to her to inquire whether she would be returning to work on May 21, 2012.

Petitioner's medical bills are found in PX 14 – 22.

Petitioner's employment records with Respondent are found in PX 13b.

The Arbitrator concludes:

(F) IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO HER WORK INJURY?

Petitioner failed to prove that her current condition of ill-being is causally related to her accident of May 17, 2012. Petitioner did prove her condition of ill-being in her right knee and low back was causally related to her work accident but only up until August 27, 2012. Petitioner failed to prove that she sustained a medial meniscus tear in her right knee as a result of her work accident. Dr. Platt's diagnosis on August 27, 2012 was that of a knee strain and he really felt she needed to have her back complaints addressed first as he felt that might be the more significant problem. A medial meniscus tear was never diagnosed with certain. Dr. Wojchiehoski credibly explained why he didn't feel Petitioner had sustained a medial meniscus tear, noting both the lack of objective findings to support the diagnosis and that the mechanism of injury would not have caused such a tear. Dr. Belich did not diagnose a tear.

Petitioner also failed to prove that the degenerative disc disease diagnosed by Dr. Harms on August 27, 2012 and/or the lumbar spine surgery later performed by him in November of 2012 were causally related to her work accident. When examined by Dr. Harms/CNP Barrett on August 27, 2012 Petitioner gave a history of having been "run into by another employee." She provided no further details. At that time it was felt that she had a prematurely aging disc in her back that could be accounting for her back and leg symptoms. Dr. Harms provided no causation opinion. While Dr. Harms was deposed (RX 4, dep. ex. 2), his deposition testimony was not introduced by either party. The summary contained in Dr. Graf's report stands on its own and negates a finding of causation. Additionally, Dr. Graf's opinions negating causation, as will be discussed below, were persuasive.

Petitioner further failed to prove that any of her treatment beginning on January 8, 2013 and thereafter was causally related to her work accident.

There is no dispute that Petitioner sustained an accident on May 17, 2012. There is some question as to the details of the accident/ exact mechanism of injury and the Arbitrator cannot help but note how the details of the accident have changed and varied over time. Petitioner's initial accident/injury report indicates that a co-worker's carts ran into Petitioner's carts and "pinned [her] leg in the cart and table. (PX 1) The other work report states a cart smashed into her work station and pinned her legs under the table." (RX 3) The first mention of Petitioner's cart being struck by a "tugger" came at the arbitration hearing almost five years post-accident. Respondent's witness credibly testified that Petitioner's description of the accident as involving a "tugger" was news to her at the time of the hearing. Despite how seriously Petitioner may have described her accident at arbitration, looking at Petitioner's original accident reports, pain

drawing, and initial histories given to treaters, nothing suggested, objectively, a force of impact quite as dramatic as the one Petitioner suggested at the arbitration hearing. At no time throughout the pendency of this claim has Petitioner attempted to clarify the details of the accident in an effort to tie things together. To the contrary, her histories over time have been inconsistent and varying with many of them being very contrary to medical evidence in the record (such as the history to Dr. Trombly about waking from surgery and having problems). Based upon Petitioner's testimony at arbitration, she was hit by her own cart on the left side (via another cart or "tugger") and pushed into her work table. "She" was not hit by another employee, "she" was not hit by a forklift, "she" was not hit by a co-worker's cart, nor was "she" hit by a "tugger."

Petitioner presented to Dr. Belich on January 17, 2013. She claimed a machine struck her on the left knee and she twisted her right knee. Petitioner saw Dr. Amin on January 25, 2013 and described the accident as involving a cart that hit her causing her to "twist" her entire body followed by severe back pain and the inability to move. While this history is close to what may have happened, Dr. Amin provided no causation opinion nor did he review her prior treatment records. Petitioner was seen for therapy at Loyola on April 29, 2013 and described her work accident as involving being "pinned against a wall at work with machinery." Petitioner told Dr. Klisiewicz on October 31, 2013 that she had been run over by a forklift (with a load) and pinned between a wall and table with her pelvis being rotated to the left. (PX 9) Petitioner underwent a second examination with Dr. Wojciehoski on October 1, 2013. She described working on an assembly line when a worker ran into her, crushed her lower leg and caused her to twist her back. Petitioner presented to physical therapy at Loyola on October 29, 2013 describing her mechanism of injury as being hit and torqued to the right as a bench with all her power tools (over 500 lbs.) had trapped her against the wall. Petitioner presented to Loyola's Osteopathic Physical Medicine and Rehabilitation Department on October 31, 2013 describing her accident as being run over by a forklift (with a load) and being pinned between a wall and a table with her pelvis being rotated to the left. Petitioner presented to Dr. Jacobs at Advocate Medical Group on May 29, 2015 and gave a history of chronic low back pain and right-sided upper and lower extremity paresthesia since a work accident in which a forklift ran into tables and then the tables hit her and she wound up with multiple back surgeries. Petitioner presented to Dr. Gilling at Advocate Medical Group on June 11, 2015 regarding a bump on her left upper arm of one year's duration. She was also following up for right-sided numbness and back pain which she related to a screw being put in the wrong place in her back. On July 30, 2015 Petitioner presented to Dr. Trombly reporting she had been struck by a forklift and walked away and went to the hospital where her right knee was evaluated. The next day she couldn't move her legs when she woke up due to pain. She also reported waking up after her first surgery and being unable to move her legs until she had an "adjustment." None of these histories were corroborated by Petitioner's testimony at the hearing.

To this Arbitrator it appears that, for whatever reason, Petitioner has been focused on her disability since shortly after the accident. She was quick to latch on to certain aspects of what treaters were telling her, such as possible diagnoses, and focus in on them with no apparent understanding that these doctors had not definitively diagnosed her with them. For example, Petitioner was telling her doctors early on that she had a medial meniscus tear when both Dr. Platt and Dr. Belich ruled it out or felt such tear was very, very insignificant and certainly didn't warrant surgical treatment. While doctors told Petitioner she "could" have certain problems (for ex. a labral tear, a possible vascular injury from a screw, and a labral tear in her hip) she often

appears to have misinterpreted them as she was never definitely diagnosed with any of those injuries.

Petitioner's efforts toward recovery were confusing and inconsistent. She did not follow up with doctors or treatment plans, she limited the extent of examinations and therapies due to perceived injuries and she painted a very confusing picture regarding her use of medications. While Petitioner testified to ongoing treatment since December of 2015 none of those records were introduced in support of her claim. Based upon her examination in December of 2015 she was not reporting any back, let, hip or groin complaints. Instead she was now focused on complaints of itching and facial swelling which she felt related back to her accident and/or initial surgery. Even the doctor expressed concern at that time that she was too focused on her accident.

Petitioner's demeanor and presentation at the arbitration hearing was "unusual" as were other aspects of her behavior set forth in the medical records. Numerous doctors have suggested that Petitioner seek psychological or psychiatric counseling and it appears that she may have done so; however, no records were admitted into evidence. Petitioner claimed at her hearing that she is unable to do anything but her medical records have shown she has traveled to Florida, to Wisconsin, to Arizona and to Texas. She shopped while vacationing in Wisconsin which is when she fell and hurt her right ankle. She also claimed having to live in the Chicago area to have family take care of her because she could not take care of herself; however, at one point she wasn't attending physical therapy because she was taking care of her grandmother. None of these inconsistencies were addressed by Petitioner at the time of trial, thus leaving many questions in this Arbitrator's mind as to the full extent and nature of Petitioner's difficulties. Furthermore, there was a "disconnect" during much of Petitioner's testimony at arbitration as though she was present but not entirely present. At times, she appeared to have trouble focusing. She denied the use of medications in favor of a more holistic approach to pain management; however, she then contradicted herself by stating she was using some medications. Her medical records have indicated that also. Exactly when, and what degree, was somewhat of an unanswered question. The Arbitrator cannot speculate as to causation, especially when, as here, there are inconsistent histories, gaps in treatment, and many unexplained issues and concerns. Medical records were lacking, such as the visit to the family doctor that led to the chiropractic referral shortly after the accident. Also problematic was the notation in NP Wallace's note in August of 2012 regarding the referrals to an orthopedist and neurosurgeon wherein she noted Petitioner had a history of knee problems for three months and a "history of back problems for over a year for which she had undergone physical therapy and injections." This would have pre-dated her accident. In light of Petitioner's denial of prior problems with her back before her accident herein, Petitioner's failure to address this contradictory note in her records was very troubling and of concern regarding causation.

The Arbitrator has also considered the deposition testimony of the various doctors: Dr. Trombly, Petitioner's treating surgeon; Dr. Graf; and Dr. Wojciehoski. Their opinions have been carefully considered with the Arbitrator finding Dr. Graf's opinions to be the most persuasive and well-informed.

On the issue of causation for Petitioner's low back condition and multiple surgeries, the Arbitrator has weighed the opinions and testimony of Dr. Trombly and Dr. Graf. Petitioner gave Dr. Trombly an incorrect history from the beginning claiming she had woke up from surgery in

November of 2012 knowing something was wrong and she "manipulated herself" and then she "felt her whole right side." She reported persistent back pain and leg pain thereafter. She reported being unable to dorsiflex her right ankle since November of 2012. The Arbitrator has extensively reviewed Petitioner's hospital admission records from the November of 2012 surgery and there is no corroboration for this history.

Dr. Trombly testified that, in his opinion, it did not matter whether Petitioner was hit by a forklift or a cart. He testified that the most important factor in his opinion was that Petitioner didn't have any prior history of back treatment and then she was in a work accident which caused right radiculopathy in her lower extremity that necessitated surgery. However, Dr. Trombly testified he had not reviewed Petitioner's prior records. He testified to opinions included in Petitioner's prior medical records without having ever reviewed them himself. He testified, "it's not – it's not lost on me that if I spent more time reviewing the medical records I might come up with a different legal understanding of what caused her problems." He testified that he believed any records documenting Petitioner displaying symptom magnification were all absurd. The Arbitrator respectfully disagrees noting her discussion above and the fact that numerous doctors, both examining and treating, have commented on Petitioner's inconsistent presentations from time to time. Furthermore, Petitioner may have undergone some treatment to her back before the accident.

Dr. Graf is a board-certified spine surgeon. Dr. Graf was afforded an opportunity to review all of Petitioner's medical records, accident reports and radiographic films. He authored a very thorough report of such. He did not believe Petitioner's first surgery was medically indicated or necessary. He was unsure why Dr. Harms would have performed the procedure that he did. He disagreed with Dr. Klisiewicz's and Dr. Trombly's opinions regarding the low back and hips. Dr. Graf testified that Petitioner's lumbar spine surgeries bore no relation to her work accident. He testified Petitioner's subjective pain complaints could not be objectively substantiated. He testified Petitioner suffered a right knee contusion due to her May 12, 2012, work accident. While he acknowledged on cross-examination that a torsion-type accident could worsen spinal stenosis in one's back, he did not feel Petitioner had evidence of spinal stenosis. However, even assuming he was wrong in that regard, he did not testify that such a torsion-type accident/movement would permanently aggravate the spinal stenosis. Thus, the Arbitrator has considered the possibility of the accident causing a temporary aggravation to Petitioner's back but it did not cause the need for the surgery performed by Dr. Harms.

As for Petitioner's cervical spine surgery, both Dr. Graf and Dr. Trombly agree that it was not related to Petitioner's May 12, 2012, work accident. There is no other medical opinion relating Petitioner's cervical spine surgery to her May 12, 2012, work accident.

Petitioner also failed to provide any expert opinion testimony regarding any left lower extremity complaints, her right-sided complaints and symptoms, her hives, her right hip/groin complaints, and any emotional problems. As such, none of these problems are found to be causally related to her work accident.

In summary, the Arbitrator finds that Petitioner injured her right knee at the time of the accident and sustained bruises/contusions and a strain to it. The Arbitrator also finds that Petitioner sustained a low back strain with some right leg radiculopathy and hip pain at the time

of the accident. Such a strain would be consistent with the mechanism of injury and is supported by the medical records issued early on after the accident. The Arbitrator, however, is unable to find that the surgery performed by Dr. Harms (or any others thereafter) were causally related to the work accident. Petitioner also failed to prove by a preponderance of the credible evidence that her cervical neck surgery, right-sided bodily complaints, groin pain, and any emotional problems were causally related to her accident of May 17, 2012.

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

Respondent is found liable for Petitioner's medical bills incurred by her through August 27, 2012. They include: (1) Advantage Chiropractic & Rehabilitation in the amount of $4160.00 (PX 19); (2) Office visits with Carle Physician Group on 8/27/12 - $620.00 (PX 17) ; (3) Family Medical Center bill for service on 5/17/12 - $99.90 which appears paid by w/c (PX 18); (4) Paris Community Hospital testing on 5/17/12 - $1126.00 which appears paid by w/c (PX 19); (5) Paris Community Hospital; Family Medical Center Chrisman visit on 8/16/12 - $99.90 which appears paid by Medicaid (PX 19); and (6) Paris Community Hospital MRI on 8/21/12 - $5,098.00 which appears paid by Medicaid (PX 19). The total amount of the bills awarded is $11,203.80. Consistent with her causation determination all other medical bills are denied. The Arbitrator adopts her findings on causal connection herein. Respondent shall receive credit for any bills it has paid through its workers' compensation carrier as shown in PX 18 and PX 19. While the attorneys discussed the issue of credit for medical bills prior to the hearing the discussion was somewhat unclear and the bills themselves show payment by the workers' compensation carrier. Therefore, Respondent should receive a credit for what it has paid previously.

(K) WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

Petitioner is awarded temporary total disability benefits from May 18, 2012 through July 16, 2012, a period of 8 4/7 weeks. In support thereof the findings and conclusions of the Arbitrator on the issue of causal connection are adopted and incorporated herein. Dr. Shroba had Petitioner off work during that time. Except for Dr. Klisiewicz's note of May 29, 2014 (PX 9), no other doctor issued an off work slip after July 16, 2012. Dr. Klisiewicz failed to indicate that Petitioner needed to be off work for a work-related problem, however.

(L) WHAT IS THE NATURE AND EXTENT OF THE INJURY?

Pursuant to Section 8.1b of the Act, for accidental injuries occurring after September 1, 2011, permanent partial disability shall be established using five enumerated criteria, with no single factor being the sole determinant of disability. Per 820 ILCS 305/8.1b(b), the criteria to be considered are as follows: (i) the reported level of impairment pursuant to subsection (a) [AMA "Guides to the Evaluation of Permanent Impairment"]; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. Applying this standard to this claim, the Arbitrator notes as follows:

There was no impairment rating submitted by either party; therefore, that factor is given no weight. Petitioner was a rework operator through Respondent's temporary staffing service. Petitioner's inability to return to work for Respondent was not due to the right knee contusion/sprain or low back strain. Petitioner failed to return to work after July 16, 2012. Petitioner was 41 years old at the time of her injury. Petitioner was released to work without restrictions four days after her work accident. She then underwent chiropractic treatment for her right knee and low back for a couple of months followed by a gap in treatment for one month between July and August of 2012. Petitioner underwent conservative treatment for a right knee contusion/sprain and low back strain. She then proceeded to treat for several more years for conditions unrelated to her accident. No evidence was presented as to any loss of future earning capacity due to her strain and sprain/contusion. The Arbitrator gives some weight to Petitioner having undergone minimal, conservative treatment for her right knee contusion/sprain and low back strain.

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 2.5% loss of the right leg, as provided in Section 8(e) of the Act and 3% man as a whole for her low back strain with radiculopathy, as provided in Section 8(d)1 of the Act.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF McLean)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jeremy Reynolds,
Petitioner,

vs.

NO: 13WC 40126

Multibrand,
Respondent,

18IWCC0197

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causation, temporary total disability, medical, permanent partial disability, penalties, fees, "Intoxican Defense" and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 27, 2016, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 2 - 2018

Charles J. DeVriendt

Joshua D. Luskin

o013018
CJD/rlc
049

DISSENT

Pursuant to Section 11 of the Illinois Workers' Compensation Act, a rebuttable presumption exists which finds an employee was intoxicated and such intoxication was the proximate cause of his injury "if there is any evidence of impairment due to the unlawful use or unauthorized use of ...(1) cannabis as defined in the Cannabis Control Act...The employee may overcome the rebuttable presumption by the preponderance of the admissible evidence that the intoxication was not the sole proximate cause or proximate cause of the accidental injuries." *820 ILCS 305/11* (West 2013). I believe the evidence does not support a finding of unlawful or unauthorized use of cannabis nor does it support a finding of impairment. Therefore, I respectfully dissent.

Petitioner testified he neither smoked nor ingested marijuana prior to the accident. T. 29. Petitioner testified he was exposed to second-hand smoke while preforming his work as an installer. T. 30. Petitioner admitted he did not advise Respondent of this exposure but explained it was his understanding Respondent left it to the discretion of the installer to perform the work if such conditions were present. *Id.* On cross-examination, the only testimony elicited regarding Petitioner's marijuana use is as follows: "Q. As I understand it, shortly after this accident occurred, you were notified that the drug test you took was positive and that you were terminated, correct? A. Correct." T. 38.

Certainly, the Arbitrator and/or the Commission majority is not required to accept unrebutted testimony, but such rejection of testimony cannot be arbitrary. *Sorenson v. The Industrial Commission*, 281 Ill. App. 3d 373, 666 N.E.2d 713 (1996). The Arbitrator and thereby the Commission in rejecting Petitioner's testimony as to exposure based the same on Petitioner's failure to provide specifics as to where and when the exposure occurred. Petitioner testified unequivocally he was exposed to second-hand smoke while performing installations. As Petitioner was never questioned regarding the specifics of the exposure, finding that his failure to provide answers renders him not credible would appear arbitrary. I do not find there is evidence of unlawful or unauthorized use.

Further, for the rebuttable presumption to apply, evidence of impairment must be presented. The only evidence in the record regarding Petitioner's marijuana use is RX1 evidencing positive marijuana metabolites at an initial test level of 50 ng/mL. There is simply no evidence prior to Petitioner's accident that he was impaired. Section 11 of the Act specifically defines intoxication for alcohol to equal "0.08% or more by weight of alcohol in the employee's blood, breath, or urine..." *820 ILCS 305/11* (West 2013). The statute does not define intoxication by specific amounts as it relates to marijuana use given the state of the present medical science but instead requires a showing of impairment. Therefore, a positive test result does not presuppose impairment.

18IWCC0197

Immediately following the accident, the Illinois State Police investigated the accident. An Illinois Traffic Crash Report (PX1) evidences no citations were issued. Petitioner was seen at St. Joseph Medical Center approximately one hour following the accident. PX2. The records evidence Petitioner "is alert and oriented to person, place, and time. No cranial nerve deficit. He exhibits normal muscle tone. Coordination normal…He has a normal mood and affect." PX2.

Based on the evidence before me, I would find Petitioner proved he sustained an accident arising out of and in the course of his employment. Accordingly, I dissent.

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

REYNOLDS, JEREMY D
Employee/Petitioner

Case# **13WC040126**

MULTIBAND
Employer/Respondent

18IWCC0197

On 7/27/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.42% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4367 SCHUM LAW PC
ANNA KALUZNY
2105 N DUNLAP SUITE 1A
CHAMPAIGN, IL 61820

1454 THOMAS & ASSOCIATES
ROBERT E HOFFMAN
500 W MADISON ST SUITE 2900
CHICAGO, IL 60661

18IWCC0197

STATE OF ILLINOIS)
)SS.
COUNTY OF MC LEAN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jeremy D. Reynolds
Employee/Petitioner

v.

Multiband
Employer/Respondent

Case # 13 WC 40126

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Bloomington, on June 29, 2016. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On November 14, 2013, Respondent was operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned $44,138.12; the average weekly wage was $848.81.

On the date of accident, Petitioner was 29 years of age, single with 2 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

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

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

ORDER

Based upon the Arbitrator's Conclusions of Law attached hereto, claim for compensation is denied.

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

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

William R. Gallagher, Arbitrator

July 24, 2016
Date

JUL 27 2016

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment for Respondent on November 14, 2013. According to the Application, Petitioner sustained an accident while "driving on the job" and sustained injuries to the "Head, neck, back and associated body parts" (Arbitrator's Exhibit 2). There was no dispute that Petitioner sustained an accident; however, Respondent disputed liability pursuant to Section 11 of the Act. Petitioner claimed that he was entitled to payment of temporary total and permanent partial disability benefits, medical bills as well as Section 19(k) and Section 19(l) penalties and Section 16 attorneys' fees (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a cable/satellite installer and he worked through the central Illinois area. He drove a company van that he kept at his residence. On November 14, 2013, Petitioner was scheduled to attend a meeting at 7:00 AM in Bloomington where various business things would be discussed with other installers. Petitioner would also drop off and pick up equipment and supplies.

Petitioner testified that while he was driving the van from his residence to the meeting, the van experienced brake failure. Petitioner lost control of the vehicle which caused it to roll. Petitioner's recollection of the specific details of the accident was unclear.

According to the police report, the brakes failed in the vehicle driven by Petitioner. Petitioner was unable to stop the vehicle at an intersection which caused it to strike another vehicle. Afterward, the vehicle driven by Petitioner went into a ditch and rolled over before coming to rest on its wheels (Petitioner's Exhibit 1).

Following the accident, Petitioner was seen in the ER of St. Joseph Medical Center. At that time, Petitioner stated that when he stepped on the brake pedal, it went to the floor and the van did not stop. Petitioner had abrasions on his left hand, left ear and head and also had complaints of pain in his right elbow (Petitioner's Exhibit 2).

When seen in the ER, a urine sample was obtained and Petitioner was tested for drugs. The test was positive for marijuana (Petitioner's Exhibit 2; Respondent's Exhibit 1). Petitioner testified that he was fired by Respondent because of the fact that he tested positive for marijuana.

In regard to the medical treatment, Petitioner was treated at Carle Occupational Medicine from November 18, 2013, through March 10, 2014, for neck/back symptoms and post-concussive syndrome (Petitioner's Exhibit 3). Petitioner also received physical therapy from December 13, 2013, through January 26, 2014 (Petitioner's Exhibit 5).

At trial, Petitioner testified that he had ongoing complaints of neck/back pain, sleep disruption and memory issues. Petitioner stated that he takes over-the-counter medications on an as needed basis.

Cathy Reynolds, Petitioner's mother, testified on his behalf at trial. Reynolds' testimony was consistent with the testimony of Petitioner and she stated that she has noted that Petitioner now

has sleep and memory issues that he did not have prior to the accident. She also stated that she has observed Petitioner with neck/back pain.

At the direction of Respondent, the vehicle that was driven by Petitioner was inspected by Clifford Bigelow, an engineer. The primary focus of Bigelow's inspection of the vehicle was to determine if there was, in fact, a brake failure at the time of the accident. Bigelow inspected the vehicle on May 2, 2014, and, in connection with his inspection of the vehicle, various photographs of it were obtained. Bigelow concluded that there was no indication of any problems with the braking system that would have prevented the brakes from functioning at the time of the accident (Respondent's Exhibit 3; Deposition Exhibit 2).

Clifford Bigelow was deposed on March 25, 2016, and his deposition testimony was received into evidence at trial. Bigelow's testimony was consistent with his report and he reaffirmed the opinions contained therein. Specifically, Bigelow stated that the brake pads and rotors were in very good condition and showed very little wear. He also did not find any defects or condition in the hydraulic systems which would have caused brake failure (Respondent's Exhibit 3; pp 13-16).

Daniel Beale testified on behalf of the Respondent when this case was tried. Beale is Respondent's general manager and was Respondent's operations manager at the time of the accident. Beale identified the service records of the vehicle that Petitioner drove and stated that there was no record of any work having been performed on the vehicle because of brake issues (Respondent's Exhibit 2).

At trial, Petitioner denied having smoked marijuana any time prior to the accident. He opined that the positive finding was due to his exposure to "second-hand smoke." When Petitioner was questioned about whether he had been around individuals who smoked marijuana, he said that it was not uncommon for various customers of Respondent that he visited to smoke marijuana. He was not specific about any times or places when he was exposed to marijuana under these circumstances. Petitioner also stated that he was not under any obligation to report such an occurrence to the company.

Conclusions of Law

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

The Arbitrator concludes that Petitioner did not sustain an accidental injury arising out of and in the course of his employment for Respondent on November 14, 2013.

In support of this conclusion the Arbitrator notes the following:

The Arbitrator finds that Petitioner's claim is barred by Section 11 of the Act. Shortly after the accident a urine test was performed which was positive for marijuana.

Petitioner denied having used marijuana prior to the accident and stated that he had been exposed to "second-hand smoke" from individuals who were customers of Respondent. Petitioner did not

provide any specifics at all as to when or where he was purportedly exposed to this "second-hand smoke." The Arbitrator finds that this testimony is not credible.

Petitioner's testimony that the accident was caused by a failure of the vehicle's brake system is also questionable. Respondent tendered service records of the vehicle which contained no reference to any brake work as having been performed on the vehicle. Further, Clifford Bigelow, an engineer, inspected the vehicle and concluded that there was no evidence of brake failure.

In regard to disputed issues (F), (J), (K), (L) and (M) the Arbitrator makes no conclusions of law as these issues are rendered moot because of the Arbitrator's conclusion of law in disputed issue (C).

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SHARON SCHOLL,

Petitioner,

vs.

NO: 14 WC 37375

WAL-MART ASSOCIATES, INC.,

Respondent.

18IWCC0216

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of nature and extent, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

On Review, the parties agreed and the Commission finds that Petitioner's permanent partial disability award should be made under §8(e)10 of the Act for the right arm as opposed to a person-as-a-whole award under §8(d)2.

Petitioner sustained a fall at work and suffered a "right three-part proximal humerus fracture with displaced greater tuberosity," per the operative report, and a forehead laceration. She underwent an "open reduction internal fixation right proximal humerus." Although the operative report indicates the surgery involved suturing through the superior and posterior rotator cuff to displace the greater tuberosity fragment, we find that Petitioner's injury was to the right humerus and not the shoulder. We affirm the Arbitrator's analysis of the five permanency factors in §8.1b of the Act but modify the decision to award 15% of the right arm instead of 7.59% of the person as a whole.

All else is affirmed and adopted.

18IWCC0216

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $299.90 per week for a period of 16-5/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $269.91 per week for a period of 37.95 weeks, as provided in §8(e)10 of the Act, for the reason that the injuries sustained caused the loss of use of 15% of the right arm.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $269.91 for one week of disfigurement to the upper forehead/scalp, as provided in §8(c) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $43.69 for medical expenses under §8(a) of the Act, subject to the fee schedule in §8.2 of the Act.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $10,400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 10 2018

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

SE/
O: 3/21/18
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SCHOLL, SHARON
Employee/Petitioner

Case# **14WC037375**

WAL-MART ASSOCIATES INC
Employer/Respondent

18IWCC0216

On 7/21/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.43% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1836 RAYMOND M SIMARD PC
221 N LASALLE ST
SUITE 1410
CHICAGO, IL 60601

0560 WIEDNER & McAULIFFE LTD
ROMA PARIKH DALAL
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

18IWCC0216

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPage)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Sharon Scholl
Employee/Petitioner

v.

Wal-Mart Associates, Inc.
Employer/Respondent

Case # **14** WC **37375**

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 **Brian Cronin**, Arbitrator of the Commission, in the city of **Wheaton**, on **December 15, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **September 15, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$23,392.80**; the average weekly wage was **$449.85**.

On the date of accident, Petitioner was **59** years of age, ***single*** with **0** children under 18.

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

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

Respondent shall be given a credit of **$5,055.50** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$5,055.50**.

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

ORDER

Respondent shall pay Petitioner TTD benefits at a rate of $299.90/week for 16-5/7 weeks, from 9/16/14 to 1/11/15, or weeks, which is the period during which Petitioner was temporarily totally disabled, pursuant to Section 8(b) of the Act.

Respondent shall pay the bill in the amount of $43.69 for reasonable and necessary medical services, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $269.91/week for 37.95 weeks, because the injuries sustained caused the 7.59% loss of use of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner $269.91/week for one week of disfigurement to the upper forehead/scalp, as provided in Section 8(c) of the Act.

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

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

Signature of Arbitrator

7-20-2016
Date

JUL 21 2016

STATEMENT OF FACTS
SHARON SCHOLL V. WALMART 14WC 37375

On September 15, 2014, Petitioner was a 59-year-old bakery department manager for Respondent. On that date, she was walking through the back room of the store on her way to the time clock to punch out for the day when caught her toe on a piece of metal protruding from the floor, tripped and fell. She struck her right shoulder and upper forehead/scalp when she fell against some metal racks.

Petitioner went immediately to Good Samaritan Hospital. The x-rays of the right shoulder showed an acute comminuted fracture of the proximal humerus. Fracture planes were seen at the surgical neck, at the base of the greater tuberosity and at the base of the lesser tuberosity. Bone displacement was noted near the greater and the lesser tuberosity fractures. (PX1 at metered page 40) Petitioner is right-arm dominant. The emergency room physician, Dipul Patadia, M.D., closed a 2.3 cm laceration to the left frontal scalp with 2 internal and 5 external sutures. (PX1 at 21). The right arm was placed in a sling and Petitioner was discharged with Norco for pain and advised to consult with an orthopedic surgeon. (PX1 at p. 21)

Petitioner saw Paul T. Atkenson, M.D., an orthopedic surgeon, on September 19, 2014. Dr. Atkenson examined Petitioner and noted swelling, ecchymosis and tenderness over the proximal humerus. After reviewing the x-rays of the right shoulder Dr. Atkenson referred Petitioner to a shoulder specialist, Edward G. Joy, M.D., for a surgical consultation. (PX2)

Petitioner was seen at Integrity Orthopedics on September 25, 2014. James Krcik, M.D., examined Petitioner and continued to prescribe use of the sling and Norco until Petitioner could be seen by Dr. Joy.

On October 2, 2014, Dr. Joy took Petitioner to surgery at Palos Community Hospital. Surgery consisted of an open reduction with internal fixation of a three-part proximal humerus

fracture with a displaced greater tuberosity. Dr. Joy found that the greater tuberosity was fractured with the main fracture component displaced posterolaterally. The humeral head was in a valgus impacted position. Dr. Joy reduced the greater tuberosity fracture to near anatomic alignment with a three-hole plate and screws. There was no evidence of a displaced lesser tuberosity fracture. Dr. Joy then sutured the subscapularis muscle and the supraspinatus and infraspinatus tendons of the rotator cuff to the plate to strengthen the reduction of the fracture.

Petitioner followed-up with Dr. Joy who discontinued the right arm sling and started Petitioner on physical therapy on November 17, 2014. Petitioner attended physical therapy until January 11, 2015, at which time she returned to light-duty work with restrictions as to overhead work, as well as no pushing, pulling or lifting greater than 15 pounds.

Dr. Joy examined Petitioner for the last time on March 27, 2015. Petitioner denied pain with activity or overhead work and denied current numbness or pain in thumb. The doctor noted that Petitioner did not require any pain medication now and that she had been returned to regular-duty work as of March 8, 2015. (PX3)

Prior to examination, Petitioner completed the Penn Shoulder Score. She noted a pain level of zero at rest with her arm by her side. She noted a pain level of zero with normal activities (eating, dressing, and bathing). She further noted a pain level of two with strenuous activities (reaching, lifting, pushing, pulling and throwing). Lastly, she noted she was very satisfied, noting a 10/10 for her current level of function of her shoulder. (PX3)

Petitioner also assigned a verbal pain rating to the following 20 activities:

1. Reach the small of your back to tuck in your shirt with your hand – no difficulty
2. Wash the middle of your back/hook bra – some difficulty
3. Perform necessary toileting activities – no difficulty
4. Wash the back of opposite shoulder – no difficulty

5. Comb hair – no difficulty
6. Place hand behind head with elbow held straight out to the side – no difficulty
7. Dress self (including put on coat and pull shirt overhead) – no difficulty
8. Sleep on affected side – no difficulty
9. Open a door with affected side – no difficulty
10. Carry a bag of groceries with affected arm – no difficulty
11. Carry a briefcase/small suitcase with affected arm – no difficulty
12. Place a soup can (1-2 lbs.) on a shelf at shoulder level without bending elbow – no difficulty
13. Place a one gallon container (8-10 lbs.) on a shelf at shoulder level without bending elbow – no difficulty
14. Reached a shelf above your head without bending your elbow – no difficulty
15. Place a soup can (1-2 lbs.) on a shelf overhead without bending your elbow – no difficulty
16. Place a one gallon container (8-10 lbs.) on a shelf overhead without bending your elbow – some difficulty
17. Perform usual sport/hobby – no difficulty
18. Perform household chores (cleaning, laundry, cooking) - no difficulty
19. Throw overhand/swim/overhead racquet sports – no difficulty
20. Work full-time at your regular job – no difficulty

(PX3)

Upon examination, Dr. Joy found that Petitioner had a full range of motion in the flexion and external rotation arcs. Muscle strength in the right shoulder was full. The drop arm, empty can, Neer and Hawkins tests were all negative. Dr. Joy found Petitioner to be at maximum medical improvement and released her to return to regular-duty work. (PX3)

William A. Heller, M.D., a board-certified orthopedic surgeon and upper extremity specialist, examined Petitioner on May 18, 2015, pursuant to Section 12 of the Act. (RX1 and 2). Dr. Heller found a full range of right shoulder motion with no crepitation. He found Petitioner had intact rotator cuff strength with no instability. Dr. Heller conducted an impairment rating according to the AMA Guides (Sixth Edition) and concluded that according to Table 15-5 of the Shoulder Regional Grid, Petitioner had a 3% right upper extremity impairment or 2% whole person impairment as a result of her proximal humerus fracture.

Petitioner testified that she is still employed as a bakery department manager. She complained of pain in her right shoulder when placing objects on a shelf overhead. She does not have the same range of motion in her right shoulder as the left shoulder. She also has stiffness in her right arm in the morning. Petitioner takes Tylenol on a daily basis for pain in her right shoulder.

Petitioner testified that Respondent paid her medical bills, with the exception of two prescriptions totaling $43.69, which she paid soon after the accident.

The Arbitrator observed Petitioner's upper forehead/scalp from a distance of six feet and could not see any scar. The Arbitrator asked the parties to proceed outside in order to view the scar in better light. The Arbitrator noted that the scar was still hard to see in natural light, primarily because of its location near the hairline.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

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

The Arbitrator finds that Petitioner sustained accidental injuries arising out of and in the course of her employment with Respondent on September 15, 2014. Such finding is based on Petitioner's undisputed testimony that she caught her toe on a piece of metal that was protruding from the floor in the back room of Respondent's premises, tripped and fell into metal shelving.

Petitioner testified that she was "on the clock" at the time of her accident. Respondent offered no evidence to dispute Petitioner's testimony.

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

The Arbitrator finds that a causal connection exists between the accident and the Petitioner's current condition of ill-being under the chain-of-events theory. When Petitioner fell, she sustained a three-part fracture of the proximal humerus with a displaced tuberosity, as well and a laceration to her upper forehead/scalp. Petitioner sought emergency medical care for this acute injury followed by a period of disability during which she received treatment from Edward G. Joy, M.D.

At the request of Respondent, and pursuant to Section 12 of the Act, Petitioner presented to William A. Heller, M.D., for an examination. Dr. Heller did not opine on the issue of causal connection.

A chain of events which demonstrates a previous condition of good health and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury. Int'l Harvester v. Indus. Comm'n, 93 Ill. 2d 59, 63-64 (1982)

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

With regard to subsection (i) of §8.1b(b) of the Act, the Arbitrator notes that Dr. Heller conducted an AMA evaluation finding an impairment rating of 3% extremity impairment/2% whole person pursuant to the most current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. (RX1) The Arbitrator notes that the level of impairment does not necessarily equate to permanent partial disability under the Workers' Compensation Act, but instead is one of five factors to be considered in making such a disability evaluation. The

Arbitrator further finds that this was the only impairment rating offered at trial and is therefore unrebutted. The Arbitrator gives moderate weight to this factor.

With regard to subsection (ii) of §8.1b(b) of the Act, the occupation of the employee, the Arbitrator notes that the record reveals Petitioner was employed as a bakery department manager at Wal-Mart at the time of the accident and that she was able to return to work at the same job that she had prior to the injury. The physical requirements of this job were not offered into evidence. The Arbitrator gives minor weight to this factor.

With regard to subsection (iii) of §8.1b(b) of the Act, the Arbitrator notes that Petitioner was 59 years old at the time of the accident. The Arbitrator takes judicial notice that, all things being equal, Petitioner has a shorter work life expectancy than a 30 year old or a 40 year old worker. The Arbitrator gives moderate weight to this factor.

With regard to subsection (iv) of §8.1b(b) of the Act, Petitioner's future earnings capacity, the Arbitrator notes that no evidence was presented to indicate that Petitioner's future earning capacity would be increased or reduced following his physical recovery from the accidental injury. The Arbitrator gives no weight to this factor.

With regard to subsection (v) of §8.1b(b) of the Act, evidence of disability corroborated the Arbitrator notes that Petitioner's treating physician, Dr. Joy performed an open reduction and internal fixation of the right proximal humerus with a plate and screws. The operative report indicates that part of the surgery included the following: "The greater tuberosity rotator cuff, superiorly and posteriorly, were sutured with Orthocord sutures passed to the superior and posterior rotator cuff so they displace greater tuberosity fragment." Therefore, the Arbitrator finds this to be a shoulder, and not an arm, injury. At her final evaluation with Dr. Joy, Petitioner stated that she

was not taking any pain medications. She had been released to return to work regular duty. In addition, MMI had been reached.

Furthermore, Petitioner filled out the Penn Shoulder Score in which she noted a pain level of zero at rest with her arm by her side. She indicated a pain level of zero with normal activities (eating, dressing, and bathing). She further indicated only a pain level of two with strenuous activities (reaching, lifting, pushing, pulling and throwing). Lastly, she noted she was very satisfied, indicating a 10/10, for her current level of function of her shoulder.

As part of the Penn Shoulder Score, Petitioner assigned a verbal pain rating to the following 20 activities of which she noted she had no difficulty with 18 activities.

Therefore, the Arbitrator gives moderate weight to this factor.

Based on the above factors, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 7.59% loss of use of his person as a whole as the result of his shoulder injury, pursuant to §8(d)2 of the Act and Will County Forest Preserve District v. Illinois Workers' Comp. Comm'n, 970 N.E.2d 16, 361 Ill. Dec. 16 (3d Dist. 2012).

Furthermore, the Arbitrator finds that an award of one week of disfigurement is appropriate for the scar on Petitioner's upper forehead/scalp at the hairline, pursuant to Section 8(c) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Arturo Barrera,
Petitioner,

vs. NO: 15 WC 15329

Unistaff,
Respondent.

18IWCC0217

DECISION AND OPINION ON REVIEW

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

The sole evidence of wages in the record is Petitioner's testimony that he "started at $11.00 and then ended up $11.60 an hour." The Arbitrator arrived at an average weekly wage (AWW) of $452.00 by taking "an average of the hourly wages of $11.00 and $11.60, and multiplie[d] that figure times 40 hours a week to arrive at an average weekly wage of $452.00." The Arbitrator properly excluded overtime from the calculation because there was no evidence that the overtime hours were either mandatory or part of a set schedule.

Section 10 of the Act does not include, as a method of calculating a worker's AWW, averaging a beginning rate of pay with the rate of pay on their termination date (which, in this case, occurred months after the alleged date of accident). The Commission notes the claimant had been on the job less than 3 weeks when his alleged injury occurred, and there was no evidence that prior to that date he received a pay increase above his starting rate of $11.00/hour.

18IWCC0217

Accepting the claimant's testimony regarding his earnings as accurate, the proper AWW calculation is $440.00 – as alleged by Respondent at the beginning of the hearing – based upon a pay scale of $11.00 per hour for a 40-hour week. Disability rates are hereby modified accordingly. All other findings of the arbitrator are affirmed.

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.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the 15 & 1/7 weeks of temporary total disability, covering the periods of March 31, 2015 to June 5, 2015 and from October 13, 2015 to November 20, 2015, as ordered by the Arbitrator, at the rate of $293.33 per week, in accordance with the above-rendered findings.

IT IS FURTHER ORDERED BY THE COMMISSION that, other than being modified as noted above, the Decision of the Arbitrator filed August 2, 2016 is hereby affirmed and adopted.

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

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $11,000.00. 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: APR 10 2018

Joshua D. Luskin

o-02/28/18
jdl-mcp
68

Charles J DeVriendt

L. Elizabeth Coppoletti

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

BARRERA, ARTURO
Employee/Petitioner

Case# **15WC015329**

UNISTAFF
Employer/Respondent

18IWCC0217

On 8/2/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2333 WOODRUFF JOHNSON & PALERMO
LYNN TAYLOR
4234 MERIDIAN PKWY SUITE 134
AURORA, IL 60504

2623 McANDREWS & NORGLE LLC
MICHAEL P LATZ
53 W JACKSON BLVD SUITE 315
CHICAGO, IL 60604

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPAGE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

18IWCC0217

Arturo Barrera
Employee/Petitioner

v.

Case # 15 WC 15329

Unistaff
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brian Cronin**, Arbitrator of the Commission, in the city of **Elgin**, on **November 20, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **02/01/15**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned an average weekly wage was **$452.00**.

On the date of accident, Petitioner was **37** years of age, ***single*** with **2** dependent children.

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

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

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

ORDER

Respondent shall pay the charges for the reasonable, necessary and related medical services rendered to Petitioner in the amount of **$6,539.38**, as provided in Section 8(a) and subject to Section 8.2 of the Act.

Respondent shall pay Petitioner **$301.33**/week for **15-1/7** weeks, from **03/31/15** through **06/05/15**, and from **10/13/15** through **11/20/15**, because Petitioner has been temporarily totally disabled, in accordance with Section 8(b) of the Act.

Respondent shall authorize and pay for the surgery that Dr. Fajardo has recommended for Petitioner's right elbow, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

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

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

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

Signature of Arbitrator

August 1, 2016
Date

AUG 2 - 2016

18IWCC0217

I. FINDINGS OF FACT

A. Accident

Petitioner worked for Respondent from January 15, 2015, until March 31, 2015, although his termination date was on April 4, 2015. Petitioner testified that he made $11.60 per hour working for Respondent. He testified that he worked 40 hours of regular time and 2-4 hours of overtime each week. He further testified that he worked on Saturdays.

While Petitioner was employed by Respondent, he worked as a forklift driver and picker in the Mazda warehouse. Petitioner testified that he used a cherry picker to pick product from the shelves and then packed product into boxes. Petitioner testified there were five levels of shelves in the warehouse (A-E) from which product could be selected. He estimated that the tallest shelf was approximately 2-3 stories from the ground. Sometimes his job required him to be suspended in the air, stretch over, and pull the product from the shelves with his right hand, while using his left hand for stabilization. When he attempted to pull heavier boxes, he would find that the box would often tear and cause a jerking motion in his elbow.

Petitioner testified on direct examination that in the second or third week in February 2015, he began to notice little throbs, little sharp pains in his right elbow. On cross-examination and redirect examination, Petitioner testified that he began to experience such symptoms on February 1, 2015. As Petitioner continued working, the pain progressively worsened. Petitioner did not experience bilateral elbow pain; the pain was limited to his right elbow. Petitioner indicated he attributed the pain in his right elbow to using his right arm to pull heavy products, such as windshields and catalytic converters, toward him while picking product.

After Petitioner began to experience pain in his right elbow, he reported the injury to Jeff and Brian, his supervisors at the Mazda facility. He reported this around the second or third week of February 2015. Petitioner told his supervisors he believed that using force to pull the heavy boxes while picking product was causing pain in his right elbow.

Petitioner continued working full duty for Respondent until March 31, 2015, at which time he sought treatment for his right elbow injury. Petitioner was removed from work for three to four days on March 31, 2015.

Respondent's witness, Norma Montanez, testified that Petitioner provided her with his work status note on March 31, 2015, which was the date Petitioner received it. Ms. Montanez testified that she had a conversation with Petitioner on March 31, 2015 at which time Petitioner stated that the pain in his elbow did not happen at work but was an existing thing that he had two years ago. Ms. Montanez further testified that Petitioner again provided her with a work status note on April 2, 2015.

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B. Medical Treatment

Petitioner testified he never sustained any injury to his right elbow prior to his employment with Respondent. Petitioner testified that at the time he began working for Respondent, he had no pre-existing injury to his right elbow, and was not experiencing any right elbow pain. Petitioner testified he never sought treatment for any right elbow injury prior to his employment with Respondent. Additionally, Petitioner testified that he did not suffer any injury to his right elbow that occurred outside of work after he began his employment with Respondent.

On March 31, 2015, due to an increase in pain in his right elbow, Petitioner sought treatment at VNA Health Care with Seema Kumar, M.D. Petitioner testified he gave a history of right elbow pain for approximately one month, and denied any direct injury to his right elbow. Petitioner indicated his job duties involved repeated jerking movements of his right elbow. Petitioner's physical exam revealed tenderness at his right lateral epicondylitis, and a limited range of motion due to pain. Dr. Kumar diagnosed Petitioner with right lateral epicondylitis, ordered x-rays, and took Petitioner off work for three to four days. (PX 2)

Petitioner was next seen at VNA on April 1, 2015, for a follow-up on his x-rays. The x-rays revealed no visible fractures, dislocations, or degenerative changes. Petitioner stated the pain was not getting better. Dr. Kumar then ordered an MRI of Petitioner's right elbow. (PX 2)

On April 1, 2015, Petitioner obtained an MRI of his right elbow at Naperville Imaging. The interpreting radiologist, Neil Gupta, M.D., made the following pertinent findings:

> There is partial thickness tearing involving the dorsal deep common extensor tendon origin fibers off the lateral epicondyle of the distal humerus at the ovoid shaped fluid-filled tear measuring approximately 2 mm. TV by 4 mm. AP by 4 mm. in CC dimension (series 4, image 11 and series 8, image 12) without full thickness/with tearing or surrounding tendinopathy with the remainder of the common extensor tendon origin fibers being intact. (PX 2)

Petitioner followed up with VNA on April 2, 2015. Petitioner was referred to an orthopedic surgeon, and placed on light duty for one to two weeks, with a re-check in two weeks. (PX 2)

Petitioner returned to VNA on April 23, 2015, for additional treatment. He was again referred to an orthopedic surgeon, referred to physical therapy, and placed on modified duty, including immobilization, with a re-check in two weeks. (PX 2)

On June 5, 2015, Marc R. Fajardo, M.D., of Hinsdale Orthopaedics, evaluated Petitioner's right elbow, and diagnosed him with right lateral epicondylitis. Petitioner gave Dr. Fajardo a history

of pain for approximately two months stemming from repetitive motions at work. Petitioner's pain was sharp, stabbing, aching, and throbbing, with associated numbness and weakness. Dr. Fajardo administered a cortisone injection to Petitioner's right elbow, and permitted him to return to work without restrictions. (PX 1)

Dr. Fajardo re-examined Petitioner on October 13, 2015. Although Petitioner indicated the cortisone injection initially relieved some of his pain, the pain returned after the effects of the injection wore off. Dr. Fajardo administered a second cortisone injection, and placed Petitioner on modified-duty work for one month. (PX 1)

Petitioner presented to Dr. Fajardo for a re-check on November 13, 2015. Although Petitioner received the two prior cortisone injections, Petitioner reported that his pain was not resolving. As Petitioner's right elbow injury was recalcitrant to two cortisone injections and failed to resolve after conservative treatment, Dr. Fajardo recommended surgical intervention, and took Petitioner off work for one month. (PX 1)

Additionally, Petitioner began physical therapy for his right elbow injury on November 13, 2015. Petitioner continues to receive treatment for his right elbow injury.

Petitioner testified that he was unable to seek treatment from April 23, 2015 until June 5, 2015, as he had no income, and would have had to pay for any and all treatment out of pocket. Petitioner indicated, for this same reason, that he was unable to seek treatment between the June 5, 2015, appointment with Dr. Fajardo and the September 1, 2015, Section 12 examination.

C. Section 12 Examination

Ajay K. Balaram, M.D., examined Petitioner on September 1, 2015, at the request of Respondent and pursuant to Section 12 of the Act. Dr. Balaram took a history from Petitioner, conducted a physical examination of Petitioner, and reviewed Petitioner's x-ray results, MRI results, and several of the treating records. Dr. Balaram wrote that the patient reports a gradual onset of symptoms that he attributes to his usual work activities and he reports that the symptoms became noticeable and reportable on or around February 1, 2015. Dr. Balaram had Petitioner demonstrate the mechanism and maneuvers Petitioner used that Petitioner believed caused his repetitive injury. Additionally, Dr. Balaram noted no history of any previous right elbow injury existed in the medical records or in the history Petitioner provided, nor did the diagnostic imaging suggest any degenerative condition existed in Petitioner's right elbow. (PX 3)

After his examination of Petitioner and his review of Petitioner's medical records, Dr. Balaram diagnosed Petitioner with right elbow lateral epicondylitis. Dr. Balaram stated that Petitioner's right elbow lateral epicondylitis was causally related to Petitioner's work activities, which involved repetitive forceful grasping and pulling with the right arm. Dr. Balaram also stated that Petitioner's subjective complaints correlated with the objective findings on the MRI. Dr.

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Balaram did not believe Petitioner was at maximum medical improvement, and depending on Petitioner's progress, thought that additional treatment may be warranted. (PX 3)

II. CONCLUSIONS OF LAW

In support of the Arbitrator's decision relating to "C," whether an accident occurred arising out of and in the course of Petitioner's employment with Respondent, the Arbitrator concludes:

The Arbitrator finds Petitioner suffered a workplace injury due to repetitive trauma he experienced while working for Respondent. Petitioner's testimony as to mechanism of repetitive injury is consistent with his medical records, which all relate a history of right elbow pain stemming from repetitive gripping, pulling, and jerking product from the shelves. Petitioner testified he did not suffer from right elbow problems prior to his employment with Respondent, nor did he suffer a right elbow injury outside of work while employed by Respondent. The Arbitrator finds that the repetitive movements of grasping, pulling, and jerking product off the shelves, particularly when done while suspended in the air, resulted in his right elbow injury.

In support of the Arbitrator's decision relating to "D," what the date of the accident was, the Arbitrator concludes:

The Arbitrator finds the accident date to be February 1, 2015. Petitioner testified that he began experiencing right elbow pain at the beginning of February 2015 and had trouble sleeping. Petitioner testified he indicated February 1, 2015, as the accident date because he began experiencing right elbow pain around that date. However, Petitioner continued to be exposed to the work duties that were causing his injury until March 31, 2015.

In support of the Arbitrator's decision relating to "E," whether timely notice was given to Respondent, the Arbitrator concludes:

The Arbitrator finds Petitioner gave notice to his supervisors within the 45 day period as required by the Act. Petitioner provided unrebutted testimony that he spoke to Jeff and Brian, his supervisors at the Mazda warehouse, around the second week or third week of February 2015, shortly after he began experiencing symptoms. Petitioner testified that he believed he was experiencing right elbow pain as a result of pulling on the racks and holding the boxes when the boxes get stuck.

Respondent's witness, Ms. Montanez, indicated that Respondent's policy dictates that accident reports should be made to her as the recruiter for Mazda. Although Ms. Montanez was not physically present at the Mazda facility, she stated she did know that Jeff was a supervisor at the Mazda facility.

The Arbitrator notes Dr. Balaram's Section 12 report also mentions that Petitioner discussed his elbow injury with his supervisors at the Mazda plant. As Petitioner alerted his direct supervisors at the Mazda warehouse to his workplace injury within the 45-day period required by the Act, the Arbitrator finds that timely notice was given.

In support of the Arbitrator's decision relating to "F," whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator concludes:

The Arbitrator finds that Petitioner's current condition of ill-being of his right elbow is causally related to his work duties for Respondent.

Respondent's witness, Juan Serrano, testified that on April 2, 2015, he was present when Petitioner told Norma Montanez that he was unable to go to work and that he has had this pain for the last couple of years but denied that such pain was the result of something that happened at work. Mr. Serrano also testified that Petitioner told Norma during this April 2, 2015 conversation that he went to VNA, and they told him he needed further treatment but that he could not continue treatment due to a lack of money.

However, a review of the records from VNA show no evidence of Petitioner seeking treatment for a right elbow injury, either in 2012 or at any other time thereafter until March 31, 2015. No other medical record that was offered into evidence indicates Petitioner ever sought treatment for a right elbow injury.

Ms. Montanez testified that she had a conversation with Petitioner on March 31, 2015, at which time Petitioner stated that the pain in his elbow did not happen at work but was an existing thing that he had two years ago.

Petitioner testified he suffered no prior injuries to his right elbow. He testified he has not suffered any injury to his right elbow since he first sought treatment on March 31, 2015.

The Arbitrator recognizes that Petitioner worked only 16 days for Respondent before he began to experience right elbow symptoms and further recognizes that Petitioner did the same type of work – picking orders – for approximately 22 months before being hired by Unistaff to work at the Mazda warehouse. However, the evidence shows that the breakdown of his bodily structure, i.e., his right elbow, occurred when he was performing work duties while in the employ of Unistaff.

Based on Petitioner's history of injury, as well as the corroborating medical records that document his right elbow injury and the opinions of Respondent's Section 12 examining physician, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that his current condition of ill-being, as it relates to his right elbow, is causally related to the repetitive trauma accident Petitioner suffered at work beginning on February 1, 2015.

In support of the Arbitrator's decision relating to "G," what Petitioner's earnings were, the Arbitrator concludes:

Petitioner testified that when he started working for Respondent, he earned $11.00/hour and "ended up at" $11.60/hour. He further testified that he worked his regular 40 hours and between 2-4 hours of overtime per week. However, Petitioner provided no evidence that these overtime hours were mandatory, in accordance with Airborne Express v. Illinois Workers' Comp. Comm'n, 865 N.E.2d 979, 310 Ill. Dec. 259 (2007). Therefore, it is not appropriate to include the overtime hours in the average weekly wage calculation. No wage records were offered into evidence. Therefore, the Arbitrator takes an average of the hourly wages of $11.00 and $11.60, and multiplies that figure times 40 hours a week to arrive at an average weekly wage of $452.00.

In support of the Arbitrator's decision relating to "J," whether the medical services were reasonable and necessary and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator concludes:

The Arbitrator concludes that the medical services provided to Petitioner were reasonable and necessary and Respondent is liable for payment of the medical bills submitted into evidence. The Arbitrator finds the medical treatment Petitioner underwent was all related to his right elbow injury beginning on March 31, 2015. The Arbitrator finds Dr. Balaram's opinion with regard to the necessity of the MRI unpersuasive, given that Dr. Balaram referred to the MRI findings a number of times in forming his opinion.

Therefore, Respondent is liable for the following medical services:

1. VNA Health Care - $560.00 (PX 4(a).)
2. Hinsdale Orthopaedics - $359.00 (PX 4(b).)
3. ATI Physical Therapy - $5,432.00 (PX 4(c).)
4. Naperville Imaging - $1,738.50 (PX 4(d).)

The Arbitrator additionally awards Petitioner $187.50 for out-of-pocket payments he made for the reasonable, necessary, and related care for his accidental injury. (PX 4(d))

In support of the Arbitrator's decision relating to "K," whether Petitioner is entitled to prospective medical care, the Arbitrator concludes:

Having found that Petitioner's current condition of ill-being is causally related to the repetitive trauma work injury beginning in February 2015, the Arbitrator finds that the Respondent shall pay all reasonable and necessary medical expenses related to the right elbow surgery that Dr. Fajardo has recommended.

In support of the Arbitrator's decision relating to "L," whether Petitioner is entitled to temporary total disability benefits, the Arbitrator concludes:

Having found that Petitioner sustained an accident arising out of and in the course of his employment, and determining Petitioner's job duties caused Petitioner's injury, the Arbitrator finds Petitioner is entitled to temporary total disability benefits. Petitioner was initially taken off work March 31, 2015. Petitioner was on light-duty restrictions and not released to return to work full duty until June 5, 2015. Although Petitioner did not have restrictions for a number of weeks after that appointment, a flare-up in his right elbow pain when the cortisone injection wore off led Petitioner to return for further treatment. As a result, Petitioner was again placed on light duty at his October 13, 2015, appointment. Petitioner testified that since that appointment, he has not been released to return to work full duty.

Petitioner testified that Respondent terminated his employment based on attendance issues.

In Interstate Scaffolding v. Illinois Workers' Compensation Commission, 933 N.E.2d 266, 337 Ill. Dec. 707 (2010), the Court held:

> For the reasons stated above, we hold that an employer's obligation to pay TTD benefits to an injured employee does not cease because the employee had been discharged - - whether or not the discharge was for "cause." When an injured employee has been discharged by his employer, the determinative inquiry for deciding entitlement to TTD benefits remains, as always, whether the claimant's condition has stabilized. If the injured employee is able to show that he continues to be temporarily totally disabled as a result of his work-related injury, the employee is entitled to TTD benefits.

Therefore, the Arbitrator determines that Petitioner is entitled to receive temporary total disability benefits from the period of March 31, 2015 through June 5, 2015, and October 13, 2015 through November 20, 2015, which was the date of the arbitration hearing.

In support of the Arbitrator's decision relating to "M," whether Respondent is liable for penalties and fees, the Arbitrator concludes:

Respondent had Petitioner examined by Dr. Balaram on September 1, 2015. Dr. Balaram issued his report on September 3, 2015. (PX 3) In response to Respondent's Question 6, as to whether Petitioner had a pre-existing condition or suffered from a degenerative condition, Dr. Balaram stated nothing in the history elicited from Petitioner, the medical records, or the diagnostic reports suggested either a pre-existing injury or degenerative condition. In response to Respondent's Question 3, as to whether a causal relationship existed between Petitioner's injury

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and the accident as described by Petitioner, Dr. Balaram opined that Petitioner's job duties were causally related to his current condition. (PX 3) Respondent presented no medical evidence to contradict Dr. Balaram's opinion.

However, while Dr. Balaram opined that Petitioner's condition was caused by the work he performed for Respondent, his opinion was based, in part, on a misunderstanding that Petitioner was working for Unistaff for many years. Dr. Balaram relied on Dr. Kumar's chart notes, which Dr. Balaram summarized as follows:

> Initial evaluation by Dr. Kumar on 3/31/15. The doctor reports that the patient complains of right elbow pain for one month. He denies any direct injury, but his work involved repeated, jerking movements of the elbow. He reports that he has been working there for many years. (PX 3, p. 3)

Petitioner testified on cross-examination that he worked for Respondent only 16 days before his elbow condition became reportable. He further testified that he used his right elbow at work for Respondent 6 out of 8 hours in a workday. Petitioner testified that he did the same type of work – picking orders – for approximately 22 months prior to being hired by Unistaff to work at the Mazda warehouse.

Respondent argues that Petitioner presented no medical evidence of duration and repetition of the work duties he performed that caused the repetitive trauma during the 16 days he worked for Unistaff, as opposed to prior warehouse work he performed for other employers.

Ms. Montanez testified that she had a conversation with Petitioner on March 31, 2015 at which time Petitioner stated that the pain in his elbow did not happen at work but was an existing thing that he had two years ago. Juan Serrano provided similar testimony with regard to an April 2, 2015 conversation Petitioner had with Ms. Montanez.

Moreover, Petitioner testified on direct examination that the right elbow symptoms manifested during the second or third week of February 2015, whereas on cross-examination and redirect examination, Petitioner testified that such symptoms began on February 1, 2015.

Based on the foregoing, the Arbitrator finds that penalties and attorney's fees are not warranted in this case.

Brian T. Cronin

8-1-11

Brian Cronin
Arbitrator

Date

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

☐ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with correction	☐ Rate Adjustment Fund (§8(g))
☒ Reverse	☐ Second Injury Fund (§8(e)18)
☐ Modify	☒ None of the above

Matthew Plummer,

Petitioner,

vs. NO: 13 WC 37868

State of Illinois/Illinois
Department of Corrections,

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Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and notice provided to all parties, the Commission after considering the issues of accident, notice, causal relationship, medical expenses, temporary total disability benefits, and nature and extent of the disability, and being advised in the facts and the law reverses the Decision of the Arbitrator.

STATEMENT OF FACTS

At the May 9, 2017 arbitration hearing, Petitioner testified he worked for Respondent since October 29, 2001. T. 13. He started his career at Tamms Correctional Center (Tamms), a super maximum-security facility, which is no longer utilized. *Id.* The overwhelming majority of his time at Tamms was spent on the 3:00 p.m. to 11:00 p.m. shift. T. 14. In addition to his duties as a correctional officer, Petitioner also works as a correctional tactical officer in 2004. *Id.* The duties of a correctional tactical officer were like being on a swat team doing cell extractions and assisting with shakedowns. At Tamms, tactical officers moved the majority of the inmates. *Id.* Petitioner worked at Tamms for 12 years until it closed in 2013. T. 15. Petitioner's position was a tactical officer in B pod. *Id.*

At Tamms, all inmate services were rendered through a chuckhole or food slider box. *Id.* A chuckhole is a small door on the front of the cell door approximately 12 inches by 6 inches, with a lock on it opened with a Folger Adams key. T. 16. A Folger Adams key is four inches

long and heavy. *Id.* Not all chuckholes functioned properly at Tamms. *Id.* Some chuckholes were poorly maintained and routinely inmates would spill food and other items on it. *Id.* The correctional officers would clean those chuckholes, but over time they would be gummed up and hard to open. *Id.* Petitioner is right-handed and would use his right hand to insert the key, turn the key and then secure the key on his duty belt; he would open the chuckhole with his left hand, enter food, mail, laundry, then close the chuckhole; he would then take the key and lock the chuckhole lock and again secure the key on his duty belt. T. 17. This process was performed approximately 60 to 90 times per shift. *Id.* When he closed a chuckhole, Petitioner went through the same procedure, so instead of 60 to 90 times, it would be double that number. *Id.* He occasionally worked overtime. *Id.* When a chuckhole would stick, if in a closed position he would have to pull very hard for the door to come down; if in the open position, Petitioner would use his knee and raise up the chuckhole door and then secure it. T. 19.

Inmates at Tamms were handcuffed, and it required two correctional officers to move an inmate. T. 19. The two correctional officers would approach a cell door and instruct the inmate to perform a strip search. Correctional officers would open the chuckhole and search the clothing passed through the chuckhole and then close the chuckhole; after searching the clothing, the chuckhole was opened and the clothing was returned to the inmate through the chuckhole; then the inmate would approach the cell front with his arms out through the chuckhole and handcuffs were placed on the inmate, who would then pull back from the chuckhole with his hands cuffed. T. 19-20. The cell door was then opened, and Petitioner then hung onto the cuffs, which would require grip and force; the inmate cannot be allowed to pull away back into the cell, although some would try. T. 20. This was true for every inmate at Tamms. *Id.*

Each pod at Tamms contained 60 cells which Petitioner rounded twice per hour. T. 20-21. A round required Petitioner to check all cell doors, making sure they were secure. T. 21. Following the rounding, he would certify his presence in the log book. *Id.* Tamms did not have inmate workers, and correctional officers performed the cleaning. T. 21. Correctional officers cleaned the floors, bathrooms and windows and carried mailbags and laundry bags. T. 22. A mailbag weighed anywhere from 40 to 60 pounds, and laundry bags weighed approximately 20 to 30 pounds each. *Id.* Petitioner used his hand and arms to perform his duties. T. 23.

Petitioner testified he previously suffered from gout but is not diabetic nor does he suffer from hypothyroidism or rheumatoid arthritis. T. 23-24. Petitioner testified while performing his job duties at Tamms, he noticed weakness in his arms and hands as well as numbness for which he sought medical care with his primary care physician, Dr. Cerny on August 28, 2013. T. 24-25. After Tamms closed, Petitioner transferred to Menard Correctional Center (Menard), the maximum-security unit as a correctional officer. *Id.* Petitioner maintained his tactical certification and opened chuckholes as well as bar rapping and deadlocking cells with Folger Adams keys. T. 26. On several occasions Petitioner reviewed PX12 through PX16, the job site analysis, the video and the position description. *Id.* In his opinion, some are accurate and correct and some are not. *Id.* The amount of bar rapping, of keying, and deadlocking cells, varied depending on whether the facility was on lockdown status or not. *Id.* In his opinion, there

is too little shown in the video. *Id.* Petitioner worked at Menard for seven months and then was transferred to Vienna Correctional Center (Vienna), starting on July 15, 2013. T. 27.

Petitioner testified he began having symptoms of numbness and tingling in approximately 2011, while working at Tamms and his symptoms steadily worsened. T. 27. When he saw Dr. Cerny on August 28, 2013, he was referred to a hand specialist. *Id.* Petitioner underwent a nerve conduction test of his upper extremities. T. 28. After Dr. Cerny reviewed the test results, Petitioner was referred to Dr. Young. *Id.* Dr. Young evaluated Petitioner on September 13, 2013 and diagnosed carpal tunnel syndrome. T. 29. Given the diagnosis, Petitioner choose September 13, 2013 as the date of accident. *Id.* After September 13, 2013, Petitioner filled out a report and attributed his condition to the working conditions throughout his career with Tamms, Menard and Vienna. *Id.* As of his August 28, 2013 visit with Dr. Cerney, Petitioner had worked at Vienna for three weeks. T. 30. As a correctional officer at Vienna, Petitioner worked different posts, but was keying and unlocking doors and performed cell searches. *Id.* There were a few locks for Folger Adams keys, but not to the same extent as at Menard or Tamms. *Id.* At Vienna bar rapping was only done in segregation. *Id.* Vienna is a less physically demanding job on his hands and arms than at Tamms or Menard. *Id.*

Petitioner testified Dr. Young performed surgery which improved Petitioner symptoms of numbness. T. 31. Dr. Young recommended home exercise which improved Petitioner's strength. T. 32. At Respondent's request, Dr. Sudekum evaluated Petitioner. T. 32. Petitioner reviewed Dr. Sudekum's report and disagreed with his finding that the carpal tunnel syndrome was attributable to Petitioner's weight gain. T. 35. In Petitioner's opinion he gained weight because he was restless at night and not sleeping due to the carpal tunnel syndrome. T. 35. Petitioner testified he continues to experience weakness in his hands and burning his right wrist, but overall his condition is significantly improved. T. 37-38.

On cross-examination, Petitioner testified he believed he worked 30 shifts of overtime in 2008, 2009. T. 39-40. Petitioner testified as to his shifts at Menard being 3 to 11 p.m. with his main assignment at north 2 segregation during his seven months of work. T. 40. Petitioner testified he currently works the same shift at Vienna as a correctional lieutenant. T. 41.

Petitioner testified he first noticed symptoms beginning in 2011; he remembered his hands going numb and becoming weak approximately two years before Tamms closed. T. 42. Petitioner testified the symptoms would occur while performing a multitude of tasks including passing out laundry, opening the chuckholes, and providing services through the chuckholes. T. 43. Petitioner testified he initially sought treatment for his complaints in 2013 from Dr. Cerney. T. 44. Petitioner did not recall seeking medical care in 2011 or 2012 nor did he report his symptoms to Respondent. *Id.*

Petitioner testified while working at Menard, he was assigned to the shower crew in North 2 segregation, and there was no unrestricted movement by the inmates. T. 46. Just as Tamms, it required two correctional officers to move an inmate to the shower. *Id.* Petitioner

believed on North 2 segregation there were 500 cells, and during his tenure, the unit was at maximum capacity meaning everyday an inmate would be transported to the shower. *Id.*

Petitioner worked at Tamms from October 29, 2001 until January 2013 on the 3 to 11 p.m. shift mainly in pod B which consisted of 60 cells. T. 48-49. The inmates remained in their cells 23 out of 24 hours. T. 51. Petitioner re-iterated the process for cuffing an inmate estimating the process took 3 to 4 minutes. T. 52. Petitioner testified in pod B as a tactical officer he was responsible for elevated security inmates numbering approximately 18. T. 53-54. Services were provided to the inmates through a food box which did not require the use of a Folger Adams key. T. 54. Petitioner testified he used a Folger Adams key approximately 10 to 20 times per shift. T. 55.

Petitioner testified on September 13, 2013 Dr. Young advised him of the diagnosis of carpal tunnel syndrome. T. 56. Petitioner testified he completed an Employee's Notice of Injury on September 13, 2013 indicating he suffered from carpal tunnel syndrome due to his work at Tamms, Menard, and Vienna. T. 57. Petitioner testified he arrived at this conclusion following his discussions with Dr. Young as well as his independent research. T. 58.

Petitioner called Respondent's representative John Cox as a witness. T. 60. Mr. Cox testified he is employed with Respondent at Vienna. T. 60. Mr. Cox knows Petitioner as he supervised him and found him to be a good employee. T. 61. Mr. Cox previously worked at Tamms and concurred with Petitioner's description of the use of arms and hands. *Id.* No cross-examination was conducted. T. 62.

The medical records evidence Dr. Cerny evaluated Petitioner on January 4, 2013 and diagnosed gout. There was no other notation for this condition in his records. PX3.
On August 28, 2013, Dr. Cerny evaluated Petitioner for an eight-week follow-up. Active problems were listed as fatty liver, hyperlipidemia/dyslipidemia, systemic hypertension, low back pain and obesity. Dr. Cerny noted the following: "He has not been checking his BP. C/O frequent headaches X 6 weeks. He does not take anything for this. He would like to have a NCV or referral to SIOC. States he has had numbness and tingling in his hands X 12-18 months." The following history was noted: "Matthew Plummer is a 31-year-old male. Pt feels better in general than few months ago. He has not checked BP. He does have carpal tunnel sx both hands as noted, has used wrist splints for months without benefit. He had been working corrections at Menard and turning lots of locks with keys. He has recently transferred to Vienna, and he feels much less stress overall with the change." On examination Petitioner's overall findings were normal. Dr. Cerny assessed probable bilateral carpal tunnel syndrome and ordered a bilateral upper extremity nerve conduction study. PX3.

Electrophysiological testing was performed by Dr. Taylor on September 3, 2013 at Union County Hospital. Dr. Taylor's impression was an abnormal electrophysiological study. Dr. Taylor noted positive electrophysiological evidence suggestive of a focal demyelinating process with conduction block of the right and left median motor and sensory nerve fibers at or

about the wrist (carpal tunnel). Dr. Taylor graded the severity of both as moderate and recommended an orthopedic referral. PX3, PX4.

Petitioner was referred to Dr. Young by Dr. Cerny for an orthopedic consultation. The medical records of the Orthopaedic Institute of Southern Illinois (PX5) evidence Dr. Young evaluated Petitioner on September 13, 2013 for a chief complaint of bilateral hand numbness and pain. The following history was noted: "The patient is a 31-year-old, right-hand dominant, male patient of Dr. Cerny who states that since late 2011, he has had numbness and tingling in the hands bilaterally. He states that he is waking up at night with the symptoms. He is also having pain in the hand. He was seen by his family care physician who ordered a nerve conduction study and then referred him to our clinic. He states today his pain level is about a 7 on a scale of 1 to 10. He has been wearing splints, and he states they have not been helping." Dr. Young performed a physical examination and reviewed the nerve conduction study arriving at a diagnosis of bilateral carpal tunnel syndrome. Dr. Young recommended surgery noting Petitioner's desire to proceed with his left hand first once appropriate arranges with his employer were made. PX5.

On September 19, 2014, Dr. Young re-evaluated Petitioner who complained of bilateral hand numbness, weakness and pain. The following history was noted: "Patient is a 32-year-old, right-hand dominant male patient who states that for quite some time he has had numbness and tingling in both hands. States it has gotten worse. We did see him last year and he did have carpal tunnel syndrome but he was unable to have surgery at that time. He states now his pain level is about an 8 on a scale of 1 to 10 and he has started having numbness in all of the fingers. He called himself to make an appointment." Dr. Young noted Petitioner's job at Respondent. Dr. Young performed a physical examination and reviewed the September 3, 2013 nerve study. Dr. Young assessed bilateral carpal tunnel syndrome and bilateral cubital tunnel syndrome and ordered a new nerve conduction study. PX5.

On September 24, 2014, Petitioner underwent electrophysiological testing by Dr. Taylor at Union County Hospital. Dr. Taylor's impression was an abnormal electrophysiological study. There was positive electrophysiological evidence suggestive of a focal demyelinating process of the right median nerve motor and sensory fibers at or about the wrist (carpal tunnel) and a focal demyelinating process with axonal involvement of the left median nerve motor and sensory fibers at or about the wrist (carpal tunnel). The severity of both was graded as moderate per the grading scale. Axonal involvement was identified on the left as moderate to severe. PX4, PX5.

On October 13, 2014, Dr. Young reviewed the September 24, 2014 electrophysiological testing. On examination, Dr. Young found positive Tinel's bilaterally and median nerve compression tests bilaterally. Petitioner was placed on the surgery schedule, with the left side to be performed first. PX5. On November 7, 2014, Dr. Young noted a pre-operative diagnosis of left carpal tunnel syndrome and performed a left carpal tunnel release. PX6. That same day, Dr. Young ordered post-operative occupational therapy and a home exercise program. PX5. During an Initial Physical Therapy Evaluation performed on November 11, 2014, Petitioner was issued a

home exercise program per protocol. On November 21, 2014, Dr. Young removed sutures and noted the incision was healing well. On examination, Dr. Young found positive Tinel's and median nerve compression testing on the right. Petitioner was discharged from physical therapy having reached a maximum level. A right carpal tunnel release surgery was scheduled and he was to continue left home exercise program. Dr. Young gave Petitioner a three to five-pound lifting restriction with his operative hand beginning December 1, 2014. PX5.

In his evidence deposition taken on October 28, 2014 (PX11) Dr. Young testified he is a board certified orthopedic surgeon. The vast majority of his practice, 85% to 90%, consists of treatment of hand and upper extremity problems. PX11, p. 4-5. He stated carpal tunnel syndrome is nerve compression at the wrist level. PX11, p. 7. Occupational risk factors for development of carpal tunnel syndrome include forceful gripping, pinching, pushing, pulling, lifting, repetitive activities with the hand or wrist in a flexed or extended position; those can all put additional pressure on the median nerve within the carpal tunnel. *Id.* Dr. Young testified by "repetitive" he meant doing things multiple times per day or repeatedly. PX11, p. 8. Non-occupational factors for developing carpal tunnel syndrome include advanced patient age, sex (females are more likely to have carpal tunnel syndrome), body habitus or obesity, smoking, diabetes, rheumatological conditions and low thyroid function. *Id.* Carpal tunnel syndrome would be considered a cumulative condition, developing slowly over time. Dr. Young did not believe carpal tunnel syndrome in most instances is going to occur acutely from a single event, although it is possible. *Id.* Dr. Young opined the longer a patient is exposed to an aggravating factor, the more likely they are to develop the symptoms or the more likely the symptoms are to be severe or increase in nature. PX11, p. 9.

Dr. Young testified he initially evaluated Petitioner on December 20, 2012. PX11, p. 10. However, the Commission notes this date is not in his records. Dr. Young stated Petitioner was a 30-year-old male referred by Dr. Cerny for complaints of numbness and tingling in his bilateral upper extremities, primarily the thumb, index and long finger. Petitioner reported his symptoms had been present for approximately six months. PX11, p. 11. Petitioner reported the symptoms were more problematic after doing strenuous work as well as first thing in the morning. He had tried braces with no relief. *Id.* His pain level was 5/10. *Id.* Following his examination, Dr. Young's impression was Petitioner had a compressive neuropathy. *Id.* Petitioner had no formal testing at that time, but a nerve conduction study was ultimately ordered and done on September 3, 2013. *Id.* Dr. Young saw Petitioner again on September 13, 2013 and diagnosed bilateral carpal tunnel syndrome. Dr. Young recited his records, already noted above.

Dr. Young testified Petitioner's attorney sent him the following, which he reviewed: Dr. Sudekum's report dated April 29, 2011, a job analysis from Menard and Tamms, a deposition of Dr. Sudekum dated June 13, 2011 and a summary of Petitioner's work history. PX11, p. 15. Petitioner worked at Tamms from October 29, 2001 to January 4, 2013.
Dr. Young noted Petitioner's job duties at Tamms included passing items of food through chuckholes, which required 240 key turns for feeding alone; using Folger Adams keys; performing wing checks, shakedowns, cuffing/uncuffing inmates, assisting in cleaning,

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maintenance, toilets, trash, sweeping, mopping and cleaning windows due to no inmate help. PX11, p. 15-16. Dr. Young opined these job duties could certainly aggravate a carpal tunnel syndrome or contribute to it. PX11, p. 17. Dr. Young opined the job duties that would aggravate Petitioner's condition included opening and closing of the chuckholes, utilizing the Folger Adams keys and cuffing/uncuffing inmates. *Id.* Dr. Young opined, "That, in conjunction with the other activities combined I think viewing that as just one combined activity could certainly contribute." *Id.* Dr. Young testified Petitioner has non-occupational risk factors for developing carpal tunnel syndrome of being above the ideal body weight as well as a history of smoking at some point. PX11, p. 17-18. Petitioner was approximately 30-years-old when he started to develop these symptoms; Dr. Young opined Petitioner's age would not be considered a risk factor and he was relatively young to develop carpal tunnel syndrome at that age. PX11, p. 18.

Dr. Young testified after Petitioner left Tamms, he went to Menard. Dr. Young testified he has treated other correctional officers employed with Menard and is familiar with their job duties. *Id.* Dr. Young testified documents indicate at Menard Petitioner was utilizing Folger Adams keys to open and close cell doors, opening and closing chuckholes, performing laundry, meals, taking out garbage, had a crank at the end of each gallery and performed bar rapping. PX11, p. 18-19. Dr. Young opined that any of those job duties would cause, contribute to or aggravate carpal tunnel syndrome. PX11, p. 19. Dr. Young opined that in particular utilization of the keys and the bar rapping could certainly contribute to the development or aggravation of carpal tunnel syndrome. *Id.*

Dr. Young testified he reviewed an IME report and deposition of Dr. Sudekum with regard to Menard in the case. *Id.* Dr. Young recited Dr. Sudekum's opinion regarding whether the job duties at Menard could cause or aggravate carpal tunnel syndrome: "It is my (Dr. Sudekum's) opinion that the job activities of a correctional officer at Menard Correctional Center would not serve as a primary etiologic factor of the development of upper extremity repetitive trauma injuries. However, I feel that these work activities could be a possible aggravating factor in the development and/or progression of these conditions." PX11, p. 19-20. Dr. Young agreed with this opinion. PX11, p. 20. Dr. Young reviewed Dr. Cerny's record from August 28, 2013 and recited same. *Id.* Dr. Young opined Petitioner had consistent complaints of carpal tunnel syndrome for the three visits he saw him. PX11, p. 21. Dr. Young did not recall that Petitioner had any substantial worsening or alleviation of his symptoms. *Id.* There was a slight change at Petitioner's last visit where he had complained of some numbness in the entire hand as opposed to simply the thumb, index and long finger. Petitioner's complaints of pain did go from a 5 to a 7 to 8; that would be hard to validate or know if that was a legitimate increase in Petitioner's symptoms. *Id.* It would not surprise Dr. Young if at trial Petitioner testified that when he was at Menard his symptoms became worse or more severe because of the job duties he was doing; if Petitioner had an increase in activity or aggravating factors then he could certainly have a worsening of his symptoms. PX11, p. 22. Dr. Young opined there is a possibility of some improvement with Petitioner being at Vienna with less hand intensive duties, but the carpal tunnel syndrome is not going away and needed to be addressed surgically. PX11, p. 22-23. Dr. Young opined turning keys at Vienna could be an aggravating factor. PX11, p. 23.

Dr. Young opined Petitioner is not at maximum medical improvement. *Id.* Dr. Young opined his medical bills were rendered as a result of the care and treatment Petitioner required due to his work injury and opined his medical bills were reasonable and customary for the same or similar services in the medical community. PX11, p. 24. Dr. Young opined causal connection for the treatment he has recommended to Petitioner. *Id.*

On cross-examination, Dr. Young testified he received documents from Petitioner's attorney the week prior to his deposition. PX11, p. 25. He received those documents after his care and treatment of Petitioner. PX11, p. 26. Dr. Young reviewed some of those documents the morning of this deposition. *Id.* Dr. Young reviewed the job analysis for Menard and Dr. Sudekum's IME report in reference to Menard dated April 29, 2011. *Id.* Dr. Young did not review Dr. Sudekum's deposition that was supplied to him. PX11, p. 27. He spent at least 30 minutes reviewing the documents. *Id.* Dr. Young did not review the CorVel Job Analysis for Tamms. *Id.* Dr. Young did not receive any kind of job analysis for Vienna. *Id.* Petitioner completed a questionnaire that touched on his work history. PX11, p. 28. Dr. Young acknowledged nowhere on that questionnaire did it mention bar rapping or putting leg irons on inmates or turning keys. *Id.* This document states where Petitioner worked and the timeline; no job duties were listed. PX11, p. 28-29.

Dr. Young evaluated Petitioner three times since 2012. PX11, p. 29. At no point either to his independent memory or in the records of those three visits did Petitioner ever mention any of the job duties that are put forth in the document he received from Petitioner's attorney. *Id.* Dr. Young has never been at Tamms. *Id.* According to the document, Petitioner turned keys at least 240 times a day at Tamms; before receiving that document, Dr. Young had no specific knowledge of how many times Petitioner would have turned keys at Tamms. PX11, p. 29-30. The document does state a Folger Adams key is utilized. PX11, p. 30. The document does not state how many times Petitioner would have to put leg irons on an inmate at Tamms. *Id.* Dr. Young did not have a specific number as to how many times a day turning keys would lead to cause or contribute to carpal tunnel syndrome or the time interval between key turns. PX11, p. 30-31. Dr. Young had no specific number in mind as to what amount of repetitive key turning would cause, contribute or exacerbate carpal tunnel syndrome. PX11, p. 31. Dr. Young opined increased force would increase the likelihood of developing carpal tunnel syndrome and it is directly correlated. *Id.* Dr. Young did not have an opinion as to what degree of force was necessary with reference to turning a key. *Id.* Dr. Young had no specific number in mind in terms of duration. PX11, p. 32. Dr. Young had no opinion as to what latency period would lead to cause, contribute or exacerbate carpal tunnel syndrome. *Id.*

Dr. Young acknowledged the Hand Questionnaire, second page under Medical and Social History, stated Petitioner answered that he used tobacco of one can a day; it is his understanding Petitioner was referring to smokeless tobacco, dip or snuff. PX11, p. 32-33. Dr. Young testified it would be a comorbid factor for carpal tunnel syndrome if Petitioner was consuming a can a day of snuff. PX11, p. 33. Dr. Young was shown Dr. Cerny's record from September 3, 2013

and under Medical History high blood pressure is circled. PX11, p. 34. Dr. Young opined high blood pressure is thought to be a contributing factor to the etiology of carpal tunnel syndrome. *Id.* Dr. Young acknowledged Petitioner has at least three co-morbid factors: 1) body habitus/body mass index; 2) high blood pressure; 3) tobacco habit. *Id.* Dr. Young opined it would be hard to say absent his job duties Petitioner would have developed carpal tunnel syndrome with those particular co-morbidities. *Id.* The September 3, 2013 nerve conduction report indicated an abnormal electrophysiological study; what is meant by that is Petitioner was found to have carpal tunnel syndrome; a normal study would mean there is no pathology and no issues. PX11, p. 35-36. Dr. Young had no knowledge of the amount of time Petitioner would cuff and uncuff an inmate. PX11, p. 36.

On re-direct examination, Dr. Young testified regarding a specific duration of exposure or a latency period, he did not think there can be a single threshold number because everyone is going to respond differently to the various stressors on their body; it is conceivable that the same stress can cause the symptoms to develop rather abruptly in one individual and another individual may develop the symptoms over the course of years or decades and another individual may never experience symptoms from it; everybody is going to react differently to it PX11, p. 37.

Petitioner admitted into evidence a Detailed Job Description dated October 30, 2014 as PX9. Petitioner also admitted into evidence a Work History Timeline as PX10.

On December 23, 2014, Dr. Young re-evaluated Petitioner who voiced no complaints relative to his left wrist. On examination, Dr. Young found full range of motion of both wrists and positive Tinel's and median nerve compression test on the right. Dr. Young authorized Petitioner off work and noted he was having surgery the following day. PX5. On December 24, 2014, Dr. Young noted a pre-operative diagnosis of right carpal tunnel syndrome and performed a right carpal tunnel release. PX6. In an Initial Physical Therapy Evaluation performed on December 30, 2014, it was recommended Petitioner attend physical therapy two times a week for two weeks. PX5. On January 7, 2015, Dr. Young removed sutures and noted the incision was well healed. Petitioner had no complaints and was discharged from physical therapy and was to continue a home exercise program. Dr. Young authored a restriction of no lifting over five pounds beginning January 12, 2015. PX5. On February 9, 2015 during examination, Dr. Young found incisions well healed and good range of motion. Dr. Young noted, "He (Petitioner) states that his symptoms have almost resolved and he has no complaints." Dr. Young released Petitioner to return to work full duty effective February 10, 2015 and released him from care. PX5.

Petitioner further admitted into evidence a February 8, 2011 Job Analysis of correctional officer at Menard done by CorVel as PX12. Petitioner admitted into evidence a Menard Correctional Officer Video as PX13. In his §12 report dated April 29, 2011 regarding a Menard correctional officer, PX14, Dr. Sudekum opined, "...the job activities of a Correctional Officer at Menard Correctional Center would not serve as a primary etiologic factor in the development of

upper extremity "repetitive trauma injuries" however, I feel that these work activities could be a possible aggravating factor in the development and/or progression of these conditions."

Petitioner admitted into evidence a June 13, 2011 deposition by Dr. Sudekum regarding Menard Correctional Officer James Bauersachs, case 10 WC 27503, as PX15. In this deposition, Dr. Sudekum testified potential provocative factors at Menard Correctional Center was the baton rapping on the cell bars due to the vibration and the opening/closing of heavy cell doors. PX15, p. 11-16. Dr. Sudekum testified even if a correctional officer bar rapped all day, it does not mean he was going to develop carpal tunnel syndrome. PX15, p. 21.

Petitioner further admitted into evidence Menard Correctional Officers Positions Descriptions as PX16. Medical bills were admitted into evidence as PX1. The total charges for medical services provided to Petitioner were $19,709.66.

Respondent admitted into evidence Dr. Sudekum's February 26, 2015 §12 report as RX2. In his report, Dr. Sudekum noted Petitioner worked 11 years at Tamms as a correctional officer, then worked approximately six months at Menard in the same capacity. Dr. Sudekum noted since July 2012, Petitioner has been a correctional officer at Vienna. Petitioner reported to Dr. Sudekum he first developed symptoms of numbness, tingling and pain in both hands in 2009-2010, but did not seek treatment until 2012. Dr. Sudekum noted on December 20, 2012, Petitioner saw Physician Assistant Kevin Rainey at Dr. Cerny's office and Dr. Young at the Orthopedic Institute of Southern Illinois for evaluation of "numbness and tingling of the bilateral upper extremities." Dr. Sudekum noted in a Patient Information form that day, Petitioner was asked if this was a workers' compensation claim and there was no answer given. On this form, Petitioner wrote his symptoms began six months before. Petitioner answered unknown to where and how this happened. His symptoms were worse at night and in the morning and his pain came and went. Dr. Sudekum noted Mr. Rainey noted on December 20, 2012 Petitioner reported having symptoms of numbness in his thumb, index and long finger for the past six months; Petitioner did feel associated tightness in the posterior aspect of the bilateral wrist in the morning; Petitioner had tried removable braces that did relieve some of the symptoms, but still complained of pain he rated at 5/10. Dr. Sudekum noted on examination Mr. Rainey found negative Tinel's at both wrist and elbow and positive compression test at bilateral hands. Mr. Rainey's plan was to order nerve conduction studies of the bilateral upper extremities. Dr. Sudekum noted Dr. Cerny's records from August 28, 2013 and the September 3, 2013 nerve conduction studies. Dr. Sudekum noted on September 13, 2013, Petitioner saw Physician Assistant Philip Erthall at the Orthopedic Institute of Southern Illinois. Petitioner completed a Patient Information form which asked, "Is this a Workmen's Compensation claim? Answer: No." Petitioner answered unknown to where and how this happened and gave no answer to what makes his symptoms worse. Dr. Sudekum noted the record from September 13, 2013, the September 23, 2013 First Report of Injury, the September 24, 2013 Nurse Note, the October 7, 2013 Intake Form, the October 11, 2013 Hand Questionnaire Petitioner filled out where he was asked, "How did this accident happen? Answer: Repetitive motion." Dr. Sudekum noted Dr. Young's September 19, 2014 record and the September 24, 2014 nerve conduction studies. Dr.

Sudekum noted the Operative Reports of November 7, 2014 and December 24, 2014 as well as Dr. Young's January 7, 2015 record.

Petitioner reported he had no significant pain, numbness or weakness of either hand or wrist and that the pain and numbness resolved after his surgeries. On examination, Dr. Sudekum found Petitioner was 5'11" and weighed 266 pounds, which equaled a body mass index of 37.1, placing him in the obese body morphology category. Petitioner had full range of motion of the bilateral elbows, forearms, wrists, thumbs and fingers. There was mild swelling at the right incision and mild tenderness of right thenar eminence, grip and pinch were normal and there were negative Tinel's and Phalen's at the bilateral wrists. Dr. Sudekum noted Petitioner's job duties at all three facilities.

Dr. Sudekum noted Petitioner developed bilateral carpal tunnel syndrome including paresthesia of the nerve distributions. Petitioner initially sought treatment in December 2012. He treated conservatively but his symptoms persisted and worsened significantly in 2013-2014 while employed as a correctional officer at Vienna Correctional Center. He subsequently underwent successful surgical treatment in November and December 2014. Post-operatively his carpal tunnel symptoms resolved. Dr. Sudekum noted currently Petitioner has no carpal tunnel symptoms or any significant upper extremity complaints. Dr. Sudekum noted there is no indication in the medical records that Petitioner ever suffered from cubital tunnel syndrome or ulnar neuropathy.

Dr. Sudekum opined Petitioner had multiple non-work-related risk factors and/or comorbid conditions that could predispose him to the development of carpal tunnel syndrome, including obesity, hypertension, hyperlipidemia and gout. Petitioner also has an increased risk of cervical disc disease which could serve to aggravate carpal tunnel syndrome and/or peripheral neuropathies in the distal upper extremities. Dr. Sudekum noted when Petitioner was initially evaluated for his upper extremity symptoms, he was working at Vienna, but had previously worked at Tamms and Menard. Dr. Sudekum noted there is no indication Petitioner made any complaints or sought treatment while a correctional officer at Menard. Dr. Sudekum opined, "I do not feel that Mr. Plummer's relatively brief period of employment at Menard (6 months) served to cause or aggravate his carpal tunnel syndrome."

Dr. Sudekum noted, "When he was initially evaluated for carpal tunnel symptoms, Mr. Plummer indicated that his upper extremity conditions were not work related. When he was initially evaluated for his upper extremity symptoms in December 2012, Mr. Plummer did not indicate that his upper extremity symptoms or conditions were caused or aggravated by any work-related activity or any work-related injury that may have occurred at any of the correctional facilities where he had worked including Tamms, Menard and/or Vienna." Dr. Sudekum noted there was no indication on the initial patient information forms that his work activities played any role in the development, aggravation or progression of his carpal tunnel symptoms or conditions. Dr. Sudekum noted Petitioner subsequently submitted Workers' Compensation forms indicating his carpal tunnel syndrome was caused by his work activities and then

subsequently filled out new patient information forms suggesting his symptoms occurred when performing work activities.

Dr. Sudekum opined carpal tunnel syndrome develops randomly and sporadically in the adult population and its origin is most commonly idiopathic and/or due to random anatomic factors and/or associated with other risk factors and/or other comorbid medical conditions. Dr. Sudekum opined carpal tunnel syndrome rarely develops as a result of an injury or specific job activity, even if an individual performs an activity which is manually strenuous, repetitive and/or potentially provocative of carpal tunnel syndrome. Dr. Sudekum opined Petitioner's employment activities at Tamms, Menard and Vienna did not cause nor were an aggravating factor in the etiology of his bilateral carpal tunnel syndrome. Dr. Sudekum noted the medical records indicate Petitioner's subjective symptomatology of possible cubital tunnel syndrome was not supported by objective findings on the nerve conduction studies. Dr. Sudekum opined Petitioner would reach maximum medical improvement by April 1, 2015 and no additional treatment or diagnostic studies were required. Dr. Sudekum opined Petitioner may immediately resume full, unrestricted duty at work.

In his evidence deposition taken on April 26, 2016, RX3, Dr. Sudekum testified he is board certified in plastic and reconstructive surgery and upper extremity surgery. RX3, p. 4. Dr. Sudekum recited from his February 26, 2015 §12 report, noted above. Dr. Sudekum noted an error in his report, that Petitioner worked at Vienna since July 2013, not 2012 as stated in his report. RX3, p. 10. Dr. Sudekum opined there is no causal connection between Petitioner's job duties and his condition of ill-being and that his job duties did not cause nor aggravate his carpal tunnel syndrome. RX3, p. 20. Dr. Sudekum opined he did not think Petitioner's job had enough strenuous manual activity to cause or aggravate carpal tunnel syndrome. RX3, p. 21. Dr. Sudekum opined there was no exposure to vibration of any significant degree and there was no sustained heavy pinching, gripping or grasping. *Id.* Dr. Sudekum opined the pace of the correctional officer's work is relatively modest and under self-direction to a large extent. *Id.*

On cross-examination, Dr. Sudekum testified Petitioner started working at Tamms in 2001. RX3, p. 23. Petitioner told Dr. Sudekum his shift was 3:00 p.m. to 11:00 p.m. RX3, p. 23-24. Dr. Sudekum did not know if Petitioner was on a tactical team or not. RX3, p. 24. Dr. Sudekum would think being on the tactical team involved specialized training. *Id.* It seemed likely being on a tactical team involved pod cell extractions and cuffing/uncuffing procedures and even the regular officers did that. *Id.* No tactical team activity was mentioned in Dr. Sudekum's report. *Id.* At Tamms, not all inmate services are given through a chuckhole, but many are. *Id.* A chuckhole is a small port or a door which has to be locked and re-locked every time services are rendered. *Id.* A Folger Adams key is used to unlock and lock the chuckholes at Tamms. RX3, p. 24-25. Folger Adams keys are four or five inches by two inches. RX3, p. 25. Most of the chuckholes Dr. Sudekum has seen are not covered from stuff, but he would not be shocked if some are covered in food, feces and urine. *Id.* Dr. Sudekum did review a video from Tamms and it showed chuckholes. *Id.* Dr. Sudekum thought Petitioner used both hands in performing the chuckhole opening activity. *Id.* Some correctional officers would use

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both hands to use Folger Adams keys, but most do not. *Id.* Most correctional officers just use one hand to use the key, but then there is a little handle that is pulled down when the key is turned that the other hand would likely be used for. *Id.* Mail is passed through the chuckhole as is laundry, food, trash and medicine. RX3, p. 26. Dr. Sudekum acknowledged Petitioner is using his hands and arms to open the chuckhole. *Id.*

Dr. Sudekum testified two correctional officers would generally be involved in the cuffing process at Tamms through the chuckhole. *Id.* Dr. Sudekum's understanding is the inmate is searched before exiting the cell. The search is usually done with a pat-down using both hands. RX3, p. 27. Sometimes an inmate is strip searched; Dr. Sudekum did not know if this was done every time an inmate comes and goes from a cell. *Id.* After a strip search, leg irons are applied to an inmate using hands. *Id.* There are 60 cells in each pod; none of them were at capacity when the analysis was done. *Id.* During a wing check, the doors can be jiggled to make sure they are locked; other times the correctional officer would simply just look in the window; Dr. Sudekum did not specifically know how Petitioner did it. RX3, p. 28. Dr. Sudekum would not be surprised if during a cuffing/uncuffing procedure inmates resisted at times; if they resist, it requires grip and force by the correctional officer to restrain them. *Id.* Dr. Sudekum testified he asked Petitioner whether he participated in shakedowns, but Petitioner did not volunteer that information; Dr. Sudekum would think Petitioner did participate as shakedowns are part of the potential normal job duties of at least some of the correctional officers at Tamms. RX3, p. 28-29. A shakedown involves strip searching the inmate, cuffing/uncuffing an inmate through the chuckhole, removing the inmate from the cell, placing him in leg irons and escorting the inmate to the shower using arms and hands. After that is done, the correctional officer goes back to the cell to look for any type of contraband using his arms and hands. RX3, p. 29.

Dr. Sudekum testified at Tamms, there was one control officer and two housing officers on each pod. RX3, p. 30. Tamms was a maximum-security facility and there were no inmate workers. *Id.* The correctional officers performed the cleaning in the communal areas; this included potentially mopping floors, cleaning windows, scrubbing washrooms and scrubbing stainless steel. RX3, p. 31. Dr. Sudekum was asked if during his career at Tamms Petitioner opened tens of thousands of chuckholes and pulled on tens of thousands of doors; Dr. Sudekum did not have a count of how many times Petitioner opened chuckholes. *Id.* Dr. Sudekum did not know if Petitioner cuffed/uncuffed tens of thousands of inmates. *Id.* Petitioner would deliver mail to inmates and would deliver and take laundry from the inmates. RX3, p. 31-32. Dr. Sudekum did not know how much the bags of mail and bags of laundry weighed. RX3, p. 32.

Dr. Sudekum reviewed a December 20, 2010 job site analysis of the duties of a Tamms correctional officer generated by CorVel. *Id.* According to the report, once a week each pod has laundry; the inmate puts his laundry into a bag and pushes the bag through the open port to the correctional officer; the bag is dropped down to the first level if the inmate is on the second level and the bag is placed in a laundry wagon; once cleaned, the correctional officer will bring the laundry bag to the cell and put it through the chuckhole; the correctional officer will then secure the chuckhole. RX3, p. 33. Correctional officers occasionally lift trays, laundry bags and

mailbags. *Id.* Regarding trash collection, the inmate would push trash through the chuckhole to the correctional officer, who would put the trash into the bag and then dispose of it. Cleaning the showers at Tamms was performed by correctional officers. RX3, p. 36. Dr. Sudekum assumed correctional officers cleaned the toilets, but he did not know for certain. *Id.* There are inmate workers in the kitchen at Tamms. RX3, p. 37. Inmate workers and dietary bring a food tray cart to the pod entrance; the control room officer opens the slider door and the floor officer rolls in the cart; on average there were 40 food trays per pod, 20 per correctional officer per meal per shift; correctional officers distribute the food trays to the cells; each food tray probably weighed two to three pounds. Rx3, p. 37-38. Dr. Sudekum was not aware the mission statement at Tamms indicated the work there will be demanding. RX3, p. 38. Dr. Sudekum did have the job analysis report by Ms. Welch, but did not have her deposition. RX3, p. 38-39.

Dr. Sudekum testified Petitioner worked as a correctional officer at Menard from January 2013 to July 2013 and worked the 3:00 p.m. to 11:00 p.m. shift. RX3, p. 41-42. Petitioner used Folger Adams keys to open and close doors and chuckholes. RX3, p. 42. When Dr. Sudekum asked Petitioner if he bar rapped, Petitioner did not mention bar rapping; some correctional officers at Menard do bar rap. *Id.* Petitioner opened cell doors and cuffed/uncuffed inmates. *Id.* Petitioner did not mention performing shakedowns, but that certainly could have been part of his job. RX3, p. 43. Dr. Sudekum would be surprised if Menard went six months without a lockdown. *Id.* Dr. Sudekum remembered authoring a report concerning the general job duties of a correctional officer at Menard and gave a deposition concerning that report. RX3, p. 44.

Dr. Sudekum testified Petitioner was 5'11" and weighed 266 pounds when he saw him. RX3, p. 46. Petitioner did not indicate he worked out. *Id.* To Dr. Sudekum's knowledge, Petitioner does not have diabetes. *Id.* Petitioner did have a history of gout. *Id.* For gout to contribute to carpal tunnel syndrome, it must be in the same area as the carpal tunnel; there was no visible evidence of any gout in the hands when Dr. Sudekum evaluated Petitioner. *Id.* Petitioner was hypertensive and had been taking medication for that; Dr. Sudekum could not really speak with any concrete knowledge of Petitioner's long-term history of hypertension control. RX3, p. 46-47. Dr. Sudekum testified Petitioner improved following surgery. RX3, p. 47. Dr. Sudekum did take issue with the late addition of cubital tunnel syndrome without any clinical evidence or any electrodiagnostic evidence to support that. RX3, p. 48. Dr. Sudekum testified he would not have had Petitioner off work for six weeks after the first surgery; if doing the surgeries, Dr. Sudekum would have had Petitioner off work a few days and then on light duty work for six weeks, then full duty released. RX3, p. 49. Dr. Sudekum opined performing surgery was appropriate. *Id.* Dr. Sudekum could not say for certain whether Vienna Correctional Center had light duty work available. *Id.*

Petitioner admitted various documents into evidence as PX8, titled Workers' Compensation Documentation Log records. Respondent admitted these same documents into evidence as RX1. An Illinois Form 45 dated September 23, 2013 indicated a date of accident of September 13, 2013. To the question, "What was employee doing when accident occurred?",

Petitioner indicated he was "Turning key." To the question, "How did accident occur?", Petitioner wrote, "From turning keys." The injury was listed as carpal tunnel syndrome.

In a Workers' Compensation Employees' Notice of Injury dated September 23, 2013, Petitioner indicated a date of injury of September 13, 2013 at approximately 10:30 a.m. Petitioner noted he was still working and reported his injury to supervisor Major Hurst on September 23, 2013. Petitioner was asked to explain if his injury was not reported on the date of accident. Petitioner noted, "Date of incident was when this R/E was informed by Dr. Young of injury." He was asked what duty he was performing at the time of injury. Petitioner answered, "Repetitive turning of keys and locks. Repetitive cuffing and placing leg irons on inmates. Repetitive bar rapping of cell doors. Repetitive dead locking of cell doors." Petitioner was asked the place where his injury occurred and answered Tamms, Menard and Vienna. Petitioner described his injury as numbness in his right and left hands, numbness in his middle index finger and thumb of his right and left hands, loss of strength and grip in his right and left hands. Under additional details of how injury occurred, Petitioner wrote, "Injury occurred from repetitive turning of keys to unlock and lock chuckholes, padlocks, doors, cell doors and cuffs. Also, the repetitive use of placing hand cuffs and leg irons on inmates. The repetitive use of a metal bar to rap cell bars and the repetitive use of 2-way radios. Injury occurred while working at Tamms C.C. (10/29/01 – 01/04/13), Menard C.C. (01/05/12 – 07/14/13) and Vienna C.C. (07/15/12 – present)." PX8, RX1.

In an Adult and Juvenile Divisions Incident Report dated September 23, 2013, Petitioner noted the Institution/Program as Vienna Correctional Center. Under Statement of Facts, Petitioner wrote, "On the above date and approx. time this R/O informed Major Hurst of an injury that has occurred from years of daily repetitive use of this R/O's right and left hands. On 9/13/13 this R/O was seen by Dr. Young at Southern Orthopedic Associates due to extreme pain, numbness and loss of strength and grip in both right and left hands. After Dr. Young reviewed the test results of a nerve conduction test, that this R/O completed, Dr. Young diagnosed this R/O with moderate carpal tunnel syndrome. This repetitive trauma to this R/O's right and left hands occurred while working at Tamms C.C. (10-29-01 to 01-04-13), Menard C.C. (01-07-13 to 07-14-13) and Vienna C.C. (07-15-13 to present time) from years of daily repetitive turning of keys to unlock/lock cuffing parts, padlocks on food boxes, cell doors, gallery grill doors, closet doors to sign wing check log, handcuffs and leg irons. Also, the repetitive use of this R/O's hands while pushing buttons to open doors from control centers, typing incident reports, writing incident reports and keying two-way radios. The repetitive use of this R/O's hands while placing handcuffs and leg irons on inmates, rapping bars on cell doors and unloading and loading ammo in weapon magazines." WC packet completed on 9-23-13 and turned in to Major Hurst." PX8, RX1.

In a Supervisor's Report of Injury dated September 23, 2013, Shift Supervisor Jane Hurst noted Petitioner's assigned duties of operating keys/locks to control inmate movement, report as needed, daily documented counts, securing equipment on post and see DC434 for additional duties as reported. Petitioner was 11 years and 11 months in his current job title. Ms. Hurst

noted Petitioner's activity at the time of accident/incident was self-reported progressive and ongoing. The date of accident/incident was reported September 23, 2013 to the major's office. Written notice from Petitioner was received September 23, 2013 at 6:45 p.m. Under Description of accident/incident, Ms. Hurst wrote, "Self-reported damage diagnosed by physician for/caused by repetitious movement over an extended time frame; reported to be slowly progressing to more severe pain and numbness. Self-report deteriorating strength in hands." The injury was described as right and left wrist affecting both hands. PX8, RX1.

On October 7, 2013, Petitioner completed an intake form for the Orthopaedic Institute of Southern Illinois. Petitioner noted a chief complaint of numbness and weakness in both hands. Petitioner noted his symptoms began in January 2012. When asked, "Where did this happen?", Petitioner wrote Tamms, Menard and Vienna. His severity of pain was 7/10. The character of pain was numbness. Holding anything made his symptoms worse. Petitioner noted the pain would last until he shook his hands. Petitioner noted previous treatment of bracing. He noted similar complaints on the opposite side. PX5.

In a Workers' Compensation Information form dated October 13, 2013, Petitioner was asked how long had his problem been present and answered, "Since January 2012." Petitioner noted the date his injury occurred was September 13, 2013. Petitioner was asked how did this accident happen and answered, "Repetitive motion." Both hands were affected. Petitioner indicated his employer was notified at the time of the accident. Petitioner listed his Supervisor or other contact as Major Hurst. He noted his job title as Correctional Officer and the duration of employment as 12 years. Petitioner indicated this injury was with his current employer. PX5.

The Commission makes the following factual findings:

*Petitioner established he sustained accidental injuries arising out of and in the course of his employment manifesting on September 13, 2013.

*Petitioner established a causal relationship exists between those injuries and his condition of ill-being of his bilateral hands.

*Petitioner established he provided timely notice of those accidental injuries to Respondent.

*Petitioner established he was temporarily totally disabled from November 7, 2014 through January 7, 2015, a period of 8-6/7 weeks.

*Petitioner established he is entitled to reasonable and necessary medical expenses in the amount of $19,709.66 pursuant to §§8(a) and 8.2 of the Act.

*Petitioner established he is permanently partially disabled to the extent of 10% loss of use of each hand.

CONCLUSIONS OF LAW

A. Accident

"To obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of the evidence, that he has suffered a disabling injury which arose out of and in the course of his employment. [citations omitted]." *Sisbro, Inc. v. Industrial Commission*, 207 Ill. 2d 1993 193, 203, 797 N.E.2d 665 (2003). "To satisfy this (arising out of) requirement it must be shown that the injury had its origins in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Id.* The "in the course of employment" phase "refers to the time, place and circumstances surrounding the injury" and, to be compensable, an injury "generally must occur within the time and space boundaries of the employment." *Id.* An employee who suffers a gradual injury due to repetitive trauma is eligible for benefits under the Act, but he must meet that same standard of proof as an employee alleging a single, definable accident. *Three "D" Discount Store v. Industrial Commission*, 198 Ill. App. 3d 43, 47, 556 N.E.2d 261 (1989). The date of the accidental injury in a repetitive-trauma case is the date on which the injury "manifests itself." *Peoria County Bellwood Nursing Home v. Industrial Commission*, 115 Ill. 2d 524, 531, 505 N.E.2d 1026 (1987). " 'Manifests itself' means the date on which both the fact of the injury and the causal relationship of the injury to the claimant's employment would have become plainly apparent to a reasonable person." *Id.*

The pertinent question is whether the tasks performed by Petitioner were a cause of his condition. Petitioner testified to these tasks in detail, explaining how the tasks required him to repeatedly use his hands in manipulating the chuckhole, using Folger Adams keys to lock/unlock same, cuffing/uncuffing an inmate, bar rapping, cleaning the floors and bathrooms and carrying mail bags and laundry bags to the inmates at Tamms from October 29, 2001 until that facility closed in January 2013. T. 15-23. Petitioner was transferred to Menard and worked there from January 2013 to July 2013, performing many of the same tasks. T. 25-26. Petitioner began having symptoms of numbness and tingling in approximately 2011. Over time, his symptoms steadily worsened. T. 24, 27. He was transferred to Vienna in July 2013, where he was keying, unlocking doors and performing cell searches. T. 27, 30. Respondent's representative John Cox testified he supervised Petitioner at Vienna and previously worked at Tamms. Mr. Cox testified he could not think of anything at all that Petitioner said was inaccurate. T. 59-61.

On August 28, 2013, Petitioner saw Dr. Cerny, his primary care physician, and reported numbness and tingling in his hands for the last 12 to 18 months and used wrist splints for months without benefit. Dr. Cerny noted carpal tunnel symptoms in both hands as well as Petitioner's work duties at Menard which required turning of locks with keys. Dr. Cerny noted Petitioner recently transferred to Vienna, and he felt much less stress overall with the change. Dr. Cerny assessed probable bilateral carpal tunnel syndrome and ordered a bilateral upper extremity nerve conduction study. PX3. Petitioner underwent electrophysiological testing on September 3, 2013

and the results were abnormal. An orthopedic referral was recommended. PX3, PX4. Dr. Young evaluated Petitioner on September 13, 2013 on referral from Dr. Cerny. Dr. Young noted Petitioner's numbness and tingling in the hands bilaterally since 2011. Dr. Young noted Petitioner's job of correctional officer with the Illinois Department of Corrections. On examination Dr. Young found full range of motion of both wrists, there was positive Tinel's and positive median nerve compression test bilaterally and pinch and grip strength were decreased. Dr. Young reviewed the electrophysiological test results and noted it evidenced bilateral carpal tunnel syndrome. Dr. Young assessed bilateral carpal tunnel syndrome and recommended surgery. PX3, PX5.

Based on the above, the Commission finds Petitioner sustained his burden of proving he sustained accidental injuries arising out of and in the course of his employment manifesting on September 13, 2013.

B. Causal Relationship

"Employment need not be the sole causative factor, or even the primary causative factor, as long as it was a causative factor in a claimant's condition of ill-being." *Sisbro*, 207 Ill. 2d 1993 193, 205 (2003). The Commission finds Petitioner proved a causal relationship between his accidental injuries manifesting on September 13, 2013 and his condition of ill-being of his bilateral hands and need for treatment. The Commission finds Dr. Young's opinions more persuasive than the opinions of Dr. Sudekum.

In his October 28, 2014 deposition, Dr. Young noted Petitioner's job duties at Tamms included passing items of food through chuckholes, which required 240 key turns for feeding alone, using Folger Adams keys, performing wing checks, shakedowns, cuffing/uncuffing inmates, assisting in cleaning, maintenance, toilets, trash, sweeping, mopping and cleaning windows due to no inmate help. PX11, p. 15-16. Dr. Young opined these job duties could certainly aggravate a carpal tunnel syndrome or contribute to it. PX11, p. 17.

In his February 26, 2015 §12 report, Dr. Sudekum opined Petitioner's employment activities at Tamms, Menard, and Vienna did not cause nor were an aggravating factor in the etiology of his bilateral carpal tunnel syndrome. RX2. In his April 26, 2016 deposition, Dr. Sudekum opined there is no causal connection between Petitioner's job duties and his condition of ill-being and that his job duties did not cause or aggravate his carpal tunnel syndrome. RX3, p. 20. Dr. Sudekum opined he did not believe Petitioner's job exhibited enough strenuous manual activity to cause or aggravate carpal tunnel syndrome. RX3, p. 21. However, in his §12 report dated April 29, 2011 regarding a Menard correctional officer, Dr. Sudekum opined, "...the job activities of a Correctional Officer at Menard Correctional Center would not serve as a primary etiologic factor in the development of upper extremity "repetitive trauma injuries" however, I feel that these work activities could be a possible aggravating factor in the development and/or progression of these conditions." PX14. The Commission concludes Dr. Sudekum's opinions are contradictory in this case. The Commission finds Petitioner's job duties at Tamms were "a"

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cause of his condition of ill-being, and the condition further deteriorated during the six months he worked at Menard.

C. Timely Notice of Accident

Section 6(c) of the Act provides, in relevant parts, "Notice of the accident shall be given to the employer as soon as practicable, but not later than 45 days after the accident." *820 ILCS 305/6(c)* (West 2010). "A claimant complies with the Act if, within 45 days, the employer possesses the known facts related to the accident." *Gano Electric Contracting v. Industrial Commission*, 260 Ill. App. 3d 92, 96, 631 N.E.2d 724 (1994).

Petitioner testified after September 13, 2013, he completed a report and attributed his condition to the working conditions throughout his career at Tamms, Menard, and Vienna. T. 29. Petitioner admitted into evidence an Illinois Form 45 dated September 23, 2013 indicating a date of accident of September 13, 2013. To the question, "What was employee doing when accident occurred?", Petitioner indicated he was "Turning key." To the question, "How did accident occur?", Petitioner wrote, "From turning keys." The injury was listed as carpal tunnel syndrome. PX8, RX1. In a Workers' Compensation Employees' Notice of Injury dated September 23, 2013, Petitioner indicated a date of injury of September 13, 2013. Petitioner noted he had reported his injury to supervisor Major Hurst on September 23, 2013. Petitioner was asked to explain if his injury was not reported on the date of accident. Petitioner noted, "Date of incident was when this R/E was informed by Dr. Young of injury." He was asked what duty he was performing at the time of injury. Petitioner answered, "Repetitive turning of keys and locks. Repetitive cuffing and placing leg irons on inmates. Repetitive bar rapping of cell doors. Repetitive dead locking of cell doors." Petitioner was asked the place where his injury occurred and answered Tamms, Menard, and Vienna. Petitioner described his injury as numbness in his right and left hands, numbness in his middle index finger and thumb of his right and left hands, loss of strength and grip in his right and left hands. Under additional details of how injury occurred, Petitioner wrote, "Injury occurred from repetitive turning of keys to unlock and lock chuckholes, padlocks, doors, cell doors and cuffs. Also the repetitive use of placing hand cuffs and leg irons on inmates. The repetitive use of a metal bar to rap cell bars and the repetitive use of 2-way radios. Injury occurred while working at Tamms C.C. (10/29/01 – 01/04/13), Menard C.C. (01/05/12 – 07/14/13) and Vienna C.C. (07/15/12 – present)." PX8, RX1.

In an Adult and Juvenile Divisions Incident Report dated September 23, 2013, Petitioner noted the Institution/Program as Vienna Correctional Center. Under Statement of Facts, Petitioner wrote, "On the above date and approx. time this R/O informed Major Hurst of an injury that has occurred from years of daily repetitive use of this R/O's right and left hands. On 9/13/13 this R/O was seen by Dr. Young at Southern Orthopedic Associates due to extreme pain, numbness and loss of strength and grip in both right and left hands. After Dr. Young reviewed the test results of a nerve conduction test, that this R/O completed, Dr. Young diagnosed this R/O with moderate carpal tunnel syndrome. This repetitive trauma to this R/O's right and left

hands occurred while working at Tamms C.C. (10-29-01 to 01-04-13), Menard C.C. (01-07-13 to 07-14-13) and Vienna C.C. (07-15-13 to present time) from years of daily repetitive turning of keys to unlock/lock cuffing parts, padlocks on food boxes, cell doors, gallery grill doors, closet doors to sign wing check log, handcuffs and leg irons. Also the repetitive use of this R/O's hands while pushing buttons to open doors from control centers, typing incident reports, writing incident reports and keying two-way radios. The repetitive use of this R/O's hands while placing handcuffs and leg irons on inmates, rapping bars on cell doors and unloading and loading ammo in weapon magazines." WC packet completed on 9-23-13 and turned in to Major Hurst." PX8, RX1.

In a Supervisor's Report of Injury dated September 23, 2013, Shift Supervisor Jane Hurst noted Petitioner's assigned duties of operating keys/locks to control inmate movement, report as needed, daily documented counts, securing equipment on post and see DC434 for additional duties as reported. Petitioner was 11 years and 11 months in his current job title. Ms. Hurst noted Petitioner's activity at the time of accident/incident was self-reported progressive and ongoing. The date of accident/incident was reported September 23, 2013 to the major's office. Written notice from Petitioner was received September 23, 2013 at 6:45 p.m. Under Description of accident/incident, Ms. Hurst wrote, "Self-reported damage diagnosed by physician for/caused by repetitious movement over an extended time frame; reported to be slowly progressing to more severe pain and numbness. Self-report deteriorating strength in hands." The injury was described as right and left wrist affecting both hands. PX8, RX1.

Based on Petitioner's testimony and the documents PX8, RX1, the Commission finds Petitioner provided timely notice of accident to Respondent on September 23, 2013.

D. Temporary Total Disability Benefits

"To show entitlement to TTD benefits, claimant must prove not only that he did not work, but that he was unable to work. [citation omitted]." *City of Granite City v. The Industrial Commission*, 279 Ill. App. 3d 1087, 1090, 666 N.E.2d 827 (1996). Petitioner underwent a left carpal tunnel release on November 7, 2014 and was off work at that time. PX6. Further "[t]he dispositive test is whether the claimant's condition has stabilized, that is, whether the claimant has reached maximum medical improvement. [Citation omitted]." *Mechanical Devices v. The Industrial Commission*, 344 Ill. App. 3d 752, 759. On December 24, 2014, Dr. Young performed a right carpal tunnel release. PX6. On January 7, 2015, Dr. Young removed sutures and noted the incision was well healed. Petitioner had no complaints and was discharged from physical therapy and was to continue a home exercise program. Dr. Young provided Petitioner light duty restrictions of no lifting over five pounds allowing Petitioner to return to work. The Commission finds Petitioner reached maximum medical improvement at that point. The Commission finds Petitioner established he was temporarily totally disabled from November 7, 2014 through January 7, 2015, a period of 8-6/7 weeks, pursuant to §8(b) of the Act. The parties stipulated to an average weekly wage of $1,229.75, which yields a TTD rate of $819.84. ArbEx1.

E. Medical Expenses

Section 8(a) of the Illinois Workers' Compensation Act entitles a claimant to recover medical expenses which are reasonable, necessary, and causally related to an accident. *820 ILCS 305/8(a)* (West 2010); *Zarley v. The Industrial Commission*, 84 Ill. 2d 380, 418 N.E.2d 718 (1981). The Commission finds Petitioner is entitled to payment of medical bills contained in PX1 and awards $19,709.66 pursuant to §§8(a) and 8.2 of the Act.

F. Permanent Partial Disability Benefits

Petitioner testified he noticed immediate change after his surgeries as the numbness subsided. T. 31. The strength in his hands is still not complete, but it is slowly resolving. T. 31. He still has some weakness in his hands and occasionally has some burning in his right wrist, which is brought on by any kind of continuous activities. T. 37. Petitioner testified, "I can't really put my thumb on any one thing, but the more you do them, the more it causes your hand to become fatigued." *Id.* Otherwise Petitioner obtained significant improvement following treatment. *Id.* Petitioner currently works full time at Vienna as a correctional lieutenant. T. 41.

The medical records evidence Petitioner last saw Dr. Young on February 9, 2015. On examination Dr. Young found the incision was well healed and Petitioner had good range of motion. Dr. Young noted, "He (Petitioner) states that his symptoms have almost resolved and he has no complaints." Dr. Young released Petitioner to return to work full duty effective February 10, 2015 and released him from care. PX5.

Pursuant to §8.1b, the Commission weighs the following five factors accordingly:

1) AMA Impairment Rating- Neither party obtained an impairment rating, so no weight is assigned to this factor.

2) Occupation of Petitioner- Petitioner continues to serve as a correctional officer at Vienna Correctional Center and is currently a correctional lieutenant. The Commission places significant weight on this factor as being indicative of reduced permanent disability.

3) Age of Petitioner- The Stipulation Sheet memorializes Petitioner was 31 years of age at the time his accidental injuries manifested. Petitioner has a significant work life expectancy which will require him to manage the effects of his injury for a greater period. The Commission finds this factor weighs in favor of increased permanent disability.

4) Petitioner's Future Earning Capacity- There is no evidence of reduced earning capacity contained in the record. The Commission places significant weight on this factor as being indicative of reduced permanent disability.

5) Evidence of Disability/Treating Records- Petitioner developed bilateral carpal tunnel syndrome and underwent bilateral carpal tunnel releases. PX5. Despite improvement from surgery and physical therapy, Petitioner continues to have weakness and fatigue in his hands and occasional burning in his right wrist. T. 36-37. On his last visit with Dr. Young on February 9, 2015, Petitioner reported his symptoms had almost resolved and he had no complaints. Dr. Young released Petitioner to return to work full duty and he has not treated since that time. The Commission places significant weight on this factor as being indicative of reduced permanent disability.

Based upon the above numerated factors as well as the record taken, the Commission awards Petitioner permanent partial disability benefits of $737.85/week for the total period of 38 weeks, because the injuries sustained caused the loss of use of 10% loss of use of the left hand and 10% loss of use of the right hand, as provided by §8(e)9 of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's June 26, 2017 decision is reversed for the reasons stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $819.84 per week for a period of 8-6/7 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 for medical expenses contained in Petitioner's Exhibit 1 in the amount of $19,709.66 pursuant to §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $737.85 per week for a period of 19 weeks, as provided in §8(e)9 of the Act, for the reason that the injuries sustained caused the permanent loss of use of the left hand to the extent of 10%.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $737.85 per week for a period of 19 weeks, as provided in §8(e)9 of the Act, for the reason that the injuries sustained caused the permanent loss of use of the right hand to the extent of 10%.

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: APR 10 2018
LEC/maw
o01/30/18
43

L. Elizabeth Coppoletti

Joshua D. Luskin

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF ARBITRATOR DECISION

PLUMMER, MATTHEW
Employee/Petitioner

Case# **13WC037868**

SOI/DEPT OF CORRECTIONS
Employer/Respondent

18IWCC0218

On 6/26/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.12% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62794-9255

0558 ASSISTANT ATTORNEY GENERAL
AARON L WRIGHT
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

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

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

JUN 26 2017

Ronald A. Parisi, Acting Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Matthew Plummer
Employee/Petitioner

v.

State of Illinois/Illinois Department of Corrections
Employer/Respondent

Case # 13 WC 37868

Consolidated cases: n/a

18IWCC0218

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Herrin**, on **May 9, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **September 13, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned **$63,947.00**; the average weekly wage was **$1,229.75**.

On the date of accident, Petitioner was **31** years of age, *single* with **0** dependent children.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, **$0** in non-occupational indemnity disability benefits and **$0** in other benefits for which credit may be allowed under Section 8(j) of the Act.

Respondent is entitled to a credit in the amount of **$IF ANY** for medical bills paid under its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Petitioner failed to prove that he sustained an accident that arose out of and in the course of his employment with Respondent, and that his current condition of ill-being is casually related to his alleged accident. All benefits are denied; the remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

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

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

Melinda M. Pope-Sullivan

Signature of Arbitrator

6/21/17

Date

JUN 26 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Matthew Plummer
Employee/Petitioner

Case # 13 WC 37868

v.

Consolidated cases: N/A

State of Illinois/Illinois
Department of Corrections
Employer/Respondent

18IWCC0218

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he has been employed by Respondent since October 29, 2001. He testified that he began his career at Tamms Correctional Center and that he worked there until it closed in 2013. He testified that he spent the overwhelming majority of his Tamms tenure working the 3-11 p.m. shift as a Correctional Officer. He testified that he also joined the Tamms tactical force in 2004 and that he spent most of his time as a Tactical Officer in B pod. He described his participation in the tactical team as being part of a "swat team" that does cell extractions and assists with shakedowns. He testified that after Tamms closed, he was reassigned to the maximum security unit at Menard Correctional Center and continued to serve as a Tactical Correctional Officer. He testified that seven months later, he transferred to Vienna Correctional Center.

Petitioner testified that as a Tamms Correctional Officer he repeatedly unlocked, opened, closed and relocked chuckholes or "food boxes" 60-90 times a day, in order to dispense food, mail and laundry to inmates. He testified that chuckholes were locked openings in the front of the cell doors, opened with a 4-inch Folger Adams key. He testified that inmates routinely spilled food, liquids and even bodily waste which caused the chuckholes to jam and become difficult to open. He testified that it was a two-handed task to open a chuckhole. He testified that when a chuckhole proved difficult to open and close, he would use his hands to "pull really hard to get it to come down" and then "use a knee" to shut the chuckhole before securing it. He testified that food boxes were openings with "two sliders" with two locks opened by a smaller master lock key. He testified that he also had to cuff and uncuff inmates and that after the offender is handcuffed, he must forcefully grip the handcuffs and hang on to them so that the inmate cannot pull away back into the cell.

Petitioner testified to performing routine 30-minute wing checks, which involved going to each of the cells within the wing he was assigned to, making sure the doors were secure and logging his activity in entry log books kept in "water closets" located on each upper and lower level, which also had to be unsecured and re-secured. He also testified that the Tamms facility had no inmate workers so that as a Correctional Officer, he was responsible for mopping the floors, cleaning washrooms and windows, carrying mailbags, delivering mail and carrying and delivering laundry. He estimated that the mail bags weighed 40-60 pounds and that the laundry bags weighed 20-30 pounds. He testified that employment at Tamms was very demanding and also reported working overtime because the facility was short-staffed.

Petitioner testified that during the course of his job duties at Tamms Correctional Center, he began having symptoms of weakness and numbness in his hands and that he was then transferred to

Menard. He testified that he continued to serve as a Correctional Officer and serve on the tactical team in Menard's North 2 segregation unit. He testified to performing tasks such as opening chuckholes, rapping bars and deadlocking cells with Folger Adams keys while at Menard Correctional Center.

Petitioner testified to improvement following surgery and physical therapy. He testified that he continues to have some symptoms such as weakness and fatigue in his hands and occasional burning in his right wrist. He testified that his hands tire with repetitive or continuous activity. He testified that his hobby of fishing has been adversely affected by his weakness.

Petitioner also called the representative present on behalf of Respondent, John Cox, to testify. Mr. Cox testified that he currently works at Vienna Correctional Center and that he also previously worked at Tamms Correctional Center. He testified that he has directly supervised Petitioner and indicated that he is a good employee. He testified that there was nothing incorrect or inaccurate in Petitioner's testimony concerning his description of the arm and hand usage at Tamms Correctional Center.

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The Medical Records List was entered into evidence at the time of arbitration as Petitioner's Exhibit 2.

The medical records of Dr. John Cerny were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on August 28, 2013, at which time it was noted that, among other things, he wanted to have nerve conduction studies or a referral to SIOC and that he stated that he had numbness and tingling in his hands for 12-18 months. It was noted that Petitioner had carpal tunnel symptoms in both hands, had used wrist splints for months without benefit, had recently been transferred to Vienna and felt much less stress overall with the change. It was noted that Petitioner was turning lots of locks with keys. The assessment was noted to include probable carpal tunnel syndrome of the bilateral upper extremities. Petitioner was ordered to undergo nerve conduction studies. (PX3).

The medical records of Union County Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner underwent electrophysiological testing on September 3, 2013, which was interpreted as revealing positive electrophysiological evidence suggestive of a focal demyelinating process with conduction block of the right and left median motor and sensory nerve fibers at or about the wrist (carpal tunnel) and that the severity of both would be graded as moderate. The Patient Intake Form noted that Petitioner had had the symptoms for 1½ years, that driving or holding anything increased his symptoms and that shaking his hand decreased his symptoms. The records reflect that Petitioner underwent additional electrophysiological testing on September 24, 2014, which was interpreted as revealing positive electrophysiological evidence suggestive of a focal demyelinating process of the right median nerve motor and sensory fibers at or about the wrist (carpal tunnel) and a focal demyelinating process with axonal involvement of the left median nerve motor and sensory fibers at or about the wrist (carpal tunnel) which was moderate but the axonal involvement was identified on the left as moderate to severe. (PX4).

The medical records of Dr. Steven Young/Orthopaedic Institute of Southern Illinois were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner was seen on September 13, 2013 for a chief complaint of bilateral hand numbness and pain. It was noted that Petitioner stated that since late 2011 he had had numbness and tingling in the hands bilaterally, that he was waking up at night with the symptoms and that he was also having pain in the hand. It was noted that Petitioner had been wearing splints and that he stated that they had not been helping. The assessment was noted to be that of bilateral carpal tunnel syndrome. It was noted that Petitioner wanted to get things

situated at work before scheduling surgery and that he wanted to do a left carpal tunnel release first and the right at a later date. At the time of the September 19, 2014 visit, it was noted that Petitioner's chief complaint was that of bilateral hand numbness, weakness and pain. It was noted that Petitioner stated that for quite some time he had had numbness and tingling in both hands, that it had gotten worse and that he had been seen last year and had carpal tunnel syndrome but was unable to have surgery at that time. The assessment was noted to be that of bilateral carpal tunnel syndrome and bilateral cubital tunnel syndrome. Petitioner was recommended to undergo another nerve conduction study. (PX5).

The records of Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen on October 13, 2014, at which time it was noted that he stated that he was still having weakness, numbness and pain in the hands. It was noted that the nerve conduction studies revealed moderate to severe bilateral carpal tunnel syndrome with the left being worse than the right. Petitioner was placed on the surgical schedule for a carpal tunnel release and it was noted that he stated that he wanted to do the left first. An order for occupational therapy was issued on November 7, 2014. At the time of the November 21, 2014 visit, it was noted that the incision site was healing well and that Petitioner wished to schedule the right carpal tunnel release. A work slip was issued on that date allowing Petitioner to participate in modified duty, beginning December 1, 2014, with a 3-5 pound lifting restriction on the operative hand. At the time of the December 23, 2014 visit, Petitioner was seen for a pre-operative history and physical. A work slip was issued on that date, indicating that Petitioner was unable to work until re-evaluated. (PX5).

The records of Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen on January 7, 2015, at which time it was noted that he had no complaints. Petitioner was issued work restrictions at that time. At the time of the February 9, 2015 visit, it was noted that the incision site had healed well, that Petitioner had good range of motion and that he stated that his symptoms had almost resolved and that he had no complaints. Petitioner was released to return as needed and was allowed to return to work full duty. (PX5).

The medical records of Southern Illinois Orthopedic Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Petitioner underwent surgery on November 7, 2014 for a left carpal tunnel release for a pre- and post-operative diagnosis of left carpal tunnel syndrome. The records further reflect that Petitioner underwent surgery on December 24, 2014 for a right carpal tunnel release for a pre- and post-operative diagnosis of right carpal tunnel syndrome. (PX6).

The medical records of Brigham Anesthesia were entered into evidence at the time of arbitration as Petitioner's Exhibit 7.

The Workers' Compensation Documentation Log was entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The Workers' Compensation Employee's Notice of Injury was dated September 23, 2013 and noted that the date of injury was that of September 13, 2013. It was noted that the accident was reported to Major Hurst on September 23, 2013. It was noted that the duties at the time of injury were that of repetitive turning of keys and locks, repetitive cuffing and placing leg irons on inmates, repetitive bar rapping of cell doors and repetitive deadlocking of cell doors. It was noted that the place where the injury occurred was that of Tamms, Menard and Vienna Correctional Centers. When asked to describe the injury, it was noted that there was numbness in the right and left hands, numbness in the middle index finger and thumbs of the right and left hands and that there was loss of grip strength in the right and left hands. The Supervisor's Report of Injury or Illness was dated September 23, 2013 and noted that Petitioner reported the accident on September 23, 2013. The Illinois Form 45 was dated September 23, 2013 and noted that Petitioner reported an accident date of September 13, 2013. It was noted that Petitioner was turning keys at the time of the accident and that the body parts affected were that of the wrists. The IDOC Incident Report dated September 23, 2013 noted that Petitioner alleged that his

hands were injured from years of daily repetitive turning of keys to unlock/lock cuffing parts, padlocks on food boxes, cell doors, gallery grill doors, closet doors to sign wing checks/logs, handcuffs and leg irons, and that Petitioner also alleged repetitive use of his hands while pushing buttons to open doors from control centers, typing incident reports, writing incident reports and keying two-way radios as well as placing handcuffs and leg irons on inmates, rapping bars on cell doors and unloading and loading of ammunition in weapon magazines. (PX8).

Petitioner's Job Description was entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The document was completed by Petitioner on October 30, 2014 and noted various requirements including lifting, pushing and pulling, bending or stooping, reaching above shoulder level, the use of the hands for gross manipulation, the use of hands for fine manipulation and loading and unloading. Petitioner also noted that he was a "tact" officer since 2004 and that his additional duties included cell extraction, prison searches and other duties that a normal "CO" did not do on a daily basis. (PX9).

Petitioner's Work History Timeline was entered into evidence at the time of arbitration as Petitioner's Exhibit 10.

The transcript of the deposition of Dr. Steven Young was entered into evidence at the time of arbitration as Petitioner's Exhibit 11. Dr. Young testified that he is board-certified in orthopedic surgery and that the vast majority of his practice consists of treatment of the hand and upper extremity. He testified that forceful gripping, pinching, pushing, pulling and repetitive activities with the hand or wrist in a flexed or extended position were some of the occupational risk factors that could lead to the development of carpal tunnel syndrome. He testified that non-occupational risk factors that could lead to the development of carpal tunnel syndrome were that of advancing patient age, female sex, obesity, smoking, diabetes, rheumatological conditions and low thyroid function. (PX11).

Dr. Young testified that Petitioner was referred to him by Dr. Cerny, a local primary care physician. He testified that he first saw Petitioner on December 20, 2012, at which time he reported complaints of numbness and tingling in the bilateral upper extremities, primarily the thumb, index and long finger, and that the symptoms had been present for approximately six months. He testified that Petitioner stated that the symptoms were more problematic after doing strenuous work as well as first thing in the morning, that he had tried braces without relief and that he had no formal testing such as a nerve conduction study. He testified that after Petitioner was evaluated, he felt that he had a compression neuropathy and that a nerve conduction study was ordered and ultimately performed on September 3, 2013. He testified that Petitioner was seen on September 13, 2013, at which time he had similar complaints involving the bilateral upper extremities. He testified that the nerve conduction study revealed moderate bilateral carpal tunnel syndrome. He testified that the diagnosis was that of bilateral carpal tunnel syndrome and that he recommended surgical intervention. (PX11).

Dr. Young testified that Petitioner was seen on September 19, 2014, at which time it was noted that his pain was an 8/10 but otherwise no substantial change and that he stated that he had numbness in all of the fingers which had not been reported previously. He testified that the recommendation was to repeat a nerve conduction study because of the complaints of numbness and tingling involving the entire hand and concern for the possibility of additional nerve compression such as the ulnar nerve at the elbow. He testified that the additional testing showed bilateral carpal tunnel syndrome but did not appear to show any involvement of the ulnar nerve. He testified that the numbers were very similar to the 2013 nerve conduction study. He testified that he believed that surgical intervention was still the best option for Petitioner. He testified that he did not expect Petitioner to improve without surgery and that it was only going to get worse with time. (PX11).

Dr. Young testified that he believed that these job duties when performed for 11 ½ years could aggravate or contribute to carpal tunnel syndrome. He testified that he thought that the opening and closing of the chuckholes, utilizing the Folger Adams keys and the cuffing and uncuffing of inmates could certainly contribute. He testified that Petitioner was above ideal body weight and that there was a history at one point of smoking but that otherwise he did not see much. He testified that Petitioner was relatively young to develop carpal tunnel syndrome at age 30. (PX11).

Dr. Young testified that Petitioner worked at Menard Correctional Center after he left Tamms. He testified that he has treated other individuals who had been employed at Menard as correctional officers and that he considered himself familiar with those job duties. He testified that he believed that the job duties at Menard Correctional Center would cause, contribute to or aggravate carpal tunnel syndrome, and that he believed that the utilization of the keys and the bar rapping could certainly contribute to the development or aggravation of carpal tunnel syndrome. (PX11).

Dr. Young testified that Petitioner had consistent complaints of carpal tunnel for the three visits that he saw him and that he did not recall that he had any substantial worsening or alleviation of his symptoms. He testified that he would not be surprised if Petitioner testified at trial that when he was at Menard his symptoms became worse or more severe because of the job duties because if Petitioner had an increase in activity or aggravating factors, then he could certainly have a worsening of his symptoms. He testified that after Petitioner left Menard he went to Vienna Correctional Center and that even if the job duties were less hand-intensive he thought there was the possibility of some improvement, but that he did not think that the carpal tunnel syndrome would go away. (PX11).

On cross examination, Dr. Young agreed that he received various documents from Petitioner's attorney after the care and treatment was rendered and that he reviewed the documents on the morning prior to the deposition. He testified that he reviewed the job description as provided by the office of Petitioner's attorney and the IME report of Dr. Sudekum dated April 29, 2011. He testified that he did not review the deposition that was supplied to him. He testified that he did not receive any kind of job analysis from CorVel for Vienna Correctional Center. He testified that Petitioner indicated on the patient questionnaire his work history and that nowhere on the document did he mention bar rapping, putting leg irons on prisoners or turning keys. He agreed that the document stated where Petitioner worked within the Department of Corrections and the timeline. He further agreed that the document did not state anything that Petitioner would do for his job duties. (PX11).

On cross examination, Dr. Young testified that at no point during any of the three visits that he had with Petitioner did he ever mention to him any of the job duties that were set forth in the document provided by his Petitioner's attorney. He denied having been to Tamms Correctional Center. He testified that according to the document he had, Petitioner turned keys at least 240 times per day while an employee at Tamms Correctional Center. He admitted that before he received the document from Petitioner's attorney, he did not have any specific knowledge of how many times Petitioner would have turned the keys at Tamms. He testified that the document did not indicate how many times Petitioner would have put leg irons on a prisoner at Tamms. He testified that he did not have a specific number of times a day that turning keys would lead to cause or contribute to carpal tunnel syndrome. He further testified that he did not have a specific number of the duration between turning the keys would need to be. (PX11).

On cross examination, Dr. Young testified that he did not have an opinion as to what degree of force was involved in turning a key. He testified that he did not have any specific numbers as to how long the actions would need to take place to cause, contribute or exacerbate carpal tunnel syndrome. He testified that he did not have an opinion as to what latency period could lead to, cause, contribute or exacerbate carpal tunnel syndrome. He agreed that Petitioner indicated on the questionnaire that he used

tobacco at the rate of one can per day and that it was his understanding that Petitioner was talking about snuff, dip or smokeless tobacco. He testified that if Petitioner was consuming snuff upwards of one can per day, it would be a comorbid factor to carpal tunnel syndrome. He testified that high blood pressure was thought to be a contributing factor to the etiology of carpal tunnel syndrome. He agreed that Petitioner had at least three comorbid factors, including his body habitus, high blood pressure and a tobacco habit. (PX11).

On cross examination, Dr. Young admitted that he had no knowledge of the amount of times that Petitioner would cuff and uncuff an inmate. (PX11).

The Menard Correctional Officer Job Site Analysis was entered into evidence at the time of arbitration as Petitioner's Exhibit 12. The job site analysis noted that the facility was toured on January 13, 2011. (PX12).

According to the Job Site Analysis, the Physical Demands included, among others, Frequent "Pushing" for pulling open doors as needed, pulling open chuckhole doors as needed during lockdowns for dining, and cuffing in R&C area only; Frequent "Reaching Horizontal" for control room and for opening doors and chuckholes; Frequent "Wrist Turning" related to opening doors and chuckholes (in two locations) with keys, based upon post and shift, less key turning on third shift as inmates are deadlocked; Occasional "Grasping" to turn key related to opening doors and chuckholes, holding keys, taking items off belt; Occasional "Pinching" to turn key; Occasional "Finger Manipulation" based on post; and Occasional "Carrying" and that carried items are housed on belts and removed for use. (PX12).

The Menard Correctional Officer Video was entered into evidence at the time of arbitration as Petitioner's Exhibit 13.

The Menard Correctional Officer IME of Dr. Sudekum dated April 29, 2011 was entered into evidence at the time of arbitration as Petitioner's Exhibit 14. The Menard Correctional Officer IME of Dr. Sudekum dated April 29, 2011 was entered into evidence at the time of arbitration as Petitioner's Exhibit 12. The report made no reference to the case at hand, and noted that Dr. Sudekum had been asked to review information pertaining to the job duties performed by Correctional Officers at the Menard Correctional Center and render an opinion regarding the possible causative affect of these job duties on the development of "repetitive trauma injuries." (PX14).

The transcript of the deposition of Dr. Sudekum dated June 13, 2011 was entered into evidence at the time of arbitration as Petitioner's Exhibit 15. The caption of the transcript noted that the deposition was taken in the case of 10 WC 27503, James Bauersachs a/k/a "Correctional Officer," *et. al.*, however, which is not the case at hand. At no point during the entirety of the deposition were any questions asked regarding Petitioner nor was reference made to Petitioner therein. (PX15).

The Menard Correctional Officer Position Description was entered into evidence at the time of arbitration as Petitioner's Exhibit 16.

The Workers' Compensation Documentation Log was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The records were effectively duplicative of those as contained in Petitioner's Exhibit 8. (RX1; PX8).

The IME Report of Dr. Anthony Sudekum dated February 26, 2015 was entered into evidence at the time of arbitration as Respondent's Exhibit 2. The report noted that Petitioner stated that he first developed symptoms of numbness, tingling and pain in both hands in 2009-2010 but that he did not seek medical treatment for his symptoms until 2012. It was noted that Petitioner stated that he currently had

no significant pain, numbness, weakness or stiffness of either hand or wrist and indicated that his subjective bilateral upper extremity pain and paresthesias resolved after undergoing the bilateral carpal tunnel surgeries in November and December 2014. It was also noted that Dr. Sudekum had the opportunity to visit and tour the Menard Maximum Security Correctional Center, Menard Minimum Security Correctional Center, the Big Muddy Correctional Center and the Centralia Correctional Center. (RX2).

The report noted that Dr. Sudekum opined that Petitioner developed bilateral carpal tunnel symptoms including paresthesias on the nerve distributions and that he subsequently underwent successful surgical treatment including staged bilateral carpal tunnel releases in November and December of 2014. It was noted that Dr. Sudekum opined that there was no indication in the medical records that Petitioner ever suffered from cubital tunnel syndrome or ulnar neuropathy. It was noted that Dr. Sudekum opined that Petitioner had multiple non-work related risk factors and/or comorbid conditions that could predispose him to the development of carpal tunnel syndrome including obesity, hypertension, hyperlipidemia and gout and that he had an increased risk of a cervical disc disease which could serve to aggravate carpal tunnel syndrome and/or peripheral neuropathies in the distal upper extremities. (RX2).

The report noted that Dr. Sudekum found that there was no indication on the initial patient information forms that Petitioner's work activities played any role in the development, aggravation or progression of his carpal tunnel symptoms or conditions. It was noted that Dr. Sudekum opined that the medical records did not support a conclusion that Petitioner's work activities as a Correctional Officer served as a causative or aggravating factor in the etiology of his bilateral carpal tunnel syndrome. It was noted that Dr. Sudekum opined that Petitioner did not sustain a work-related injury to either his upper extremities or develop carpal tunnel syndrome as a result of his employment at the Vienna Correctional Center, the Tamms Correctional Center and/or the Menard Correctional Center and that it was his opinion that Petitioner developed bilateral carpal tunnel syndrome due to non-work related factors and comorbid conditions. (RX2).

The transcript of the deposition of the Dr. Anthony Sudekum taken on April 26, 2016 was entered into evidence at the time of arbitration as Respondent's Exhibit 3. Dr. Sudekum testified that he is board-certified in plastic and reconstructive surgery and that he also holds a separate board certification in surgery of the upper extremity. (RX3).

Dr. Sudekum testified that he performed the IME on February 24, 2015, at which time Petitioner reported having worked at Tamms Correctional Center for approximately 12 years, at Menard Correctional Center for approximately six months and at Vienna Correctional Center since July of 2013. He testified that Petitioner indicated that he had had some upper extremity complaints and symptoms since 2009 or 2010 and that he did not seek evaluation for those symptoms until 2012, that he was initially seen by his primary care physician who ordered a nerve conduction study that revealed evidence of bilateral carpal tunnel syndrome and that he was referred to Dr. Young who diagnosed him clinically with bilateral carpal tunnel syndrome. He testified that Petitioner eventually had carpal tunnel releases conducted and that he saw him after the surgeries were performed. (RX3).

Dr. Sudekum testified that Petitioner indicated to him that he had spent most of his tenure as an IDOC employee at Tamms Correctional Center, that he had worked there from 2001 through January of 2013 and that he worked the 3-11 shift either as a pod control officer or a housing officer on one of the pods. He testified that Petitioner reported that the pods were a group of four wings that had a central hub or control center where the officer sat and monitored movement of the inmates and the pod officers as they entered and exited the cells, and that they hit a touchscreen to open and close doors and/or pushed a button to do the same. He testified that Petitioner reported that it also involved observing video monitors, some writing and talking on the phone or radio. He testified that Petitioner reported that when acting as a

housing officer, his job involved doing every 30-minute wing checks and inmate counts, that his job also involved cuffing and uncuffing inmates when they were to be moved and that since it was a maximum security prison, the inmates all moved with cuffs and that he would walk or transport them from one area within the facility to another. He testified that Petitioner reported that this involved monitoring shower lines, writing disciplinary reports and intermittently performing computer keyboard entry, and that he also performed some routine housekeeping tasks including picking up and emptying trash, collecting laundry and sweeping. He testified that Petitioner estimated that he spent about 30 minutes a day performing these tasks, and that he would also lock and unlock doors approximately 260 times per day. (RX3).

Dr. Sudekum testified that he did not feel that Petitioner's employment activities as a correctional Officer at the Tamms Correctional Center, the Menard Correctional Center or the Vienna Correctional Center caused or aggravated his carpal tunnel syndrome on either side. He testified that Petitioner had several comorbid conditions that could contribute to and/or cause the condition of carpal tunnel syndrome, including obesity, gout, arthritis, hypertension and hyperlipidemia. He testified that he had opportunity to tour Menard Correctional Center and three others, had seen extensive video analysis, had reviewed written job descriptions and also had the opportunity to talk to many different Correctional Officers who worked there and that, based on his evaluation, he did not feel that Petitioner's job would have caused or aggravated the development of carpal tunnel syndrome because he did not think that the job had enough strenuous manual activity. He testified that there was no exposure to vibration of any significant degree, that there was no sustained heavy pinching, gripping and grasping and that the pace of the Correctional Officer's work was relatively modest and self-directed and did not require sustained gripping, grasping, heavy impact or the types of things that would be likely to either cause or aggravate carpal tunnel syndrome. (RX3).

On cross examination, Dr. Sudekum admitted that he did not know if Petitioner was on the tactical team. He testified that he thought the tactical team would involve special training and that it seemed likely that it would involve pod cell extractions. He testified that he did not recall mentioning any tactical team activity in his report. He testified that not all inmate services were given through a chuckhole but that many were. He testified that to various items that would be passed through the chuckhole, including food, trash and medications. (RX3).

On cross examination, Dr. Sudekum admitted that he did not have a count of how many times Petitioner had opened chuckholes during his career at Tamms Correctional Center and further admitted that he did not have a count of the number of doors that Petitioner pulled on. (RX3).

On cross examination, Dr. Sudekum agreed that in order for gout to contribute to carpal tunnel it had to be located in the same area as the carpal tunnel. He testified that on examination there was no evidence of gout in the hands when he evaluated Petitioner. (RX3).

The Original Errata Sheet for the deposition of Dr. Sudekum was entered into evidence at the time of arbitration as Respondent's Exhibit 4.

CONCLUSIONS OF LAW

With respect to disputed issues (C) and (F), given the commonality of facts and evidence relative to both issues, the Arbitrator addresses those jointly.

The Arbitrator finds that Petitioner failed to prove that he sustained accidental injuries that arose out of and in the course of his employment with Respondent on September 13, 2013, and that his current condition of ill-being is causally related to his work activities.

In so concluding that Petitioner failed to prove that he sustained accidental injuries that arose out of and in the course of his employment with Respondent, the Arbitrator finds the opinions of Dr. Sudekum to be more persuasive than the opinions provided by Dr. Young. The Arbitrator finds to be highly significant the fact that Dr. Sudekum had personally toured the Menard maximum security and medium security correctional centers and that during his tours, he had the opportunity to meet and speak to many of the Correctional Officers at the facilities. (RX3). The Arbitrator notes that Dr. Young on cross examination made multiple significant admissions, including the fact that he did not have an opinion as to what degree of force was involved in turning a key; that he did not have any specific numbers as to how long the actions would need to take place to cause, contribute or exacerbate carpal tunnel syndrome; and that he did not have an opinion as to what latency period could lead to, cause, contribute or exacerbate carpal tunnel syndrome. (PX11). These admissions, when coupled with Dr. Young's testimony that at no point during any of the three visits that he had with Petitioner did he ever mention to him any of the job duties that were set forth in the document provided by Petitioner's attorney prior to the deposition, cause the Arbitrator to place lesser weight upon the opinions proffered by him. Furthermore, the Arbitrator finds to be significant in this case that Dr. Young agreed that Petitioner had at least three comorbid factors, including his body habitus, high blood pressure and a tobacco habit. (PX11). The Arbitrator notes that this was similar to the testimony of Dr. Sudekum, who indicated that Petitioner had multiple non-work related risk factors and comorbid conditions which could predispose him to the development of carpal tunnel syndrome including obesity and hypertension. (RX3). As such, the Arbitrator finds that Petitioner failed to prove that he sustained accidental injuries that arose out of and in the course of his employment with Respondent.

Based upon the foregoing and the record as a whole, the Arbitrator concludes that Petitioner has failed to prove that he sustained accidental injuries that arose out of and in the course of his employment with Respondent on September 13, 2013, and that his current condition of ill-being is causally related to his work activities. All benefits are denied. The remaining issues of notice, medical bills, temporary total disability and nature and extent are moot, and the Arbitrator makes no conclusions as to those issues.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jennifer Myers

Petitioner,

vs. NO: 12WC 23130

18IWCC0219

FW Enterprises, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 28, 2017 is hereby affirmed and adopted.

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

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

18IWCC0219

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $32,400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 10 2018
SJM/sj
d-3/22/2018
44

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MYERS, JENNIFER
Employee/Petitioner

Case# **12WC023130**

18IWCC0219

FW ENTERPRISES INC
Employer/Respondent

On 9/28/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.17% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2934 BOSHARDY LAW OFFICE PC
JOHN V BOSHARDY
1610 S 6TH ST
SPRINGFIELD, IL 62703

2904 HENNESSY & ROACH PC
EMILIE A MILLER
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

18IWCC0219

STATE OF ILLINOIS)
)SS.
COUNTY OF Adams)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jennifer Myers
Employee/Petitioner

v.

FW Enterprises, Inc.
Employer/Respondent

Case # 12 WC 23130

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Quincy, IL**, on **August 3, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ 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 6/06/2012, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $22,572.16; the average weekly wage was $434.08.

On the date of accident, Petitioner was 36 years of age, *married* with 2 dependent children.

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

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services incurred through February 10, 2015, pursuant to the fee scheduled as provided in Section 8(a) and 8.2 of the Act.

Respondent shall be given a credit for any medical benefits paid.

Respondent shall pay Petitioner $319.00/week for a period of 101.2 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused 40% loss of use of the left arm.

Respondent shall pay Petitioner compensation that has accrued from June 6, 2012 through August 3, 30 2017 and shall pay the remainder of the award, if any, in weekly payments.

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

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

Carl Lee
Signature of Arbitrator

9/25/17
Date

ICArbDec p. 2

SEP 28 2017

STATEMENT OF FACTS

The issue in this case centers around Petitioner's need for permanent restrictions related to her work accident and treatment after February 10, 2015. Respondent does not dispute Petitioner's accident or her underlying injury to her left elbow or left arm.

Petitioner is employed by Respondent as its office manager. Respondent is engaged in the fundraising business. On June 6, 2012, Petitioner went to the restroom in her office and slipped and fell on water leaking from the ceiling of another bathroom. Upon falling Petitioner landed on her left arm/elbow.

Petitioner notified her supervisor of her accident and began experiencing swelling in her left elbow. Petitioner had not had any problems with her left elbow prior to her accident.

Petitioner initially sought treatment at the Ambulatory Care Center at Quincy Medical Group and then transitioned treatment to her primary care physician, Dr. Kathy Asbury. Due to persistence of Petitioner's left elbow pain, Dr. Alsbury ordered a MRI of Petitioner's elbow on June 20, 2012 and referred her to orthopedics.

Petitioner's was first seen in orthopedics on June 20, 2012 by physician assistant, Steve Dement, at Quincy Medical Group's Department of Orthopedics. Petitioner was examined and diagnosed with left lateral epicondylitis. An elbow strap was prescribed and Petitioner was referred to occupational therapy.

Petitioner's MRI was completed on June 26, 2012 and revealed an abnormal signal in the common extensor tendon at its attachment to the lateral epicondyle, consistent with mild lateral epicondylitis.

Petitioner returned to Mr. Dement on June 28, 2012 and a corticosteroid injection was administered into her elbow. Petitioner also began occupational therapy.

Petitioner was next seen by Mr. Dement on July 16, 2012 and reported only slight improvement in her pain with therapy and the injection. Due to Petitioner's ongoing complaints, she was referred for a surgical consultation.

Petitioner first saw Dr. Mark Greatting at Springfield Clinic on August 16, 2012. After examining Petitioner and reviewing her MRI, Dr. Greatting diagnosed left lateral epicondylitis and cubital tunnel syndrome and recommend splinting, EMG/NCV testing, and additional therapy. Dr. Greatting also discussed with Petitioner the option of a second injection.

Petitioner's EMG/NCV testing was performed on September 18, 2012 by Dr. David Gelber and revealed left cubital tunnel syndrome.

Petitioner returned to Dr. Greatting's office and underwent a second injection into her left elbow. While the injection helped significantly, Petitioner remained tender over the lateral epicondyle. Upon review of Petitioner's EMG/NCV, Dr. Greatting recommended a six-week waiting period to be followed by surgery if Petitioner's elbow showed no improvement.

On January 2, 2013, Petitioner underwent fasciotomy and partial ostectomy of the left lateral epicondyle, as well as release of the ulnar nerve of the left elbow with Dr. Greatting. Petitioner's sutures were removed on January 16, 2013.

While Petitioner's numbness and tingling resolved following her surgery, she continued to report pain in her elbow. Petitioner was referred for physical therapy on March 27, 2013.

On April 23, 2013, Petitioner reported to Dr. Greatting that her symptoms were improving with physical therapy. On April 30, 2013, Petitioner returned to work after Dr. Greatting released her to work light duty with restrictions of no lifting more than five pounds.

On June 6, 2013, Petitioner returned to Dr. Greatting complaining of significant left elbow pain and a updated MRI was ordered.

Petitioner's MRI was completed on July 10, 2013 and revealed trace elbow joint effusion, but no significant abnormalities as interpreted by Dr. Greatting. However, Dr. Greatting did administer another corticosteroid injection into Petitioner's elbow.

After her injection Petitioner continued to complain of left elbow pain and was referred by Dr. Greatting for a second opinion with Dr. Christopher Wottowa.

Petitioner saw Dr. Wottowa on September 25, 2013. Dr. Wottowa concluded Petitioner was not a candidate for additional surgery and had reached MMI, but may benefit from work conditioning.

Petitioner returned to Dr. Greatting on October 10, 2013 and was referred by for additional therapy.

Respondent then referred Petitioner for an updated Section 12 IME with Dr. David Brown. Petitioner was seen by Dr. Brown on November 13, 2013. Dr. Brown agreed with Petitioner's diagnosis of left lateral epicondylitis and cubital tunnel syndrome and recommended updated EMG/NCV testing and a MR arthrogram.

Petitioner's tests were both completed on March 5, 2014. The MR arthrogram findings indicated a strain of the extensor carpi radialis longus muscle, while the EMG/NCV was suggestive of ulnar neuropathy at the left elbow mild to moderately severe in testing terms with a possible persistent/residual lesion.

Upon review of the test results, Dr. Brown gave Petitioner the option of continuing to control her symptoms with medication or surgery to include an anterior submusclar transposition and revision lateral epicondylectomy with debridement of the lateral epicondyle.

Dr. Greatting performed the recommended surgery on June 14, 2014.

Petitioner was again placed in therapy following her surgery and remained off work until being released by Dr. Greatting on August 25, 2014 to return to work six hours a day with restrictions of no lifting more than five pounds and no repetitive or forceful, gripping, pushing or pulling with the left arm.

On December 17, 2014, Petitioner returned to Dr. Greatting and reported that while she had been working within her restrictions she continued to experience pain in her elbow and ongoing symptoms in her left arm. Dr. Greatting concluded that Petitioner may have chronic ongoing problems in her left elbow and arm and noted she may require permanent restrictions.

On February 10, 2015, Petitioner was sent for another updated Section 12 IME with Dr. Brown. Upon physical examination, Dr. Brown noted good active range of motion of the left wrist and digits of the left hand with no intrinsic muscle atrophy. Petitioner displayed negative Tinel's sign, as well as negative elbow flexion test. Active range of motion in the left elbow was 0 to 138 degrees flexion with 70 degrees supination to 81 degrees pronation. Dr. Greatting did note mild tenderness to palpation over the medial and lateral elbow. A three-view x-ray of the left elbow compared to the right elbow revealed post-operative changes on the left with suture anchors in the area of the lateral epicondyle with no significant bone or joint abnormality. Dr. Brown opined that Petitioner had regained good function of the upper extremity with good range of motion and reasonable strength. He felt Petitioner would receive no further benefit from ongoing treatment outside of continued use of over-the-counter anti-inflammatory medication and opined that Petitioner had achieved MMI and could return to work without restrictions.

Petitioner returned to Dr. Greatting on February 18, 2015. Dr. Greatting recommended Petitioner continue her restrictions and return in June for a one year follow up.

Petitioner was last seen by Dr. Greatting on June 11, 2015. Petitioner confirmed she was continuing to work within her restrictions but noted that if she tried to increase her activity she experienced increased pain. After examining Petitioner Dr. Greatting concluded Petitioner would not benefit from further treatment of her elbow or arm and placed her at maximum medical improvement. He also issued permanent work restrictions limiting Petitioner to no work more than 6 hours a day and no lifting, pushing or pulling more than 10 pounds with the left arm. Dr. Greatting also prescribed Petitioner Norco to be using as needed.

CONCLUSIONS OF LAW

In regard to disputed issues (F) and (J), the Arbitrator finds that Petitioner's condition after February 10, 2015 is not causally connected to her work accident. The Arbitrator agrees with Dr. Brown's findings that Petitioner's condition had stabilized as of February 10, 2015 and that she had reached maximum medical improvement related to both her left lateral epicondylitis and cubital tunnel syndrome. Dr. Brown's opinion is supported by the fact that there was no change in Petitioner's complaints or report of symptoms or exam findings after February 10, 2015. While Dr. Greatting continued to see Petitioner after February 10, 2015, he made no new recommendations for

treatment of Petitioner and made no change in her work restrictions. The only thing he did after February 10th was convert Petitioner's restriction from temporary to permanent.

The Arbitrator also agrees with Dr. Brown's opinion that Petitioner does not require permanent restrictions related to her work injury. There is no objective evidence in the medical records to support Petitioner's ongoing complaints of pain in her left elbow or arm after two surgeries. Furthermore, on examination by both Dr. Greatting and Dr. Brown, Petitioner was noted to have nothing more than tenderness over the lateral epicondyle and mildly positive Tinel's, both of which are consistent Petitioner's surgical procedures.

Based the foregoing, Petitioner is found to have reached maximum medical improvement by February 10, 2015. Respondent is liable for Petitioner's medical services incurred through February 10, 2015. Respondent shall have a credit for any bills already paid.

In regard to disputed issue (L), for accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of Section 8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) the evidence of disability corroborated by the treating medical records. 820 ICLS 305/8.1b. No single factor should be the sole determinant of disability. *Id.*

(i) Neither party admitted an impairment rating into evidence. The Arbitrator therefore gives no weight to this factor.

(ii) Petitioner is employed as an office manger, which is a light duty position. The Arbitrator therefore gives little weight to this factor.

(iii) Petitioner was 36 years old at the time of her accident. Therefore, the Arbitrator gives moderate weight to this factor.

(iv) Petitioner provided no evidence of impairment in earning capacity as a result of her work accident. In fact, Petitioner testified that since returning to work she has received several increases in pay and continues to work 80 to 84 hours per week. Therefore, the Arbitrator gives little weight to this factor.

(v) Petitioner testified that she continues to have pain every day and that it affects her activities of daily living. Petitioner testified she has difficulty going to the grocery store and doing dishes and laundry. Petitioner also testified she has difficulty sleeping. These symptoms are corroborated by the extensive surgeries set forth in the medical records. The Arbitrator gives great weight to this factor.

Based on the foregoing factors, the Arbitrator finds that Petitioner sustained accident injuries that caused the 40% loss of use of the left arm pursuant to Section 8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DAVID HERNANDEZ-ROMERO,

Petitioner,

vs. NO: 13 WC 26452

HIGHLAND BAKING COMPANY,

18IWCC0220

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, notice, temporary total disability, medical, and penalties, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof, but makes a clarification as outlined below.

The Commission finds that Petitioner failed to prove that he sustained a repetitive trauma that manifested on December 28, 2012, as a result of repeatedly lifting bread molds, stacking baked goods on pallets, de-molding bread, and stacking empty molds while working 8-hour shifts in the same position. Respondent produced multiple witnesses who testified that employees were rotated among various positions every two hours of each shift. Although there was an initial, illegible record from December 29, 2012, wherein Petitioner may have complained to his physician about shoulder pain, he did not relate this pain to a work injury. Petitioner additionally sustained a shingles outbreak coinciding with the timing of the alleged accident and was off work for several weeks as a result of that outbreak. Petitioner's primary care physician related problems with Petitioner's shoulder to his shingles outbreak as a result of non-use or "frozen shoulder", rather than to any repetitive work duties. The Commission notes that the first time in his treatment that Petitioner relayed any potential work-related injury as the cause of his symptoms to his treating physicians, was in February of 2013. Petitioner did not

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report the alleged injury to either his supervisor or human resources, nor did he seek medical attention from the company doctor. It was not until Petitioner returned to work following his shingles outbreak that he first brought up a potential repetitive trauma injury.

Additionally, the Commission finds the Respondent's experts more credible than Petitioner's treating physicians on the issue of causation as all of the treating physicians based their opinions on an inaccurate job description and medical history from Petitioner. Petitioner may suffer from degenerative conditions that resulted in his neck and shoulder pain, but he failed to prove that these conditions were caused by and/or aggravated by any work accident.

Based on our finding of failure to prove accident and causation, all of the remaining issues are moot.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 15, 2016 is hereby affirmed and adopted.

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

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: APR 11 2018

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

CJD/dmm
O: 2/28/18
049

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

HERNANDEZ-ROMERO, DAVID
Employee/Petitioner

Case# **13WC026452**

HIGHLAND BAKING COMPANY
Employer/Respondent

18IWCC0220

On 7/15/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.39% 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:

2383 THE LAW OFFICE OF IVAN A RUEDA
1217 N MILWAUKEE AVE
2ND FLOOR
CHICAGO, IL 60642

4234 RIPES NELSON BAGGOT KALOBRATSO
KIMBERLY SCOTT
650 E DEVON AVE SUITE 110
ITASCA, IL 60143

18IWCC0220

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

David Hernandez-Romero
Employee/Petitioner

v.

Highland Baking Company
Employer/Respondent

Case # 13 WC 26452

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **10/25/2015**. 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: third choice of physician

FINDINGS

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On the date of accident, **12/28/2012**, Respondent ***was*** operating under and subject to the provisions of the Act.
On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.
On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.
Timely notice of this accident ***was not*** given to Respondent.
Petitioner's current condition of ill-being ***is not*** causally related to the accident.
In the year preceding the injury, Petitioner earned **$26,313.66**; the average weekly wage was **$506.03**.
On the date of accident, Petitioner was **63** years of age, ***married*** with **0** dependent children.
Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services.
Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$8,777.47** for other benefits, for a total credit of **$8,777.47**.
Respondent is entitled to a credit of **$0** under §8(j) of the Act.

ORDER

Petitioner failed to prove that an accident arose out of and in the course of his employment by Respondent on or about December 28, 2012 and, therefore, benefits are denied.

Also, Petitioner failed to prove that he provided timely notice to Respondent of the claimed accident and, therefore, benefits are denied.

Also, Petitioner failed to prove that his current conditions of ill-being in his right shoulder, cervical spine, or left shoulder were causally related to the claimed injury of December 28, 2012 and, therefore, benefits are denied.

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

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

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

Signature of Arbitrator

June 22, 2016
Date

JUL 15 2016

18IWCC0220

INTRODUCTION

This matter proceeded to hearing on October 9, 2015 before Arbitrator Steven Fruth. The disputed issues were: ***C:*** Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?; ***E:*** Was timely notice of the accident given to Respondent?; ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; ***K:*** What temporary benefits are in dispute? *TTD*; ***M:*** Should penalties be imposed upon Respondent?; ***N:*** Is Respondent due any credit?; ***O:*** Is Petitioner entitled to prospective medical care and services?; ***P:*** Did Petitioner exceed the two physician limit set forth in the Act?

Petitioner, Martin Castillo, and Jose Rodriguez testified at trial, all through a Spanish interpreter. Dr. Derrick Wallery and Arlene Salas also testified at trial.

FINDINGS OF FACT

Petitioner, David Hernandez-Romero, had been employed with the Respondent, Highland Baking Company, in a full time capacity since April 2007. Petitioner confirmed that he worked on the north packing line on night shift, from 1:00 a.m. to 9:30 a.m. Petitioner's supervisor was Jose Rodriguez.

Petitioner testified alternatively that his accident occurred on December 28, 2012 or on December 29, 2012, admitting that he sometimes got the date confused. He was doing his regular job of dumping bread molds when he began to feel pain in his right arm and shoulder. He testified that he had been turning over molds at work since he started working there. He testified that he would work at the mold dumping station for one day and then he would be moved the next day. However, he testified that he only overturned molds at work for the 4 years prior to his accident.

Petitioner stated that the bread molds were made of steel and weighed up to 15 pounds when full of bread. He stated that to demold the bread, he would grab the mold with both hands while standing, lift it over his head, and bang it on a table in front of him. If the bread was stuck, he would have to lift the mold higher and bang the mold several times or turn it over to shake it to release the loaves. After emptying the molds, petitioner stated that he would stack the empty molds on a pallet up to 69 inches high. On cross-examination, Petitioner testified that he worked in the molding station all day long throughout each shift. He stated that when there was no bread, he would be sent to rest, but said that it only happed about 8 times a year. On further cross-examination, Petitioner admitted that he also worked at unloading boxes, in quality control, at

stacking completed boxes of bread, and on the conveyor lines, along with his work at the molding station.

Petitioner stated that his neck and both shoulders were fine in 2008, 4 years before the alleged injury. He had felt a little pain in his shoulders in the 4 years from 2008 to 2012. Petitioner testified that he reported his shoulder pain to Mr. Castillo prior to December 28, 2012. He testified that he requested a transfer from the mold dumping station but was not changed.

Petitioner admitted that he did not report his injury at work on December 28, 2012. He worked the remainder of his shift that day. He testified that he reported his injury to co-workers whom he did not identify. He told his co-workers his pain was different from before. He returned home as normal, had breakfast and went to bed. Petitioner testified that he started to have more pain in the afternoon.

Petitioner testified that he attempted to call the factory 3 times to report his injury but there was no answer and so left messages. Petitioner testified that he called Manager Martin Castillo at his house at 10:00 a.m. on December 29, 2012 to report that he left work in pain after his last shift and was going to go to the doctor for evaluation. Petitioner testified that he recognized Mr. Castillo's voice on the phone as he had been dealing with him for 6 years. Petitioner confirmed that Mr. Castillo was the only person at Highland Baking Company he notified about his injury, but then added that he notified Jose Rodriguez after he saw "Dr. Rodriguez" [*sic*] on January 21, 2013 at 1:00 a.m. Petitioner testified that Mr. Rodriguez "scolded" him on January 21, 2013 on why Petitioner had not informed him of his right arm pain.

On re-direct examination Petitioner testified that he notified Mr. Rodriguez of his shoulder injury on January 24, 2013, after working 4 days. He further testified that he also notified his co-worker Bernardino Randa of his injury on January 24. He testified that Mr. Randa is left "in charge" when other supervisors are not present.

Petitioner testified that he first presented to Dr. Jorge Tamayo for treatment on December 29, 2012. Dr. Tamayo provided him with a muscular cream and pain medication. Petitioner testified that he applied the cream to his right shoulder neck, but stopped using it when boils appeared on his shoulder. Petitioner then saw Dr. Cordero (PX #1). Petitioner reported pain in his right shoulder only since the previous day. He denied any trauma. There is no description of a work accident or Petitioner's job duties. Petitioner was diagnosed with right shoulder bursitis. Petitioner testified that he was truthful and honest with Dr. Tamayo and reported all of his complaints.

Petitioner testified that he was off work in January 2013 for a shingles outbreak.

Petitioner testified that he next presented to St. Mary and Elizabeth Medical Center (PX #2) on January 2, 2013 for evaluation and treatment of his boils and pain in his arm and neck. The clinical notes are mostly indecipherable handwritten entries. Clinical checkmarks indicate no musculoskeletal complaints. Petitioner's diagnosis of shingles is readable. He was given doses of Toradol and morphine.

Dr. Salvador Gutierrez was Petitioner's primary care physician before the claimed accident (RX #3). On March 16, 2010 Petitioner saw Dr. Gutierrez with pain complaints of pain in his shoulders, elbows, hands, and knees. He reported that his mother had a history of osteoarthritis. He was diagnosed with arthralgias. On April 16, 2010 Petitioner returned to Dr. Gutierrez complaining of shoulder, knee, and back pains due to lifting and pulling at work. Bilateral shoulder and spine X-rays from April 30 were reviewed on May 14, 2010. Petitioner was diagnosed with osteoarthritis of the bilateral shoulders and lumbosacral spine. He was provided with medications for treatment of these conditions. On cross-examination Petitioner admitted that Dr. Gutierrez treated him for shoulder complaints in 2010 and that he was diagnosed with arthritis in May of 2010.

Petitioner was also seen at St. Mary and Elizabeth Medical Center on March 25, 2010 for bilateral shoulder X-rays due to pain, ordered by Dr. Salvador Gutierrez. Dr. Gutierrez also ordered X-rays of the shoulders, lumbosacral spine, dorsal spine, and the knees on April 30, 2010. The March 25 films revealed moderate degenerative arthritis in the right shoulder and mild degenerative arthritis in the left shoulder. The April 30 films of the shoulders and dorsal spine were negative. The films of the lumbosacral spine showed a degenerative L5-S1 disc. The knees also had degenerative changes. X-rays of the right shoulder were done a by order of Dr. Gutierrez on January 25, 2013. No significant change from the previous study was noted.

PX #2, billing records, indicates a cervical MRI was done on February 2, 2013 on order of Dr. Gerald Cicero, but no report of that procedure is within PX #2.

Petitioner testified that he treated with Dr. Gutierrez (PX #3) between January 4, 2013 and August 29, 2013. On January 4, 2013 Petitioner presented to Dr. Gutierrez for continued treatment of Herpes Zoster (shingles) on his right shoulder. He was seen again on January 11 and January 15, 2013 for shingles care. Petitioner was released to return to work on January 21, 2013.

Petitioner later returned to St. Mary and Elizabeth Medical Center (PX #2) for an X-ray of his right shoulder on January 25, 2013 due to complaints of decreased range of motion. This examination revealed mild degenerative changes with occasional small subchondral erosions at the joint margins without significant change as compared to his April 30, 2010 x-rays.

Petitioner returned to Dr. Gutierrez on January 24, 2013 for further treatment. He reported that he had attempted to return to work but was unable to raise his right arm over his head. Dr. Gutierrez indicated that Petitioner's decreased range of motion was secondary to the non-use of his right arm during his herpetic episode. He was diagnosed with a frozen shoulder/adhesive capsulitis on the right from shingles residual. Petitioner was referred for an x-ray of his right shoulder and to a chiropractor for right shoulder treatment. Petitioner testified that he was truthful and honest with Dr. Gutierrez and reported all of his complaints. He confirmed that Dr. Gutierrez was his primary care physician.

Petitioner next saw Dr. Cicero at the Neck and Back Clinic (PX #4) on January 30, 2013. His chief complaint was right shoulder pain. He indicated he was told he had right shoulder and right arm pain secondary to adhesive capsulitis. Petitioner marked a pain diagram showing right shoulder, arm, and low back. Petitioner reported on a pain questionnaire that his present symptoms began January 1, 2013. He noted that the pain was caused by too much work and an infection from a lotion. Petitioner reported that he worked in a bakery for 6 years doing heavy labor. Petitioner was referred for a MRI of his cervical spine and right shoulder. Petitioner continued to treat with Dr. Cicero until February 11, 2013. Petitioner testified that he was truthful and honest with Dr. Cicero and reported all of his complaints.

Petitioner testified that Dr. Gutierrez then referred him to Dr. Ramirez at Marque Medicos. Petitioner was first seen at Marque Medicos on February 11, 2013 (PX #5). A referral form from Dr. Gutierrez dated March 2, 2013 was submitted into evidence as Petitioner's Exhibit #20. Dr. Derrick Wallerey, President and CEO of Marque Medicos, testified that this referral form was included in the Marque Medicos chart for Petitioner. On cross-examination, Dr. Wallerey admitted that he had no independent knowledge of how or when the referral form was received in the Marque Medicos office. There is no reference of the above noted referral or a copy of the referral form in Dr. Gutierrez's records (PX #3 & RX #3).

Petitioner first presented to Dr. Lorena Ramirez at Marque Medicos (PX #5) on February 11, 2013. Petitioner reported a history of a gradual onset of right shoulder, arm, and neck pain. He reported that he continued to work hoping that it would go away, but it did not. He reported that as of December 29, 2012, he could no longer tolerate the pain. Petitioner stated that he was injured doing moldings. He reported that he worked at the same station for 8 hours a day where he received hot bread, turned the bread out, and lifted racks of loaves up onto a rack throughout the day. Dr. Ramirez referred Petitioner for physical therapy treatments. Petitioner testified that he was truthful and honest with Dr. Ramirez and reported all of his complaints.

Petitioner then saw Dr. Andrew Engel of Medicos Pain & Surgical Specialists (PX #7) on February 18, 2013. Petitioner complained of right shoulder and right sided neck pain. He reported a history of working at Highland Baking Company for 6 years where he had a gradual onset of right shoulder and right neck pain over the previous 6 months. He reported that he worked at the same station for 8 hours a day where he received hot bread, turned the bread, and lifted them onto a rack overhead throughout the day. Petitioner was assessed with shoulder pain and cervicalgia. Petitioner testified that he was truthful and honest with Dr. Engel and reported all of his complaints. Petitioner further confirmed that he told Dr. Engel that he was not happy with the care he received from Dr. Gutierrez and Dr. Cicero so he chose to go to Marque Medicos.

On April 3, 2013 Petitioner had an MRI of the right shoulder (PX #11).

Petitioner next saw Dr. Steven Sclamberg of Orthopaedics of the Northshore (PX #13) on April 23, 2013. He reported a work related injury on December 19, 2012 while working in a bakery where he had to forcefully strike baking sheets to remove bread about 1,000 times a day when he developed pain in his shoulder and down to the deltoid region. Petitioner testified that he was truthful and honest with Dr. Sclamberg and reported all of his complaints. On cross-examination Petitioner confirmed that he denied a history of shoulder problems in the history provided to Dr. Sclamberg.

Dr. Sclamberg performed an arthroscopic right shoulder subacromial decompression, synovectomy, and debridement on June 24, 2014 (PX #6).

Petitioner testified that he saw Dr. Brian Forsythe of Midwest Orthopedics at RUSH for an §12 IME (RX#4) on April 29, 2013. He confirmed that there was an interpreter present at the examination. Petitioner gave a history of working at Highland Baking Company for 6 years. He stated that pain in his right shoulder, right upper extremity, and neck developed over approximately 6 months. Dr. Forsythe diagnosed Petitioner with a right C6-7 herniated disc and C6 radiculitis. Dr. Forsythe did not find any clinical manifestation of rotator cuff disease on his examination as petitioner exhibited full and symmetric shoulder range of motion and normal and symmetric rotator cuff strength on his examination. Dr. Forsythe opined that the petitioner's symptoms were related to his underlying degenerative conditions. While Dr. Forsythe did not believe that petitioner's conditions were work related, he did continue to opine that petitioner was not a candidate for cervical surgery as he had no evidence of a current radiculopathy or motor weakness.

On May 22, 2013 Petitioner was seen by Dr. Robert Erickson of American Center for Spine and Neurosurgery (PX #8). Petitioner reported a history of a work injury while performing repetitive lifting of objects onto a high rack overhead. Petitioner further claimed that due to a steadily increasing pain, he had to stop work in the middle of the day. Dr. Erickson recommended that Petitioner proceed with surgery for his cervical spine.

Dr. Erickson performed an anterior cervical discectomy and fusion at C5-6 and C6-7 on November 20, 2103 (PX #6).

Petitioner testified that he chose Dr. J. Michael Morgenstern to obtain a second opinion evaluation on his continued right shoulder complaints. Petitioner consulted Dr. Morgenstern of Gold Coast Orthopedics (PX #14) on October 29, 2014 for a second opinion about surgery. Petitioner reported a history of working for Highland Baking Company for 6 years. He denied any prior work injuries. Petitioner stated that his job required him to take trays of bread and bang them against a table in order to loosen the baked bread. Petitioner stated that he performed these activities all day long, except for periods of rest. He claimed that he began to experience severe pain and stabbing sensation in his right shoulder, arm and forearm with numbness and tingling. He further reported that he continued to work and two days later his pain numbness and tingling became severe. He reported that he told his supervisor of his condition.

Petitioner admitted to having right shoulder pain for approximately one year prior to his December 2012 incident. Dr. Morgenstern recommended that Petitioner have an MR arthrogram of his right shoulder and return to physical therapy.

Petitioner had the MR arthrogram of his right shoulder ordered by Dr. Morgenstern on November 26, 2014 (PX #16).

Petitioner testified that he chose Dr. Roberto Levi (PX #15) for further evaluation and treatment. Petitioner presented to Dr. Levi on December 8, 2014 for evaluation of his right shoulder. He reported a history of an injury on or around December 29, 2012 at work. He reported that he carried and lifted molds for 8 hours a day at work for at least 4 years. Based on Petitioner's continued complaints of right shoulder pain, Dr. Levi performed a steroid injection to the right shoulder and referred Petitioner for physical therapy.

On March 12, 2015, Dr. Sclamberg recommended a repeat arthroscopic repair of Petitioner's right shoulder (PX #13).

Petitioner returned to Dr. Brian Forsythe for a supplemental §12 IME on May 14, 2015 (RX #5) at the request of Respondent. He confirmed that again there was an interpreter present at this examination. Petitioner reported that he had worked as a packer in a bakery for 6 years. He stated that he injured his right arm in December 2012 while emptying cases. Dr. Forsythe noted Petitioner's guarding and symptom magnification during the examination. Petitioner had symmetric upper extremity strength at 5/5. Dr. Forsythe reviewed Petitioner's right shoulder MRI and found no evidence of significant tearing of the rotator cuff.

Petitioner returned to Dr. Brian Forsythe for a supplemental §12 IME on May 14, 2015 (RX #5) at the request of Respondent. He confirmed that again there was an interpreter present at this examination. Petitioner reported that he had worked as a packer in a bakery for 6 years. He stated that he injured his right arm in December 2012 while emptying cases. Dr. Forsythe noted Petitioner's guarding and symptom magnification during the examination. Petitioner had symmetric upper extremity strength at 5/5. Dr. Forsythe reviewed Petitioner's right shoulder MRI and found no evidence of significant tearing of the rotator cuff.

Based upon a lack of any significant objective findings on the MRI, Dr. Forsythe opined that there was no indication for the recommended surgery. Dr. Forsythe also opined that he found no causal relationship between Petitioner's right shoulder condition and the work activities performed at work. Petitioner's medical treatment to date for his right shoulder was believed to be reasonable but not work related. Based on Petitioner's guarded presentation and symptom magnification during this physical examination, Dr. Forsythe recommended that Petitioner be released to return to work full duty without right shoulder restrictions. Finally, Petitioner was found to be at MMI with no permanent disability in his right shoulder related to the December 2012 incident.

Dr. Levin opined that Petitioner's cervical fusion was consistent with symptoms beginning 6 months before December 29, 2012, as well as the natural aging process. Dr. Levin further opined that the job activities described by Petitioner did not aggravate or exacerbate his pre-existing condition, but rather Petitioner had developed a cervical herniation in mid-2012 as part of the natural aging process. Petitioner's cervical treatment to date was found to be reasonable, but unrelated to work. Dr. Levin opined that Petitioner did not require any further treatment for his cervical spine related to the December 2012 incident and Petitioner was released to return to full duty work, without any restrictions related to the December 2012 incident.

Petitioner testified that he has continuing right shoulder complaints at the time of trial, as well as similar symptoms in his left shoulder to a lesser degree. Petitioner testified that he wished to proceed with a second surgery for his right shoulder with a different physician. Petitioner also testified that he was now seeking treatment for his left shoulder as well. Petitioner claimed that he had left shoulder pain at the same time of his right shoulder injury, but to a lesser degree. Petitioner has not returned to work since January 30, 2014.

Petitioner testified that he described his job duties to his doctors.

Martin Castillo

Mr. Castillo testified that he worked for Highland Baking Company for 25 years. He testified that his current title was night shift manager and he had been working in this position for 15 years where his hours were from 5:00 p.m. to 3:00 a.m. Mr. Castillo confirmed that the night shift hours in 2012 were from 1:00 a.m. to 9:00 a.m. and thus he only had the opportunity to work with the Petitioner briefly during the change of shifts.

Mr. Castillo testified that the standard procedure for reporting a work accident at Highland Baking Company is to file a report and complete an accident form which is then turned into Human Resources. However, he testified that Petitioner never reported a work related injury in 2012 to him. Further, he denied that Petitioner called him at this home to report a work accident.

Mr. Castillo testified that a north packing line workers had multiple job duties including bagging bread, packing bread into boxes, stacking bread into baskets, cleaning trays, and overturning products from molds. Mr. Castillo testified that no employee worked in the same position for a full shift as they were required to rotate them every 2 hours.

Mr. Castillo testified that when Petitioner returned to work in January 2013 he did not complaint about specific pain but did mention he did not feel right. Mr. Castillo then sent him to HR.

Jose Rodriguez

Mr. Rodriguez testified that he worked at Highland Baking Company as Packing Supervisor for about 15 years. He confirmed that he was Petitioner's supervisor. Mr. Rodriguez testified that an employee was expected to report any incident, even the smallest thing, to his supervisor as a standard procedure. Mr. Rodriguez testified that Petitioner never reported a 2012 work accident to him. Mr. Rodriguez denied that Petitioner had ever requested to be removed from the molding station. Mr. Rodriguez also denied scolding Petitioner upon his return to work on January 21, 2013. He testified that Petitioner reported that he could return to work without restrictions on January 21, 2013.

Mr. Rodriguez testified that Petitioner reported that he was unable to move his arm in January 2013 due to his blisters and he then took him to Human Resources for further processing.

Mr. Rodriguez further testified that Petitioner worked on the north packing line at Highland Baking Company. He stated that employees were assigned to one position at the start of each shift and were then shifted to a new position every 2 hours throughout the day. Mr. Rodriguez denied that an employee was ever left to work in the same position for a full 8 hour shift. Mr. Rodriguez continued to state that production requirements for loaf bread at Highland Baking Company did not require an employee to work at the demolding station at all times during an 8 hour shift. Mr. Rodriguez finally testified that empty molds were only stacked to about 5 feet high.

Arlene Salas

Ms. Salas testified that she worked for Highland Baking Company as HR Director as of the time of trial. She was an HR Supervisor in December 2012. As the HR Supervisor, she dealt with daily employee relations including direct deposit issues, sick pay, hiring, interviews, performance management and receipt of doctors' notes. She testified that Petitioner reported in January 2013 claiming that he was suffering from shingles previously and believed he was having a bad reaction from an injection he received. She denied that Petitioner reported any neck complaints to her. She denied that petitioner had ever presented to her office prior to January 2013. Ms. Salas testified that the company medical facility was North Shore Omega.

Ms. Salas further testified that Respondent's Exhibit #6 was a complete and accurate description of a packing line worker job description. She confirmed that Petitioner's last date worked in December 2012 was December 28 and that he worked a full 8 hour shift that day.

CONCLUSIONS OF LAW

C: Did an accident occur that arose out of an in the course of Petitioner's employment by Respondent?

Petitioner has claimed repetitive trauma injuries to his right shoulder, neck, and left shoulder, with a manifestation date of December 28, 2012, his last date of work in 2012. Petitioner testified on direct examination that he worked only at the molding station for the 4 years prior to December 28, 2012. He testified that he worked at this station for 8 hours a day, every day. Petitioner reported similar histories to his treating physicians and Respondent's IME physicians.

Petitioner's testimony with respect to his job duties was contradicted by credible testimony of Jose Rodriguez and Martin Castillo. Mr. Castillo testified that packing line workers did not work at the same position for their entire shift as they were required to rotate every 2 hours. Mr. Rodriguez, Petitioner's supervisor, confirmed Mr. Castillo's testimony, indicating that employees were shifted among the various positions on the packing line every 2 hours of each shift. He also confirmed that no employee ever worked in the same position for a full 8 hour shift. Further, Mr. Rodriguez testified that the loaf bread production requirements at Highland Baking Company were not high enough to require an employee to work at the molding station at all times during an 8 hour shift.

Furthermore, Petitioner's testimony on direct examination that he worked in the same mold station for 8 hours a day for the 4 years before December 28, 2012 was contradicted by his own testimony on cross-examination, wherein he admitted to not only working at the mold station, but also working at unloading boxes, working in quality control, stacking completed boxes of bread, and working on the conveyor lines.

The Arbitrator finds Petitioner's testimony that he worked in the same mold station solely in the 4 years prior to December 28, 2012, 8 hours a day, was not credible. The Arbitrator finds the job description testimonies of Mr. Castillo and Mr. Rodriguez to be credible and persuasive. In fact, the work schedule described by Mr. Castillo and Mr. Martin is apparently designed to prevent the type of repetitive injury claimed here.

Therefore, the Arbitrator finds that Petitioner failed to prove that he sustained an accidental injury that arose out of and in the course of his employment.

E: Was timely notice of the accident given to the Respondent?

Petitioner testified that he called Martin Castillo at his home on December 29, 2012 to report his injury on the shift before. He testified to earlier unsuccessful attempts to call into Respondent's office to report his injury. This testimony was contradicted by Mr. Castillo. Mr. Castillo denied that Petitioner ever reported a work related injury to him. The Arbitrator notes evidence that Respondent's operations were conducted on a 24 hour schedule. The Arbitrator finds it unlikely that Petitioner could

not contact anyone at Respondent's offices in order to report his claimed injury. Further, the Arbitrator also finds in unlikely that Petitioner phoned Mr. Castillo at his home as he claimed.

Petitioner also testified that he spoke to Jose Rodriguez about the claimed December 28, 2012 work incident on January 21, 2013 when he returned to work after his shingles outbreak. Petitioner testified that it was his impression that Mr. Rodriguez was already aware of the December 28, 2012 incident as he felt that he was being scolded by Mr. Rodriguez for not reporting same earlier. This testimony was contradicted by Mr. Rodriguez. Mr. Rodriguez denies that he scolded Petitioner for not reporting of the alleged accident upon his return to work on January 21, 2013. In fact, Mr. Rodriguez denied being informed of the alleged work related incident in December 2012 or January 2013. Mr. Rodriguez testified that the only right arm complaints he received from Petitioner were reportedly related to his previous shingles outbreak. Further, Mr. Rodriguez denied that Petitioner ever reported a work related injury to him.

Petitioner also testified that he reported his work related injury of December 28, 2012 to Arlene Salas in Human Resources when he turned in his off work slips on January 30, 2013 or February 1, 2013. This testimony was contradicted by Ms. Salas. Ms. Salas testified that Petitioner only presented to her office in Human Resources on one occasion, January 24, 2013, when he reported right arm complaints from a bad reaction to an injection he received from his prior shingles outbreak. Ms. Salas denied that Petitioner ever reported a work related accident to her.

The Arbitrator finds Petitioner's testimony that he gave timely notice of his claimed injury to Respondent was not credible. Petitioner testified to two different dates for his injuries, admitting that his memory was faulty. More importantly, Petitioner's testimony regarding notice was contradicted by credible witnesses presented by Respondent.

The number of witnesses testifying to a particular fact may not be convincing if a lesser number of witnesses is more convincing when testifying to that fact. Here, however, the greater number of witnesses on the issue of notice is more believable than Petitioner. The Arbitrator finds that Petitioner was not credible and that the testimonies of Mr. Castillo, Mr. Rodriguez, and Ms. Salas that Petitioner did not give timely notice of his claimed injury were credible. Accordingly, the Arbitrator finds that Petitioner failed to prove that he gave notice of his claimed injury to Respondent in accord with §6 of the Act.

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

Whether Petitioner can prove that his current condition of ill-being is causally related to the claimed accident rests on the credibility and reliability of medical opinion. Any medical opinion lacks credibility or reliability if it is based on inaccurate or

incomplete information provided by the patient. If the patient lacks credibility then opinions based on the history provided by that patient cannot be reliable or accurate. The Arbitrator has previously found that Petitioner is not credible and, therefore, finds that Petitioner failed to prove his claimed current condition of ill-being is causally related to the claimed work accident on or about December 28, 2012.

As noted above, the Arbitrator found Petitioner's testimony that he worked in the same mold station solely in the 4 years prior to December 28, 2012 was not credible. The Arbitrator finds the job description and rotation schedule for a packing line worker described by Mr. Castillo and Mr. Rodriguez to be more credible than Petitioner's description.

The Arbitrator notes that Petitioner did not report a work related incident history to Dr. Gutierrez during the course of the treatment that he received for his right shoulder condition between January 4, 2013 and August 29, 2013. In fact, Dr. Gutierrez, Petitioner's primary care physician, opined that Petitioner's frozen shoulder/adhesive capsulitis was secondary to the non-use of his right arm during his shingles outbreak rather than any repetitive work duties.

The Arbitrator notes that all causation opinions contained in Petitioner's treating medical records are based upon an inaccurate job description provided by Petitioner. Therefore, the Arbitrator finds that the causation opinions of Petitioner's treating physicians are not credible, as they are based on an inaccurate job description and history of Petitioner's work duties, as well as an inaccurate medical history where he denied prior complaints to treating physicians.

Respondent's §12 expert, Dr. Brian Forsythe, examined Petitioner on April 23, 2013 and May 14, 2015. Dr. Forsythe diagnosed Petitioner with a right C6-7 herniated disc and C6 radiculitis. Dr. Forsythe did not find any clinical manifestation of rotator cuff disease, as Petitioner exhibited full and symmetric shoulder range of motion and normal and symmetric rotator cuff strength on his examination. Dr. Forsythe opined that Petitioner's symptoms were related to his underlying degenerative conditions.

These opinions were confirmed by Dr. Forsythe at his May 14, 2015 re-examination. At that time, Petitioner was noted to exhibit guarding and symptom magnification. Even with his guarding, Petitioner was found to exhibit symmetric upper extremity strength at 5/5. Petitioner's right shoulder MRI revealed no evidence of significant tearing of the rotator cuff. Based on a lack of any significant objective findings on the MRI, Dr. Forsythe opined that there was no indication for the surgery recommended by Dr. Sclamberg.

Dr. Forsythe further opined that he found no causal relationship between Petitioner's right shoulder condition and the work activities. While Petitioner's medical treatment to date for his right shoulder was believed to be reasonable, Dr. Forsythe did not believe the right shoulder condition was related to Petitioner's work activities. Based on Petitioner's guarded presentation and symptom magnification, Dr. Forsythe recommended that Petitioner be released to return to work full duty without restrictions

for his right shoulder. Finally, Petitioner was found to be at MMI, with no permanent disability in his right shoulder related to the December 2012 incident.

Petitioner was also examined Dr. Jay Levin for his cervical spine on July 23, 2015. Petitioner reported that he had right shoulder and neck pain for 6 months prior to December 29, 2012. Petitioner reported that he had spoken to his supervisor about changing work stations but was never moved. Petitioner was noted to be status post C5-6 and C6-7 anterior cervical discectomy and fusion. Dr. Levin noted that Petitioner reported complaints of pain beginning 6 months prior to December 29, 2012 and was unable to identify a specific traumatic event occurring in December 2012.

Dr. Levin opined that Petitioner's cervical fusion was consistent with his beginnings of symptoms 6 months prior to December 29, 2012 and the natural aging process. Dr. Levin further opined that the job activities described by Petitioner did not aggravate or exacerbate his pre-existing condition, but, rather, Petitioner had developed a cervical herniation in mid-2012 as part of the natural aging process. Petitioner's cervical treatment to date was found to be reasonable, but unrelated to his work activities. Dr. Levin opined that Petitioner did not require any further treatment for his cervical spine and that Petitioner was released to return to full duty work, without any restrictions related to a December 2012 incident.

The Arbitrator finds the opinions of Dr. Forsythe and Dr. Levin to be credible and persuasive. They reviewed the full medical treatment history of Petitioner and had the benefit of having Petitioner's correct job description. For these reasons, the Arbitrator adopts the opinions of Dr. Forsythe, Dr. Levin, and finds, upon review of all the evidence, that Petitioner failed to prove that his current claimed condition of ill-being in his shoulders and neck are causally related to the alleged work activities performed on or about December 28, 2012.

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?

Dr. Forsythe opined in his May 14, 2015 report, that, while Petitioner's medical treatment to date for his right shoulder was believed to be reasonable, it was not related to his work activities. In his August 14, 2015 report, Dr. Levin opined that Petitioner's cervical treatment to date was reasonable, but unrelated to his work activities. As noted above, the Arbitrator found the opinions of Drs. Forsythe and Levin to be more credible than those of the treating physicians. The treating physicians based their opinions on Petitioner's history and subjective complaints. The Arbitrator reiterates his finding that petitioner was not a reliable of credible witness. Further, as above, the Arbitrator notes that Drs. Forsythe and Levin had a more complete view of Petitioner's case due to their more complete review of Petitioner's medical history by records.

For these same reasons, the Arbitrator adopts the opinions of Drs. Forsythe and Levin with respect to the necessity of the medical treatment that he received for his right

shoulder and neck. While the treatment received by the petitioner was reasonable for treatment of petitioner's underlying degenerative conditions, this treatment was note necessary for treatment of any injuries arising out of the alleged December 28, 2012 injury. Therefore, the Arbitrator finds that Petitioner failed to prove that he is entitled to payment for any medical bills incurred for services received for treatment of his right shoulder, left shoulder, or neck.

K: What temporary benefits are in dispute? *TTD;*

The Arbitrator has found that Petitioner failed to prove that his claimed injury of December 28, 2012 arose out of and in the course of his job duties for the Respondent and failed to prove that his current conditions of ill-being are causally related to any repetitive trauma from his work duties on or about December 28, 2012 and failed to prove that he gave timely notice of his claimed injury in accord with the Act. Accordingly, the Arbitrator finds that Petitioner is not entitled to any TTD benefits as a result of the claimed December 28, 2012 injury.

M: Should penalties or fees be imposed upon Respondent?

The Arbitrator finds that Petitioner failed to prove that he is entitled to penalties or fees in this matter. The Arbitrator notes that the claim was disputed since the inception due to a failure of Petitioner to report a work related injury to the Respondent. Subsequently, this denial was confirmed by the opinions of Dr. Forsythe in his IME reports dated April 29, 2013 and May 14, 2015, as well as the opinions of Dr. Levin in his IME report dated August 14, 2015. Based on the numerous disputed issues identified above, the Arbitrator finds that Respondent's denial in this claim was not be unreasonable or vexatious.

N: Is Respondent due any credit?

Based on previous findings that Petitioner failed to prove that his claimed injury of December 28, 2012 arose out of and in the course of his job duties for the Respondent and failed to prove that his current conditions of ill-being are causally related to any repetitive trauma from his work duties on or about December 28, 2012 and failed to prove that he gave timely notice of his claimed injury in accord with the Act, the Arbitrator finds that Respondent is entitled to a credit of &8,777.47, for benefits previously paid.

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

The Arbitrator finds that Petitioner failed to prove that he is entitled to prospective medical care. As noted above, the Arbitrator finds that Petitioner's current

conditions of ill-being in his shoulders and neck are not related to the alleged December 28, 2012 injury. The Arbitrator has found that the causation opinions of Drs. Forsythe and Levin are credible and persuasive. Dr. Forsythe opined that, based upon a lack of any significant objective findings on Petitioner's MRI, there was no indication for the right shoulder surgery recommended by Dr. Sclamberg. Dr. Levin opined that Petitioner did not require any further treatment for his cervical spine.

P: Did Petitioner exceed the two physician limit set forth in the Act?

Petitioner testified that he sought care from Dr. Cordero for his initial evaluation of December 29, 2012. Dr. Cordero was Petitioner's first choice. The Arbitrator notes that Dr. Gutierrez was Petitioner's primary care physician and not the "company" doctor as Petitioner reported to Marque Medicos. As such, Dr. Gutierrez was Petitioner's second choice. Further, the Arbitrator notes that Petitioner confirmed that he chose Marque Medicos on February 11, 2013 because he was unsatisfied with the treatment that he was receiving from Drs. Gutierrez and Cicero.

The Arbitrator notes that the referral purportedly from Dr. Gutierrez to Marque Medicos (PX #20) was not dated until March 2, 2013. Dr. Wallery, the custodian of records for Marque Medicos, was unable to confirm how or when the alleged referral was received in their offices. Dr. Wallery could only testify that the referral note was maintained in the records of Marque Medicos. There was no evidence that PX #20 was made by Marque Medicos staff.

Illinois Supreme Court Rule 236 defines the foundation for admission of business records: if the memorandum is made in the regular course of business and that it is the regular course of business to make such a memorandum. PX #20 was admitted over insufficient objection of Respondent. Nonetheless, the Arbitrator finds no weight in the purported referral of Dr. Gutierrez, PX #20, due to the lack of proper Rule 236 foundation, and therefore does not find PX #20 to be sufficient proof of a referral of Petitioner to Marque Medicos by Dr. Gutierrez. The Arbitrator further notes that Dr. Gutierrez's records have no reference any referral to Marque Medicos, even though the prior referral to Dr. Cicero is clearly noted in his records.

For these reasons, the Arbitrator finds that Marque Medicos was Petitioner's third choice and that Respondent is not liable for any medical bills from Marque Medicos or its chain of referrals.

Likewise, the Arbitrator notes that Petitioner testified that he chose Drs. Morgenstern and Levi for second opinions on his ongoing complaints. Based on Petitioner's admissions that he chose these providers without a referral from his initial two choices of physicians, the Arbitrator finds that Respondent is also not liable for the medical bills for any services provided by Dr. Morgenstern or Dr. Levi as they are outside of his two choices of physicians.

18IWCC0220

Steven J. Fruth, Arbitrator

June 22, 2016

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARK LAY,

Petitioner,

vs. NO: 13 WC 27858

CROWN, CORK & SEAL,

Respondent.

18IWCC0221

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, temporary total disability benefits (TTD), maintenance, nature and extent, and penalties and attorney's fees, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all of the testimony, exhibits, pleadings, and arguments submitted by the parties.

The Arbitrator found that Petitioner's current condition of ill-being was not causally related to the March 5, 2013 accident. The Arbitrator further found that the surgery performed on Petitioner was not causally related to the March 5, 2013 accident. By its brief, Respondent disputes causal connection after the May 7, 2014 surgery to Petitioner's right knee.

Although the Arbitrator does not indicate from which of the four Section 12 reports he relied on, it appears that the bulk of the Arbitrator's information rests with Dr. Paul Belich's first Section 12 report of December 5, 2013. The Arbitrator noted that Petitioner suffered from residual

mild prepatellar bursa of the right knee as a result of the March 5, 2013 accident. The Arbitrator also considered the diagnosis made by Petitioner's treater, Dr. Thomas Poepping, on August 29, 2014, of right knee pain and patellar chondromalacia, as well as Dr. Poepping's opinion that the cartilage wear behind Petitioner's knee cap was the possible source of Petitioner's dysfunction and pain. In light of Dr. Poepping's medical record of August 29, 2014, the Arbitrator found that Petitioner's current condition of right knee pain and patellar chondromalacia was not causally related to the March 5, 2013 accident.

The Commission notes that Petitioner had no complaints, injuries, or treatment to his right knee prior to March 5, 2013; further, despite indication that an MRI [not made part of the record] of the right knee suggested degenerative changes in the patellofemoral joint, no doctor opined that the March 5, 2013 accident aggravated a pre-existing condition. There was also no evidence that Petitioner's work duties were restricted in any manner prior to March 5, 2013 due to a right knee condition. Following the March 5, 2013 accident, Petitioner's right knee became symptomatic, and neither physical therapy nor injections served to alleviate his condition; Petitioner was given work restrictions. Respondent eventually authorized surgery to the right knee, which Petitioner proceeded with on May 7, 2014; Dr. Thomas Bilko performed an arthroscopic-aided excision of the prepatellar bursa of the right knee. (T.19; PX4).

Respondent's Section 12 examiner, Dr. Belich, physically examined Petitioner twice and authored four separate reports. In his first report, dated December 5, 2013, Dr. Belich noted slight thickening of the prepatellar bursa, and diagnosed Petitioner with right knee residual mild prepatellar bursa. He believed the March 5, 2013 accident caused Petitioner's condition. Dr. Belich specifically opined that Petitioner sustained direct trauma to the kneecap and the bruising of the kneecap was the primary source of Petitioner's pain. He did not believe the patellofemoral joint was the cause of Petitioner's residual symptoms because Petitioner did not have any direct tenderness at the patella. (RX1). Petitioner's treating surgeon, Dr. Bilko, also found that the March 5, 2013 accident caused an issue in the area of the prepatellar bursa in the right knee, namely traumatic bursitis. (PX3).

With this in mind, Petitioner's other treating physician, Dr. Poepping, noted tenderness to palpation over the anterior aspect of the knee in the region of the prepatellar bursa; Dr. Poepping also found that Petitioner had severe retropatellar tenderness to palpation. This finding on August 29, 2014, together with Dr. Poepping's review of a 2013 MRI [not in the record] which revealed mild patellar chondromalacia, led him to diagnose Petitioner with right knee pain and patellar chondromalacia. Although Dr. Poepping did not provide a causal connection statement relative to his findings and diagnosis, he stated, "This is certainly a difficult problem during the arthroscopy for the endoscopic bursal resection, they did not look inside his joint. It is certainly possible that this cartilage wear behind his knee cap is providing him some degree of dysfunction and pain." (PX4).

By November 13, 2014, Petitioner returned to Dr. Belich for a second Section 12 examination. Dr. Belich's examination revealed minimal soft tissue swelling and hypersensitivity of the prepatellar bursa; Dr. Belich's diagnosis was right knee pain and post arthroscopically assisted prepatellar bursal excision, and patellofemoral pain secondary to patellofemoral chondromalacia. Dr. Belich indicated in his report that "[t]he alleged work injury was a substantial

contributing factor to his symptoms." (RX3). He further stated,

> I thought that this patient had primarily patellofemoral type symptoms, of an intra-articular nature, as the cause of his pain. Apparently he also had a very mild and small prepatellar bursa which I did not feel was contributing significantly to his symptoms. Apparently his treating physician did and decided that a surgical procedure was appropriate. I believe the fall on the knee was enough sufficient force to cause at least some patellofemoral pain in the right knee. (RX3).

Notwithstanding the fact that Dr. Belich had initially stated that Petitioner's primary condition involved the prepatellar bursa and not the patellofemoral joint [see December 5, 2013 Section 12 report], Dr. Belich now indicated the opposite, stating that Petitioner's primary condition involved the patellofemoral joint and not so much the prepatellar bursa. Nonetheless, after a very careful reading, the Commission finds that Dr. Belich does provide causal connection for both conditions surrounding the patella, namely the prepatellar bursitis and the patellofemoral pain.

Therefore, given the chain of events in this claim together with a careful reading of the record in its entirety, the Commission finds that the record supports a finding that Petitioner's current condition of ill-being is causally related to the March 5, 2013 accident.

Consequently, Petitioner is entitled to reasonable, necessary, and related medical expenses as contained in Petitioner's Exhibit 1, totaling $36,136.76. Petitioner is also entitled to additional TTD and maintenance benefits.

The Arbitrator only awarded TTD benefits from August 16, 2013 through February 12, 2015; Petitioner's claim for maintenance benefits was denied. Petitioner argues that he is entitled to TTD from August 16, 2013 through February 20, 2015 [the date Petitioner was released per the functional capacity evaluation (FCE)], and maintenance benefits from February 21, 2015 through July 15, 2015 [when he secured other employment as a mechanic]. According to Petitioner's brief, he had received TTD through February 12, 2015.

Petitioner testified that he had contacted Respondent regarding returning to work with his permanent restrictions, but had never received a response. (T.27; T.40). Respondent claims that Petitioner contacted Respondent only one time looking for work. (T.27; T.40). Thereafter, Petitioner began his own job search and maintained a search log. (T.27-28; T.38; PX5). Respondent argues that according to the job log, Petitioner did not begin to look for work until June 22, 2015, and there was no evidence that Petitioner looked for work between February and June 2015. (PX5). Petitioner was eventually able to find employment with Benttenhausen Dodge, and began working on July 12, 2015 as a mechanic. (T.28-29).

In reviewing the record, the Commission finds that the first time Petitioner was released back to work was on February 20, 2015. At that time, Dr. Poepping had reviewed the results of the FCE and released Petitioner with permanent restrictions of no lifting/pushing/pulling more than

20 pounds, no squatting, no kneeling, no crawling, no prolonged walking, no ladder climbing, no prolonged standing, and Petitioner could climb stairs on occasion. (T.26-27; PX4). The Commission notes that according to the Concentra medical records, Respondent had at one time accommodated Petitioner's restrictions, but for whatever reason not evident by the record, Respondent could not or would not provide Petitioner with any additional light duty work. (PX2). Further, Respondent never denied that Petitioner had requested a job within his restrictions – even if it was at the very least one time, and Respondent did not dispute or rebut Petitioner's testimony that Petitioner had never received a response to his job inquiry. As such, the Commission finds that the record supports an award of TTD from August 16, 2013 through February 20, 2015.

The Commission further finds that the record supports an award of maintenance benefits. Section 8(a) of the Act provides that an employer "shall *** pay for treatment, instruction and training necessary for the physical, mental and vocational rehabilitation of the employee, including all maintenance costs and expenses incidental thereto." 820 ILCS 305/8(a) (West 2012). The Act permits maintenance benefits only while a claimant is engaged in a prescribed vocational rehabilitation program, and if the claimant is not engaged in some type of "rehabilitation" such as physical rehabilitation, formal job training or a self-directed job search, there is no obligation to provide maintenance. *Greaney v. Indus. Comm'n*, 358 Ill. App. 3d 1002, 1019 (1st Dist. 2005).

Although Petitioner offered into evidence an extremely limited job search log that commenced June 22, 2015, Petitioner did testify that his search included more jobs than what was listed on the log. (T.38-39; PX5). In fact, Petitioner testified to securing three jobs after the accident date, namely Benttenhausen Dodge, Tuffy Automotive, and G & W Electric Company in Bolingbrook, none of which were included on the job search log. (T.10-11; T.30-31; T.42). It is clear that Petitioner was in fact engaged in a self-directed job search which resulted in him returning to the work force on July 12, 2015. (T.28-29). Therefore, the Commission finds that Petitioner is also entitled to maintenance benefits from February 21, 2015 through July 11, 2015.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed May 9, 2017, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $36,136.76 for reasonable and necessary medical expenses as identified in Petitioner's Exhibit 1, and as provided in Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $551.81 per week for a period of 79 weeks, from August 16, 2013 through February 20, 2015, that being the period of temporary total incapacity for work under Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner maintenance benefits of $551.81 per week for 20 weeks, commencing February 21, 2015 through July 11, 2015, as provided in Section 8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner

the sum of $496.63 per week for a period of 32.25 weeks, as provided in Section 8(e) of the Act, for the reason that the injuries sustained caused the loss of use to the right leg to the extent of 15% thereof.

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 $61,600.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: APR 11 2018

Michael J. Brennan

Thomas J. Tyrrell

MJB/pm
O: 2-20-18
052

Dissent

I respectfully dissent from the decision of the majority. I would affirm and adopt Arbitrator Kane's findings. I find the decision to be well reasoned. The Arbitrator's findings are persuasive and well grounded in the record. I would affirm the decision in its entirety.

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LAY, MARK
Employee/Petitioner

Case# **13WC027858**

CROWN CORK & SEAL
Employer/Respondent

18IWCC0221

On 5/9/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.01% 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:

1067 ANKIN LAW OFFICE LLC
JOSHUA E RUDOLFI
10 N DEARBORN ST SUITE 500
CHICAGO, IL 60602

1120 BRADY CONNOLLY & MASUDA PC
MARK VIZZA
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603-1016

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

MARK LAY
Employee/Petitioner

Case # 13 WC 27858

v.

Consolidated cases: N/A

CROWN, CORK & SEAL
Employer/Respondent

18IWCC0221

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **March 29, 2017, and April 27, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On 3/05/2013, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $43,009.20; the average weekly wage was $827.71.

On the date of accident, Petitioner was 56 years of age, *married* with no dependent children.

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

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

Respondent shall be given a credit of $45,327.33.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $551.81/week for 78 weeks, commencing August 16, 2013, through February 12, 2015, as provided in Section 8(a) of the Act.

The Arbitrator finds that the petitioner's current condition of ill-being is not causally related to any accident arising out of and in the course of his employment with the Respondent. The Arbitrator finds that the surgery performed on the Petitioner was not related to any accident arising out of and in the course of his employment with the Respondent.

The Arbitrator finds that the medical bills submitted into evidence by the Petitioner as Petitioner's Exhibit 1 are not the responsibility of the Respondent.

The Arbitrator denies the Petitioner's claim for maintenance benefits.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a line maintainer at the time of the accident and that he *is* not able to return to work in his prior capacity as a result of said injury. The Arbitrator notes that the Petitioner had employment as a mechanic after his return to work. Because of the fact the Petitioner did not testify as to a wage loss, the Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 56 years old at the time of the accident. Because of the fact that the Petitioner has less years to retirement, the Arbitrator therefore gives *lesser* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes the Petitioner did not testify to a wage loss. Because of the lack of evidence on this issue, the Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner only testified to some soreness at the end of the day. Because of lack of medical treatment after his release to return to work, the Arbitrator therefore gives *greater* weight to this factor.

Respondent shall pay to Petitioner the sum of $**496.63** /week for a period of **32.25** weeks under section 8(e) of the Act, , as the injuries sustained caused the complete and permanent loss of use of the right leg to the extent of 15% thereof.

The Arbitrator denies the Petitioner's Petition for Penalties and Attorney's Fees.

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

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

David A. Kane
Signature of Arbitrator

May 9, 2017
Date

MAY 9 - 2017

FINDINGS OF FACT

The petitioner testified he is currently employed by G&W Electrical Contractors in Bolingbrook. He is a receiving/shipping clerk. He will be employed there for one year this April. Before that, he worked for Tuffy Automotive for approximately 70 days and Bentenhausen Automotive for approximately 70 days. He was a mechanic for those companies. Before that, he worked for Crown, Cork & Seal for approximately three years as a line maintainer. On March 15, 2013, he fell on oil that was on the floor and hurt his right knee. He told the plant supervisor about the accident. He did not seek medical treatment that day and, in fact, did not seek medical treatment for approximately five months. He testified that his knee hurt continuously during that time and he mentioned it a number of times to the plant superintendent who finally told him in August 2015 to go to human resources.

On August 5, 2013, he went to human resources and they sent him to Concentra. He was released with restrictions at that time. The respondent did not have light duty. On August 16, 2013, he was referred to Dr. Forman. He had physical therapy and was kept off work. The physical therapy did not help. After a while, Dr. Forman referred him to an orthopedic specialist, Dr. Bilko. He saw Dr. Bilko in February 2014 and

noted he had no improvement. He was seen for an independent medical evaluation with Dr. Belich in December 2013 and April 2014. He had surgery in May 2014. Subsequent to that, he had physical therapy. The surgery was not helping, so he was referred to Dr. Poepping. Dr. Poepping recommended physical therapy. In December 2014, he had an MRI and a functional capacity evaluation. When he was released to return to work light duty, he called Crown, Cork & Seal and left a message, but never heard back from them. In February 2015, he was released with permanent restrictions. He was shown Petitioner's Exhibit 5, which is a job log that showed that he applied to five different locations. He testified that he applied to many others through the internet. He was able to return to work in July 2015 at Bentenhausen. He worked as a mechanic and that work which did not involve using a ladder. He then worked for Tuffy Automotive again as a mechanic and no use of ladders. He then went to work for G&W Automotive and his knee is sore at the end of the day. He might take an over-the-counter drug, such as Aleve. He has good days and bad days. Some days, his knee is perfect, some days it is sore. He did discuss surgery with Dr. Poepping, but doesn't recall what Dr. Poepping said. He has restrictions of no using a ladder and no kneeling. Since his release by Dr. Poepping, he has not seen any other doctors for his knee. Since he

has been working G&W, he has not missed any days from work because of his knee and actually is getting an attendance award.

CONCLUSIONS OF LAW

In support of the arbitrator's decision regarding whether or not the petitioner's current condition of ill-being is causally related to the injury, the arbitrator finds the following facts:

Dr. Belich examined the petitioner and found that he suffered from residual mild patellar bursitis of the right knee. He found that the MRI showed some degenerative changes in the patellofemoral joint. However, on examination, he did not have any direct tenderness at the patella. Dr. Belich felt this would rule out the patellofemoral joint as a cause of his residual symptoms. Dr. Belich also found that he had very little in the way of residual bursal type thickening in the front of his knee. He found that his bursal thickening was so minimal it was difficult to see how it could be causing him as much pain as he has. (Respondent's Exhibit 1) He found that the petitioner suffered a direct contusion to the anterior aspect of the bony patella. (Respondent's Exhibit 1) Dr. Belich found that when he examined the petitioner, he did not feel he had very much tissue to resect. (Respondent's Exhibit 2) Dr. Belich found that the petitioner was able to perform his regular duty work without restrictions. (Respondent's Exhibit 4)

Based upon the medical records and the testimony, the arbitrator finds that the petitioner suffered residual mild prepatellar bursa right knee as a result of the accident. This resulted in surgery to the right knee. Dr. Poepping diagnosed the petitioner with right knee patellar chondromalacia, right knee pain and left heel pain. Dr. Poepping indicated that some of the cartilage wear behind his kneecap is providing some of the dysfunction and pain. This condition of ill-being is not causally related to the accident of March 5, 2013. The petitioner has recovered from his injury of March 5, 2013, and his current condition of ill-being is not causally related to any such accident.

In support of the arbitrator's decision regarding whether or not the petitioner is entitled to temporary benefits, the arbitrator finds the following facts:

The petitioner is entitled to temporary total disability benefits from August 16, 2013, through February 12, 2015, for a total of 78 weeks. At that time, the petitioner was able to return to work full duty as a result of the accident of March 5, 2013. Any subsequent periods of maintenance or temporary total disability benefits are related to a condition that is not related to any accident arising out of and in the course of the petitioner's employment with the respondent.

In support of the arbitrator's decision regarding were the medical services that were provided to the petitioner reasonable and necessary, the arbitrator finds the following facts:

As the arbitrator has found that the petitioner's current condition of ill-being is not causally related to any accident arising out of and in the course of his employment with the respondent, the arbitrator finds that the medical bills as submitted by the petitioner as Petitioner's Exhibit 1 are not the responsibility of the respondent.

In support of the arbitrator's decision regarding the nature and extent of the petitioner's injury, the arbitrator finds that the petitioner suffered injury to his prepatellar bursa in this incident.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a line maintainer at the time of the accident and that he *is* not able to return to work in his prior capacity as a result of said injury. The arbitrator notes that the petitioner had employment as a mechanic after his return to work. Because of the fact the petitioner did not testify as to a wage loss, the arbitrator therefore gives *no* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the arbitrator notes that petitioner was 56 years old at the time of the accident. Because of the fact that the petitioner has less years to retirement, the arbitrator therefore gives *lesser* weight to this factor.

With regard to subsection (iv) of §8.1b(b), petitioner's future earnings capacity, the arbitrator notes the petitioner did not testify to a wage loss. Because of the lack of evidence on this issue, the arbitrator therefore gives *no* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the arbitrator notes the petitioner only testified to some soreness at the end of the day. Because of lack of medical treatment after his release to return to work, the arbitrator therefore gives *greater* weight to this factor.

Based on the above factors, and the record taken as a whole, the arbitrator finds that petitioner sustained permanent partial disability to the extent of 15% loss of use of right leg pursuant to §8(e)(12) of the Act.

In support of the arbitrator's decision whether or not penalties and fees should be imposed upon the respondent, the arbitrator finds the following facts:

As the arbitrator has found that the petitioner's present condition of ill-being is not causally related to any accident arising out of and in the course

of his employment, the arbitrator finds that the petitioner is not entitled to penalties and fees, and therefore his petition for penalties and fees is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert Eppenstein,

Petitioner,

vs. NO: 15WC 29997

All Sealants,

18IWCC0222

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 7, 2016, is hereby affirmed and adopted.

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

18IWCC0222

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

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

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

DATED: APR 12 2018
o022018
KWL/jrc
042

Michael J. Brennan

Thomas J. Tyrrell

Dissent

I respectfully dissent from the decision of the majority affirming and adopting the decision of the Arbitrator. I would find Petitioner failed to prove his condition was casually related to the work accident and as such would reverse the Arbitrator's decision. Petitioner prior to his accident was diagnosed with both spondylolisthesis and degenerative disc disease, and as such had a significant history of low back problems prior to the work accident. A review of the medical records shows three weeks prior the accident forming the subject of this hearing Petitioner presented to an emergency room provider complaining of numbness down the right leg radiating to the toes. Petitioner's diagnostic testing post-accident is not different. Petitioner's complaints stem from his preexisting conditions which were not altered because of his work accident. Petitioner is entitled to TTD and medical treatment through October 12, 2015 for his contusion and strain injuries.

Kevin W. Lamborn

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

EPPENSTEIN, ROBERT
Employee/Petitioner

Case# **15WC029997**

ALL SEALANTS
Employer/Respondent

18IWCC0222

On 11/7/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.50% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0274 HORWITZ HORWITZ & ASSOC
MITCHELL W HORWITZ
25 E WASHINGTON ST SUITE 900
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2461 NYHAN BAMBRICK KINZIE & LOWRY
DANIEL R EGAN
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF LAKE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Robert Eppenstein
Employee/Petitioner

Case # **15** WC **29997**

v.

All Sealants
Employer/Respondent

18IWCC0222

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Waukegan**, on **August 22, 2016,** and **Rockford**, on **September 22, 2016**. After reviewing all of the evidence presented. the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **August 31, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$83,382.00**; the average weekly wage was **$1,603.50**.

On the date of accident, Petitioner was **34** years of age, ***married*** with **2** dependent children.

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

Respondent shall be given a credit of **$28,252.16** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$28,252.16**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$1,069.01**/week for **55 - 3/7** weeks, commencing **9/1/2015** through **9/22/2016**, as provided in Section 8(b) of the Act. The Respondent will be given a credit of **$28,252.16** for TTD benefits it has paid.

Respondent shall pay the reasonable and necessary medical services, pursuant to the medical fee schedule, of **$223,964.99**, as provided in Section 8(a) and 8.2 of the Act.

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

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

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

Arbitrator Anthony C. Erbacci

November 3, 2016
Date

NOV 7 - 2016

FACTS:

On August 31, 2015 the Petitioner sustained an undisputed accident which arose out of and in the course of his employment with the Respondent as a roofer/waterproofer. The Petitioner testified that his regular job duties required him to lift 50-200lbs of materials and products which included concrete "paver" stones, rolls waterproofing materials, tools, saws, and buckets of deck coating. The Petitioner testified that he was also required to climb ladders, scaffolding, and stairs. The Petitioner testified that on August 31, 2015 he was working on a foundation wall when he lost his balance and fell, striking the lower right side of his back on a ledge. The Petitioner reported his injury and sought treatment that same day at Concentra Immediate Care Center.

Prior to the accident of August 31, 2015 the Petitioner had received medical treatment for his lower back and had taken prescription medications for back pain. From 2008 to 2013, the Petitioner treated intermittently with Dr. Bruce Burkhart at Homer Chiropractic Clinic, for low back pain as well as other complaints. The Petitioner was not restricted from work during that treatment.

In January 2013 the Petitioner saw Dr. McKeigue and reported back pain with symptoms that went into his right leg and ankle. He was prescribed muscle relaxers and pain killers and underwent a course of physical therapy. In May and June of 2013, the Petitioner treated with Dr. Hurley for complaints of moderate low back pain. Dr. Hurley's assessment was lumbar disc degeneration and he recommended epidural steroid injections. The Petitioner testified that he received injections in 2013 and 2014 for his back complaints and attended physical therapy.

In 2014, the Petitioner treated with Dr. Najera at the Pain Treatment Centers of Illinois. Dr. Najera noted that the Petitioner had improved pain with injections and, on June 24, 2014, Dr. Najera performed a block of the medial branch of the lumbar spinal nerve.

On November 18, 2014 the Petitioner went to Silver Cross Hospital's emergency room after he slipped and fell in his driveway at home. He subsequently presented to Dr. Hensley at Joliet Doctor's Clinic and he underwent a lumbar MRI in January 2015. That MRI was reported to demonstrate early degenerative changes and diffuse disc bulges at L4-L5 and L5-S1 without neurological compromise.

The Petitioner then sought treatment with Dr. Okpareke. He reported pain in his lower back and right leg and he received two epidural steroid injections. In April 2015 Dr. Okpareke noted that the Petitioner's current pain medications were adequately controlling his pain and he also referred the Petitioner to Dr. Kouloumberis for surgical evaluation.

The Petitioner testified that he did not see Dr. Koloumberis because he was feeling better.

The Petitioner testified that, following the winter slowdown in work, he returned to work for the Respondent in April 2015. The Petitioner also testified that he stopped taking narcotic pain medications at the end of May 2015. From April through August 31, 2015 the Petitioner continued to work for the Respondent, performing the regular duties of a roofer/waterproofer.

On August 10, 2015, the Petitioner presented to Silver Cross Hospital ER with complaints of cervical radiculopathy and dizziness. A CT scan of his neck was performed and he was sent home and prescribed pain medications. On August 23, 2015, the Petitioner presented to Advocate Christ

Hospital's ER where he again complained of dizziness and neck pain. The Petitioner testified that he discussed his diet with the doctors at Advocate Christ and reported that he had been drinking a lot of "Monster" Energy Drinks. He testified that the doctors advised him to stop drinking "Monster", which he did, and that his dizziness and neck pain subsided.

The Petitioner testified that he experienced some low back and right leg symptoms up to his injury on August 31, 2015 but he did not miss any work due to this pain. The Petitioner also testified that no doctor imposed any work restrictions due to his low back or right leg symptoms and no doctor ordered lower back surgery. The Petitioner testified that his symptoms did not interfere with his social or work life and that the conservative medical treatment he received provided him with relief of his pain.

The records of Concentra demonstrate that the Petitioner was seen there on August 31, 2015 with complaints of sharp, severe pain, radiating into his buttocks, after a fall onto his lower back at work. A drug screen was noted to be negative and x-rays of the lumbar spine were reported to demonstrate Pars defects at L5 – S1 with very slight spondylolisthesis and mild narrowing of disc height at L4-5. X-rays of the right wrist were negative and a CT scan of the abdomen was ordered. The Petitioner was assessed as having a contusion of the lower back, a lumbar strain, and a wrist sprain and was given lifting restrictions of lifting and pushing/pulling 10lbs occasionally.

The Petitioner testified that because there was blood in his urine, he was sent to Silver Cross Hospital Emergency room. The records of Silver Cross demonstrate that the Petitioner was seen there on August 31, 2015 for complaints of pain from the iliac crest level into the right buttocks after a fall at work. A CT scan of the Petitioner's abdomen was completed and reported to demonstrate no significant abnormalities. The Petitioner was diagnosed with a back injury and buttocks contusion and he was discharged with instructions to follow-up with Dr. Cary Templin at Hinsdale Orthopedics.

The Petitioner presented to Dr. Cary Templin at Hinsdale Orthopedics on September 2, 2015. Dr. Templin recorded a consistent history of the Petitioner's work injury and noted the Petitioner rated his pain at 8/10 with 70% back symptoms and 30% leg symptoms. Dr. Templin diagnosed acute low back pain with right leg radiculopathy with underlying grade one L5-S1 spondylolisthesis. He prescribed physical therapy and a Medrol Dosepak and ordered an MRI of the Petitioner's lumbar spine. Dr. Templin opined that the Petitioner was unable to return to work.

On September 3, 2015 the Petitioner saw Dr. Chan at Advocate Medical group for pain medication.

On September 4, 2015, the Petitioner underwent an MRI of his lumbar spine which was reported to demonstrate: 1) chronic appearing bilateral L5 pars defects with slight grade I anterolisthesis of L5 over S1; 2) L4-5 disc desiccation and small posterior central disc protrusion with disc annular tear but no central canal narrowing or significant neural foraminal stenosis; 3) small Schmorl's node indenting the superior central T12 vertebral endplate.

The Petitioner then began attending physical therapy at ATI on September 10, 2015. The Petitioner testified that the physical therapy made his pain worse.

The Petitioner returned to Dr. Templin on September 23, 2015 complaining of 7/10 levels of pain. Dr. Templin reviewed the MRI noting the disc desiccation and bulging at L4-5 and L5-S1 with an annular tear at L4-5. He also noted trace L5-S1 spondylolisthesis with bilateral pars defect but no significant central canal or neural-foraminal narrowing. Dr. Templin recommended continued physical therapy with a trial of epidural steroid injections.

On September 25, 2015 the Petitioner presented to Dr. Babino at Loyola University Medical Center for refill of his medications. The Petitioner was noted to complain of low back pain that was "excruciating" at times with radiation to his right lower extremity with tingling and numbness. He reported that Tylenol and ibuprofen provided minimal relief. Dr. Babino noted that the Petitioner was diagnosed with lumbar radiculopathy and he prescribed Norco for the Petitioner's pain. The Petitioner testified that he presented to Loyola because of the wait time to be seen at Pain Treatment Centers of Chicago and his excruciating pain.

On October 2, 2015, the Petitioner presented to the Pain Treatment Centers of Chicago and saw Dr. Abusharif. Dr. Abusharif noted complaints of pain at 7-8/10 in the lower back with pain radiating to the right lower extremity. Dr. Abusharif diagnosed lumbar radiculopathy and he recommended right transforaminal epidural steroid injections at L5-S1 and prescribed Cyclobenzaprine. On October 6, 2015 and December 1, 2015, Dr. Abusharif performed the prescribed transforaminal epidural steroid injections. The Petitioner reported that these injections provided very mild pain relief.

The Petitioner returned to see Dr. Templin on October 22, 2015. Dr. Templin recommended that the Petitioner stop physical therapy because it was only making the Petitioner's pain complaints worse. Dr. Templin discussed potential surgical intervention and recommended a discogram to assess whether the Petitioner's L4-5 disc degeneration was contributing to his pain.

On November 5, 2015, the Petitioner underwent the prescribed discogram which was reported to reveal degenerative discs with an annular tear at L5-S1 with concordant pain. Dr. Abusharif noted degenerative discs and annular tears at L4-5, L5-S1, and he also noted leak of contrast at L5-S1 and corresponding concordant pain of 7-8/10 with distribution to right lower back and right buttock. A post-discogram CT scan was performed on November 6, 2015 and was reported to reveal a Grade 5 annular tear at L4-5 and at least grade 3 annular tear of the L5-S1 disc with altered level spondylosis.

At the request of the Respondent, the Petitioner was examined by Dr. Julie Wehner on November 9, 2015. Dr. Wehner diagnosed a resolved right wrist strain and requested additional medical records regarding the Petitioner's prior lower back complaints and treatment. Dr. Wehner opined that the discogram was not reasonable and that surgical intervention may be an option for symptomatic L5-S1 spondylolysis, but not if the symptoms had only been present for 2 ½ months.

The Petitioner returned to Dr. Templin on December 2, 2015 and Dr. Templin noted that the Petitioner had failed conservative care and that medication, physical therapy, and injections did not provide the Petitioner with relief of his pain. Dr. Templin prescribed an L5-S1 fusion surgery for the Petitioner.

Dr. Wehner issued additional reports on February 18, 2016 and March 30, 2016. In her February 18, 2016 report, Dr. Wehner opined that the Petitioner had back and right leg radiculopathy

since 2013 and that he was on high doses of narcotics prior to his fall. She opined that the Petitioner's mechanism of injury would indicate a soft tissue injury of a contusion or a sprain, at most, which would last 4-6 weeks. She further opined that the Petitioner was a surgical candidate before his fall in August 2015. In her March 30, 2016 report, Dr. Wehner indicated that she reviewed a spreadsheet documenting the Petitioner's use of narcotic pain medication which demonstrated that the Petitioner had a history of extensive use of narcotic pain medicine prior to his August 2015 accident date. Dr. Wehner opined that the slip and fall accident did not change the Petitioner's narcotic complaints, did not change his use of narcotics, and did not change his need for surgery. Dr. Wehner opined that there was no new injury on August 31, 2015 when the Petitioner fell at work.

In a letter report dated April 6, 2016, Dr. Templin noted that he had reviewed the Petitioner's previous treating records regarding his prior low back and right lower extremity pain and that he had also reviewed the Petitioner's medical treatment since his fall in August 2015. Dr. Templin noted that the Petitioner had a well-documented history of lower back problems from 2013 to early 2015 with no evidence of any surgical recommendations. He also noted that the Petitioner stopped treating for his lower back from early 2015 and did not receive treatment for his low back until his accident in August 2015. Dr. Templin noted that this treatment gap also corresponded with a significant decrease in medication. Dr. Templin noted that there was a "drastic increase" in narcotic medication after his August 2015 injury and he opined that the Petitioner had an aggravation of pre-existing lower back conditions as a result of his work injury in August 2015.

The Petitioner returned to Dr. Templin on April 28, 2016 and Dr. Templin continued to recommend an L5-S1 fusion. On May 4, 2016, the Petitioner underwent the prescribed surgery which consisted of a L5-S1 anterior lumbar interbody fusion. Dr. Templin's post-operative diagnosis was L5-S1 spondylolisthesis, foraminal stenosis, and radiculopathy. Post surgically, Dr. Templin noted that the Petitioner was "doing great" with some aching pain in his lower back but complete relief of his leg pain and numbness. The Petitioner then began a course of physical therapy at ATI Physical Therapy on July 25, 2016. As of the time of hearing, the Petitioner had not yet completed that course of physical therapy.

At trial, the Petitioner testified that the constant shooting pain that began after the fall of August 31, 2015 was gone almost immediately after his surgery. He testified that he has had no other injuries to his low back since August 2015. He no longer has complaints to his right wrist. The Petitioner testified that he continues to have stiffness and soreness in his low back but his leg pain is completely gone. The Petitioner testified that he also continues to experience some weakness and that he continues to take Norco. He testified that he has not yet been released to return to work.

The April 29, 2016 deposition testimony of Dr. Templin was admitted into the record as Petitioner's Exhibit 6. Dr. Templin testified that he reviewed the Petitioner's pre-injury medical records and that he did not see any recommendation for spine surgery or any work restrictions in those records that would preclude the Petitioner was working as a construction worker. He testified that the Petitioner had epidural steroid injections in the years before his August 2015 work injury and that these injections "improved his pain and allowed him to continue to work." He also reviewed the Petitioner's emergency room visits on August 10 and 23, 2015 and opined that those visits were "primarily for neck pain."

Dr. Templin opined that the Petitioner suffered an aggravation of his pre-existing low-back condition as a result of his August 31, 2015 fall. Dr. Templin further opined that the Petitioner's treatment, including the discogram and surgery, was reasonable, necessary, and related to the August 31, 2015 accident. He testified that that the Petitioner had been disabled from work since his accident.

The May 11, 2016 deposition testimony of Dr. Wehner was admitted into the record as Respondent's Exhibit 13. Dr. Wehner testified that the Petitioner had been getting high doses of narcotics from multiple physicians prior to his injury and that it was obvious that the Petitioner had lots of pre-existing back problems and treatment. Dr. Wehner opined that the Petitioner's condition of ill-being was related to lifting his child in 2013 and not from any work injury in August 2015. She further opined that the Petitioner's low back and right leg condition was not aggravated or accelerated by his accident in August 2015 because there was no substantial change in the subjective complaints, the clinical exam, or the radiographic findings, and she indicated that the Petitioner had already had recommendations for surgical intervention in the past. Dr. Wehner acknowledged, however, that direct trauma can make spondylolysis and spondylolisthesis become symptomatic or more symptomatic.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

The Arbitrator finds that the Petitioner's current condition of ill-being is causally related to his work injury on August 31, 2015. In so finding, the Arbitrator notes that the Petitioner sustained an undisputed injury involving a direct trauma to his lumbar spine and that, despite his previous complaints and treatment, the Petitioner was able to work full duty as a roofer/waterproofer for the approximately five months immediately before the accident. The Petitioner was taken off work immediately after the work accident and has not as yet been released to return to any type of work.

The Arbitrator notes that the Petitioner's pre-injury treating records clearly demonstrate that the Petitioner had pre-existing low back and right lower extremity symptoms before his August 31, 2015 injury. However, the Arbitrator notes that these records, as well as the testimony from Dr. Templin and the Petitioner, indicate that the Petitioner had never had a surgical recommendation before his August 31, 2015 injury and that he never had any work restrictions as a result of his pre-existing back pain.

The Arbitrator also notes the opinions and testimony of Dr. Julie Wehner and Dr. Cary Templin. The Arbitrator notes that while their opinions as to the actual extent of the Petitioner's injury differ, both Dr. Templin and Dr. Wehner agree that the mechanism of the Petitioner's injury would be sufficient to cause an aggravation of the Petitioner's pre-existing condition. While the Arbitrator notes the opinions of Dr. Wehner, the Arbitrator finds the opinions of Dr. Templin to be more persuasive in the instant matter. The Arbitrator further finds that the opinions of Dr. Templin are sufficiently credible, reliable, and persuasive so as to satisfy the Petitioner's burden of proof regarding the issue of causation.

In Support of the Arbitrator's Decision relating to (J.), Were the medical services that were provided to Petitioner reasonable and necessary/Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds and concludes as follows:

Having found that that the Petitioner's current condition of ill-being is causally related to his work injury on August 31, 2015, the Arbitrator also finds that the medical services provided to the Petitioner were reasonable and necessary and causally related to the accident. The Arbitrator bases this opinion on the Petitioner's credible testimony regarding his injury, as well as the medical records from the Petitioner's treating physicians and the testimony from Dr. Templin, which the Arbitrator has found to be credible, reliable, and persuasive in the instant matter.

The Petitioner's medical records support the diagnosis of an aggravation of pre-existing conditions in his lower back and left leg. The Arbitrator finds that the Petitioner established causation as to his need for physical therapy, MRIs, his discogram and CT scan, injections, physician's visits, emergency room treatment, surgery, and medical management.

The Petitioner introduced evidence of the following medical bills, which correspond to the medical records admitted into the record and the testimony of the Petitioner and Dr. Templin regarding the Petitioner's medical treatment. Based upon the Arbitrator's findings and conclusions relating to the issue of causation, which are adopted and included herein, the Arbitrator awards the following bills, subject to the fee schedule:

Provider	Dates of Treatment	Charges
Advocate Medical Group	9/3/15	$ 185.00
American Anesthesiology	5/4/16	$ 3,915.00
Associated Pathologists of Joliet	4/6/16 – 5/8/16	$ 217.00
Associated Radiologists of Joliet	8/31/15	$ 240.00
ATI Physical Therapy	7/25/16 – 8/17/16	$ 5,827.92
Comprehensive Pathology Services	8/31/15	$ 16.90
EM Strategies	8/31/15	$ 597.00
Hinsdale Orthopedics	9/2/15 – 7/21/16	$ 41,911.00
Homer Glen Open MRI	11/5/15	$ 1,500.00
Joliet Radiological	4/6/16	$ 43.00
Loyola University Medical Center	9/25/15	$ 399.00
Pain Treatment Centers of Illinois	3/1/16 – 6/29/16	$ 1,135.20
Pain Treatment Surgical Suites	10/6/15 – 12/1/15	$ 21,031.53
Presence St. Joseph Medical Ctr	4/6/16 – 5/8/16	$ 143,186.24
Silver Cross Hospital	8/31/15 – 9/1/15	$ 3,760.20
	Total:	**$223,964.99**

In Support of the Arbitrator's Decision relating to (L.), What temporary benefits are due, the Arbitrator finds and concludes as follows:

The Petitioner claims that he is entitled to Temporary Total Disability benefits from September 1, 2015 through September 22, 2016. The medical records admitted into the record demonstrate that the Petitioner was taken off work when he sought medical treatment immediately after his work injury and that he has not been released to return to work by any of his treating physicians. Additionally, Dr. Templin testified that the Petitioner has been unable to work since his injury in August 2015 as a result of his work place injury and aggravation of his low back condition.

Having found that that the Petitioner's current condition of ill-being is causally related to his work injury on August 31, 2015, and that the Petitioner's medical treatment has been reasonable and necessary and related to his work injury of August 31, 2015, the Arbitrator finds that the Petitioner is entitled to Temporary Total Disability benefits from September 1, 2015 through September 22, 2016, a period of 55 3/7 weeks..

The Arbitrator notes that the parties have stipulated that the Respondent has paid $28,252.16 in Temporary Total Disability benefits as of the date of hearing and that the Respondent is entitled to credit for that amount.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Cynthia Desper,

Petitioner,

vs. NO: 13 WC 40678

Granite City School District,

Respondent.

18IWCC0223

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice provided to all parties, the Commission, after considering the issues of accident, causal relationship, temporary total disability benefits, medical expenses, and permanent disability and being advised of the facts and the law, affirms the Decision of the Arbitrator, which is attached hereto and made a part hereof with supplemental reasoning as noted below.

Conclusions of Law

On the threshold issue of accident, the Commission affirms the Arbitrator's finding Petitioner failed to prove she sustained an accidental injury arising out of her employment on November 4, 2013. The Commission affirms the Arbitrator's finding that all the remaining issues are moot.

Regarding falls, "a claimant must present evidence supporting a reasonable inference that the fall stemmed from an employment-related risk. After all, the 'arising out of' requirement contemplates 'a causal connection between the accidental injury and some risk incidental to or connected with the activity an employee must do to fulfill [her] duties.' *Stapleton, 282 Ill. App. 3d at 15.* Awarding compensation for a purely unexplained fall would eviscerate this requirement." *Builders Square v. The Industrial Commission*, 339 Ill. App. 3d 1006, 1010, 791 N.E.2d 1308 (2003).

18IWCC0223

As the Arbitrator noted, Petitioner testified she did not know what caused her to fall. T. 33-34. By Petitioner's own testimony, her fall is unexplained. For an unexplained fall to be compensable, Petitioner is required to "present evidence which supports a reasonable inference that the fall stemmed from a risk related to the employment…By, itself, the act of walking up a staircase does not expose an employee to a risk greater than that faced by the general public. [citations omitted]." *Baldwin v. Illinois Workers' Compensation Commission*, 409 Ill. App. 3d 472, 478, 949 N.E.2d 1151 (2011). Petitioner failed to present such evidence.

Petitioner offered three theories in support of an inference her fall was work-related. One, Petitioner testified she was a carrying a file in her left hand when she fell, but there is no evidence the carrying of such file lead to or heightened the risk of Petitioner's fall. Two, Petitioner testified while descending the stairs, she was distracted by the thoughts of a former student. Certainly, caring about a student is laudable, but it does not "support an inference which reasonable and probable, not merely possible. [citation omitted]." *First Cash Financial Services v. The Industrial Commission*, 367 Ill. App. 3d 102, 106 853 N.E.2d 799 (2006). Three, Petitioner testified a student was in the stairwell when she fell, but again there is no evidence the student's presence lead to or heightened the risk of Petitioner's fall.

In reviewing the video evidence documenting Petitioner's fall, the Commission notes Petitioner did not attempt to halt the progress of her fall. Instead she slumps forward and rolls down the stairs. PX4; RX3; RX4. Such video evidence is consistent with a loss of consciousness. Further, Petitioner's medical records document a history of syncopal episodes.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's November 30, 2016 decision is affirmed for the reasons stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that since Petitioner failed to prove she sustained accidental injuries arising out of her employment on November 4, 2013, her claim for compensation and medical expenses is hereby denied.

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

DATED: APR 12 2018
LEC/maw
o01/31/18
43

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

Joshua D. Luskin

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DESPER, CYNTHIA
Employee/Petitioner

Case# **13WC040678**

15WC031356

GRANITE CITY SCHOOL DISTRICT
Employer/Respondent

18IWCC0223

On 11/30/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.61% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4324 LASHLY & BAER PC
ANDREW TOENNIES
714 LOCUST ST
ST LOUIS, MO 63101

2396 KNAPP OHL & GREEN
L DAVID GREEN
6100 CENTER GROVE RD
EDWARDSVILLE, IL 62025

STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Cynthia Desper
Employee/Petitioner

v.

Granite City School District
Employer/Respondent

Case # 13 WC 40678

Consolidated cases: 15 WC 31356

18IWCC0223

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Collinsville**, on **September 27, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Additional Credit towards TTD of $9,676.82**

FINDINGS

On **November 4, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, per the stipulation of the parties, Petitioner earned **$68,779.72** and the average weekly wage was that of **$1,763.58**.

On the date of accident, Petitioner was **46** years of age, ***married*** with **2** dependent children.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, **$16,714.01** in non-occupational indemnity disability benefits and **$82.63** in other benefits, for a total credit of **$16,796.64.**

Respondent is entitled to a credit of **$See Exhibits** for medical bills paid through its group medical plan under Section 8(j) of the Act.

ORDER

Petitioner failed to prove that she sustained an accident that arose out of and in the course of her employment with Respondent and, as such, all benefits are denied. The remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, **$16,714.01** in non-occupational indemnity disability benefits and **$9,759.45** in other benefits, for a total credit of **$26,390.83.**

Respondent is entitled to a credit of **$See Exhibits** for medical bills paid through its group medical plan under Section 8(j) of the Act.

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

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

Melinda M. Pope-Sullivan

Signature of Arbitrator

11/28/16

Date

NOV 30 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Cynthia Desper
Employee/Petitioner

Case # 13 WC 40678

v.

Consolidated cases: 15 WC 31356

Granite City School District
Employer/Respondent

18IWCC0223

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that she is a special education teacher for Respondent and has been employed in that capacity for twenty-six (26) years. According to the Application for Adjustment of Claim for 13 WC 40678, Petitioner claims she injured her "neck, head, left shoulder, back" when she "fell downstairs" on November 4, 2013. (AX2).

Petitioner testified that she was at school on November 4, 2013 when, before school started, she was walking down a flight of stairs and fell. When asked by her attorney on direct examination if she knew what caused her to fall, she responded "no." When asked a second time by her attorney on direct examination if anything caused her to fall, she responded "I don't know." There was no testimony that she was in a hurry, that there was anything on the floor or that there was any defect with the floor that caused the fall. Petitioner testified, however, that at the time of the fall she was thinking about a student named Breanna Maldonado, who had stabbed another student to death in a gang-related stabbing approximately one month prior to this incident.

The Video of Petitioner's Fall was entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The video showed Petitioner walking at a normal pace down the stairs and a student grabbing her right arm during the course of the fall. (PX4).

According to the Application for Adjustment of Claim for 15 WC 31356, Petitioner claims she injured her "left arm, left shoulder, back, hips" when "students were fighting and shoved employee down causing injuries" on September 2, 2015. (AX4). Petitioner testified she fell on her "shoulders," "elbows" and "butt." She further testified she did not have any permanent aggravation to her left shoulder and that she did not feel like her left shoulder changed at all because of the fight on September 2, 2015. The only body part Petitioner identified as having any permanent injury from the September 2, 2015 incident was her right hip.

The transcript of the deposition of Dr. Gelberman was entered into evidence at the time of arbitration as Petitioner's Exhibit 5. Dr. Gelberman testified that he is a board-certified orthopedic surgeon. He testified that he first saw Petitioner on February 10, 2014, at which time she presented with multiple issues including pain in the left neck area, left shoulder, arm, elbow and forearm, with numbness and tingling in the ring and little fingers of the left hand. He testified that Petitioner reported that her symptoms had been present for three months, and that she had fall in November down 15 steps, injuring her left upper extremity. He testified that his diagnosis was cubital tunnel syndrome. (PX5).

Dr. Gelberman testified that when Petitioner returned on February 26th, she continued with radicular symptoms on the left upper extremity and numbness and tingling in the left long, ring and little fingers that she felt was worsening over time. He testified that as Petitioner had not improved with non-operative measures, he recommended decompression of the ulnar nerve which was ultimately performed on April 3rd. He testified that he typically required the patient to be off work for approximately one month following the procedure. He testified that he continued to see Petitioner post-operatively and that at the time of the June 2nd visit, Petitioner reported that two weeks prior, she was reaching overhead and noted pain along the inner aspect of her elbow and, ever since that time, had popping in the inner aspect of her elbow. He testified that this was a relatively common occurrence with the decompression procedure. He testified that the popping incident was related to the injury and the surgery that was done. He testified that in an effort to stabilize the nerve, he put Petitioner's elbow in a splint for three weeks. He testified that at the June 23rd visit, Petitioner continued to have some symptoms of popping and some numbness and tingling, so he recommended a medial epicondylectomy. He testified that the subluxation symptoms were related to the underlying injury for which he saw her. (PX5).

Dr. Gelberman testified that the medial epicondylectomy was performed on June 26th. He testified that he last saw Petitioner on November 3, 2014, and that she was scheduled to see him in two months. He testified that at the November 3rd visit, Petitioner had some residual pain along the inner aspect of her elbow, that she was tender to deep palpation, that the nerve was no longer subluxating, that her strength was excellent and her sensibility was still normal and that her nerve was functioning normally. With respect to the issue of causation, Dr. Gelberman testified that Petitioner reported no symptoms of cubital tunnel syndrome prior to the fall to his knowledge and that, with the amount of trauma in the fall and the onset of her symptoms shortly thereafter, he believed it was more likely than not that the fall caused her cubital tunnel syndrome. (PX5).

On cross examination, Dr. Gelberman agreed that he reached his opinion on the fall being the cause for the carpal tunnel syndrome before he saw the video based on Petitioner's history. He testified that the video showed a very forceful fall, and that he could see pulling on her left arm so it was consistent with her history. He testified that he could not tell how hard the person pulled on her left arm, and that he did not know if the individual pulled on Petitioner's right arm in the video. When asked to assume that Petitioner's symptoms started after the fall and when her symptoms started in relation to the fall, Dr. Gelberman testified that her symptoms started sometime between November and February. When asked if an individual has cubital tunnel syndrome sufficient enough to be positive on an EMG/nerve conduction study and whether that would make a difference, Dr. Gelberman responded that it would be significant although the fall could exacerbate underlying carpal tunnel syndrome. (PX5).

On cross examination, Dr. Gelberman testified that the fall caused Petitioner's symptoms requiring treatment. When asked if Petitioner had any left elbow complaints in the year before the accident, Dr. Gelberman responded that he did not know. He testified that he spent a few minutes reviewing the video before the deposition, and denied that Petitioner's attorney gave him any other information regarding Petitioner, the accident or the case. He testified that he did not have any understanding as to whether or not Petitioner had any elbow pain or complaints when she appeared in the emergency room after the fall, and that as far as her treatment and findings were concerned, it had no bearing on it. He testified that it did not make much difference whether the emergency room physician indicated that there were no bruises or marks of injury on the arms. He testified that a bruise did not occur after many direct compression injuries, and that you did not have to have a bruise or minimal swelling but it could be sufficient to cause significant injury. (PX5).

On cross examination, Dr. Gelberman testified that it was fairly common for an individual to have complaints of pain in the medial aspect of the elbow approximately one month post-operatively. When asked if he thought Petitioner would have had the subluxation problem from reaching had she not had the prior surgery, Dr. Gelberman responded that he thought it was unlikely that the prior surgery was

related to it as the release relieved the roof of the cubital tunnel. He testified that as to what he saw at the time of the first surgery, he could not tell whether the appearance of the nerve was from a trauma. He testified that as to the September 3, 2014 note, there was no list of any medications at that time and that he would have listed anything that she would have been taking for pain. He testified that when he saw Petitioner on November 3, 2014, she had some residual medial epicondyle pain which was fairly common and that Petitioner had some tenderness to deep palpation, but that everything else was essentially normal. He agreed that no restrictions or medications were noted in the medical records at that time. (PX5).

The medical records of Dr. Gelberman were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Petitioner was seen on February 10, 2014, at which time it was noted that she had left neck, left shoulder, arm, elbow and forearm pain, as well as numbness and tingling in the ring and little fingers on the left hand. It was noted that Petitioner had a constant ache and decreased range of motion in the left shoulder. It was noted that on November 4th, Petitioner fell down 15 steps, injuring her left upper extremity. The disposition was that of neck pain, being evaluated by Dr. Riew; left shoulder pain, being assessed by Dr. LaBore; left cubital tunnel syndrome, documented on electrophysiologic study, for which non-operative measures would be started until her left shoulder pain was under control. At the time of the February 26, 2014 visit, it was noted that Petitioner had continued left radicular symptoms, left upper extremity, numbness and tingling in the long, ring and little fingers, worsening over time. It was noted that Petitioner had treatment for frozen shoulder and an injection. It was noted that Dr. Gelberman recommended *in situ* decompression of the left ulnar nerve when the shoulder was improved. (PX6).

The records of Dr. Gelberman reflect that Petitioner underwent surgery on April 3, 2014. At the time of the visit on April 9, 2014, it was noted that Petitioner was post-operative day 6 status post left ulnar nerve *in situ* decompression and was doing well. It was noted that Petitioner would go into a removable splint for the next week, after which she would begin range of motion exercises. At the time of the May 5, 2014 visit, it was noted that Petitioner complained of pain in the medial aspect of her elbow. It was noted that Petitioner's sensation improved and that she was engaging in therapy. At the time of the June 2, 2014 visit, it was noted that two weeks ago Petitioner was reaching overhead and noted excruciating pain in the medial aspect of the left elbow, and that ever since she had popping of the elbow and pain and described a situation that appeared to be subluxation of the ulnar nerve. It was noted that Petitioner's splint was to be maintained continuously for three weeks, then she was to begin active motion. At the time of the June 23, 2014 visit, it was noted that Petitioner continued to have symptoms of numbness, tingling and popping about the elbow. Petitioner was recommended to undergo medial epicondylectomy, which was performed on June 26, 2014 for a pre- and post-operative diagnosis of left recurrent ulnar nerve irritation. (PX6).

The transcript of the deposition of Dr. Keener was entered into evidence at the time of arbitration as Petitioner's Exhibit 7. Dr. Keener testified that he is a board-certified orthopedic surgeon who specializes in shoulder and elbow disorders. (PX7).

Dr. Keener testified that he first saw Petitioner on February 18, 2015, at which time she stated that her shoulder pain began after a fall at work when she fell down a flight of stairs on November 4, 2013. He testified that his review of the MRI was that he thought it was pretty normal, that there were some subtle age-related changes in the shoulder, and that he felt like there may be a degenerative SLAP tear which were relatively common in people in their 40s and not necessarily painful. (PX7).

Dr. Keener testified that when he saw Petitioner back after therapy, she was struggling, that she felt like the injection was wearing off and that was why she was hurting, and that she did not think the therapy was helping dramatically. He testified that when he examined Petitioner on April 27th, in addition to her rotator cuff inflammation she had positive biceps findings, which could have been coming from a SLAP tear or just biceps tendinitis. He testified that when Petitioner returned on June 3rd, given that she

had exhausted appropriate conservative treatment his plan was to do a shoulder arthroscopy with subacromial decompression and a biceps tenodesis. He testified that when surgery was performed on June 11th, the surprise finding was on Petitioner's humeral head where she had a large defect on the articular cartilage, which he was not expecting to see. He testified that the location and nature of a lesion like that would definitely be trauma-related, and that it did not have the appearance of wear and tear glenohumeral arthritis. He testified that he believed that it was causing some of her complaints, but that it was hard to say. He testified that in the absence of any other history of injury or trauma, he believed that the fall of November 4th created the defect. (PX7).

Dr. Keener testified that following the procedure, Petitioner waxed and waned for multiple visits. He testified that overall Petitioner had required a couple of injections to get her shoulder calmed down, and that she also had a reinjury where she was involved in an altercation that irritated her shoulder. He testified that Petitioner was currently doing well, but that he thought her prognosis was guarded. He testified that he last saw Petitioner on January 13, 2016, and that she was doing pretty well at that time. He testified that he considered the surgery partially successful. He testified that his note that referenced an exaggerated examination meant that her exam was a little non-specific, that she had multiple positive findings and that her pain was a little out of proportion with the pathology that he was seeing. He testified that in retrospect, the humeral head defect helped explain some of the exaggerated findings but that Petitioner would also admit that she did not have the best pain tolerance. (PX7).

Dr. Keener testified that he believed that all of his treatment was related to the November 4, 2013 incident, and that the fight at school that she described that occurred in September of 2015 was maybe a small aggravation. He testified that even his treatment in January of 2016 was still related to the original treatment that he saw her for in February of 2015 because they really had not fixed the problem in her shoulder and it persisted. (PX7).

On cross examination, Dr. Keener testified that he believed that Dr. LaBore referred Petitioner to him because after his treatment of the frozen shoulder, she still had pain. He testified that the triage note dated January 22, 2015 was not generated by him or his office. He agreed that he had not reviewed any outside records regarding Petitioner other than the two MRIs from February 5, 2015 and September 19, 2015. He testified that the intake questionnaire was something that Petitioner completed, not someone from his office. When asked if someone has a specific trauma injury to the shoulder that results in subacromial inflammation or bursitis and whether it usually settled down within a few weeks, Dr. Keener responded that for most patients it would improve but that for 10-20% of patients, the pain would persist. He testified that he did not know whether it would be fair to say that it was possible that in the fall of 2014 something else happened to Petitioner's shoulder that explained her increase in symptoms or complaints. (PX7).

On cross examination, Dr. Keener agreed that as for a home exercise program, the success or lack thereof would assume that the patient would actually do it. He testified that if Petitioner had done the therapy as he suggested, she would in all likelihood get better if she was in the 80-90% of individuals that improved. He testified that there was no way to gauge when the trauma to the articular cartilage occurred, but that there was some loose cartilage fragments in the bottom of the joint. He testified that his "guess" was that the lesion was no more than two years old, but that it was a rough estimate. He agreed that it was possible it could have been a six-month lesion as well. (PX7).

On cross examination, Dr. Keener agreed that after the surgery but before the September 2, 2015 altercation at school, Petitioner continued to have complaints. He testified that he saw Petitioner shortly after the altercation on September 9, 2015, and that he thought that she suffered a strain or a sprain of the AC joint. He testified that his review of the September 19, 2015 MRI revealed that she had some subacromial fluid and some inflammation in the subacromial space that could be normal three months after a shoulder scope. When asked to assume that Petitioner saw Dr. LaBore in late February of 2014,

that she received the last bit of left shoulder therapy in late March of 2014, that she saw her primary care physician in June 2014 and early January 2015 and that at those two visits there were no left shoulder issues or complaints noted and no left shoulder treatment mentioned in either visit and whether that changed any of his opinions, Dr. Keener responded that it was concerning and that he would expect that she would have had some symptoms during that timeframe. (PX7).

On redirect examination, Dr. Keener agreed that it was fair to say that Petitioner was not using her arm for a period of time because of the elbow procedures that Dr. Gelberman performed, and that it made sense that if Petitioner was recovering from the surgeries her shoulder would calm down and that once she resumed her normal activities, it seemed as if her shoulder flared up again. (PX7).

The medical records of Dr. Keener were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The records reflect that Petitioner was seen on February 18, 2015, at which time she presented for evaluation of her left shoulder. It was noted that Petitioner fell down some steps on November 4th, and that she had neck, shoulder and arm pain. It was noted that Petitioner was followed by Dr. LaBore and diagnosed with a frozen shoulder, that she had a glenohumeral injection and went to therapy. It was noted that Petitioner had a lot of arm pain at the time, that an EMG showed cubital tunnel syndrome and that Petitioner had two ulnar nerve surgeries by Dr. Gelberman. It was noted that Petitioner's shoulder pain had never really completely resolved, that it bothered her quite a bit, and that she had a constant low grade ache in her deltoid and upper arm that was aggravated with motion in any direction. The impression was that of chronic shoulder pain related to a fall, as well as findings consistent with bursitis but the exam was a little bit exaggerated. An injection was recommended and was ultimately performed on February 19, 2015. At the time of the March 18, 2015 visit, it was noted that since her last visit, Petitioner had an injection that hurt a lot for about 5-7 days. It was noted that Petitioner's pain was significantly better, that she felt like her range of motion was much better, that she was sleeping better at night and that she still had some discomfort but it was nowhere near what it was before. It was noted that Dr. Keener thought Petitioner had developed subacromial inflammation/bursitis sometime last fall that had explained her more recent shoulder symptoms, and that it was a result of her work-related injury. It was noted that Petitioner would be sent to physical therapy. (PX8).

Included within the records of Dr. Keener was the interpretive report for an MRI of the left shoulder performed on February 5, 2015, which was interpreted as revealing (1) tear of the anterior to posterior superior glenoid labrum; (2) mild linear loss arthritis with partial-thickness loss at the anterosuperior glenoid; (3) small ganglion cyst and soft tissue with increased T2 signal likely representing active synovitis at the rotator cuff interval likely related to partial tear of the superior glenohumeral ligament; although increased soft tissue density at the rotator cuff interval can be seen with adhesive capsulitis the normal degree of external rotation of the humerus, lack of significant capsular thickening at the axillar recess and mild distention of the posterior capsule resulting from a small glenohumeral joint effusion would both be atypical in this setting of adhesive capsulitis. Also included within the records was the interpretive report for x-rays of the left shoulder performed on February 18, 2015, which were interpreted as normal. (PX8).

The records of Dr. Keener reflect that Petitioner underwent physical therapy at Gateway Regional Medical Center for the left shoulder beginning on April 7, 2015. At the time of the April 30, 2015 visit with Dr. Keener, it was noted that Petitioner was struggling a lot with her shoulder and that she went through therapy which did not help much. It was noted that Petitioner thought that the pain was getting worse, and that she felt like the effect of the medicine was wearing off. It was noted that Petitioner was concerned about having any more injections because of her clinical adverse reactions to her previous injection. The impression was that of chronic cuff tendonitis with subacromial inflammation as well as fluctuating biceps signs. It was noted that noted that a tentative surgery date was going to be scheduled for June, as Dr. Keener would consider a diagnostic scope with decompression and possible biceps tenodesis based on intraoperative findings. (PX8).

The records of Dr. Keener reflect that Petitioner was seen on June 3, 2015 to discuss the left shoulder. It was noted that Petitioner's symptoms were not improving in her shoulder, and that she had been doing an exhaustive conservative treatment course. It was noted that Petitioner initially had a frozen shoulder which probably complicated a fall, and that it got better with conservative management. It was noted that Petitioner went back to school in the fall and that her shoulder pain worsened, and that she was again treated for a frozen shoulder. It was noted that Petitioner's frozen shoulder was mostly gone, but she was left with persistent shoulder pain and imaging that suggested bursitis, biceps inflammation and a possible SLAP tear. Surgery was discussed and Petitioner indicated her wish to proceed. The Operative Report dated June 11, 2015 noted pre-operative diagnoses of (1) left shoulder SLAP tear; (2) left shoulder cuff tendonitis and post-operative diagnoses of (1) left shoulder glenohumeral osteoarthritis; (2) left shoulder SLAP tear; (3) left shoulder cuff tendonitis. The procedures performed were that of (1) left shoulder subacromial decompression acromioplasty; (2) left shoulder open biceps tenodesis. (PX8).

The records of Dr. Keener reflect that Petitioner was seen on June 22, 2015, at which time it was noted that Petitioner was noted to have a full-thickness cartilage lesion in her humeral head and that the glenoid cartilage appeared healthy. It was noted that Petitioner was short of breath after surgery, that she had a chest x-ray that initially showed some atelectasis, that she was later evaluated and noted to have pneumonia, and that she had spent the last few days in the hospital receiving oral and IV antibiotics. It was noted that Petitioner's shoulder had been mildly painful. Petitioner was instructed to begin physical therapy. The Plan of Care for physical therapy at Gateway Regional Medical Center was dated June 29, 2015. (PX8).

The records of Dr. Keener reflect that Petitioner was seen on July 27, 2015, at which time it was noted that she was slowly getting better and that she still had a lot of bad days. It was noted that Petitioner was making good progress in therapy and was now out of her sling completely. It was noted that Petitioner freely admitted that she did not have the best pain tolerance, and that a glenohumeral steroid injection would be performed. Petitioner was instructed to continue rehab. It was noted that it was ok for her to return to work as a teacher at the beginning of the school year. (PX8).

The medical records of Gateway Regional Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The records reflect that Petitioner was seen on November 4, 2013 and was discharged on November 5, 2013. The Discharge Summary noted that Petitioner came to the emergency room with a complaint of having fallen down 15 flights of stairs and having severe back pain, losing consciousness and having pain all over her body. It was noted that the examination of her back, abdomen and extremities did not show any signs of bruise or any signs of ecchymoses from falling. It was noted that Petitioner was also counseled as she was on several pain medications and also sedative medications, and that she was counseled that might cause her to be at risk of falling from the medications. It was noted that Petitioner stated it was offending to her because she did not take that during the week. X-rays of the pelvis performed on November 4, 2013 were interpreted as unremarkable. X-rays of the lumbar spine performed on the same date were interpreted as revealing no radiographic evidence of acute bony abnormality. A CT of the head performed on the same date was interpreted as revealing no CT evidence of an acute intracranial process. A CT of the cervical spine performed on the same date was interpreted as revealing an anterior fusion at C5 and C6 without CT evidence of acute bony abnormality in the cervical spine. X-rays of the thoracic spine performed on the same date were interpreted as revealing no radiographic evidence of acute bony abnormality in the thoracic spine. The Encounter Summary noted diagnoses of fall, back pain, lumbar, and head injury. The ED Nurse Documentation noted that Petitioner reported that she fell down approximately 10 steps, that she complained of pain to her lower back, left hip and left arm, and that she stated that she has fibromyalgia and hurts all the time but that this was different than "her normal hurt." (PX9).

The medical records of Dr. LaBore were entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The records reflect that Petitioner was seen on February 10, 2014, at which time

it was noted that Petitioner had seen Dr. Gelberman regarding cubital tunnel syndrome on the left. It was noted that Dr. Gelberman had recommended treating the frozen shoulder before attempting treatment of the cubital tunnel syndrome due to the post-operative care necessary and the risk for further exacerbation of the frozen shoulder syndrome. It was noted that Petitioner's symptoms were unchanged. The impression was that of left frozen shoulder syndrome. Petitioner was recommended to undergo an intraarticular injection followed by physical therapy. At the time of the February 3, 2014 visit, it was noted that Petitioner had been doing well status post C5-6 ACDF in November 2009 until she fell down stairs in November 2013. It was noted that Petitioner's pain was centered in the shoulder and referred into the elbow, at times into the forearm. It was noted that there was some neck pain associated, but not significantly. It was noted that Petitioner had difficulty with reaching, particularly overhead, and that she had experienced numbness in the hands and difficulty with manual activity. The impression was that of a presentation most consistent with a left frozen shoulder syndrome, pain onset with fall down stairs. It was noted that Petitioner's rotator cuff appeared functionally intact, but that Dr. LaBore could not rule out a tear based on the limitations of the examination. Ultrasound evaluation of the left rotator cuff was recommended if Petitioner was able to tolerate positioning and that she also consider intraarticular glenohumeral injection to treat frozen shoulder syndrome with anticipated progression to physical therapy. It was noted that Petitioner was also there for electrodiagnostic evaluation of the left upper extremity, which was normal except for mild ulnar conduction slowing at the left elbow of uncertain clinical significance. (PX10).

The records of Dr. LaBore reflect that Petitioner underwent x-rays of the left shoulder on February 3, 2014, which were interpreted as normal. The shoulder sonogram performed on February 13, 2014 was interpreted as normal and no rotator cuff tear. (PX10).

The Off Work Slips were entered into evidence at the time of arbitration as Petitioner's Exhibit 11.

The MRI Photographs entered into evidence at the time of arbitration as Petitioner's Exhibit 12.

The Dr. Kostman Bills for IME and Deposition were entered into evidence at the time of arbitration as Petitioner's Exhibit 13.

The medical records of Dr. Kopjas were entered into evidence at the time of arbitration as Petitioner's Exhibit 14. The records reflect that Petitioner was seen on December 7, 2012 for a hospital follow-up. It was noted that Petitioner reported syncope/dizziness, that the alleviating factors were that of "[f]ell to floor and was transported by hospital to ambulance" and that Petitioner stated that she had recently gotten over the "flu" and was still not feeling very well. At the time of the April 2, 2013 visit, Petitioner was seen for hypertension. It was noted that Petitioner stated that she had been seeing a doctor because she was fainting and was told that it was because of her blood pressure. It was noted that Petitioner had four syncopal episodes since December of 2012, and that she had seen neurology and was still being worked up. Petitioner was given a referral to cardiology and rheumatology in light of her extreme fatigue and pain from fibromyalgia. (PX14).

The records of Dr. Kopjas reflect that Petitioner was seen on August 19, 2013 for emergency room follow-up of her back pain. It was noted that Petitioner had pain radiating to the buttocks, and pain radiating to the legs. It was noted that the assessment included, among other issues, syncope and collapse and that the Holter monitor still needed to be completed, and that Petitioner had not had any recent syncope but dizziness only. (PX14).

Included within the records of Dr. Kopjas was that of a note from Dr. Riew on January 14, 2014 for a chief complaint of neck and arm pain with numbness and weakness. It was noted that Petitioner last saw Dr. Riew on September 14, 2010 and was status post ACDF at the C5-6 level from November 16,

2009. It was noted that Petitioner's neck and arm pain with numbness and weakness had been present since November 4, 2013 and had worsened in the last month. It was noted that the problem started after a fall down the stairs. The impression/diagnosis was that of left limb pain likely related to her arm since increased motion of the arm and palpation over the arm increased the pain. It was noted that if Petitioner's symptoms were problematic, she could have an EMG/nerve conduction studies of the upper extremities and follow-up with physiatry for the left upper arm and shoulder pain. (PX14).

Included within the records of Dr. Kopjas was an interpretive report for an MRI of the cervical spine performed on December 7, 2013, which was interpreted as revealing (1) anterior fusion at C5-C6; (2) mild cervical spondylosis. The records reflect that Petitioner was seen on November 7, 2013 for hospital follow-up. It was noted that Petitioner stated that she fell down stairs, that a CT and x-rays were performed, and that Petitioner was given pain medications. It was noted that Petitioner stated she was told that nothing was broken and that she did not have any bruises. It was noted that Petitioner had diffuse pain to the neck, shoulders, thoracic and lumbar spine areas, that she had no radiation of pain and that she just hurt "all over." The assessment was that of contusion of multiple sites of trunk, and it was noted that Petitioner had no bruising or discoloration noted; myalgia and myositis, unspecified; lumbago. At the time of the January 7, 2014 visit, Petitioner was seen for a chief complaint of musculoskeletal pain and it was noted that it was mainly on the left side of her neck and left arm. It was noted that Petitioner had been to physical therapy and it was not helping. It was also noted that Petitioner stated that she did not think she could go back to work. The assessment was that of cervical radiculopathy. (PX14).

Included within the records of Dr. Kopjas was an interpretive report for an MRI of the thoracic spine performed on December 19, 2013, which was interpreted as revealing (1) mild thoracic spondylosis; (2) anterior fusion procedure at C5-C6. (PX14).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 15.

The Medical Payout was entered into evidence at the time of arbitration as Respondent's Exhibit 1.

The transcript of the deposition of Dr. Kostman (dated April 29, 2015) was entered into evidence at the time of arbitration as Respondent's Exhibit 2. Dr. Kostman testified that he practices orthopedics, and that he has treated patients in the past with cubital tunnel conditions and epicondylitis. He testified that he authored a report dated January 7, 2015. (RX2).

Dr. Kostman testified that Petitioner stated that when she fell down the stairs, she did not lose consciousness and did not know if she slipped in anything particular. He testified that he asked Petitioner about whether she had any left arm or shoulder pain with the neck injury that she had in 2008, and that she stated that she did not. He testified that Petitioner indicated that she had had no nerve conduction studies before November of 2013 of the left extremity. (RX2).

Dr. Kostman testified his examination demonstrated some mild tenderness to palpation involving Petitioner's cervical spine and along her left trapezius and left clavicle, and that the shoulder examination revealed some mild tenderness to palpation along the lateral anterior acromion on the left, but otherwise no AC joint tenderness, normal and full range of motion, negative impingement sign, negative Hawkins test, negative crossarm adduction test and no shoulder instability. He testified that there were no objective signs of any shoulder pathology at the time of his examination. He testified that as to the elbows, Petitioner had full elbow range of motion but some tenderness along the lateral aspect of the left proximal humerus, as well as some tenderness specifically over the medial epicondyle of the left elbow. He testified that Petitioner had a positive Tinel's over the cubital tunnel on the left which was negative on the right, that she had no elbow instability, that she had a full wrist range of motion, that her motor

examination was intact distally and that her sensory examination and two point discrimination was equal in the left and right. (RX2).

Dr. Kostman testified that the diagnosis of the left elbow was that of left elbow cubital tunnel syndrome. He testified that he believed that the left cubital tunnel syndrome was not caused by the fall of November 4, 2013, and that based on her positive prior EMG/nerve conduction study and the timing of presentation of symptoms following her fall, he did not believe that the left cubital tunnel syndrome was aggravated by the fall on November 4, 2013. He testified that the initial emergency room record and noted form Tri-City Neurology dated November 11, 2013 that made no reference to any elbow complaints were significant in that if a patient had taken a direct impact to the elbow and was the cause of cubital tunnel syndrome, there would be initial symptoms and findings specific for that diagnosis. When asked how likely it was to have an acute cubital tunnel syndrome from a fall if the fall were not of sufficient force to create swelling or bruising, Dr. Kostman responded that although it was possible it was unlikely, and that it was also unlikely to have that as a result of an impact without having initial symptoms recorded. (RX2).

Dr. Kostman testified that he reviewed the videos, and that there was no evidence that the student pulled on Petitioner's left arm and that the video showed the student pulling on Petitioner's right arm. He testified that a student pulling on Petitioner's right arm as she fell down the step would not cause a left cubital tunnel syndrome condition because the left arm was not involved. (RX2).

Dr. Kostman testified that his diagnosis of Petitioner's left shoulder at the time he examined her was that she gave a history consistent with a left shoulder contusion. He testified that the medical records, specifically the emergency room records and the initial treatment records after the fall, were not consistent with any injury to the left shoulder as a result of the fall because there no initial findings positive for an injury to the left shoulder by initial examiners. He testified that he did not believe that the treatment by Dr. Gelberman, specifically the April 2014 cubital tunnel syndrome surgery and the June 2014 epicondylectomy were procedures that were performed as a result of the November 4, 2013 fall. He testified that patients can have symptoms off and on over a period of time and that this is what is seen in a chronic cubital tunnel condition. He testified that Petitioner did not need any restrictions regarding the left upper extremity at the time that he saw her. (RX2).

On cross examination, Dr. Kostman agreed that he had a general orthopedic practice and that he did not specialize in the elbows or shoulders, but testified that he primarily does upper and lower extremity surgery. When asked if there were any records after the 2008 regarding complaints of numbness in her arms or tingling in her arms or left arm in particular up until the accident of November 4, 2013, Dr. Kostman responded that the note dated March 12, 2013 of Dr. Naseer described that Petitioner's examination was positive for tingling in the arms. He testified that the note of April 19, 2013 also described tingling in the arms and tingling in the legs. (RX2).

On cross examination when asked if there was a complaint of left arm pain in the emergency room records from November 4, 2013, Dr. Kostman responded that the triage assessment referenced complaints of pain in the left arm and left hip. He testified that Dr. Gelberman's note of February 10, 2014 did not state that he diagnosed Petitioner with a frozen shoulder, but agreed that Dr. LaBore's records indicated that he felt she had a frozen shoulder in February of 2014. He testified that he did not examine Petitioner in February of 2014 so he did not have an opinion whether Petitioner had a frozen shoulder in February of 2014. He testified that he did not disagree with Dr. LaBore, but that he did not do the examination. (RX2).

On cross examination, Dr. Kostman testified that he had no reason to disagree with Dr. Gelberman's exam finding on February 10, 2014 of a positive Hawkins' sign. He testified that he did not have any idea what was causing Petitioner's shoulder complaints in February of 2014. He testified that

tears of the anterior to posterior superior glenoid labrum were typically degenerative but could be traumatic. He agreed that he did not know what caused the tear identified in the February 2, 2015 MRI report. As to the video, Dr. Kostman testified that the video showed Petitioner rolling down stairs and that it was difficult to assess whether there was any direct trauma to the left elbow. He testified that he believed that it was appropriate for Petitioner to be evaluated in the emergency room after the fall, but that the visits to Dr. LaBore and Dr. Gelberman were unrelated to the fall in his opinion. (RX2).

On cross examination, Dr. Kostman testified that he did not believe that Petitioner's frozen shoulder was related to the fall because her initial evaluation did not demonstrate evidence of frozen shoulder. (RX2).

On redirect examination, Dr. Kostman testified that someone who has a frozen shoulder does not, by definition, have normal range of motion. He testified that the note of Dr. Naseer dated November 11, 2013 indicated that Petitioner did not suffer a frozen shoulder in the accident. He testified that the tests performed at the time of the IME were to check for rotator cuff pathology, and that at the time that he examined Petitioner there was no rotator cuff pathology. (RX2).

On further cross examination, Dr. Kostman testified that usually someone who had trauma to their shoulder or injured their shoulder that eventually results in a frozen shoulder will usually develop pain right away and that they have some limitation to start with that persists over time. He testified that frozen shoulders can persist for an extended period of time. (RX2).

The Accident Video (students omitted) was entered into evidence at the time of arbitration as Respondent's Exhibit 3. The Accident Video (25% speed and brightened) was entered into evidence at the time of arbitration as Respondent's Exhibit 4.

The transcript of the deposition of Dr. Kostman (dated July 20, 2016) was entered into evidence at the time of arbitration as Respondent's Exhibit 5. Dr. Kostman testified that he was asked to examine Petitioner regarding an incident primarily that occurred on September 2, 2015, and that the second examination was performed on May 11, 2016. He testified that the physical examination findings were pretty typical following a biceps tenodesis, that there was some muscle asymmetry that was consistent with performing that procedure and that her strength and range of motion looked good. He testified that Petitioner presented well following the procedure by Dr. Keener. (RX5).

Dr. Kostman testified that the examination performed also involved the low back and the left lower extremity, and that Petitioner did not demonstrate any abnormality in that portion of the exam. He testified that the elbow examination was fairly unremarkable, and that she had some tenderness along her medial epicondyle on the inside aspect of her left elbow. (RX5).

Dr. Kostman testified that based on the medical records available, he believed that Petitioner had an acromioclavicular joint strain of the left shoulder as a result of the September 2015 accident. He testified that Petitioner was at maximum medical improvement from that incident on follow-up with Dr. Keener on September 23, 2015, and that any of Dr. Keener's treatment after that date was not related to the September 2, 2015 incident. He testified that he believed that Petitioner did not need any work restrictions because of the accident of September 2, 2015. (RX5).

The Accident Photographs were entered into evidence at the time of arbitration as Respondent's Exhibit 6. The photographs show the student grabbing Petitioner's right arm during the course of the fall. (RX6).

The Granite City High School Bell Schedule was entered into evidence at the time of arbitration as Respondent's Exhibit 7. The Granite City High School Calendars were entered into evidence at the time of arbitration as Respondent's Exhibit 8.

The Select Employee Handbook re: Sick Leave and TTD was entered into evidence at the time of arbitration as Respondent's Exhibit 9. The Wage Records were entered into evidence at the time of arbitration as Respondent's Exhibit 10. The Teachers' Retirement System Select Disability Records were entered into evidence at the time of arbitration as Respondent's Exhibit 11.

The medical records of Gateway Regional Medical Center were entered into evidence at the time of arbitration as Respondent's Exhibit 12. The records reflect that Petitioner was seen on February 27, 2008 after she was brought by ambulance after falling that morning. It was noted that Petitioner complained of pain to the left arm, shoulder and hip, and that she denied loss of consciousness. It was noted that Petitioner fell in the parking lot at work. The clinical impression was that of musculoskeletal pain status post fall, and Petitioner was discharged home in stable condition. The interpretive report for x-rays of the left shoulder performed on the same date were interpreted as revealing no radiographic evidence of bone or joint disease of the left shoulder, and the interpretive report for x-rays of the left elbow performed on the same date were interpreted as revealing no radiographic evidence of bone or joint disease of the left elbow. (RX12).

The medical records of Dr. Kopjas were entered into evidence at the time of arbitration as Respondent's Exhibit 13. The records reflect that Petitioner was seen on February 28, 2008 after a fall on the left side on the ice. It was noted that Petitioner had a headache, neck pain and that the left hand first finger and thumb were hard to move and hurt. The impression was noted to be that of left hip contusion; left shoulder sprain and contusion; left arm, left wrist and left hand contusion; and cervical strain. Petitioner was recommended to undergo physical therapy. At the time of the April 22, 2008 visit, it was noted that Petitioner fell two months ago, that she had physical therapy and that she was having severe pain in the knees and hips. The impression was that of cervical spine disc bulging and a history of fibromyalgia. Petitioner was instructed to continue physical therapy and to undergo a third epidural injection. (RX13).

The records of Dr. Kopjas reflect that Petitioner was seen on June 2, 2008 in follow-up on the fall, the bulging disks and the shoulder and neck pain. It was noted that Petitioner had 0% improvement since her last visit, and that she had no help from physical therapy. The impression was that of cervical spine C5-C6 bulging disc; left shoulder pain with cervical strain. Petitioner was referred to neurosurgery and was ordered to undergo an MRI of the left shoulder. At the time of the February 12, 2009 visit, it was noted that Petitioner tried to return to work on February 9th, that her pain had increased and that she could not return to work after that. It was noted that Petitioner was still seeing Dr. Kennedy every month, that she had a cervical fusion in August 2008 with no post-operative complications, that she had been off work since February 27th of the last year and that she had no surgical improvement in pain. The impression was that of cervical radiculopathy status post cervical fusion, fibromyalgia and left shoulder/arm pain. (RX13).

The records of Dr. Kopjas reflect that Petitioner was seen on April 3, 2012 for complaints of neck pain and anxiety. It was noted that the onset was three years ago, that the location of the pain was the bilateral lateral neck, and that the events surrounding the occurrence of the symptoms included a hard fall. It was noted that the injections that had been performed had not worked. Petitioner was assessed with anxiety and depression, among other issues. At the time of the December 7, 2012 visit, Petitioner was seen in hospital follow-up. It was noted that Petitioner reported syncope/dizziness, that it occurred one time at work while teaching and it was of an abrupt onset without warning, and that she fell to the floor and was transported by ambulance to the hospital. Petitioner was instructed to wear a Holter monitor and undergo an EEG. (RX13).

The records of Dr. Kopjas reflect that Petitioner was seen on June 23, 2014 for a follow up on her ulnar neuropathy for her disability. It was noted that Petitioner had palpable pain to the right lower lumbar area with radiation into the right buttock and right posterior lateral upper thigh. The assessment

was that of lumbar radiculopathy, for which an MRI of the lumbar spine was ordered; ulnar nerve entrapment, for which Petitioner was scheduled to have additional surgery on the left elbow to "shave the bone." At the time of the January 12, 2015 visit, Petitioner was seen for a routine examination, and it was noted that she was reporting anxiety/depression that had improved. (RX13).

The medical records of Associated Physicians Group were entered into evidence at the time of arbitration as Respondent's Exhibit 14. The records reflect that Petitioner was seen for an EMG/nerve conduction studies on March 12, 2008, at which time it was noted that Petitioner slipped and fell on ice on February 27, 2008, that she had neck pain with left arm pain and that she had some weakness in the left bicep and tricep. The impression of the studies was that of (1) mild bilateral median nerve entrapment at the wrists, slightly more severe on the right side; (2) left ulnar nerve neuropathy across the elbow, suggestive of entrapment at the elbow; (3) right ulnar nerve sensory neuropathy, suggestive of pathology along the ulnar nerve; (4) clinical correlation is recommended. (RX14).

The medical records of Anderson Hospital were entered into evidence at the time of arbitration as Respondent's Exhibit 15. The records reflect that Petitioner was seen on September 17, 2008 for post-operative pain, vomiting and dizziness. Petitioner was seen on December 7, 2012 for syncope and collapse. (RX15).

The medical records of Dr. Riew were entered into evidence at the time of arbitration as Respondent's Exhibit 16. The records reflect that Petitioner was seen on July 9, 2009 for a chief complaint of neck pain and that she had the problem since February 27, 2008 after she fell on ice. It was noted that Petitioner had 90% neck pain and 10% arm pain, and that there was 25% right arm pain and 75% left arm pain. It was noted that the previous doctors seen for the problem included Dr. Kennedy who performed a cervical fusion at C5-6 in September of 2008, Dr. Feinberg in pain management who performed trigger point injections and prescribed physical therapy and Dr. Kopjas. The impression was that of pseudoarthrosis at C5-6 for which Petitioner was recommended to undergo conservative treatment including exercises. A phone note dated November 30, 2009 noted that Petitioner called stating that she was in a lot of pain, and that she finished her Percocet and wanted a refill because the Tylenol #3 were not helping. Petitioner was given a script for Vicodin, and it was noted that it was the final pain script she would be given. At the time of the July 6, 2010 visit, it was noted that Petitioner was last seen on April 1, 2010 and that she was status post ACDF from C5-6 from November 16, 2009 and that she continued to complain of right upper trapezial pain but her left-sided trapezial pain was now improved. The impression was that of right upper trapezial pain may be coming from another level or possible nonunion of the C5-6 level. Petitioner was recommended a home exercise program and to undergo a CT to see if she was solidly fused. (RX16).

The records of Dr. Riew reflect that Petitioner was seen on September 14, 2010, at which time she complained of a significant amount of pain. It was noted that Petitioner had called the office asking for an expedited appointment due to the pain, and that she noted that her pain was located in the mid to lower aspect of her cervical spine and that she had occasional upper arm and forearm tingling bilaterally. The impression was that of degenerative changes at the T1-T2 and T2-T3 levels may be causing the lower axial neck pain and spondylosis. Surgery was not recommended as it was not a dangerous condition as she had no neurological deficits. It was noted that Petitioner could take over-the-counter medications to relieve her symptoms, and that she could also try physical therapy. (RX16).

The medical records of Dr. Swarm were entered into evidence at the time of arbitration as Respondent's Exhibit 17. The records reflect that Petitioner was seen on October 13, 2011 for neck pain radiating to the left shoulder and down the left arm. It was noted that Petitioner's neck pain began in 2008 following a fall on ice, that she had initial surgery in 2008 but there was a non-union, and that a C5/6 revision fusion was performed on November 16, 2009. The assessment was that of other chronic pain; cervical spondylosis; post-cervical laminectomy/fusion syndrome; and depression/irritability.

Petitioner was recommended to undergo injection therapies and additional physical therapy. The records reflect that a cervical epidural steroid injection at left C6 was performed on that date. At the time of the October 31, 2011 visit, it was noted that Petitioner had been to physical therapy multiple times and that she had no benefit from the injection at the last visit. Petitioner underwent an additional cervical epidural steroid injection at left C6 on that date. (RX17).

The records of Dr. Swarm reflect that Petitioner was seen on November 30, 2011 at which time it was noted that she was doing better but still had significant left neck pain. It was noted that Petitioner's second injection was of significant benefit, and that she went to physical therapy close to home due to difficulty in getting an appointment with St. Louis Rehab. It was noted that Petitioner was independent with a home exercise program and that it seemed to be helpful. Petitioner was recommended to undergo an additional injection and to return as needed. At the time of the December 12, 2011 visit, it was noted that Petitioner returned for follow-up with regard to severe right chest wall pain and other adverse effects associated with the spinal steroid injection performed November 30, 2011. Petitioner was instructed to hold off on injections and it was noted that she was going to focus on non-interventional therapies for management of neck pain. (RX17).

The medical records of Dr. Naseer were entered into evidence at the time of arbitration as Respondent's Exhibit 18. The records reflect that Petitioner was seen on March 12, 2013 for fibromyalgia. It was noted that the onset was 20 years ago, that it occurred intermittently and was fluctuating. It was noted that Petitioner was not responding to current treatment, that she was having no difficulty with ambulation, that she was able to perform activities of daily living and that she had no spasticity, tremor or memory loss. At the time of the November 11, 2013 visit, it was noted that Petitioner reported falling down a set of 11 steps on November 4th. It was noted that Petitioner was compliant with her medications and current therapy, that she was responding to her current treatment, that she was having no difficulty with ambulation and that she was able to perform activities of daily living. (RX18).

The medical records of Barnes Jewish Hospital were entered into evidence at the time of arbitration as Respondent's Exhibit 19. The records reflect that Petitioner was seen on March 18, 2013 for a chief complaint of syncope, that she fell and hit her forehead, and that she had passed out three times in the past week. A CT of the head performed on that date was interpreted as revealing no acute intracranial abnormalities. X-rays of the bilateral hips were interpreted as revealing no acute fracture, dislocation or destructive osseous lesion is identified; the bilateral hips are congruent; no joint effusion is seen; phleboliths project over the pelvis. Petitioner was diagnosed with syncope and hip joint pain and was discharged home in stable condition. (RX19).

The medical records of Dr. Moore were entered into evidence at the time of arbitration as Respondent's Exhibit 20. The records reflect that Petitioner was seen on July 18, 2013 for fibromyalgia, and it was noted that she had a longstanding history of FMS with multiple trigger points and had tried multiple medications. It was noted that Petitioner had extreme fatigue and diffuse myalgias and prolonged morning stiffness. Petitioner was recommended to enroll in a water aerobics program, continue swimming, to try yoga, tai chi and/or Pilates, to fax the results of x-rays and to undergo various lab work. (RX20).

The Gateway Regional Medical Center therapy records were entered into evidence at the time of arbitration as Respondent's Exhibit 21. The records reflect that Petitioner was seen on March 24, 2014 for physical therapy. It was noted that Petitioner had no new complaints and that she stated "My shoulder is good, I am ready for my surgery. I don't think I need to come back for my shoulder." At the time of the May 1, 2014 visit, it was noted that Petitioner the day prior was in significant pain and almost called the doctor, that her arm was burning, and that she thought she overdid it at home. At the time of the May 13, 2014 visit, it was noted that Petitioner stated that she overdid her arm over the weekend, that she talks

with her hands and that every time she extended her elbow she had some pain. Petitioner cancelled the May 20, 2014 visit, and it was noted that she fell hurting her arm and was waiting to hear from the doctor. The Discharge Summary was dated May 20, 2014. (RX21).

The medical records of Dr. LaBore were entered into evidence at the time of arbitration as Respondent's Exhibit 22. The records reflect that Petitioner called on January 22, 2015, at which time it was noted that Petitioner had an exacerbation of an old problem and that her left shoulder felt like it was on fire radiating down the right arm, and that it started the first of January. (RX22).

The July 3, 2014 note of Dr. Gelberman was entered into evidence at the time of arbitration as Respondent's Exhibit 23. The records reflect that Petitioner was seen on July 3, 2014, at which time it was noted that she had had medial elbow pain dating back to an injury that she sustained falling down stairs at Granite City High School in November. It was noted that Petitioner had multiple aches and pains for a month or so and then had neck and left upper extremity pain. Petitioner was placed in a posterior elbow splint. (RX23).

The Dr. Koptas noted of March 17, 2016 was entered into evidence at the time of arbitration as Respondent's Exhibit 24. The records reflect that Petitioner was seen on March 17, 2016 for hyperlipidemia and fibromyalgia. It was noted that Petitioner was not adhering to medications for her hyperlipidemia, and that the associated symptoms included joint pain and myalgia. As to Petitioner's fibromyalgia, it was noted that it occurred constantly and that associated symptoms included decreased mobility and joint tenderness. Petitioner was instructed to undergo various blood work and refills were given of Hydrocodone and Flexeril. (RX24).

CONCLUSIONS OF LAW

With respect to disputed issue (C) as it pertains to 13 WC 40678, to obtain compensation under the Illinois Workers' Compensation Act, a claimant must show by a preponderance of the evidence that he has suffered a disabling injury arising out of and in the course of his employment. 820 ILCS 305/2; *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill. App. 3d 1010, 1013 (1st Dist. 2011); *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 57 (1989). However, the fact that an injury arose "in the course of" the employment is not sufficient to impose liability, for to be compensable, the injury must also "arise out of" the employment. *Id.* at 58.

The "in the course of" component refers to the time, place and circumstances under which the accident occurred. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 483 (1989). If an injury occurs within the time period of employment, at a place where the employee can reasonably be expected to be in the performance of her duties, and while she is performing those duties or doing something incidental thereto, the injuries are deemed to have been received in the course of the employment. *Caterpillar Tractor Co.*, 129 Ill. 2d at 58. The "arising out of" component refers to an origin or cause of the injury that must be in some risk connected with or incident to the employment, so as to create a causal connection between the employment and the accidental injury. *Id.* There are three categories of risk to which an employee may be exposed: (1) risks distinctly associated with the employment; (2) risks personal to the employee; and (3) neutral risks, which have no particular employment or personal characteristics. *Springfield Urban League v. Illinois Workers' Compensation Comm'n*, 2103 IL App (4th) 120219WC; *Young v. Illinois Workers' Compensation Comm'n*, 2014 IL App (4th) 130392WC. Injuries resulting from a neutral risk are not generally compensable and do not arise out of the employment unless the employee was exposed to the risk to a greater degree than the general public. *Id.*

With respect to disputed issue (C) as it pertains to 13 WC 40678, the Arbitrator concludes that Petitioner failed to prove by a preponderance of the evidence that she sustained an injury on November 4, 2013 that arose out of her employment with Respondent. In so concluding, the Arbitrator finds that Petitioner failed to proffer any evidence that she sustained injury as a result of an employment-related risk and finds that Petitioner was not exposed to any greater risk than the general public when walking down the stairs at the time of the fall at issue. The Arbitrator notes that when asked by her attorney on direct examination if she knew what caused her to fall, Petitioner responded "no." When asked a second time by her attorney on direct examination if anything caused her to fall, Petitioner responded "I don't know." The Arbitrator further notes that the video of the fall shows Petitioner walking at a normal pace down the stairs. (PX4; RX3; RX4). The Arbitrator notes that there was no testimony that Petitioner was in a hurry, that there was anything on the stairs or that there was any defect with the stairs that caused the fall. As a result of the foregoing, the Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that she sustained an injury on November 4, 2013 that arose out of her employment with Respondent.

In light of the Arbitrator's findings with disputed issue (C) as it pertains to 13 WC 40678, the Arbitrator makes no findings with respect to disputed issues (F), (J), (K) and (L) as those issues are rendered moot. The claim is denied.

With respect to disputed issue (F) pertaining to causation as it pertains to 15 WC 31356, the Arbitrator finds that Petitioner's current condition of ill-being is not causally related to the injury of September 2, 2015. The Arbitrator notes that Petitioner testified that the only body part which suffered any permanent injury from the September 2, 2015 incident was that of her right hip, but there were no medical records entered into evidence at the time of arbitration which supported and/or referenced any right hip complaints or treatment after September 2, 2015. The Arbitrator notes that the only medical record entered into evidence at the time of trial for a date of service after September 2, 2015 was that of the March 17, 2016 note from Dr. Kopjas, which was devoid of reference to any right hip issues. (RX24).

As the Arbitrator finds that Petitioner failed to prove that her current condition of ill-being is causally related to her accident of September 2, 2015, all benefits are denied. The remaining issue of permanent partial disability is moot and the Arbitrator makes no conclusions as to that issue.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Cynthia Desper,

Petitioner,

vs. NO: 15 WC 31356

Granite City School District,

Respondent.

18IWCC0224

DECISION AND OPINION ON REVIEW

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

The Commission affirms the Arbitrator's finding that although Petitioner sustained accidental injuries arising out of and in the course of employment on September 2, 2015, she failed to prove a causal relationship exists between those injuries and her current condition of ill-being. The Commission affirms the Arbitrator's denial of Petitioner's claim.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 30, 2016 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that since Petitioner failed to prove a causal relationship exists between those injuries sustained on September 2, 2015 and her current condition of ill-being, her claim for compensation and medical expenses is hereby denied.

18IWCC0224

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: APR 12 2018
LEC/maw
o01/31/18
43

L. Elizabeth Coppoletti

Joshua D. Luskin

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DESPER, CYNTHIA
Employee/Petitioner

Case# **15WC031356**

13WC040678

GRANITE CITY SCHOOL DISTRICT
Employer/Respondent

18IWCC0224

On 11/30/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.61% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4324 LASHY & BAER PC
ANDREW TOENNINES
714 LOCUST ST
ST LOUIS, MO 63101-1699

2396 KNAPP OHL & GREEN
L DAVID GREEN
6100 CENTER GROVE RD
EDWARDSVILLE, IL 62025

STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Cynthia Desper
Employee/Petitioner

v.

Granite City School District
Employer/Respondent

Case # **15** WC **31356**

Consolidated cases: **13 WC 40678**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Collinsville**, on **September 27, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **September 2, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

Petitioner's condition of ill-being *is not* causally connected to the injury.

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

In the year preceding the injury, per the stipulation of the parties, Petitioner earned **$70,578.84** and the average weekly wage was that of **$1,809.71**.

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

Respondent is entitled to a credit of **$See Exhibits** for medical bills paid through its group medical plan under Section 8(j) of the Act.

ORDER

Petitioner failed to prove that her current condition of ill-being is causally related to her accident of September 2, 2015. All benefits are denied; the remaining issue of permanent partial disability is moot and the Arbitrator makes no conclusions as to that issue.

Respondent is entitled to a credit of **$See Exhibits** for medical bills paid through its group medical plan under Section 8(j) of the Act.

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

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

Melinda M. Rowe-Sullivan

Signature of Arbitrator

11/28/16

Date

NOV 30 2016

18IWCC0225

STATE OF ILLINOIS)
) SS.
COUNTY OF MCLEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JEREMY BARROW,
Petitioner,

v.

NO: 12 WC 08796
12 WC 08798
12 WC 17676

LOGAN COUNTY PARAMEDIC ASSOCIATION,
Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the First District Appellate Court, Workers' Compensation Division. The case originally proceeded to trial on February 25, 2014. In his April 29, 2014 decision, the Arbitrator found Petitioner sustained a repetitive trauma injury manifesting on January 9, 2012 and his C6-7 disc herniation and C7 radiculopathy are causally related to the accidental injury. The Arbitrator awarded Temporary Total Disability benefits from February 2, 2012 through April 2, 2012; Temporary Partial Disability benefits from April 2, 2012 through September 6, 2012; as well as $127,276.41 in medical expenses, and found Petitioner sustained permanent disability of 25% loss of the person as a whole.

Both parties filed Petitions for Review. On December 19, 2014, a prior iteration of Commission Panel C unanimously reversed the decision of Arbitrator, found Petitioner failed to prove accident or causal connection, and denied all benefits.

Petitioner subsequently appealed to the circuit court and thereafter the Appellate Court. On September 27, 2016, the Appellate Court entered an Order finding the Commission's determinations that Petitioner failed to prove the threshold issues of accident and causal connection were against the manifest weight of the evidence.

The matter is now before this panel to address the remaining issues. Having considered the issues identified in the parties' original review, *i.e.*, temporary disability, medical expenses, and permanent disability, and being advised of the facts and law, the Commission reinstates and modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Initially, the Commission notes the single-volume record received from the circuit court does not include Petitioner's Exhibits 14, 15 and 16 or Respondent's Exhibits 1 and 2. However, the Commission file contains the original copies of the exhibits submitted at trial, and we have reviewed all the documentary and testimonial evidence.

I. Temporary Total Disability

Referencing the Form 45 prepared by Petitioner's supervisor, the Arbitrator awarded Temporary Total Disability from February 2, 2012 through April 2, 2012. The Commission observes, however, this document evidences Petitioner worked on February 2, 2012. Therefore, the Commission modifies the Temporary Total Disability award to February 3, 2012 through April 2, 2012.

II. Temporary Partial Disability

The Arbitrator awarded Temporary Partial Disability benefits of $385.50 per week from April 2, 2012 through September 6, 2012. Initially, the Commission notes Temporary Total Disability was awarded through April 2, 2012; therefore the Temporary Partial Disability period commences on April 3, 2012.

Moreover, the Commission observes the benefit amount was calculated based on Petitioner's Exhibit 14, which is a printout of payroll transactions. This exhibit demonstrates that for the paychecks issued between April 19, 2012 through September 6, 2012, deposits totaled $5,945.23; dividing $5,945.23 by the number of weeks in that span, the Arbitrator found Petitioner earned $272.00 per week and based his calculation of the Temporary Partial Disability amount accordingly.

Significantly, a comparison of Petitioner's Exhibit 14 with the paystubs contained in Petitioner's Exhibit 15 makes it clear the deposit amounts reflected in Petitioner's Exhibit 14 are Petitioner's net pay. It is certainly true the Temporary Partial Disability provision formerly specified the calculation was to be predicated on a claimant's net earnings; however, the current language of Section 8(a), as amended in 2011, requires Temporary Partial Disability be calculated based on "the gross amount which he or she is earning in the modified job." *820 ILCS 305/8(a)* (Emphasis added). Petitioner's Exhibit 15 demonstrates Petitioner worked 80 hours at $14.14 per hour, for total hourly earnings of $1,131.20 per two-week pay period; this yields average weekly

18IWCC0225

gross earnings of $565.60. Utilizing this figure, Petitioner's weekly Temporary Partial Disability benefit is $190.07. ($850.70 - $565.60 = 285.10 x 2/3 = $190.07)

The Commission modifies the Temporary Partial Disability award to $190.07 per week for 22 3/7 weeks, representing April 3, 2012 through September 6, 2012.

III. Permanent Disability

In his discussion of §8.1(b)ii, Petitioner's occupation, the Arbitrator "takes judicial notice that this position is heavy work." The physical demand level of a profession is not subject to judicial notice, and the Commission strikes that language. Instead, the Commission relies on the extensive testimony from Petitioner regarding the rigorous nature of his work as well as the significant weights he must repeatedly lift and carry as support for its finding that Petitioner works a heavy, physically demanding job.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that, pursuant to the order of the First District Appellate Court, Petitioner sustained an accidental injury arising out of and in the course of his employment with Respondent on January 9, 2012, and his condition of ill-being is causally related to his work injury.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay Petitioner the sum of $567.13 per week for a period of 8 4/7 weeks, representing February 3, 2012 through April 2, 2012, that being the period of temporary total incapacity for work under Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay Petitioner the sum of $190.07 per week for a period of 22 3/7 weeks, representing April 3, 2012 through September 6, 2012, that being the period of temporary partial incapacity for work under Section 8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay Petitioner the sum of $510.42 per week for a period of 125 weeks, as provided in Section 8(d)2 of the Act, for the reason the injuries sustained caused 25% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the sum of $127,276.41 for medical expenses as provided in Sections 8(a) and 8.2 of the Act. Respondent is entitled to credit for any related medical expenses that have been paid and Respondent shall hold Petitioner harmless from any claims by any providers for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

18IWCC0225

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

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

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

DATED: APR 12 2018

L. Elizabeth Coppoletti

LEC/mck

D: 2/28/18

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Charles J. DeVriendt

Joshua D. Luskin

STATE OF ILLINOIS)
) SS.
COUNTY OF MCHENRY)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Pamela Bohlman,

Petitioner,

18IWCC0226

vs.

NO: 15 WC 10253

First Student a/k/a First American,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, and prospective medical treatment and being advised of the facts and law, reverses the §19(b) Decision of the Arbitrator which is attached hereto and remands this case to the Arbitrator for further proceedings pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill. Dec. 794 (1980).

Petitioner, a 56-year-old school bus driver, filed an Application for Adjustment of Claim alleging injuries to her left leg, left hand, and neck as a result of a work-related injury on November 10, 2014. It is undisputed that Petitioner sustained a work-related accident on that date when a vehicle ran a stop sign and collided with Petitioner's school bus. At the §19(b) hearing, Petitioner sought authorization for a C6-7 anterior cervical discectomy and fusion and an award of disputed medical expenses. In a §19(b) Decision dated July 5, 2017, the Arbitrator found that Petitioner's current condition of ill-being is causally related to the work-related accident and awarded the disputed medical expenses and prospective surgery. Respondent sought review of the Arbitrator's Decision.

Petitioner has a longstanding preexisting cervical condition of multilevel degenerative disc disease. She underwent a C4 to C6 anterior cervical discectomy and fusion on June 12, 2014 by Dr.

Braaksma. Petitioner's reportedly worsening symptoms of neck and right shoulder pain in early 2014 were not attributable to any recent trauma or inciting activity. By September 8, 2014, Petitioner was doing well and she reported only some intermittent right arm numbness. Dr. Braaksma released Petitioner to return to full duty work and she testified that she had no problems performing her job driving the school bus.

An ambulance was called to the scene of the November 10, 2014 accident. The ambulance report states that Petitioner complained of neck pain at a level of 4 out of 10. She reported that she was wearing her seatbelt, and that when the vehicle struck her school bus on the passenger side the bus tilted significantly. Petitioner denied striking her head or losing consciousness, and she reported a history of neck surgery in June. The paramedic's trauma assessment at the scene identified no acute injury. Petitioner was transported to the hospital for further evaluation. The ambulance report notes that a passenger on the school bus did not require EMS attention or transport.

At St. Anthony Medical Center, Petitioner complained of neck pain at a level of 5 out of 10. She was examined by Dr. Coggin and had a CT of her cervical spine and an x-ray of her left knee. Dr. Coggin noted that Petitioner's complaints were minimal other than neck and left knee stiffness. He concluded that the diagnostic imaging studies were normal. Dr. Coggin diagnosed a cervical sprain, prescribed cyclobenzaprine and ibuprofen, and discharged Petitioner from the ER.

On November 12, 2014 Petitioner was examined by Dr. McFadden at Physicians Immediate Care for complaints of severe pain in her left hand and thumb that began the day after the accident. The record from this evaluation reflects no complaints of neck or upper extremity symptoms. Petitioner was issued work restrictions for her left hand and she eventually came under the care of Dr. Foster at OrthoIllinois and had left wrist surgery on June 1, 2015. Respondent stipulated to periods of temporary total disability with respect to Petitioner's right wrist injury.

On November 14, 2014 Petitioner returned to Dr. Braaksma at OrthoIllinois. Petitioner complained of neck pain at a level of 6 out of 10 at rest and 8 out of 10 with activity. Dr. Braaksma reviewed Petitioner's recent CT scan and found no evidence of hardware loosening or failure and he noted that Petitioner had no recurrent radicular symptoms. Dr. Braaksma diagnosed axial neck pain and recommended physical therapy and restrictions of no bending or twisting, no lifting more than 10 pounds, and no sitting or standing for longer than two hours.

Petitioner showed improvement with physical therapy and transitioned to a home exercise program. Dr. Braaksma released Petitioner from care on January 2, 2015. He noted that Petitioner had not been working due to her wrist injury, but that from a cervical standpoint she could work full duty.

On May 7, 2015 Petitioner was examined by Dr. Srivastava at Rockford Neuroscience Center. Petitioner complained of headaches and persistent neck discomfort and pain radiating to the right upper extremity associated with numbness and tingling. Petitioner returned to Dr. Braaksma on June 29, 2015. Dr. Braaksma noted that Petitioner was not working due to her wrist injury and had recently been examined by a neurologist for her headaches. Petitioner complained of neck pain with radiation to the

right shoulder and arm and tingling and numbness in both hands. Dr. Braaksma stated that the May 18, 2015 cervical spine MRI (ordered by Dr. Srivastava) indicated no evidence of hardware complications. Dr. Braaksma recommended a trial of C7-T1 epidural steroid injections. Dr. MacKenzie performed the recommended injections on July 14, 2015 and Petitioner began another course of physical therapy for her cervical spine. She reported to the physical therapist that her cervical symptoms returned in May of 2015. On August 19, 2015 Dr. Braaksma issued a narrative letter opining that Petitioner had adjacent segment degeneration with bilateral C6-7 foraminal stenosis and bilateral C7 radiculopathy. He recommended a C6 to C7 anterior cervical discectomy and fusion to address Petitioner's symptoms. Furthermore, he opined that Petitioner's cervical condition was exacerbated by the work-related accident and accelerated her need for additional surgery.

Petitioner continued treating for her left hand and thumb complaints with physical therapy and work conditioning through October 27, 2015. The records show that she occasionally mentioned cervical complaints to the therapist, but Petitioner never returned to Dr. Braaksma.

On December 8, 2015, Respondent had Petitioner examined by Dr. Hsu pursuant to §12. Dr. Hsu reviewed the records of Dr. Braaksma, Petitioner's accident report and post-accident medical records, and Petitioner's physical therapy records. Dr. Hsu also reviewed the diagnostic imaging studies from June 12, 2014, November 10, 2014, and May 18, 2015. On examination, Petitioner complained of bilateral shoulder pain and bilateral upper extremity numbness and tingling. Dr. Hsu found Petitioner's neurologic and physical examination to be unremarkable. He diagnosed Petitioner with cervical spondylosis and resolved cervical and lumbar strains. Dr. Hsu opined that Petitioner sustained soft tissue injuries as a result of the motor vehicle accident. He opined that Petitioner's current condition was the result of the natural progression of her pre-existing degenerative conditions (cervical spondylosis) and not injuries sustained on November 10, 2011. He noted that he saw no significant findings on the cervical spine MRI other than age-appropriate spondylotic changes and he did not recommend any further treatment. He noted that Petitioner was working full duty and had only mild symptoms.

Dr. Braaksma testified via deposition. On direct-examination, Dr. Braaksma testified that the last time he saw Petitioner was June 29, 2015. He testified that his office followed-up with Petitioner over the phone after her July 14, 2015 C7-T1 epidural steroid injections. Dr. Braaksma testified that Petitioner reported she had some relief from the injections and he recommended she undergo a repeat injection. Petitioner never followed-up with Dr. Braaksma's office. Dr. Braaksma testified that his opinion, as set forth in his narrative letter of August 19, 2015, was that Petitioner recovered fully from her prior cervical surgery but was made symptomatic by the accident of November 10, 2014. He testified that conservative treatment failed to resolve her complaints. He testified that the MRI demonstrated worsening stenosis at the adjacent C6-7 level, he could not "directly relate" this worsening to the accident itself. He opined that if Petitioner required surgical intervention to address her symptoms, it would be related to the accident because without the accident she was not likely to have needed surgery again so soon. He testified that if Petitioner returned to him with the same complaints, he would advise her to live with her symptoms, continue conservative care, or consider surgical intervention (adjacent level fusion at the C6-7 level).

On cross-examination, Dr. Braaksma agreed that Petitioner's condition as of May 2014 was not caused by any acute trauma, but was caused by degenerative changes leading to a slow progression of spinal cord and nerve root compression. He agreed that she had degenerative findings at C6-7 at that time. Dr. Braaksma performed a C4 through C6 anterior cervical discectomy and fusion on June 12, 2014. Dr. Braaksma testified that Petitioner's symptoms of C7 radicular pain and paresthesia were new complaints on June 29, 2015. Even though Dr. Braaksma agreed that these complaints were new, he testified that the symptoms still could have been caused by the accident. He suggested that Petitioner had "distracting injuries" (her left wrist) after the accident. We note there is no evidence that Dr. Braaksma reviewed all the treatment records from the ambulance, emergency room, and Physicians Immediate Care.

On review, we note that Petitioner specifically denied any radicular symptoms following the accident. The records show that new complaints arose at least four months after Dr. Braaksma discharged Petitioner from care in January of 2015. Dr. Hsu did not testify with respect to his opinions, but his §12 report states that he found Petitioner sustained only soft tissue injuries and her current complaints were not related to the accident. Petitioner had preexisting arthritis at C6-7 with prominent diffuse disc bulging, uncovertebral joint hypertrophy, mild central canal stenosis, and moderate bilateral foraminal narrowing. Dr. Hsu found Petitioner's current complaints to be mild and they did not prevent her from working full duty. Dr. Hsu did not see any reason for further treatment. It is well known that in Illinois, a claimant with a preexisting condition may be entitled to benefits under the Act, but the claimant must still show that the preexisting condition was accelerated to a material degree by the work injury in order for it to be compensable. After considering all of the evidence, we are persuaded by the credible medical records and the opinion of Dr. Hsu that Petitioner sustained only a temporary aggravation of her preexisting condition as a result of the work-related accident of November 10, 2014.

Petitioner was thoroughly evaluated in the weeks after the accident by her spine surgeon and her knee surgeon, considering that she had both a cervical fusion and a total knee replacement earlier in 2014. The surgeons found no evidence of new damage to these body parts. The evidence shows that Petitioner's neck and left knee complaints improved following the accident, although she continued to actively treat for her left wrist. Dr. Braaksma's testimony and records show that Petitioner's condition returned to its baseline by January 2, 2015. We find that Petitioner's current condition of ill-being with respect to her cervical spine is not causally related to the accident of November 10, 2014. We reverse the Arbitrator's award of prospective medical treatment and disputed medical expenses and remand this case to the Arbitrator for further proceedings.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $322.91 per week for a period of 8 2/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is not liable for medical expenses incurred by Petitioner for treatment for her cervical spine after her release by Dr. Braaksma on

January 2, 2015 and or for physical therapy expenses after her discharge from OrthoIllinois physical therapy on January 27, 2015.

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

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

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

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

DATED: APR 12 2018
DLS/plv
o-2/15/18
46

Deborah L. Simpson

Deborah L. Simpson

Stephen J. Mathis

Stephen J. Mathis

DISSENT

I respectfully dissent from the majority decision and would affirm the Arbitrator's well reasoned decision in its entirety.

David L. Gore

David L. Gore

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

18IWCC0226

BOHLMAN, PAMELA
Employee/Petitioner

Case# **15WC010253**

FIRST STIDENT A/K/A FIRST AMERICAN
Employer/Respondent

On 7/5/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0222 GOLDBERG WEISMAN & CAIRO LTD
KITRA K KILLEN
ONE E WACKER DR SUITE 3800
CHICAGO, IL 60601

0560 WIEDNER & McAULIFFE LTD
EDUARO CALDERON
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

18IWCC0226

STATE OF ILLINOIS)
)SS.
COUNTY OF Winnebago)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Pamela Bohlman
Employee/Petitioner

v.

First Student a/k/a First American
Employer/Respondent

Case # **15** WC **10253**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Woodstock**, on **May 5, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0226

FINDINGS

On the date of accident, **November 10, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$25,187.24**; the average weekly wage was **$484.37**.

On the date of accident, Petitioner was **54** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of **$2,675.54** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$2,675.54**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $322.91/week for 8 2/7 weeks, commencing June 4, 2015 through June 7, 2015, and September 4, 2015 through October 27, 2015 as provided in Section 8(b) of the Act. Respondent shall be given a credit of **$2,675.54** for TTD

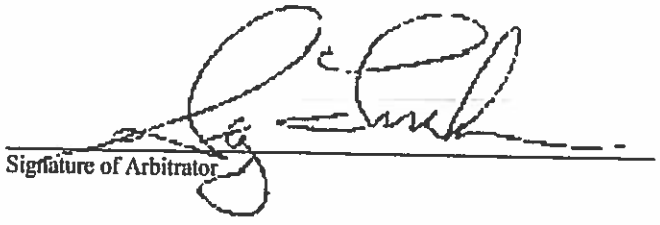
Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of **$1,112.12** to **Rockford Orthopedic Associates**, **$90.00** to **Rockford Neuroscience Center**, and **$777.04** to **Blue Cross/Blue Shield**, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall also reimburse Petitioner **$100.00** for out of pocket payments.

Respondent shall authorize and pay for additional reasonable and necessary treatment consistent the recommendations of Dr. Braaksma, including a C6-7 fusion, any post operative treatment, physical therapy or other reasonable and necessary care.

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

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

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



Signature of Arbitrator

July 1, 2017
Date

ICArbDec19(b)

JUL 5 - 2017

Statement of Facts

Petitioner Pamela Bohlman testified that on November 10, 2014, she was employed by Respondent as a school bus driver. She had been employed with Respondent for about 5 years. Petitioner's duties included driving a route. She picked up children from their houses and took then to school and then took them from school to their homes, as well as driving for other trips.

Petitioner testified that she had received treatment for her neck prior to November, 2014. Petitioner testified that she had a cervical MRI in 1994 and may have had epidural injections. She testified she saw Dr. Srivastava who diagnosed a disc on the right at C4. That was after an accident.

She received additional treatment in 2014, prior to November. Dr. Warren, her primary care physician, ordered a cervical MRI which was performed on April 22, 2014. The impression was multilevel degenerative changes superimposed on a congenitally small central canal producing varying degrees of central canal and foraminal stenosis most severe at C4-5 and C5-6 (RX 2). She treated with Dr. Braaksma at Rockford Orthopedic Associates, now known as OrthoIllinois. She first saw Dr. Braaksma on May 19, 2014 (RX 3). Petitioner complained of neck pain that started in her right shoulder and now is located in the back of her neck. The onset was 3 months ago with no known injury, although Petitioner reported being hit on the head with a hydraulic jack 21 years ago. She stated her pain radiated into her head and right shoulder. Her hands were clumsy. Dr. Braaksma found numbness bilaterally in the C5 and C6 dermatomes. He diagnosed cervical spondylosis with myelopathy, herniated disc and cervical radiculopathy. He recommended a C4 to C6 anterior cervical discectomy and instrumented fusion (RX 3). Petitioner underwent the recommended surgery on June 12, 2014 (RX 4). On June 23, 2014, Dr. Braaksma noted pain levels at 2/10 at rest and 4/10 with activity. Petitioner was scheduled for follow up in 6 weeks (RX 5). Petitioner was seen on August 4, 2014 (RX 6) and September 8, 2014 (RX 7). At that time, Petitioner reported pain at rest of 0/10 and 2/10 with activity. She had not started physical therapy. The examination noted full strength and normal reflexes and sensation. There was no tenderness. Dr. Braaksma stated that she appears to be doing well with sustained resolution of her radicular symptoms and improvement in her neck pain. She was instructed to gradually resume usual activities within her pain threshold. She was to be seen as needed if new problems arose (RX 7). Petitioner contacted Dr. Braaksma for a Naprosyn refill in October, 2014 and was advised that it needs to come from her primary care physician (PX 4).

Petitioner testified that she returned to full duty work for Respondent on September 8, 2014 and continued to perform full duty work until November 10, 2014. She testified that during this time, she initially had a little bit of tingling in one hand which then resolved and disappeared. She described her recovery from the cervical fusion surgery as "perfect" and said she felt great.

Petitioner testified that on the morning on November 10, 2014, she was involved in a vehicular accident. She was driving the school bus back to the base. Petitioner testified she was headed eastbound on Spring Creek when another driver who was heading north failed to stop at the stop sign at the intersection and struck the bus. Petitioner testified that the car first struck the front then the middle and finally the back of the bus. A traffic accident report was made (PX 1). Petitioner testified that the diagram inaccurately shows the bus striking the car. Petitioner described significant damage to the bus including the front end on the side and the hood being "smashed in". She described an impact that caused the bus to tip over onto just the driver's side tires causing her body to be pushed into the window from the force of the impact. The other vehicle spun out. It ended up in a cornfield with the windows blown out. The vehicle was so smashed that the driver had to be

cut out by the emergency responders. Petitioner testified that immediately following the accident she noticed pain in her neck, into her shoulders, hands and left knee.

The accident report notes that Petitioner was transported from the scene by ambulance (PX 1). Petitioner was transported to St. Anthony Medical Center. The records document complaints of pain in the neck and left knee stiffness. She had no arm numbness or hand tingling. The history notes a prior left total knee replacement and the prior cervical fusion. A cervical CT scan noted no traumatic osseous injury evident to the cervical spine, but C4-5 and C5-6 predominant neural foraminal stenosis. The CT findings also noted osteophyte and disc complexes/disc bulges at C3-4 and C6-7 result in an element of spinal canal stenosis. Upon discharge, Petitioner again denied paresthesia. She was prescribed pain medication and instructed to follow-up with her primary care physician (PX 2). She also contacted Dr. Braaksma on November 10, 2014 to schedule an appointment for November 14 (PX 4).

Petitioner began treating at Physician's Immediate Care on November 12, 2014. Petitioner testified she was sent there by her employer. On November 12, 2014, her chief complaint upon presentation was pain in the left wrist. Petitioner had x-rays to the left wrist and was diagnosed with tenosynovitis (PX 3). Petitioner testified that she saw her family doctor, Dr. Warren on November 13, 2014.

Petitioner saw Dr. Braaksma on November 14, 2014 for a recheck of the C4-6 ACDF/MVA. Petitioner reported pain at 6/10 at rest and 8/10 with activity. The examination noted full painless range of motion in both upper extremities and shoulders. There was no cervical tenderness. Strength, sensation and reflexes were normal. Review of the CT scan noted no evidence of hardware loosening or failure. Dr. Braaksma noted axial neck and back pain with no recurrent radicular symptoms. He found no significant findings on imaging and no evidence of neurological impingement. He recommended physical therapy and stated that if she continued to have symptoms that he would obtain a repeat MRI, but he expected that the muscle spasm is from recent trauma and will resolve with conservative means (PX 4). Petitioner saw Dr. Barba for her left knee on November 19, 2014. He found the implant looked fine and stated Petitioner should advance activity as tolerated and follow up in 5 years (PX 4).

Petitioner returned to Physician's Immediate Care on November 19, 2014 with complaints in the left hand, right shoulder and left knee. She advised of referral by her primary physician to a hand specialist for the left hand and her visit with her spine surgeon who placed her on restrictions and scheduled physical therapy. Petitioner was placed on work restrictions (PX 3). Petitioner testified that she worked restricted duty.

Petitioner was initially evaluated by Dr. Foster for her left wrist on November 20, 2014. He diagnosed De Quervain's tenosynovitis. Petitioner chose conservative treatment with a thumb spica, therapy and NSAIDS (PX 4). Petitioner underwent physical therapy at OrthoIllinois (PX 4). Dr. Braaksma saw Petitioner on January 2, 2015 with continued complaints of pain. Petitioner's physical examination of the neck and upper extremities was normal. He noted that she continues with axial neck pain and right upper extremity paresthesia. Petitioner was advised that she may resume usual activities within her pain threshold from the standpoint of her cervical spine. She will return on an as needed basis if new problems arise (PX 4). Dr. Foster administered a cortisone injection into the 1st dorsal compartment on January 6, 2015 (PX 4).

Petitioner continued physical therapy. On January 22, 2015, she stated that she had returned to work without difficulty with respect to her cervical spine. Her shoulders were a little achy which she relates to stopping her medication. She denied right upper extremity numbness and tingling. Her primary complaints involved the left

hand. On January 27, 2015, Petitioner reported 0-1/10 pain in the cervical region and denied numbness and tingling in the right upper extremity, only intermittent left hand numbness and tingling in the first through third digits. Petitioner was discharged from physical therapy for her neck and continued with respect to the left hand only (PX 4). Petitioner continued to treat for her left wrist De Quervain's tenosynovitis with Dr. Foster. His records reference complaints of numbness and tingling limited to the first three digits of the left hand. On March 3, 2015, Petitioner reported improved range of motion but worsening pain. Dr. Foster proposed surgery consisting of a first dorsal compartment release. Petitioner underwent surgery performed by Dr. Foster on June 1, 2015 consisting of a first dorsal compartment release and tenosynovectomy and ganglion cyst excision (PX 4). Petitioner testified that she was off work and returned to restricted office duty on June 8, 2015. She began further physical therapy on June 17, 2015 for her left hand (PX 4).

On May 7, 2015, Petitioner was seen by Dr. Srivastava at Rockford Neuroscience Center. The reason for the visit was paresthesia in her hand and headaches. She complained of persistent neck discomfort and pain radiating to the right upper extremity associated with numbness and tingling. Dr. Srivastava recommended a cervical MRI. The MRI performed on May 18, 2015 revealed chronic spondylosis and C6-7 bilateral foraminal stenosis from joint arthritis that could be a potential source of persistent radiculopathy. It was noted that there was no significant change from the study on April 22, 2014. On June 18, 2015, Dr. Srivastava advised her to see her spine surgeon (PX 5).

Petitioner returned to Dr. Braaksma on June 29, 2015. She reported cervical spine pain at 8/10 radiating through the right shoulder into the arm with tingling and numbness in both hands. Dr. Braaksma reviewed petitioner's cervical MRI, noting that the most significant finding was at the C6-7 level where she had bi-foraminal right greater than left disc osteophyte complex resulting in severe right and moderate to severe left neuroforaminal stenosis. Dr. Braaksma stated that Petitioner had C7 radicular pain and paresthesia which had initially improved with physical therapy but had since returned. He recommended a trial C7-T1 epidural steroid injection which was performed by Dr. McKenzie on July 14, 2015 (PX 4).

Dr. Braaksma referred Petitioner for additional physical therapy which began on July 17, 2015. Petitioner reported her neck and upper back pain had improved after her last bout of therapy but she had begun to have symptoms again in May. She complained of tingling in the right hand but stated that the left had resolved (PX 4). Petitioner continued with therapy and was advanced to a work conditioning program beginning September 11, 2015. Petitioner was restricted to light duty with 10 pounds of lifting. On September 25, 2015, she reported a significant increase in symptoms related to her cervical disc herniation, including bilateral radicular pain into the arms. On October 19, 2015, Petitioner again reported that her radicular symptoms continued to worsen bilaterally but were more pronounced in the left upper extremity. Petitioner continued sessions with complaints of her left arm "killing her." On October 23, 2015, Petitioner's bilateral upper extremity radicular complaints were more severe and she stated that she planned to contact Dr. Braaksma's office immediately for an evaluation. No further treatment was scheduled. The note states she is released to full duty for the left thumb/wrist. It was recommended that she follow up with her treating physician regarding the progression of her cervical radicular symptoms (PX 4).

Petitioner had further follow up visits with Dr. Foster for her left thumb through March 24, 2016. He released her for full duty as of October 28, 2015. He performed an injection into the CMC joint of the left thumb on February 4, 2016. On March 24, 2016, Petitioner reported the injection benefits lasted about 3 weeks and then the pain returned. Petitioner was to proceed with conservative care including Voltaren gel (PX 4).

On August 19, 2015, at the request of Petitioner's attorney, Dr. Braaksma authored a narrative report. He outlined Petitioner's pre-accident treatment. He notes that she did not have any symptomatic C7 radiculopathy. Petitioner was released without restrictions on September 8, 2014. He described the post accident treatment with improvement through January 2, 2015. He notes her return on June 29, 2015 with complaints of pain in the cervical spine radiating to the right shoulder. The May, 2015 MRI demonstrated interval development of biforaminal, right greater than left, disc osteophyte complexes resulting in neuroforaminal stenosis. He noted the injection performed provided significant relief. He diagnosed adjacent segment degeneration with bilateral C6-7 foraminal stenosis and bilateral C7 radiculopathy which has failed to respond to conservative treatment. He recommended a C6 to C7 anterior cervical discectomy and fusion. Dr. Braaksma opined that Petitioner's current condition in the cervical spine was causally connected to the accident He states that the condition was aggravated by the accident. She has had a progression of the degenerative condition (PX 7).

Dr. Braaksma testified by evidence deposition taken August 12, 2016 (PX 6). He testified to his initial treatment and the full release on September 8, 2014 as well as the treatment beginning November 14, 2014 through January 2, 2015. He testified that on that date Petitioner reported doing somewhat better with pain rated as 2/10 at rest and 8/10 with activity. Her complaints were pain in the neck with numbness and some pain radiating into her right arm. He noted her return on June 29, 2015 with worsening pain. He testified that he compared the May, 2014 pre-operative MRI to the May, 2015 MRI and found significant progression and worsening of the biforaminal stenosis at C6-7. He diagnosed C7 radicular pain and numbness. He opined that Petitioner's condition was causally related to the accident and that she had the treatment options of living with the condition or undergoing a C6-7 adjacent level fusion (PX 6).

Dr. Braaksma testified that the cause of the condition that led to her original surgery was the degenerative changes leading a slow progression of spinal cord and nerve root compression. There were degenerative findings at that time at C6-7. On September 8, 2014, Petitioner was clinically and radiographically healed from her surgery and released without restriction. Her pain rating was 2/10 with activity. The October, 2014 prescription for Naproxen could be for pain in the neck or arthritic symptoms in other joints. On his November 14, 2014 visit he noted axial neck and back pain. That is distinguished from radicular pain. Petitioner had no radicular complaints at that time. His statement on January 2, 2015 telling Petitioner symptoms may take up to 18 months to improve or may never completely resolve refers to the C5-6 dermatomal symptoms consistent with his working diagnosis of C5-6 degenerative conditions. He did not order an MRI because her symptoms were improving. On June 29, 2015, he first diagnosed C7 radiculopathy. Petitioner had new symptoms consistent with that diagnosis. He stated that Petitioner had distracting injuries. It is not unusual for symptoms to arise after an injury like she sustained (PX 6).

Petitioner underwent an evaluation with Dr. Wellington Hsu on November 18, 2015 at Respondent's request (RX 1). Dr. Hsu reviewed pre and post-accident medical records from Dr. Braaksma, Dr. Foster, OSF Healthcare, Physicians Immediate Care, therapy records, imaging studies related to the cervical spine including the June 12, 2014 x-rays, November 10, 2014 CT scan and May 18, 2015 MRI. He also reviewed Dr. Braaksma's August 19, 2015 narrative report. He opined Petitioner sustained a cervical strain and temporary aggravation of her pre-existing cervical spondylosis as a result of the November 10, 2014 accident. Dr. Hsu did not find Petitioner's current condition with respect to the cervical spine was traceable to the accident, but to the natural progression of pre-existing degenerative cervical spondylosis. He felt she returned to baseline following the accident when she was discharged from care in January, 2015.

Petitioner testified that she still experiences pain in her hands and shoulder making it hard to sleep. She also experiences numbness and tingling in her hands and her entire arm is painful. She has been working full duty since October 28, 2015. She testified that her symptoms affect her job including making it difficult to hold the bus steering wheel. She often has to shake her hands when at a stop sign in order to try to get rid the numbness sensation. Petitioner testified that she wishes to pursue further treatment with Dr. Braaksma.

Conclusions of Law

In support of the Arbitrator's decision with respect to (F) Causal Connection, the Arbitrator finds as follows:

A Workers' Compensation Claimant bears the burden of showing by a preponderance of credible evidence that his current condition of ill-being is causally related to the workplace injury. *Horath v. Industrial Comm'n*, 449 N.E.2d 1345, 1348 (Ill. 1983) citing *Rosenbaum v. Industrial Comm*'n. (1982), 93 Ill.2d 381, 386, 67 Ill.Dec. 83, 444 N.E.2d 122). If the claimant had health problems prior to a work-related injury, he bears the burden of showing that the pre-existing condition was aggravated by the employment and that the aggravation occurred as a result of an accident which arose out of and in the course of his employment. Petitioner herein is seeking additional treatment for the condition of ill being in her cervical spine. It is undisputed that Petitioner had a pre-existing condition which resulted in a two level cervical fusion in June, 2014. Petitioner had been released from care and back to work for only two month's before the accident. It is also undisputed that she sustained accidental injuries in the November 10, 2014 motor vehicle accident which included complaints in the neck and right arm. Respondent has disputed that Petitioner's condition of ill being in the cervical spine and right arm after her return to work following Dr. Braaksma's release on January 2, 2015 is causally related to the accident.

In *Nanette Schroeder v. Illinois Workers' Compensation Comm'n*, 2017 IL App (4th) 160192WC, No. 4-16-0192WC (May 31, 2017), the Appellate Court has recently addressed the standard of establishing causation where there is an aggravation of a pre-existing condition. It is well-established that an accident need not be the sole or primary cause—as long as employment is a cause—of a claimant's condition. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 205 (2003). Furthermore, an employer takes its employees as it finds them. *St. Elizabeth's Hospital v. Illinois Workers' Compensation Comm'n*, 371 Ill. App. 3d 882, 888 (2007). A claimant with a preexisting condition may recover where employment aggravates or accelerates that condition. *Caterpillar Tractor Co. v. Industrial Comm'n*, 92 Ill. 2d 30, 36 (1982).

In the present case, Petitioner is not relying on a chain of events theory, but presented the opinions of Dr. Braaksma that her current condition is causally related to the accident and that she is in need of further medical care. Respondent presented the opinions of Dr. Hsu that Petitioner sustained a cervical strain and temporary aggravation of her pre-existing cervical spondylosis as a result of the November 10, 2014 accident and that Petitioner's current condition with respect to the cervical spine was not traceable to the accident, but to the natural progression of pre-existing degenerative cervical spondylosis.

It is the Commission's function, to choose between conflicting medical opinions. Not only may the Commission decide which medical view is to be accepted, it may attach greater weight to the opinion of the treating physician. *International Vermiculite Co. v. Industrial Comm'n*, 77 Ill.2d 1, 31 Ill.Dec. 789, 394 N.E.2d 1166 (1979); *ARA Services, Inc. v. Industrial Comm'n*, 226 Ill. App. 3d 225, 168 Ill. Dec. 756, 590 N.E. 2d 78 (1992).

Expert testimony shall be weighed like other evidence with its weight determined by the character, capacity, skill and opportunities for observation, as well as the state of mind of the expert and the nature of the case and its facts. *Madison Mining Company v. Industrial Comm'n*, 309 Ill. 91, 138 N.E. 211 (1923). The proponent of expert testimony must lay a foundation sufficient to establish the reliability of the bases for the expert's opinion. If the basis of an expert's opinion is grounded in guess or surmise, it is too speculative to be reliable. Expert opinions must be supported by facts and are only as valid as the facts underlying them. A finder of fact is not bound by an expert opinion on an ultimate issue, but may look 'behind' the opinion to examine the underlying facts.

Having reviewed the opinions of the doctors as well as the medical records and the Petitioner's credible testimony as to the severity of the accident and the progression of her symptoms, the Arbitrator finds the opinions of Dr. Braaksma more persuasive that those of Dr. Hsu. The Arbitrator considers that Dr. Braaksma is the treating surgeon and has seen the Petitioner on multiple occasions both before and after the November 10, 2014 accident. He reviewed the MRI from before the June, 2014 surgery, not mentioned in Dr. Hsu's report. The Arbitrator also notes that Dr. Hsu's report does not reference his review of the treatment by Dr. Srivastava. The Arbitrator also notes that Dr. Hsu's report does not reference his review of the treatment by Dr. Srivastava.

The Arbitrator finds Dr. Braaksma's explanation of the Petitioner's condition and the progression of symptoms credible, including his comments on distracting injuries. The Arbitrator notes that Dr. Braaksma opined that Petitioner suffered a progression of the underlying degenerative condition as a result of the accident. Such a progression would be consistent with the medical records showing no initial radicular complaints but a gradual worsening of the Petitioner's symptoms. With respect to the comment on distracting injury, the Arbitrator notes that Petitioner was also treating for a disabling left wrist injury which required surgery by Dr. Foster. The left wrist was a primary complaint in many of the early treating records.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that her current condition of ill being in the cervical spine and right arm is causally connected to the accidental injuries sustained on November 10, 2014.

In support of the Arbitrator's decision with respect to (J) Medical, the Arbitrator finds as follows:

Based upon the Arbitrator's finding with respect to Causal Connection, Petitioner's condition of ill being in the neck and right arm is causally connected to the accident. Petitioner is entitled to payment for reasonable and necessary treatment related to that condition.

Petitioner admitted Exhibits 8 and 9 with respect to unpaid bills and Exhibit 10 with respect to payments by Blue Cross/Blue Shield. After reviewing these exhibits and the supporting medical records admitted, the Arbitrator finds that the treatment reflected in the bills is reasonable, necessary and causally related to the accident. The Arbitrator finds:

Rockford Orthopedic Associates: PX 8 reflects unpaid balances for the July 17, 2015 therapy evaluation and the July 14 injection. The balance of $1,112.12 is owed by Respondent

Rockford Neuroscience Center: PX 9 reflects the June 24, 2015 balance to Dr. Srivastava for related treatment on December 1, 2014, May 7, 2015, and June 18, 2015 at $140 per visit. Blue Cross has covered the 2015 visits (PX 10). The record, confirmed by Petitioner's testimony was that she paid $50.00 for the December 1, 2014 visit. To the extent there is a balance on the December 1, 2014 visit, Respondent is responsible. Petitioner also is entitled to reimbursement for the $100.00 she paid directly.
Blue Cross/Blue Shield: PX 10 documents payment by Blue Cross Blue Shield for Dr. Srivastava's visits on May 7 and June 18, 2015 as well as the charges for the May 18, 2015 MRI. These charges are related to the accident. There is also a payment for a visit to Dr. Warren on July 16, 2015. No records were admitted to document that this visit to Petitioner's primary care physician was related to the accident and this payment of $87.52 is denied. The total related charges paid are $777.04.

Based upon the record as a whole and the Arbitrator's finding with respect to Causal Connection, the Arbitrator finds that Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $1,112.12 to Rockford Orthopedic Associates, $90.00 to Rockford Neuroscience Center, and $777.04 to Blue Cross/Blue Shield, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall also reimburse Petitioner $100.00 for out of pocket payments.

In support of the Arbitrator's decision with respect to (K) Prospective Medical, the Arbitrator finds as follows:

Based upon the Arbitrator's finding with respect to Causal Connection, Petitioner's condition of ill being in the neck and right arm is causally connected to the accident. Petitioner is entitled to payment for reasonable and necessary treatment related to that condition. As noted above, the Arbitrator finds that Dr. Braaksma's opinions are more persuasive that those of Dr. Hsu. Dr. Braaksma diagnosed adjacent segment degeneration with bilateral C6-7 foraminal stenosis and bilateral C7 radiculopathy which has failed to respond to conservative treatment. He recommended a C6 to C7 anterior cervical discectomy and fusion. He testified that Petitioner could either live with the current symptoms and undergo a functional capacity examination or proceed with surgery. Petitioner testified that she wanted to pursue further treatment with Dr. Braaksma. The Arbitrator finds that the proposed medical care including the recommended surgery is reasonable, necessary and causally connected to the accident.

Based upon the record as a whole and the Arbitrator's finding with respect to Causal Connection, the Arbitrator finds that Respondent shall authorize and pay for additional reasonable and necessary treatment consistent the recommendations of Dr. Braaksma, including a C6 to C7 anterior cervical discectomy and fusion, any post operative treatment, physical therapy or other reasonable and necessary care.

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Chadrick Carlton,
Petitioner,

18IWCC0227

vs.

NO: 13 WC 18872
15 WC 22659

Peoria Public Schools District #150,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 7, 2016, is hereby affirmed and adopted.

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

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

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

DATED: APR 12 2018
o4/5/18
DLS/rm
046

Deborah L. Simpson

Deborah L. Simpson

David L. Gore

David L. Gore

Stephen J. Mathis

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0227

CARLTON, CHADRICK
Employee/Petitioner

Case# **13WC018872**
15WC022659

PEORIA PUBLIC SCHOOLS DISTRICT #150
Employer/Respondent

On 6/7/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.43% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1824 STRONG LAW OFFICES
TODD A STRONG
3100 N KNOXVILLE AVE
PEORIA, IL 61603

5354 STEPHEN P KELLY
ATTORNEY AT LAW
2710 N KNOXVILLE AVE
PEORIA, IL 61604

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

CHADRICK CARLTON,
Employee/Petitioner

v.

PEORIA PUBLIC SCHOOLS DISTRICT #150,
Employer/Respondent

Case # **13** WC **18872**

Consolidated cases: **15 WC 22659**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Peoria**, on **5/19/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **1/9/13 and 4/9/13**, Respondent ***was*** operating under and subject to the provisions of the Act.

On these dates, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On 1/9/13, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

On 4/9/13, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.

Timely notice of the accident on 1/9/13 ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is not*** causally related to the accidents on 1/9/13 or 4/9/13.

In the year preceding the injuries, Petitioner earned **$41,766.40**; the average weekly wage was **$803.20**.

On the date of accident, Petitioner was **31** years of age, ***single*** with **no** dependent children.

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

Respondent ***has or will*** pay all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$3,438.84** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$00.00** for other benefits, for a total credit of **$3,438.84**.

Respondent is entitled to a credit of under Section 8(j) of the Act for any medical expenses pursuant to this Section of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $535.47/week for 0 weeks, as provided in Section 8(b) of the Act, because petitioner was not temporarily totally disabled from 5/18/13 through 1/14/14.

Respondent shall pay reasonable and necessary medical services related to petitioner's right shoulder and thoracic back strain from 1/9/13 through 1/16/13, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive credit for any of these medical services that have already been paid.

Respondent shall pay Petitioner permanent partial disability benefits of $481.92/week for 0 weeks, because the injuries sustained caused the petitioner a 0% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Petitioner's Petition for Penalties is denied.

Petitioner's Motion to Strike Defenses is denied.

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

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

Signature of Arbitrator

6/2/16
Date

ICArbDec p. 2

JUN 7 - 2016

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 31 year old preventative maintenance technician, sustained an accidental injury to his cervical spine that arose out of and in the course of his employment by respondent on 1/9/13 (13 WC 18872), and alleges he sustained an accidental injury that arose out of and in the course of his employment by respondent on 4/9/13 (15 WC 22659). Petitioner started working of respondent in September of 2012.

Petitioner has a 10th grade education. He does not have a GED. Prior to working for respondent he worked in construction and performed farm work.

On 1/9/13 petitioner testified at trial that he was standing between the hood and the tire, fueling up one of the school buses. As another bus was trying to get around the bus he was working on it clipped the mirror of the bus he was working on and made the hood of the bus he was working on shake. Petitioner testified that he moved back as fast as he could by jumping over the tire, so that the hood of bus did not fall on him. Petitioner testified that he felt nothing for 45 minutes. Thereafter, he stated that his right shoulder starting hurting him.

He testified that after lunch he reported the injury to John Henry, his supervisor. He testified that he told Henry that his right shoulder was sore around the shoulder blade. Petitioner completed a safety sheet. An Illinois Form 45: Employer's First Report of Injury was completed for petitioner regarding an injury on 1/9/13 at 4:40pm. Petitioner wrote that while adding oil to bus #4, bus #22 came around pump and swiped the mirror on the hood of bus #4 while he was under the hood adding oil. Petitioner also wrote that he reported it to Lance. He noted that nothing struck him. He wrote "It sparred me and I jumped".

Petitioner presented to Proctor Care around 6:30 pm. He reported that he was under the hood of a bus and another bus hit the bus he was working under the hood on. He reported that he jumped when it happened. He reported pain in his right upper back. Petitioner reported that he was not struck, but believed he twisted his back. Petitioner was examined and assessed with thoracic back pain. He was prescribed Naproxin. Petitioner was released to full duty work without restrictions. Petitioner did not seek any further treatment until 4/11/13.

Between 1/9/13 and 4/9/13 petitioner testified that his right shoulder did not improve and his right arm was going numb to his fingers, which were tingling. He testified that he started getting more and more pain and weakness, and was working slower. He also testified that he had some headaches. Before 4/9/13 petitioner had some teeth pulled and was taking Vicodin for his teeth pain. He testified that he told Henry about it. Petitioner denied any other accidents during this period, and continued to work in respondent's bus barn. Petitioner testified that during this period he reported his ongoing problems to Henry and Darren, the union steward.

On 4/11/13 petitioner presented to IWIRC for evaluation of his right shoulder. Petitioner reported an injury on 1/9/13 at 6:30 pm. He testified that he was working under the hood of a bus and another bus hit his. Petitioner tried to get away and later noticed right shoulder pain. He rated his initial pain at 5/10, and his current pain was 1/10. He described his symptoms as dull aching pain with some pain radiating down his right arm.

Petitioner reported that 2 days ago he developed pain in the right upper back. He reported that he worked as a preventative maintenance worker on the buses. He reported that he was lifting and closing hoods and working under them all day. He reported that he developed pain and soreness in the upper right back and by the evening had moderate pain and left early. Petitioner took a Vicodin the night of 4/9/13 after work and the pain was much improved by the morning of 4/10/13. He only complained of mild soreness/tightness. He denied any specific job as the cause of his problems. He stated that he was just doing his job. He stated that the area that hurt him was the same area he hurt on 1/9/13. Petitioner reported that following the injury he had on 1/9/13, his pain resolved after about one week, and he had no problems until 2 days ago. Following an examination he was assessed with a thoracic strain. He was again given Naproxen. He was released to regular duty.

On 4/22/13 petitioner followed-up at IWIRC for his right shoulder. Petitioner reported that his symptoms were improved but he was still experiencing numbness in his right shoulder. He denied any pain and reported that he was not taking any medication for symptom relief. He reported that his upper back symptoms had resolved. Petitioner continued to report intermittent numbness in the posterior left arm that occurs with increased frequency. He reported that it had been occurring since the injury on 1/9/13. He denied any other radiating symptoms. Following an examination petitioner was assessed with a resolved right thoracic strain; and right arm numbness. Petitioner was unable to explain his symptoms as they relate to the injury described on 1/9/13 and 4/9/13. An MRI of the shoulder was ordered to assess for occult injury versus degenerative origin. Petitioner was continued on regular duty.

On 4/29/13 petitioner returned to IWIRC. Petitioner reported no change since last visit. He reported an episode where numbness/burning progressed into second right digit. He stated that he had no problems with his regular work duties, and his symptoms were more annoying than anything else. He stated that as the week progresses his right arm feels more tired. The cervical spine and right shoulder were examined. He was assessed with a resolved right thoracic strain, and right arm numbness. The nurse could not explain symptoms as they related to the injury described on 1/9/13 and 4/9/13.

On 5/6/13 petitioner returned to IWIRC after his MRI of the cervical spine that revealed a disk herniation at C6-C7 with nerve root. He was assessed with herniated cervical disc with right arm irritation. Petitioner was

given a Medrol Dose Pack. An EMG of the upper extremities was ordered, he was referred for a neurosurgery consultation, and was released to work with no use of the right arm above the shoulder height.

On 5/8/13 petitioner reviewed to IWIRC. He stated that his right arm still hurt with intermittent sharp, pulling pain and burning in his right forearm. He reported 2 hours of pain at an 8/10 the night before. He stated that it felt like a Charlie Horse. He reported increasing symptoms in the right arm, with burning pain in the arm starting the night before. Petitioner reported no relief with the Medrol Dose Pack. Petitioner was examined and assessed with a C6-C7 herniation with nerve root impingement. Petitioner was prescribed Vicodin and continued on Medrol Dose Pack. He was released to work on sedentary duty (sitting mostly with lifting up to 10 pounds occasionally; no above shoulder work; no commercial driving; and no safety sensitive duties).

By 5/13/13 petitioner reported to IWIRC that his symptoms had improved. However, he stated that if he moved around too much he has soreness and stiffness. His right arm pain was unchanged. He rated his current pain as 1/10, and noted that he was taking Vicodin. Petitioner stated that he sits 4 hours a shift and then walks around the lot for the rest of the time. Petitioner was examined and his assessment was unchanged. Petitioner was prescribed Mobic and Vicodin. He was released to work on sedentary duty (lifting up to 10 pounds occasionally, no above shoulder work, and no safety sensitive duties).

On 5/14/13 petitioner underwent an EMG/NCV of the his upper extremities. The assessment was right median neuropathy-mild to moderate, and right ulnar nerve entrapment of the cubital tunnel. No cervical radiculopathy was noted.

On 5/20/13 petitioner returned to IWIRC. He reported that his condition was unchanged. He rated his pain at a 6-7/10. He reported soreness and stiffness after moving around too much. Following an examination, petitioner was assessed with a C6-C7 disc herniation with nerve root impingement; right carpal tunnel syndrome and right cubital tunnel syndrome. Petitioner was referred to Dr. Mulconrey. Minimal bending and twisting of the back were added to his current restrictions. On 5/23/10 petitioner's medications were refilled.

By 5/28/13 petitioner reported that his symptoms had improved but he still had some bad days where he has soreness. He rated his pain at a 0/10. He stated that he has good days and bad days, and was doing very little activity. He reported loss of range of motion when the arm is numb. He stated that he was filing at work at chest level. An examination revealed good strength and FROM of arms bilaterally. His assessment and restrictions remained the same. On 6/4/10 petitioner reported that his symptoms had improved a little, but he still had tenderness and stiffness in his neck and shoulder area. He rated his pain at 3/10. Petitioner was examined and his assessment and restrictions remained the same.

On 6/9/13 petitioner presented to Dr. Daniel Mulconrey at Midwest Orthopaedic Center. His chief complaint was axial neck pain, upper extremity pain, numbness and weakness. Petitioner gave a history of working on a bus when he was struck by another bus and the hood struck him in the neck. He stated that since then he has had axial neck pain and upper extremity pain. He reported his pain at a 4/10. He complained of pain in the right upper back, forearm, upper arm and hand. Dr. Mulconrey was of the opinion that this was mainly in the C7 dermatomal distribution in the right upper extremity. He complained of moderate headaches. Following an examination and x-rays of the cervical spine; review of the EMG of the upper extremities that indicate petitioner had evidence of median and ulnar entrapment, which Dr. Mulconrey did not feel correlated with his current symptomatology; and review of the cervical MRI that indicated that petitioner had significant disc protrusion on the right at C6-C7, Dr. Mulconrey assessed disc displacement right C6-C7, right upper extremity radiculopathy, and failure of medical management. He discussed the possibility of surgical excision due to the fact that it had been 5 months and petitioner only had minimal improvement in his axial neck pain or upper extremity radiculopathy.

On 6/10/13 petitioner filed his Application for Adjustment of Claim with respect to 13 WC 18872 (DOA of 1/9/13). He alleged injuries to his neck, both arms and man as a whole, "injured when bus was struck in lot".

Petitioner continued to treat at IWIRC. On 6/11/13 petitioner reported that his symptoms included intermittent pulling pain in the right arm with some burning. He rated his pain at 2-7/10. Petitioner stated that he was not working due to his restrictions. He reported increased pain doing paperwork. On 6/25/13 he reported that he no longer had numbing sensations, but still had pain in the neck and right arm. He rated his pain at a 3/10. Physical therapy was ordered.

On 6/26/13 petitioner began a course of physical therapy at IWIRC. He gave a history of a neck strain in 1/13 when the bus he was working on was struck by another bus. He reported that he initially had paresthesias in the upper extremity that progressed to pain by 4/13. On 7/1/13 petitioner reported that his symptoms were unchanged. He reported ongoing central cervical pain and tightness. He complained of pain shooting down his right arm with any raising motion.

On 7/2/13 petitioner returned to IWIRC and reported that he was a little better. He reported increased pain with lifting his right side to the arm. He was still not working. Petitioner was given a Medrol Dose Pack. He was continued in physical therapy. On 7/5/13 petitioner reported that therapy was causing him right arm numbness. He stated that he was going to stop therapy. He also stated that the Medrol Dose Pack was not working. He reported that his neck was doing great and the numbness had dissipated. He also stated that his restrictions were lightened and he was going back to work. On 7/12/13 petitioner reported that his symptoms

had improved. He rated his pain at 2/10. He stated that he was back at work on the computer doing fine, but a little sore. He reported that he could not file because it is too painful for his shoulder.

On 7/8/13 Dr. Mulconrey drafted a letter stating that he was recommending an anterior cervical decompression and fusion at C6-C7 with instrumentation.

On 7/24/13 petitioner underwent a Section 12 examination by Dr. Andrew Zelby at the request of the respondent. Petitioner gave a history of adding oil to the school bus on 1/9/13 when another school bus clipped his bus. The hood of his bus started to move and he panicked, and jumped over the bus tire to get away from the hood. The hood never fell. He reported that he noticed right shoulder pain 30 minutes later. Petitioner reported that sometime in April 2013 he felt something else was going on because he developed numbness and tingling down the back of the right arm into the dorsal aspect of the forearm to the right second and third fingers. He stated that after 2 weeks of physical therapy he was a little better but as other exercises were added all his right arm symptoms returned. Following an examination and record review, Dr. Zelby's impression was cervical spondylosis, herniated cervical disc, and cervical radiculopathy. Dr. Zelby was of the opinion that petitioner's claim that his radicular symptoms in the right upper extremity that began in April of 2013 are causally related to his injury in January of 2013, is inconsistent with the natural history of a herniated cervical disc. Dr. Zelby opined that the onset of any radicular symptoms associated with his herniated disc would have typically began within 24-48 hours, and within 4-6 weeks at most. Dr. Zelby opined that petitioner' symptoms are related to his herniated C6-C7 disc, but his herniated C6-C7 disc is not related to any injury from January 2013, or any sequelae of that injury. He further opined that there is no medical evidence to even suggest that this condition that began in April 2013 was more likely to occur as a consequence of his injury in January of 2013. Dr. Zelby did not see findings suggestive of cubital or carpal tunnel. Dr. Zelby opined that petitioner sustained no permanent impairment from his work incident. Dr. Zelby opined that petitioner should not have an anterior cervical discectomy and fusion unless he stops smoking. Dr. Zelby opined that petitioner was at maximum medical improvement for his work injury prior to April 2013.

After the examination by Dr. Zelby respondent terminated petitioner's benefits.

On 8/6/13 petitioner presented to Dr. Kube at Prairie Spine & Pain Institute, at the request of his attorney. On his Intake Form petitioner reported that on 1/9/13 he hurt his shoulder in the scapular region. He stated that since April 2013 his problem worsened. He reported that his problem started with a bus accident at work. He reported that he was under the bus hood, and another bus hit his bus and he jumped out of the way and had pain within a half hour. Ne noted that his pain was mild. Following an examination and record review. Dr. Kube was of the opinion that petitioner has a cervical disk herniation and radiation. He believed petitioner was

initially misdiagnosed. He noted that he could see how a non-specialist could look at petitioner's condition and consider his periscapular pain as a shoulder disorder. However, pain in that region can often be shoulder or it can be cervical in nature. Dr. Kube was of the opinion that since the pain never resolved that disqualifies shoulder strain or muscle injury as the diagnosis as the pain should have resolved if that was the only issue. Since petitioner stated that his symptoms had continued consistently since January and there were no other intervening accidents and no history of any significant problems before that, Dr. Kube was of the opinion that petitioner probably herniated his C6-C7 disk at the time of the bus incident in January of 2013. He believed a decompression would be in order. However, he wanted to see the MRI films because he thought a cervical disc replacement may work due to the fact that there were no significant degenerative changes at C6-C7.

On 8/12/13 petitioner followed up with Dr. Kube. Dr. Kube had the chance to review all the images from the MRI of the cervical spine. Based on these films Dr. Kube was of the opinion that the films demonstrated a right sided C6-C7 disk herniation impinging the C7 root on the right side. He was of the opinion that the compression was significant. Based upon the absence of any kind of disc desiccation, Dr. Kube was of the opinion that this is an acute herniation that is consistent with the petitioner's history. He was also of the opinion that the herniation was directly caused by the incident petitioner described. He recommended a decompression and disk replacement.

On 8/8/13 petitioner filed a Motion to Strike the IME Opinion of Dr. Zelby. He also filed a Notice of Motion and Order for penalties under Sections 19(k) and 19(l) of the Act. Both Motions were to be heard before Arbitrator Fratianni on 10/15/13.

On 8/26/13 petitioner underwent a complete disk replacement at C6-C7, and decompression of C6-C7 performed by Dr. Kube. His post-operative diagnosis was right-sided herniated disc at C6-C7 with radiculopathy. Petitioner followed-up post-operatively with Dr. Kube. This treatment included a course of physical therapy.

On 11/6/13 petitioner filed a Notice of Motion and Order and Petition for Application of Issuance of Subpeona and Award of Attorneys' Fees pursuant to Section 16 of the Act, to be heard before Arbitrator Fratianni. Petitioner stated that he filed a subpoena for records from respondent regarding petitioner.

On 11/26/13 petitioner followed-up with Dr. Kube. He was doing really well, but continued to complain of pain when trying to raise his right arm out to the side.

On 12/6/13 Geri Hammer with Peoria Public Schools drafted a letter to petitioner re: work status. She wrote that petitioner was off work due to a non-work related injury since 7/31/13. Since that time he was

deemed ineligible for a FMLA leave because he did not meet FMLA's 12 month length of service requirement. Therefore, on 7/31/13 he became subject to the Board Policy 5:180 Temporary Illness or Temporary Incapacity. She noted that on 12/9/13 he would exhaust all leave available to him. She noted that as such, a recommendation would be made to the Board of Education to dismiss him from employment from Peoria Public Schools at their meeting on 12/16/13.

On 1/10/14 respondent's attorney sent petitioner's attorney a letter stating that petitioner was no longer an employee of respondent's. He requested petitioner's keys and uniform back.

On 1/23/14 petitioner filed a Notice of Motion and Order to Strike Defenses, or in the Alternate Motion to take a Negative Inference to be heard by Arbitrator Erbacci on 3/3/14.

On 1/10/14 petitioner underwent a Functional Capacity Evaluation to determine his present abilities and limitations. Petitioner's material handling abilities were occasional floor to waist 45#, waist to shoulder 30#, shoulder to overhead 22.5#, carry 27.5#, pushing 80#, pulling 81#; frequent floor to waist 22.5#, waist to shoulder 20#, shoulder to overhead 15#, carry 13.5#, pushing 40#, pulling 40.5#; and constant floor to waist 11.25#, waist to shoulder 10#, shoulder to overhead 7.5#, carry 6.75#. Non-material handling were occasional overhead reaching; frequent bending, reaching at head height or below, kneeling, and crawling; and constant sitting, standing, grip/fine motor, an climbing..

On 1/14/14 Dr. Kube restricted petitioner to Medium Activity per the Functional Capacity Evaluation. He was of the opinion that these restrictions are permanent. Petitioner had no further treatment with Dr. Kube.

On 7/7/14 the evidence deposition of Dr. Kube, a spine surgeon, was taken on behalf of the petitioner. Dr. Kube testified that petitioner told him that he had ongoing right shoulder blade region pain since the accident on 1/9/13. Dr. Kube reviewed the MRI of May 2013 and opined that petitioner's cervical disk herniation appeared acute rather than degenerative. Dr. Kube testified that within several months you would start to see degenerative stuff. Dr. Kube saw no problem with petitioner's reports that he had no radicular complaints until three months after the alleged work injury. Dr. Kube took petitioner off work on 8/26/13 and returned him to light duty work on 10/15/13. Dr. Kube testified that on 1/14/14 he placed petitioner at a physical demand level of medium activity. Dr. Kube was of the opinion that radicular pain going down the arm within the first few days following an injury is consistent with a cervical herniated disc. Dr. Kube opined that petitioner's cervical disc replacement was reasonable and necessary and causally related to the injury petitioner sustained in January of 2013. He further opined that petitioner's permanent restrictions are causally related to his injury in January 2013. Dr. Kube admitted that he did not review the records from IWIRC.

On cross-examination, Dr. Kube admitted that he did not know petitioner's exact job duties after 1/9/13. He also testified that he did not know any of petitioner's outside activities after 1/9/13. Dr. Kube admitted that when petitioner followed-up in October, November and December of 2013, a couple times he said he felt excellent and his pain level was very, very low. Dr. Kube testified that he knew of no other places petitioner worked other than for respondent. Dr. Kube admitted that he was not totally clear on the mechanism of injury as it pertains to how petitioner got out of the way when he thought the hood was going to fall. He also did not know if petitioner fell to the ground, or twisted his body. Dr. Kube agreed that petitioner's complaints appeared to change in April 2013. Dr. Kube agreed there was medical literature to support a finding that radicular symptoms would appear by 4-6 weeks following a herniated disk. Dr. Kube was of the opinion that if there are medical records that show petitioner had been examined, and was pain free in January or early February 2013, and stayed that way for months then that type of scenario could mean his condition of ill-being is not related to the work accident in January of 2013.

On 8/14/14 Bob Hammond, Vocational Consultant, issued a Vocational Report at the request of petitioner's attorney, after meeting with petitioner and reviewing the file information. Hammond noted that petitioner had been released to medium level work with occasional overhead and frequent posture activities. He was of the opinion that petitioner has skills with knowledge of mechanic parts, but will have reduced access to the labor market because of his weight limits and lack of education. Hammond noted that petitioner was looking into getting his GED, but this may take a significant amount of time. Because of petitioner's limits and lack of education, Hammond was of the opinion that petitioner would have a significant wage loss. He noted that petitioner earned $29.06 per hour at his previous position which he cannot perform, and will at best earn $9-$9.50/hr. Hammond opined that petitioner will have a significant wage loss for other positions in the area.

On 10/30/14 the evidence deposition of Bob Hammond, vocational consultant, was taken on behalf of respondent. Hammond testified that he reviewed some job logs but could not produce them or remember how many there were, but mentioned in his report that petitioner told him he applied for 50 to 60 jobs. Hammond was of the opinion that petitioner had a number of skills that would carry into other positions. He defined them as a skilled mechanic in gas and diesel engines. Hammond testified that petitioner's salary was $20.06 an hour, not the $29.06 per hour mentioned in his report. He opined petitioner was permanently and totally disabled from returning to his regular job because he cannot do overhead work and the job of a mechanic requires it. He opined that petitioner could not make more than $12 an hour now.

On cross examination Dr. Hammond testified that he never contacted respondent regarding this case. He also did not review the deposition of Dr. Kube; any more current FCEs; or any records after his FCE.

Hammond testified that petitioner called him and told him he was going to drive a grain truck for a farmer. He testified that petitioner told him he was not working when he interviewed him. Hammond agreed that raising deer can be more than a medium type work. He testified that petitioner told him he did not sell any deers when he interviewed him. Dr. Hammond was of the opinion that petitioner has deer hunted and that could at times exceed a medium level. Hammond testified that job logs do not tell him whether a client can work or not, just that they were looking for work. Dr. Hammond opined that petitioner's job for respondent did not fall within his permanent restrictions, but then admitted that he never reviewed petitioner's job description for respondent. He agreed that petitioner could work jobs that start between $14 and $15. Hammond admitted that he did perform a labor market survey or do any testing of petitioner.

On 11/14/14 petitioner underwent another Section 12 examination performed by Dr. Zelby at the request of the respondent. Dr. Zelby was of the opinion that petitioner's cervical range of motion was normal, except for a little diminished hyperextension. His Hoffman's, Spurling's, squatting, straight leg raise, toe walking, heel walking, gait, tandem gait, strength, sensation, and reflexes were normal. Dr. Zelby examined petitioner and reviewed additional medical records including Dr. Kube's surgical report and the FCE. He noted that petitioner noted definite improvement after the surgery. Dr. Zelby was of the opinion that petitioner was at maximum medical improvement and based on his examination could return to heavy physical labor without restrictions.

On 6/15/15 the evidence deposition of Dr. Zelby, a neurosurgeon, was taken on behalf of the respondent. Dr. Zelby opined that petitioner had cervical spondylosis, which is degeneration; a herniated cervical disk; and cervical radiculopathy. He recommended an anterior cervical diskectomy and fusion if he stopped smoking, or a microdiscectomy of right C6-C7. He had no problem with Dr. Kube's recommendation for a cervical disk replacement. Dr. Zelby opined that the cervical surgery recommendation is not causally related to the accident on 1/9/13 because at the time of the injury he reported right shoulder pain at the bottom of the right scapula, and it was not until 3 months later that he complained of pain radiating down the right upper extremity. He opined that this is inconsistent with the natural history of a herniated disk. He noted that petitioner noted a new set of symptoms in April of 2013 and based on the appearance of the disk herniation, the onset of radicular symptoms would typically begin within 24-48 hours, and certainly within 4-6 weeks. He opined that the symptoms in January of 2013 were on the right shoulder blade and were diagnosed as a thoracic strain and resolved. These symptoms were then replaced in April 2013 with radicular symptoms radiating down the arm. He opined these symptoms are consistent with a herniated disk that might have occurred in April of 2013. Dr. Zelby opined the symptoms are related to the herniated disk, but the herniated disk is not causally related to the January 2013 injury. Based on the IWIRC note from 4/11/13 Dr. Zelby was of the opinion that petitioner's symptoms

following the injury in January 2013 resolved within a week and he did not have any additional problems until 2 days before 4/11/13 without any injury.

On cross examination, Dr. Zelby opined that the FCE was an inaccurate representation of petitioner's abilities. Dr. Zelby opined that the surgery petitioner underwent for his cervical spine condition was reasonable and necessary, but not related to the injury in January 2013.Dr. Zelby did not believe petitioner sustained an accident on 4/9/11 that could account for his symptomatology as documented on 4/11/13 because petitioner reported that he did not know what brought on those symptoms, and that they just seemed to come on. Dr. Zelby opined that pain in the right upper scapular region and trapezius is not indicative symptomatology of a C6-C7 herniated disk.

On 7/9/15 petitioner's Application for Adjustment of Claim with respect to the alleged accident on 4/9/13. He alleged injuries to his neck, right arm and whole person. He described his accident as "lifting/closing hoods and working under them all day". Petitioner signed this Application on 6/30/15.

Currently, petitioner testified that any time he is overactive his right shoulder hurts and he gets headaches. He testified that he only takes over the counter medicine.

Petitioner testified that he underwent a self directed job search and got a job in September of 2014 with a farmer named John Meegan. He testified that he operates a tractor, and performs preventative maintenance on them. Petitioner testified that the farm is 18 miles from his home. Petitioner testified that he still works as a farm hand for $10/hour. He works 25-30 hours a week. Some weeks he works over 70 hours and some weeks works less than 15 hours a week. His duties include machinery work using a cultivator, chisel plow, one pass, aerator, and disc. He also works the combine and has climbed on the silo to line up the auger. Petitioner also does field work and helps with the harvest. Petitioner claims none of this work requires him to lift over 45 pounds.

Petitioner testified that he was trying to rehab himself and started his own business raising white tail deer. He raises and sells bucks for hunting. Petitioner testified that he sold some deer last year and this year. On cross examination he testified that he had this business in May of 2013. As part of this business he lifts animals and things weighing more than 45 pounds.

On cross-examination petitioner testified that the accident of 1/9/13 caused his problems, not the accident in April of 2013. Petitioner admitted that when he filled out the accident report for the 1/9/13 accident he had no neck complaints or radiating pain down his right arm. He only had shoulder complaints.

Petitioner testified that on 1/9/13 that he did not fall on the ground, and did not hit anything on the bus. Petitioner testified that he was standing parallel to the engine. When the mirror was hit he jumped over the tire to get out of the way. He stated that the tire was 3 feet high. After that he continued working until lunch.

Petitioner testified that he worked from 1/9/13 through 4/9/13 and reported no accidents or problems while working full duty. He admitted he sought no treatment during this period.

Petitioner testified that he went to IWIRC on 4/11/13 because of increased activities. He testified that he was doing farm work and was lifting more than 45 pounds. He stated that he was doing vigorous activity at home and this was aggravating his neck.

Petitioner testified that before the accident he worked for Wagenbacks as a farm hand, but not after his surgery.

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

The parties stipulate that petitioner sustained an accidental injury that arose out of and in the course of his employment by respondent on 1/9/13. However, although the petitioner alleges he sustained an accidental injury that arose out of and in the course of his employment by respondent on 4/9/13, the respondent disputes this claim. Respondent claims petitioner did not sustain an accidental injury that arose out of and in the course of his employment by respondent on 4/9/13.

With respect to the alleged accident on 4/9/13, petitioner did not report an injury on that date, and did not seek any treatment on that day. The first treatment petitioner had after 4/9/13 was his visit to IWIRC on 4/11/13. On that day petitioner presented for evaluation of his right shoulder. He reported that two days ago he developed pain in the right upper back. He did not report a specific incident occurring on 4/9/13. All he reported was lifting and closing hoods and working under them all day and developed soreness in the upper right back. He reported that he took Vicodin that night and was much improved the next morning. Petitioner had Vicodin as a result of having some teeth pulled.

On 6/9/13 petitioner presented to Dr. Molconrey and gave a history of a work injury on 1/9/13. He gave no history of a work accident on 4/9/13.

On 6/10/13, two months after the alleged injury of 4/9/13 petitioner filed an Application for Adjustment of Claim. However, the only accident date he put on it was the accident on 1/9/13. Petitioner made no reference to an injury on 4/9/13.

On 7/24/13 petitioner was evaluated by Dr. Zelby. He gave a detailed history of the accident on 1/9/13. With respect to the alleged injury on 4/9/13, he reported that sometime in April of 2013 he felt something else was going on because he developed numbness and tingling down the back of the right arm into the dorsal aspect of the forearm to the right second and third fingers.

On 8/6/13 petitioner presented to Dr. Kube. Again he reported a specific injury to his shoulder in the scapular area while at work in 1/9/13. All he said with regard to his alleged accident was that in April 2013 his problem worsened. Dr. Kube noted that petitioner's symptoms changed in April of 2013.

On 7/9/15, over two years after the alleged injury, and after the depositions of Dr. Kube and Dr. Zelby were taken, petitioner filed an Application for Adjustment of Claim for an injury on 4/9/13. He alleged that he injured himself lifting/closing hoods and working under them all day. He did not allege any specific incident occurring on 4/9/13.

Petitioner testified at trial that the accident on 1/9/13 caused his problems, not the accident in April of 2013. Petitioner also testified that he went to IWIRC on 4/11/13 because of increased activities. He testified that he was doing farm work and lifting more than 45 pounds. He also testified that he was doing vigorous activity at home and that was aggravating his neck.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that he sustained an accidental injury that arose out of and in the course of his employment by respondent on 4/9/13. The arbitrator bases this on the fact that at no time on or after 4/9/13 did the petitioner ever put forth a specific injury that occurred at work on 4/9/13. Additionally, the arbitrator finds it significant that petitioner had no injury report for this alleged injury like he did after the one on 1/9/13, and that he did not file an Application for Adjustment for Claim for this alleged injury two months after the alleged injury when he filed his Application for Adjustment of Claim for the accident on 1/9/13. The arbitrator finds it suspect that petitioner did not file any Application for Adjustment of Claim for an alleged injury on 4/9/13 until over two years later, and not until after the depositions of Dr. Kube and Dr. Zelby had been taken. Lastly, the arbitrator finds it very significant that at trial petitioner testified that when he went to IWIRC on 4/11/13 it was because of increased activities. He testified that he was doing farm work and lifting more than 45 pounds. He also testified that he was doing vigorous activity at home and this was aggravating his neck.

E. WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO RESPONDENT?

The parties stipulate that petitioner gave timely notice of the accident to the respondent with respect to the accident on 1/9/13. However, having found the petitioner has failed to prove by a preponderance of the credible evidence that he sustained an accidental injury that arose out of and in the course of his employment by respondent on 4/9/13, the arbitrator finds this issue moot as it relates to the alleged accident on 4/9/13.

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

Petitioner is alleging that his current condition of ill-being is causally related to the injury he sustained on 1/9/13. Respondent claims petitioner's current condition of ill-being is not causally related to the injury on 1/9/13.

Petitioner testified that following the injury on 1/9/13 he reported the same to his supervisor, John Henry. However, the Form 45 he completed on 1/9/13 states that he reported the injury to Lance. On that report petitioner noted that another bus swiped the mirror of the bus he was working on. He wrote that he injured his right shoulder. There is no mention of any neck pain. He noted that nothing struck him and "it sparred me and I jumped." When he presented to Proctor Care later that day he a gave a history of working under the hood of the bus when another bus hit his bus. He reported that he jumped back when it happened. He made no mention of jumping over a three foot tire to get out of the way. He only reported pain in right upper back. He stated that he was not struck, but believed he twisted his back. He was assessed with thoracic back pain. Petitioner did not seek any further treatment until he presented to IWIRC on 4/11/13.

Although petitioner testified that between 1/9/13 and 4/9/13 his right shoulder did not improve and his right arm was going numb to his fingers, which were tingling. He also testified that during this period he started getting more and more pain and weakness and was working slower. He also claimed he had some headaches.

Despite this testimony at trial, the arbitrator finds no credible evidence to support these claims. In fact, when petitioner presented to IWIRC on 4/11/13 he reported that following the injury he had on 1/9/13, his pain resolved after about one week and he had no problems until 2 days ago. He reported that he developed pain and soreness in his right upper back while opening and closing hoods and working under them all day. He did not report any specific incident occurring on 4/9/11. He was assessed with a thoracic spine sprain. The arbitrator finds it significant that despite these records, at trial, petitioner testified that when he went to IWIRC on 4/11/13 it was because of increased activities. He testified that he was doing farm work and lifting more than 45 pounds. He also testified that he was doing vigorous activity at home and this was aggravating his neck.

On 4/22/13 petitioner denied any pain and reported that he was not taking any medicine for symptom relief. He reported that his upper back symptoms had resolved. He was assessed with a resolved right thoracic strain and right arm numbness. On 4/29/13 he reported no change in his condition. He reported an isolated incident where numbness/burning progressed into his 2nd digit. His assessment remained unchanged.

Petitioner underwent an MRI of the cervical spine that revealed a disk herniation at C6-C7 with nerve root. Petitioner continued to complain of right arm pain. By 5/3/13 he reported that his symptoms had improved and he rated them at a 1/10. Around this time petitioner had his own business for raising white tail deer. Although petitioner was restricted to light duty at this time, he admitted that as part of this business he lifts animals and things weighing more than 45 pounds.

An EMG of the upper extremities performed 5/14/13 showed median neuropathy-mild to moderate, and right ulnar nerve root impingement, unrelated to the alleged injury. No cervical radiculopathy was noted. Based on the MRI and EMG petitioner was assessed with a C6-C7 disk herniation with nerve root impingement, right carpal tunnel and right cubital tunnel syndromes. On 5/28/13 petitioner rated his pain at a 0/10.

When petitioner presented to Dr. Mulconrey on 6/9/13, for the first time he provided a entirely different history of what occurred on 1/9/13. Petitioner reported that when he was working on a bus he was struck by another bus and the hood struck him in the neck. He reported that since 1/9/13 he has had axial neck pain and upper extremity pain. The arbitrator finds this history totally inconsistent with the credible medical records, and accident report most contemporaneous to the accident that provided a clearly different accident history. Based on this accident history to Dr. Mulconrey the arbitrator finds the petitioner less than credible.

On 6/11/13 petitioner reported that his pain was increased with doing paperwork for respondent, but admitted at trial that during this period he was raising white tail deer. On 7/5/13 petitioner reported that his neck was doing great and the numbness had dissipated.

When petitioner presented to Dr. Zelby, he gave a history of adding oil to the bus on 1/9/13 when another bus clipped his bus. For the first time he did not just state that he jumped back. Instead he elaborated a bit and stated that he jumped over the bus tire to get away from the hood. He then went on to state that he had right shoulder pain at that time. He reported no other problems until sometime in April of 2013 when he felt something else going on because he developed numbness and tingling down the back of the right arm into the dorsal aspect of the forearm to the right second and third fingers.

Dr. Zelby opined that petitioner's claim that his radicular symptoms in the right upper extremity that began in April of 2013 were causally related to his injury in January 2013, was inconsistent with the natural history of

a herniated cervical disk. He opined that the onset of any radicular symptoms associated with a herniated disk would typically begin within 24-48 hours, and no later than 6-8 weeks after the incident. The Arbitrator puts this timeframe no later than 3/8/13. He opined that there is no medical evidence to suggest that the cervical condition that began in April 2013 was more likely to occur as a consequence of his injury in January 2013.

Petitioner presented to Dr. Kube on 8/6/13. He reported that on 1/9/13 he hurt his shoulder in the scapular region and since April of 2013 his problem worsened. Dr. Kube was of the opinion that since the petitioner reported that his symptoms had continued consistently since January 2013, and there were no intervening accidents and no history of any significant problems before that, that petitioner probably herniated his C6-C7 disk at the time of the bus incident in January. The arbitrator finds the history petitioner provided Dr. Kube with respect to his symptoms continuing from 1/9/13 and 4/9/13 is unsupported by the credible medical record. As such, the arbitrator finds the opinions of Dr. Kube less than persuasive.

During his deposition Dr. Kube stated that reviewed the MRI of May 2013 and opined that petitioner's cervical disk herniation appeared acute rather than degenerative. Dr. Kube admitted that he did not review the records from IWIRC. He also admitted that he did not know petitioner's exact job duties after 1/9/13, or any of petitioner's outside activities after 1/9/13. Dr. Kube testified that he knew of no other places petitioner worked other than for respondent. Dr. Kube admitted that he was not totally clear on the mechanism of injury as it pertained to how petitioner got out of the way when he thought the hood was going to fall. He also did not know if petitioner fell to the ground, or twisted his body. Dr. Kube agreed that petitioner's complaints appeared to change in April 2013. Dr. Kube agreed there was medical literature to support a finding that radicular symptoms would appear by 4-6 weeks following a herniated disk. He was of the opinion that if there are medical records that show petitioner had been examined, and was pain free in January or early February 2013, and stayed that way for months then that type of scenario could mean his condition of ill-being is not related to the work accident in January of 2013. The arbitrator notes that the IWIRC records, which Dr. Kube did not review, clearly show that petitioner was pain free in late January of 2013, following the injury on 1/9/13.

Based on the above, as well as the credible evidence, it is clear that the credible records support a finding that as a result of the injury on 1/9/13 petitioner sustained a thoracic strain and right shoulder pain that essentially resolved after about one week. The arbitrator finds petitioner's claims that his problems continued to worsen between the injury on 1/9/13 and 4/9/13 to be totally unsupported by the credible record which includes his own history that the injuries he sustained on 1/9/13 resolved within a week of the incident. In further support of this finding the arbitrator finds petitioner sought no treatment between 1/10/13 and 4/10/13. Additionally, the arbitrator found the petitioner's histories to some of the healthcare providers less than credible

and unsupported by any credible medical evidence. The arbitrator also has significant concerns regarding the etiology of petitioner's neck symptoms especially given the fact that petitioner himself testified at trial that he went to IWIRC on 4/13/11 because of increased activity. He testified that he was doing farm work and vigorous activity at his home that was aggravating his neck.

The arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that his current condition of ill-being is causally related to the accident on 1/9/13. The arbitrator finds the petitioner sustained some right shoulder pain and thoracic pain for which he was prescribed Naproxin. Petitioner reported on 4/11/13 at IWIRC that following the injury on 1/9/13 his pain resolved after one week and he had no problems until 2 days ago.

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

Having found the petitioner's current condition of ill-being is not causally related to the injury petitioner sustained on 1/9/13, the arbitrator denies petitioner's claim for any medical expenses after 1/16/13, one week after the accident on 1/9/13.

Having found the petitioner had right shoulder pain following the injury on 1/9/13, and was diagnosed with a thoracic back strain, and sought no further treatment until 4/11/13, when he reported that following the injury on 1/9/13, his pain resolved after about one week, and he had no problems until 2 days ago, the arbitrator finds the respondent shall pay all reasonable and necessary medical expenses pursuant to Section 8(a) and 8.2, that are related to petitioner's right shoulder and thoracic spine through 4/16/13, the date petitioner reported that his pain related to the injury on 1/9/13 had resolved.

K. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

Petitioner claims he was temporarily totally disabled from 5/18/13 through 1/14/14. Having found the petitioner's cervical spine condition is not related to his injury on 1/9/13, and that petitioner had reached maximum medical improvement with respect to his injury on 1/9/13 by 1/16/13, the arbitrator finds the petitioner is not entitled to any temporary total disability benefits as a result of his cervical spine condition.

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

The arbitrator finds the petitioner sustained some right shoulder pain and thoracic back strain as a result of the injury on 1/9/13, and these conditions had resolved by 1/16/13 based on the petitioner's own history.

Having found the petitioner's current condition of ill-being is not related to the injury on 1/9/13, and petitioner was pain free with respect to the right shoulder and thoracic back strain he sustained on 1/9/13 by

1/16/13, the arbitrator finds the petitioner has not sustained any permanent disability. In support of this finding the arbitrator also relies on the opinion of Dr. Zelby that petitioner sustained no permanent impairment for his work incident.

M. SHOULD PENALTIES OR FEES BE IMPOSED UPON RESPONDENT?

On 8/8/13 petitioner filed a Motion for Penalties pursuant to Section 19(k) and 19(l) of the Act with respect to the accident on 1/9/13. The petitioner claims that there is a causal connection between petitioner's work injuries and the accident he had at the workplace, and the respondent has willfully and vexatiously refused to pay medical benefits, temporary total disability benefits, and future authorized medical treatment.

The arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that petitioner's current condition of ill-being as it relates to his complaints on 4/9/13 and after are causally related to the injury on 1/9/13 after 1/16/13 based on the credible medical records that show petitioner sustained right shoulder pain and thoracic strain pain as a result of the injury on 1/9/13, and these problems resolved by 1/16/13.

The petitioner's claim for penalties is denied.

O. MOTION TO STRIKE DEFENSES

Petitioner filed a Motion to Strike Defenses on 1/23/14. This Motion was to be heard by Arbitrator Erbacci on 3/3/14. On 3/3/14 this Motion was not ruled on by Arbitrator Erbacci. It is unclear whether or not this Motion was presented to Arbitrator Erbacci on this date. Petitioner's claim is that it sent a subpoena to respondent for specific records pertaining to petitioner, and respondent did not comply with the subpoena by 9/17/13. Therefore, the petitioner wants the arbitrator to make negative inferences based on petitioner's refusal to comply with the subpoena, or strike the respondent's defenses as to accident, causal connection, and medical expenses.

Although that the arbitrator has no authority to enforce a subpoena, the arbitrator can rule on a Notice and Motion of Order to transfer the matter to the Circuit Court for enforcement. The arbitrator notes the petitioner never filed such a Notice of Motion and Order, and as such did not take all steps available to it for having the respondent comply with their subpoena. As such, the arbitrator denies the petitioner's Motion to Strike Defenses.

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

Emilio Jauregui Salas,
Petitioner,

18IWCC0228

vs.

NO: 12 WC 26641

Dawn Martin Haught,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical, causal connection, notices, wages, wage rate, employer/employee relationship and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 27, 2017, is hereby affirmed and adopted.

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

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

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

DATED: APR 12 2018
o4/5/18
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0228

JAUREGUI SALAS, EMILIO
Employee/Petitioner

Case# 12WC026641

DAWN MARTIN HAUGHT
Employer/Respondent

On 2/27/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.67% 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:

3229 BRUNTON LAW OFFICES PC
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COLLINSVILLE, IL 62234

0286 SMITH AMUNDSEN LLC
LESLIE T JOHNSON
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CHICAGO, IL 60601

18IWCC0228

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

EMILIO JAUREGUI SALAS
Employee/Petitioner

v.

DAWN MARTIN HAUGHT
Employer/Respondent

Case # **12** WC **26641**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Collinsville**, on **January 25, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0228

FINDINGS

On **April 23, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did not*** exist between Petitioner and Respondent.

On the date of accident, Petitioner was **29** years of age, ***married*** with **1** dependent child.

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

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

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

ORDER

The Arbitrator finds that the Petitioner, based on the totality of the evidence, has failed to prove that an employee-employer relationship existed between the Petitioner and the Respondent on April 23, 2012.

No benefits are awarded.

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

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

Signature of Arbitrator

February 22, 2017
Date

FEB 27 2017

STATEMENT OF FACTS

The Petitioner testified that he has worked as a racehorse exerciser for seven years. While he regularly worked full time for Wildwood Stables in 2012, he testified that he also worked part time exercising horses for the Respondent, Ms. Haught. The Petitioner testified that he currently works for Fairmount Park racetrack exercising horses for a Dr. McClusky, and has for approximately 8 months. Exercising racehorses is done to keep them race fit, and involves follow the horse trainers' direct instructions, whether it's riding the horses, galloping or walking them.

Petitioner alleges that he was injured at Respondent's farm on 4/23/12. He testified he started working there a little more than a week prior to this. He testified on direct exam that Haught contacted him about exercising horses. On cross exam he testified that another exercise rider, his friend Maximino Cazares, worked for Respondent Haught and told Petitioner she was looking for help. He said he thereafter spoke to Respondent Haught at the Fairmount racetrack and started working for her that day or a day later.

Petitioner alleges that he was riding a horse at Respondent Haught's farm on 4/23/12 when the horse started bucking and he fell off the horse, injuring his left ring finger. He testified that Respondent Haught provided him with equipment and training instructions. He stated that he was coming out of the barn and was about 10 yards out when the incident occurred. He could not recall the name of the horse. Petitioner testified that Mr. Cazares was riding another horse right next to him when the accident occurred. He said that Respondent Haught was also at the property, and that she and Cazares went to him when he fell. As to Respondent Haught, Petitioner testified she was a few feet out of the barn and was watching him - "She saw it and she walked to me to see what happened". Petitioner then testified that Ms. Haught told him that he didn't need an ambulance but should seek medical care, and that she would pay for it.

Petitioner testified he initially sought treatment with a chiropractor (Beltline), and underwent x-rays. The 4/26/12 report of chiropractor Dr. Hack simply notes that the Petitioner reported that he "fell off a horse at work, went to the emergency room and was told he needed to go to the hospital and didn't take any x-rays." No records were submitted into evidence regarding an emergency room visit. Petitioner was diagnosed with a left ring finger fracture and was referred to Dr. McKee. Interestingly, the report is dated 4/26/12 while the only x-rays in Px1 are dated 6/6/12, and indicate an oblique fracture of the fourth proximal phalanx with multiple fragments, but minimal fracture displacement and that there were good signs of healing. This x-ray report was read by a chiropractor, who is noted as "Second Opinion." (Px1).

The initial 4/27/12 report of Dr. McKee indicates the right-handed Petitioner "was riding a horse and began to have a problem. He feels that the reins twisted in his hands and then he fell to the ground." An intake form that goes with the 4/27/12 x-ray report from Anderson Hospital notes "WW Stables" as Petitioner's employer, but that Petitioner was "Self pay". The report noted an oblique fracture of the fourth proximal phalanx with minimal displacement and no significant angulation. Dr. McKee indicated the fracture was rotated with a gap in the bone and some angulation, and Dr. McKee attempted a closed reduction, but the finger remained somewhat rotated. Dr. McKee told Petitioner he could leave it as is, and that it would heal with some rotational deformity and probably some joint stiffening, he could return in ten days to attempt another closed reduction with hope that it would stay reduced after it started healing, or he could opt for surgery. Petitioner wanted to think about it, Norco was prescribed and he was taken off work. (Px2 & Px3).

Petitioner ended up undergoing surgery with Dr. McKee on 5/3/12, and three screws were placed in his left ring finger, which remain in place. He was referred to physical therapy at Apex on 5/18/12, with Dr. McKee noting:

"He is self pay at this time and has agreed to try to get into therapy for a couple of visits. (Px2 & Px3). The Arbitrator notes that the hospital records related to the surgery (Px3) note the Petitioner twisted in the reins and then fell from a horse on 4/25/12.

The initial 5/24/12 report from Apex Physical Therapy indicates Petitioner spoke little English but was there with his wife who spoke better English. He reported he was riding a horse on 4/24/12 and twisted his ring finger with the reins, and that "he works on a horse farm in Caseyville". He reported going to the hospital the next day, then to a chiropractor and then to Dr. McKee. The report states: "He reports current his injury is not workers compensation, but plans to obtain a lawyer to make a claim." Petitioner reported he was not working with his employer at that time but was working at home. Petitioner testified that he could not afford any further visits at Apex after the first two, which is noted in the 5/31/12 Apex report. (Px5).

On 6/4/12, Dr. McKee noted significant stiffening of the finger, and while Petitioner was not doing his usual job, he was working and being very active with his hand. Petitioner last saw Dr. McKee on 6/25/12, noting Petitioner was doing therapy on his own and reported gradual improvement. He was advised to continue his own therapy and was discharged from care. (Px2). He hasn't treated for the finger since.

The Petitioner testified that at some point after surgery he handed his medical bills to Respondent Haught, but did not testify to a conversation. He indicated that he believed he never talked to her again after that, that she never contacted him and he "just stayed away". To his knowledge, other than what he himself paid, the bills remain outstanding.

Petitioner testified both that the horse trainers would tell exercisers like him exactly what to do with the horse, as well as that "we knew what to do". He testified that Respondent Haught told him which horses were to be exercised and the way she wanted it done, as she was the trainer. Each horse was different. Petitioner testified that he couldn't say for sure whether Respondent Haught stayed on the property or what she did after providing him with instructions. He would not stay at the Fairmount track for the races, as his job as an exerciser would be over by then. Racehorses have to be exercised to stay in shape to be able to run races, and Petitioner testified that the horse trainer decides what is to be done with each horse, and he would try to do what the trainer wanted. Each horse was different.

He had no written employment contract or agreement with Respondent Haught. He testified that she agreed to pay him $10 per exercised horse. Petitioner testified he was paid by Respondent only one time, in cash, after he got hurt. He couldn't say how much he received, but estimated that he had exercised over 20 horses for her, about 3 to 6 per day. Petitioner did not keep records of which horses he exercised or how many, he relied on Ms. Haught's count. Respondent never sent him any tax documents, while Wildwood Stables provided him with a W2 tax form yearly.

The Petitioner testified that in April 2012, the Respondent had about 19 racehorses being trained at the Fairmount racetrack, and another 10 to 20 of them at the Respondent's Caseyville farm. Petitioner testified that there was a small racetrack at the farm, and he would exercise her horses at both locations. The farm is about a mile and half from the Fairmont racetrack, and it would only take a few minutes to travel between them. He indicated he didn't know if Ms. Haught actually owned the horses or not, but that they were under her responsibility.

With regard to equipment, such as saddles, bridles, blinders, blinkers, etc., Petitioner testified Respondent Haught provided all this equipment, and that she would hand it to him. The only thing he would bring is his helmet, because it was sized to his head.

Petitioner testified he earned $570 per week working at Wildwood. Petitioner testified that after his surgery he went back to work at his regular job, initially performing one handed for less money. He testified his left ring finger remains stiff and he cant completely flex it, but otherwise reported no problems. He got used to accommodating the injury by using his other fingers.

On cross examination, Petitioner testified that the Fairmount racing season runs from March to September, and in April 2012 he was exercising horses full time at Wildwood. Horses are trained year round because they are often sent to race at other locations. At Wildwood, he would usually work from 7 a.m. until his work was completed, which he estimated would be two 2 hour periods with a break between. Wildwood also had a farm property, but Petitioner testified he would only work at that location a couple times every season, otherwise he worked for them at the racetrack. Petitioner agreed that he himself owned one or two racehorses in 2012. He believed that the trainer he used at that time was Lenny Brooks, not "Gabe". He agreed that he raced one of his horses in Ohio, and that sanctions were issued by the racing board for illegal substances being used with his horse, but that it was the trainer who was sanctioned, and he denied any personal involvement. The Petitioner denied injuring himself on 4/23/12 on his own horse.

Petitioner could not recall exactly how much Respondent Haught paid him, but that it was in cash and less than $300.00. He never received any tax form from her, and never claimed this as income on his own taxes. He testified that he did not deposit the money, he spent it.

Also on cross examination, Petitioner testified that he fell off the horse on 4/23/12 at Respondent's farm between noon and 1 p.m., and that Respondent Haught was at the farm when it happened. He testified that he didn't know if racing was going on at Fairmount at that time or not, but then indicated he believed racing started at 1:15 p.m. He would go to Respondent's farm after he was done with his full time job with Wildwood. Petitioner testified that he had been working for Respondent Haught for quite a few days before he got hurt, and that she was usually at the farm when he was there. He then indicated she would tell him exactly what to do, and she would then go and do other things, so he didn't know if she left or stayed at the farm. He stated: "You never know if she was around or wasn't around". He also appeared to testify that it wasn't always Respondent Haught that would tell him what to do. She would be at the Fairmount racetrack during training hours there, and then would go to the farm.

Maximino Cazares testified at the hearing via interpreter. He testified that he has worked at the Fairmount racetrack facility for about 16 years for different people, and currently works there as a horse exerciser for one person. He did the same job in the Chicago area for 7 years before that.

Mr. Cazares testified that he knows both Petitioner and Respondent Haught. He has worked with Petitioner at Fairmount and considers him a friend. He worked for Respondent Haught a long time ago, he believed for 2 to 3 or more years starting around 2008 or 2009, helping with grooming and exercising the racehorses. Mr. Cazares testified that he worked for Respondent both prior to and after Petitioner's injury, indicating he worked 4 to 5 hours per day from Monday through Saturday, and that during that time Respondent Haught was his only employer. He had no specific work hours, but testified he worked "full time" and considered himself her employee. Ms. Haught sometimes paid him in cash, sometimes by check. She did not provide him with any tax forms. Mr. Cazares testified that Respondent Haught would tell him which horses to exercise and what to do, and that she provided equipment like saddles and braces.

Mr. Cazares and Petitioner were working together at Respondent Haught's ranch on 4/23/12 when the Petitioner was injured. He testified the ranch was in Collinsville, close to the Fairmount racetrack. He noted it was in front

of a high school and contained stables and a small racetrack with "many" horses, and the house on the property was near the track. While riding out of the stables there side by side, the Petitioner's horse started standing on his hind legs, and he saw the Petitioner fall off. Mr. Cazares testified that the Petitioner was riding one of Respondent Haught's horses at the time. He said he continued on riding because he had to train his horse, and while he was worried about Petitioner, "that's our job". He testified that Respondent Haught and "Yani" (correct spelling unknown) came out to look for Petitioner when Petitioner's horse went back to the stable alone. He didn't know if Ms. Haught actually saw Petitioner fall, but he saw them talking after Petitioner got hurt, though he doesn't know what was said. He didn't see the Petitioner's finger until he was done exercising the horse, and saw that he couldn't move his hand.

Mr. Cazares indicated other people were present at Respondent's farm/ranch when the Petitioner fell, including Respondent Haught, but that he was the closest one to Petitioner. This included friends of him and the Petitioner who would saddle the horses for them. One was Yani (Sp.) Lopez, who lives in Troy, IL, and another was "Alberto". Mr. Cazares indicated that Respondent Haught did not hire or pay these people, but rather that he himself paid them $30 each and brought them so they could get the job done faster. Yani/Yoni lives in Troy, and Alberto went back to Mexico. He sees him (Yani/Yoni) in the mornings, as they still work together.

On cross examination, Mr. Cazares agreed that he "led horses out" at Fairmount racetrack for cash, and that he had done this before for Respondent Haught both at Fairmount and at her ranch. He received no tax records for this income. Mr. Cazares agreed he worked with Petitioner at Wildwood Farms, and he worked for a trainer there named "Scottie". Mr. Cazares was asked about whether he spoke to Respondent Haught about Petitioner telling him that Ms. Haught had turned Cazares in to either Fairmount security for something or to immigration. He did not recall having any such conversation with Petitioner or Haught. Respondent Haught always paid him for his work, and Cazares testified she did not owe him any money. He testified that he obtained his legal status three years before the hearing date.

Respondent Haught also testified at hearing. She owns and trains racehorses, including in 2012. She testified that she would hire people to do any activities that she couldn't do, such as shoeing, hay and sawdust deliveries, and farm equipment work. She also would send her horses to other states for training and breeding. However, Ms. Haught testified that in 2012 she did not have anyone helping her exercise her horses because she couldn't afford it.
The Fairmount racetrack is open all year, but they don't have racing all 12 months. In the downtime from January to March, it was open for training, and her horses would be there then, as well as during racing season through September. In winter months, she tries to stay at the farm and work with her young horses. She indicated that it is important to exercise race horses to prepare for races.

Ms. Haught testified that she learned Petitioner was hurt about a week after he was injured. She saw him with a bandage on his finger at the racetrack, and noted she laughed at him about a finger being bandaged up. She testified the Petitioner told her he injured himself while galloping one of Scotty Becker's horses and it stumbled really hard, noting Scotty is a trainer at Wildwood Stables that the Petitioner works for.

In April 2012, Respondent Haught testified that she had about 10 horses at Fairmount Park for conditioning and exercise. The horses at her farm at that time were not being exercised as the horses there were not in training. She testified that when Fairmount racetrack is open, she is there. The only time she is training her horses at the farm is around November and December.

In her experience, some horse exercisers want to saddle their own horse, others have trainer who have people do it. She testified that she keeps a training board and her own log at Fairmount so she can keep track of who is doing what with her horses, but does not keep such a board or log at the farm.

Ms. Haught testified that in 2012 her farm was located in Caseyville, Illinois, near two schools, and she indicated it was right across the street from Collinsville, Illinois. She denied that Petitioner ever worked for her on the farm exercising horses or doing any other type of work. To her knowledge, he worked for Wildwood and Scotty Becker for several years. For the most part, people know who works for whom at the racetrack.

Ms. Haught testified that she has known Mr. Cazares for over 20 years. She agreed he has taken horses to the paddock for her at Fairmount, or other "hit or miss" work, and she paid him in cash for it, but he otherwise did not work for her or work at her farm, and he was not her employee. She testified she has never even seen the Petitioner at her farm in her life. She testified she has no idea who Yani or Alberto are, and that to her knowledge they were not at her farm on 4/23/12.

Ms. Haught testified that she does hire out vendors and independent contractors to do work for her that she cannot do, and that Respondent's Exhibit 1 indicates everyone she paid in 2012. None of them were employees, as she has no employees. This included hay suppliers, horseshoers, and even her son (Chase Carter) whom she paid to train horses. Rx1 is her worksheet for her tax person. She agreed on cross examination that the list of people on Rx1 were the people she provided 1099's to in 2012 per her tax person's instructions. She testified that her tax person indicated she needed to provide 1099's to people she purchased hay from. The Arbitrator notes that at the top of this document it says: "1099" under the year 2012. She testified that if she would have paid Petitioner or Cazares, their names would have been indicated on this document. On cross examination, she agreed she brought Rx1, not her tax returns to the hearing with regard to whom she provided 1099's.

On cross examination, Ms. Haught denied that the Petitioner ever gave her medical bills or asked her to pay them. She did indicate that about a week after she first saw Petitioner with the bandage, he said something about hurting his finger on her horse. She told him he didn't know what he was talking about, and believed that was the last time she spoke to the Petitioner. She didn't know if he had already undergone surgery at that time. She reiterated that Petitioner initially indicated he was hurt on Scotty's horse.

Ms. Haught agreed that her feelings were hurt because Mr. Cazares said that Petitioner claimed that she turned Cazares into the police for something, and that he went to jail for several months as a result. She had known him and his family for many years.

Again on cross exam, Respondent Haught stated that she kept about 10 horses at Fairmount in 2012, and about 20 more at the farm/ranch. She had no employees to help her with horses that year. She agreed she has raced her horses in Indiana, and admitted a tax lien was filed against her there. She testified this was because she didn't understand she had to file a tax return in every state she ran horses in, and once she did so in Indiana the lien was "fixed". She got the lien fixed by filing Indiana taxes.

Noting that on direct she testified that Mr. Cazares had been at her farm, Ms. Haught explained that he worked with horses there for Carmelo Mendoza before she purchased the farm approximately 15 years ago. She testified that Cazares would not have had any reason to be there since then.

Petitioner submitted his claimed medical expenses as Petitioner's Exhibit 7, and they total $15,176.84. Petitioner testified that he paid the following out-of-pocket: 1) Dr. McKee ($50.00), 2) prescriptions from Dr. McKee ($53), 3) co-pays to Apex therapy, and 4) $1,100 plus for anesthesiologist. He submitted a copy of his

2012 W2 form from Wildwood Stables as Petitioner's Exhibit 11, indicating earnings of $29,399.89. This document does not indicate when or how many hours he worked for Wildwood in 2012.

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (B), WAS THERE AN EMPLOYEE-EMPLOYER RELATIONSHIP, THE ARBITRATOR FINDS AS FOLLOWS:

The Petitioner initially testified that he was contacted by Respondent Haught to do work for her. He then testified that Mr. Cazares told him she was seeking workers, and he then met with Haught at the racetrack.

The Arbitrator took the Petitioner's testimony of the incident to indicate that he injured his finger falling off a horse. Records from Dr. McKee and Anderson Hospital both reference that he got the finger caught in the reins.

Petitioner testified that he initially sought treatment with a chiropractor at Beltline. There are multiple records in evidence which indicate that the Petitioner initially sought treatment at the emergency room following his injury. The Arbitrator could not locate any records in evidence regarding such an ER visit. Instead, the initial medical report in evidence comes from a chiropractor, which seems to be a very unusual choice of medical provider for a finger dislocation / fracture injury.

The records of Anderson Hospital from both the time of his x-ray and his surgery indicate the Petitioner's employer was Wildwood Stables.

The first indication in the medical records that the Petitioner was injured in a particular location is in the records of Apex Physical Therapy. The initial report of 5/24/12 note the injury occurred at a horse farm in Caseyville. However, they also note that the Petitioner's wife was present, who spoke better English, and that this was not a workers' compensation matter, though the Petitioner was going to seek help from an attorney. The note also states he was working at home.

The Petitioner did not receive a paycheck or tax documents from the Respondent. The Petitioner testified he only worked for the Respondent for a very short time, and that after he was injured he was paid less than $300 in cash. He couldn't recall exactly how much, but he did not make any deposit and had no other proof of receipt of such funds.

Mr. Cazares' testimony was relatively consistent with that of the Petitioner. However, the Arbitrator notes that he is friends with Petitioner, and this testimony was not taken until almost 5 years after the alleged accident date. There is some evidence that Mr. Cazares may have had an ax to grind with Respondent Haught. This was based on the allegation that Petitioner told Mr. Cazares that Respondent Haught had turned him in in some fashion and ended up going to jail. Mr. Cazares denied this; Respondent Haught testified that this was the case and that the accusation hurt her feelings because she had known Mr. Cazares and his family for many years.

The Arbitrator notes that Mr. Cazares testified that when the Petitioner fell from his horse, that he himself stayed on his horse and continued riding, as that was his job. This also seems unusual to the Arbitrator, that he would be riding side by side with the Petitioner and, when Petitioner fell, that he wouldn't have stopped to see if he was okay.

Testimony was elicited from Mr. Cazares that another worker, "Yoni/Yani", was present at the Respondent's farm when the Petitioner fell, and that he went to the Petitioner with Respondent Haught. Mr. Cazares also testified that he was working with Yoni/Yani at the time of the hearing. However, the Petitioner did not call this witness to corroborate his allegations of being injured on Respondent's farm.

Respondent Haught denied that the Petitioner ever worked for her at her farm, or that the Petitioner had even ever been to her farm. While Petitioner testified to some details about the farm property, again, this testimony took place several years after the fact, allowing opportunity to view the land at any point in time with regard to the limited details provided about the farm. She testified that not only was there no need to exercise horse on her property in April, as the horses that needed exercise were kept at the racetrack, but also that she could not afford to pay exercisers in 2012.

Overall, the Arbitrator found aspects of Respondent Haught's testimony to also be somewhat suspect. It appears that the hiring of various personnel both at the track and at horse owner farms / ranches is somewhat loose. She also produced a document which purported to list all of the parties to whom she produced a 1099 tax form in 2012. The Petitioner's name was not on the document, but the names of people she bought hay from were, which also seems odd in that it is unclear why a 1099 would be needed for a transaction of goods. However, Respondent Haught testified she was told by her tax preparer that it was needed. At the same time, she did appear credible in describing what she indicated was the first time she saw Petitioner's finger injured and bandaged at the Fairmount racetrack.

The Arbitrator notes that the decision in this case was difficult, given issues with evidentiary accuracy and credibility on both sides, and inconsistencies with the stories that were painted on both sides. That said, the Petitioner bears the burden of proof under the law. This case has the feeling of a fifty/fifty belief in the credibility of both Petitioner and Respondent. The Petitioner, however, bears the burden of proof to establish an employment relationship with Martin. It is well-settled that the claimant has the burden to prove all elements in his case in order to recover benefits under Workers' Compensation; this burden of proof must be met by the preponderance of credible evidence and liability cannot be based on imagination, speculation or conjecture. *Illinois Bell Telephone Company v. Industrial Commission*, 265 Ill.App.3d 681, 638 N.E.2d 307 (1994). The Arbitrator believes that, taking all of the evidence as a whole, the Petitioner has failed to fulfill that burden of proof, and finds that the Petitioner as failed to prove an employer – employee relationship with the Respondent on 4/23/12.

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

Based on the Arbitrator's finding that the Petitioner failed to prove an employer – employee relationship between the Petitioner and Respondent on 4/23/12, this issue is moot.

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

Based on the Arbitrator's finding that the Petitioner failed to prove an employer – employee relationship between the Petitioner and Respondent on 4/23/12, this issue is moot.

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

Based on the Arbitrator's finding that the Petitioner failed to prove an employer – employee relationship between the Petitioner and Respondent on 4/23/12, this issue is moot.

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

Based on the Arbitrator's finding that the Petitioner failed to prove an employer – employee relationship between the Petitioner and Respondent on 4/23/12, this issue is moot.

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:

With regard to medical expenses, the Arbitrator notes that the Respondent's dispute is based on liability for medical expenses, not the reasonableness and necessity of the treatment itself. However, based on the Arbitrator's finding that the Petitioner failed to prove an employer – employee relationship between the Petitioner and Respondent on 4/23/12, this issue is moot.

WITH RESPECT TO ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's finding that the Petitioner failed to prove an employer – employee relationship between the Petitioner and Respondent on 4/23/12, this issue is moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Christopher Johnson,

Petitioner,

vs.

NO: 11 WC 41652 and
13 WC 23566

Greyhound,

18IWCC0229

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Petitioner herein and notice given to all parties, the Commission, after considering all issues, and being advised of the facts and law, modifies the Decision of the Arbitrator and finds Petitioner's diagnosis of contact dermatitis is causally related to the May 29, 2011, work accident. However, the Commission finds Petitioner's diagnosis of gastroenteritis is not causally related to either the May 29, 2011, or June 9, 2013, work accidents. As such, the Commission finds Respondent is only liable for reasonable and necessary medical bills and prospective medical treatment related to Petitioner's diagnosis of contact dermatitis. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Comm'n*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

FACTS

On October 28, 2011, Petitioner filed an Application for Adjustment of Claim in case 11 WC 41652 alleging a work accident exposed Petitioner to chemicals and human waste on May 29, 2011. Petitioner sought compensation pursuant to the Occupational Diseases Act. Petitioner filed an Application for Adjustment of Claim in case 13 WC 26566 on July 22, 2013, alleging a work accident exposed him to carbon monoxide on June 9, 2013. Petitioner sought compensation for this claim pursuant to the Workers' Compensation Act. The Commission notes that while both cases are consolidated and were in dispute during the April 4, 2016, hearing, the vast majority of the evidence, including the testimony, only addresses the May 29, 2011, work accident.

The parties do not dispute that Petitioner suffered an exposure to fluids and waste on May

18IWCC0229

29, 2011, following a waste tank spill at work. Petitioner testified some of the spilled contents came into contact with his right hand and leg. (Tr. at 16-18). In the days and months following the work accident, Petitioner experienced nausea, diarrhea, and a purple, itchy rash. *Id.* at 20-21. Petitioner testified that the rash continued to worsen and spread. *Id.* at 25. In August 2011, Petitioner's doctor suspected Petitioner suffered from contact dermatitis and recommended Petitioner visit a dermatologist. (PX 2). On November 29, 2012, a dermatologist examined Petitioner and noted a history of hand dermatitis beginning 18 months earlier. (PX 1). A December 2012 patch test revealed Petitioner was allergic to cobalt, nickel, carbamates, and thiuram. *Id.* On December 14, 2012, Dr. Mary Martini diagnosed dermatitis secondary to allergic contact dermatitis. *Id.* She wrote that Petitioner was "now able to return to work as long as he wear[s] industrial vinyl gloves at all times in the workplace." (PX 3).

Petitioner eventually returned to work with the recommended vinyl gloves and suffered additional exposures in January, March, and April 2013. (Tr. at 26-28; PX 4). Petitioner testified he missed work following an exposure in August 2013. (Tr. at 30). Petitioner sought treatment with Dr. Parikh on August 1, 2013, and complained of a periodic skin rash, upset stomach, and diarrhea. (PX 4). Petitioner told the doctor he had an allergic reaction after exposure to chemicals at work. Petitioner reported his reaction was in the form of a skin rash, nausea, vomiting, and diarrhea. *Id.* Dr. Parikh diagnosed allergic urticaria (hives) and dermatitis. On August 21, 2013, Petitioner returned to Dr. Parikh and reported symptoms since July 26, 2013. *Id.* Petitioner continued to follow up periodically with Dr. Parikh during the fall of 2013 through the spring of 2014. *Id.* Dr. Parikh continued to note Petitioner's history of contact dermatitis and allergic gastritis as well as the presence of a rash during various visits. *Id.*

Petitioner testified that he no longer seeks treatment for every allergic reaction. (Tr. at 34). Petitioner testified that he continued to seek treatment throughout 2015 and continues to suffer an allergic reaction when he comes into contact with the allergens identified in the December 2012 patch test. *Id.* at 33. The Commission notes Petitioner did not submit medical records that show ongoing treatment relating to his reaction to either cobalt, nickel, carbamates, and thiuram. The medical records show Petitioner developed a rash on his legs, arms, and face in April 2015 due to an allergic reaction to insecticide. (PX 4). Petitioner also received treatment at an ER in July 2015 for a rash attributed to a reaction to bug bites. (PX 2).

Expert Medical Reports and Testimony

Dr. Shirley Conibear – Petitioner IME

Dr. Conibear wrote a June 4, 2014, narrative report after conducting a review of Petitioner's medical records at Petitioner's request. (PX 9). Dr. Conibear opined that Petitioner suffered from allergic contact dermatitis and gastroenteritis. She further opined that Petitioner's May 29, 2011, work accident caused his allergic contact dermatitis. *Id.* Dr. Conibear noted that Dr. Martini opined the May 29, 2011, work accident may have caused Petitioner's allergic reaction. Dr. Conibear stated that while there is no documentation that cobalt, nickel, carbamates, or thiuram were present in the liquid that spilled onto Petitioner, it is "well documented[] that carbamates and thiuram are frequently present in rubber and natural rubber latex gloves" and in "many industrial and non-industrial products." *Id.* She opined that Petitioner's gastroenteritis

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was also initially attributable to the May 29, 2011, work accident based on the timing of his symptoms; however, she concluded the causal link stopped as of August 4, 2011. Dr. Conibear opined that subsequent complaints of gastroenteritis were most likely attributable to Petitioner's use of antibiotics for dental work. She determined that Petitioner required no further treatment and could return to work full duty using the appropriate protective equipment. *Id.*

On February 23, 2016, Dr. Conibear authored an addendum to her June 4, 2014, narrative report. (PX 10). In the addendum, the doctor states she received a letter from Petitioner's counsel as well as medical records regarding care Petitioner received from Drs. Martini and Parikh. After reviewing the attorney's letter and the included medical records, Dr. Conibear stated the medical records show Petitioner had repeat "episodes of improved skin condition after removal from work and reoccurrence with return to work while wearing 'thick vinyl gloves free of known allergens.'" *Id.* Dr. Conibear concluded Petitioner's use of thick vinyl gloves free from known allergens had not prevented further episodes of contact dermatitis; thus, Petitioner must work in an environment where he has no exposure to the noted allergens. *Id.*

The doctor testified via evidence deposition on February 26, 2016. (PX11). Dr. Conibear reiterated the opinions explained in her narrative report and addendum, including her opinion that Petitioner suffered from allergic contact dermatitis. She testified that contact dermatitis is a permanent condition. Dr. Conibear testified that the records she reviewed prior to her February 23, 2016, addendum were the same records she reviewed before writing her June 4, 2014, narrative. *Id.* at 19. On cross-examination, Dr. Conibear testified that she received information regarding Petitioner's condition after September 2013 from the February 11, 2016, letter she received from Petitioner's counsel. *Id.* at 21. She did not review any medical records of any treatment Petitioner may have received after September 2013.

Dr. Andrew Scheman – Respondent IME

Dr. Scheman performed a Section 12 examination of Petitioner on September 22, 2015. (RX 1 at Exh. 2). After examining Petitioner, taking his history, and reviewing the medical records, Dr. Scheman opined that Petitioner had contact allergies that may or may not have been caused by his May 29, 2011, workplace accident. *Id.* He noted Petitioner did not have active dermatitis on the date of his examination. Although Dr. Scheman opined that it was impossible to determine the cause of Petitioner's allergies, he noted Petitioner's lack of prior complaints supports a finding of causation. *Id.* Dr. Scheman concluded Petitioner will require treatment for future flare-ups of his dermatitis. The doctor opined a 1% hydrocortisone cream would be sufficient to control any future flare-ups. *Id.* Dr. Scheman determined Petitioner should restrict exposure to metals containing nickel or cobalt. *Id.* He also concluded Petitioner should avoid contact at work to rubber which may contain carbamates or thiurams. Dr. Scheman advised Petitioner to wear vinyl gloves at work as Dr. Martini recommended in December 2012. *Id.*

Dr. Scheman testified via evidence deposition on February 10, 2016. (RX 1). Dr. Scheman testified that Petitioner's work accident likely caused the outbreak that immediately followed the accident, given the timing and the fact that Petitioner's rubber gloves could have triggered the rubber-allergy breakout. *Id.* at 23-24. The doctor further testified that any attribution of later episodes to the May 2011 accident would depend on the accuracy of

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Petitioner's history that he had not suffered allergic reactions prior to the accident. *Id.* at 24-25. He testified that Petitioner could work without restriction if he wore the proper gloves. *Id.* at 26. Dr. Scheman further testified that, even if Petitioner suffered outbreaks (for work-related allergens or other allergens) while wearing gloves, he could continue to work as his symptoms would only involve skin issues. *Id.* at 47.

Dr. Jerrold Leikin – Respondent IME

Dr. Leikin performed a Section 12 examination on April 10, 2013. (RX 12). Dr. Leikin also produced an addendum to his April report October 29, 2013 addendum. *Id.* After examining Petitioner, reviewing his history, and reviewing the medical records, Dr. Leikin concluded that Petitioner's May 2011 work accident likely caused his immediate rash; however, the doctor did not believe the work accident caused Petitioner's continuing condition. *Id.* He also concluded that Petitioner's gastroenteritis was not related to his accident. Dr. Leikin wrote that Petitioner may require further treatment in the form of creams and avoidance of certain materials. In his addendum, Dr. Leikin opined that he would have expected Petitioner's work-related condition to resolve within three to four months. *Id.*

Vocational Rehabilitation

Petitioner admitted that he has not sought any alternative work. (Tr. at 37). Petitioner testified he has not sought work because he does not know what jobs would allow him to avoid his allergens. *Id.* Petitioner testified that he has a high school education with no certifications, and his work history includes apartment complex maintenance. *Id.*

Edward Pagella, Petitioner's vocational expert, produced a December 1, 2015, vocational report after reviewing Petitioner's medical records and interviewing Petitioner. (PX 12). Pagella opined that in light of Petitioner's allergies, there is "no occupation that he would be capable of performing." In his addendum, Pagella acknowledged the medical recommendation that Petitioner use vinyl gloves while working and avoid certain allergens. (PX 13). He opined that if Petitioner complied with that recommendation, he would require vocational placement services to help identify a proper job. *Id.* Pagella noted that the gloves could not with certainty forestall all exposures. He was skeptical that Petitioner could find an appropriate placement. *Id.* Pagella's opinions relied particularly on Dr. Conibear's opinions. (Tr. at 74, 77, 83-84).

Tytiana Brown, Respondent's vocational expert, produced a vocational assessment of Petitioner dated March 1, 2016. (RX 8). Brown detailed Petitioner's refusal to meet with her (Petitioner cited concerns about allergens despite her offers to find a safe location, and his attorney cited an acute reaction that prevented Petitioner from joining a conference call). *Id.* Brown opined that Petitioner could return to work using protective measures described by physicians. She recommended proceeding with further vocational services with a goal of finding a placement for Petitioner, and in a transferable skills analysis she identified several low-skill jobs he could perform to earn a wage comparable to the wage Respondent paid Petitioner. *Id.* During the hearing, Brown testified that Petitioner would be able to apply for these jobs without the assistance of a vocational counselor. (Tr. at 116-17). Those jobs included receptionist, telephone solicitor, reservations agent, data entry clerk, and advertising material distributor. *Id.*

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at 115.

FINDINGS

Petitioner bears the burden of proving each element of his case by a preponderance of the evidence. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 203 (2003). A claimant alleging an occupational disease must prove that he suffers from an occupational disease and that a causal connection exists between the disease and his employment. *Omron Elecs. v. Ill. Workers' Comp. Comm'n*, 2014 IL App (1st) 130766WC, 36. After carefully reviewing all the evidence, the Commission finds Petitioner proved by a preponderance of the evidence that his current condition of ill-being, relating solely to his diagnosis of contact dermatitis, is causally related to the May 29, 2011, work accident.

The Commission finds the Arbitrator applied an inappropriate burden of proof when considering Petitioner's claims. The Arbitrator denied causation because Petitioner presented no "definitive medical evidence establishing a causal connection." Relevant case law explicitly rejects this heightened burden of proof. The language of the Occupational Diseases Act does not require Petitioner to present proof of a direct causal connection. *Id.* at 38. "A causal connection may be based on a medical expert's opinion that an accident 'could have' or 'might have' caused an injury." *Id.* (quoting *Consol. Coal Co. v. Indus. Comm'n*, 265 Ill. App. 3d 830, 839 (1994)). Additionally, "a chain of events suggesting a causal connection may suffice to prove causation even if the etiology of the disease is unknown." *Id.*

The totality of the evidence clearly supports a finding of causal connection between the May 2011 work accident and Petitioner's contact dermatitis. Petitioner testified that he never suffered from any symptoms prior to the work accident. There is no evidence refuting Petitioner's testimony. In fact, the medical records show Petitioner began to suffer skin problems immediately after the work accident. The Commission finds the opinions of Dr. Conibear, Petitioner's expert, lack credibility. Dr. Conibear never examined Petitioner and in the absence of receiving additional medical records was unable to give a credible reason for her sudden change of opinion regarding Petitioner's work capabilities. Despite Dr. Conibear's less than credible expert opinion, Petitioner still proved a causal connection between his chronic contact dermatitis and the May 2011 work injury. After all, Respondent's expert, Dr. Scheman, opined the waste spill most likely caused Petitioner's condition immediately after the work accident. Dr. Scheman notably opined that he could only attribute Petitioner's chronic condition to the work accident if Petitioner had no prior symptoms. Furthermore, the experts acknowledge that it is impossible to know whether the contents of the waste tank contained cobalt, nickel, carbamates, and thiuram. The Commission finds at the very least, the chain of events provides ample evidence to support a finding that Petitioner's chronic contact dermatitis is causally related to the May 2011 work accident.

After carefully reviewing the evidence, the Commission finds Petitioner's diagnosis of gastroenteritis is unrelated to the May 2011 work accident. The Commission notes that both Dr. Scheman and Dr. Conibear agree that Petitioner's current condition of gastroenteritis is not related to the work accident. Dr. Scheman credibly testified that there is no relationship between gastrointestinal issues and Petitioner's chronic allergic reactions. Likewise, even Dr. Conibear opined that any connection between the May 2011 work accident and Petitioner's gastroenteritis

ceased as of August 4, 2011. The Commission also notes that Petitioner suffered a work accident on June 9, 2013, during which he was exposed to carbon monoxide. After a careful review of the evidence, the Commission finds Petitioner's current condition of ill-being, particularly his gastroenteritis, is not related to the June 9, 2013, work accident.

As the Commission reverses the Arbitrator's causal connection decision, the Commission must also reverse the Arbitrator's denial of past and prospective medical benefits. Petitioner shall receive all reasonable and necessary medical care causally related only to his contact dermatitis. The Arbitrator noted that many of the submitted medical bills are not supported by corroborating medical records. Additionally, Petitioner may have submitted bills that include charges for care unrelated to Petitioner's chronic dermatitis. The Commission finds Respondent is liable only for reasonable and necessary medical care causally related to Petitioner's contact dermatitis. Furthermore, Respondent is only responsible for such charges supported by the submitted medical records. The Commission further finds that Respondent is entitled to a credit for any reasonable, necessary, and related medical expenses paid by its group insurer, Cigna, pursuant to §8(j). Finally, Petitioner is entitled to reasonable and necessary prospective medical treatment related to his diagnosis of contact dermatitis as Dr. Scheman opined that Petitioner will continue to have mild flare-ups from time-to-time.

The Commission affirms the Arbitrator's denial of penalties and fees in this matter. Although the Commission has determined that Petitioner met his burden of proving his current condition of ill-being relating to his contact dermatitis is causally related to the May 2011 work accident, the Commission finds Respondent did not deny benefits unreasonably or without good cause. Respondent reasonably relied on Dr. Scheman's expert opinion regarding causation, ongoing medical care, and work capabilities to deny ongoing treatment and benefits. An award of penalties and fees pursuant to §§16, 19(k), and 19(l) of the Act is allowable only when the evidence supports a finding that Respondent's denial of benefits is unreasonable, vexatious, or without good cause.

Petitioner did not seek additional TTD or TPD benefits relating to either case. Instead, Petitioner sought maintenance benefits from October 15, 2015 through April 4, 2016. Petitioner also sought vocational rehabilitation. The Commission agrees with the Arbitrator's conclusion that Petitioner did not meet his burden of proving an entitlement to any maintenance benefits. The Commission also agrees with the Arbitrator's finding that Petitioner failed to meet his burden of proving he is only able to work in an environment completely free of nickel, cobalt, carbamates, and thiuram as a result of the May 29, 2011, work accident. Petitioner also failed to prove vocational rehabilitation is warranted as the Commission finds Petitioner's only work restriction relating to the May 29, 2011, work accident is the requirement that Petitioner wear the appropriate vinyl gloves.

Finally, on December 1, 2017, Petitioner filed a Motion for Leave to File a Supplemental Brief Instanter. Petitioner then filed his Supplemental Brief in Support of Petitioner's Statement of Exceptions / Additions and Supporting Brief on December 21, 2017, without the Commission's consent. Both parties appeared before Commissioner Thomas J. Tyrrell on January 17, 2018. After hearing all arguments, Commissioner Tyrrell denied Petitioner's December 1, 2017, motion. As such, the Commission strikes Petitioner's Supplemental Brief in Support of Petitioner's Statement

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of Exceptions / Additions and Supporting Brief from the record.

The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated August 1, 2016, is modified as stated herein.

IT IS FURTHER ORDERED that Petitioner's current condition of ill-being relating to his contact dermatitis is causally related to the May 29, 2011, work accident. Petitioner's gastroenteritis is causally related to neither the May 29, 2011, work accident nor the June 9, 2013, work accident.

IT IS FURTHER ORDERED that Respondent shall receive credit for $38,153.07 in TTD benefits, $357.43 in TPD benefits, and $3,002.40 in previously paid medical bills. Petitioner shall receive no further temporary disability benefits.

IT IS FURTHER ORDERED that Respondent is not liable for any maintenance benefits or vocational rehabilitation services as Petitioner did not meet his burden of proof regarding his request for maintenance benefits and ongoing vocational rehabilitation.

IT IS FURTHER ORDERED that Respondent shall pay reasonable and necessary medical charges that relate only to treatment for Petitioner's contact dermatitis, as provided in Sections 8(a) and 8.2 of the Act. Respondent is only liable for such charges supported by the submitted medical records. Respondent shall receive credit for all related bills paid by its group insurer, Cigna.

IT IS FURTHER ORDERED that Respondent shall pay for reasonable and necessary prospective medical services relating to Petitioner's contact dermatitis.

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

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

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Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $5,000.00. 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: APR 13 2018

o: 2/20/2018
TJT/jds
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Thomas J. Tyrrell

Michael J. Brennan

DISSENT

While I concur with the Majority's ruling regarding Petitioner's supplemental brief, I respectfully dissent from all other aspects of the Majority's opinion and would affirm and adopt the Arbitrators decision in its entirety and without modification.

Kevin W. Lamborn

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

JOHNSON, CHRISTOPHER
Employee/Petitioner

Case# **11WC041652**

13WC023566

GREYHOUND
Employer/Respondent

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On 8/1/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.42% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1505 SLAVIN & SLAVIN LLC
KATHARINE BARNES
100 N LASALLE ST 25TH FL
CHICAGO, IL 60603

1120 BRADY CONNOLLY & MASUDA PC
VALERIE PEILER
ONE N LASALLE ST SUITE 900
CHICAGO, IL 60602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

CHRISTOPHER JOHNSON
Employee/Petitioner

v.

GREYHOUND
Employer/Respondent

Case # **11** WC **41652**

Consolidated cases: **13 WC 23566**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **DOUGLAS S. STEFFENSON**, Arbitrator of the Commission, in the city of **CHICAGO**, on **APRIL 4, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **5/29/11**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$21,048.56**; the average weekly wage was **$404.78**.

On the date of accident, Petitioner was **49** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of **$38,153.07** for TTD and maintenance, **$357.43** for TPD, and **$3,002.40** for other benefits, for a total credit of **$41,512.90**.

Respondent is entitled to a credit under Section 8(j) of the Act pursuant to Respondent's Exhibit 4.

ORDER

As the Petitioner's current condition of ill-being is not causally related to his May 29, 2011 work accident, benefits are denied.

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

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

Signature of Arbitrator

JULY 29, 2016
Date

ICArbDec19(b)

AUG 1 - 2016

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CHRISTOPHER JOHNSON v. GREYHOUND

11 WC 41652 & 13 WC 23566

FINDINGS OF FACT AND CONCLUSIONS OF LAW

INTRODUCTION

This matter was tried on a Section 19(b) Petition before Arbitrator Steffenson in Chicago on April 4, 2016. The issues in dispute were causal connection, medical services, prospective medical care, temporary benefits, penalties and attorney's fees, and vocational rehabilitation.

FINDINGS OF FACT

The Petitioner, Christopher Johnson, testified that on May 29, 2011 he was employed with the Respondent, Greyhound, as a service worker. (Transcript at 17). The Petitioner further stated that his job duties as of May 29, 2011 included fueling, detailing the buses and dumping the waste tank. (Transcript (*hereinafter*, T.) at 17). The Petitioner testified that on May 29, 2011 he was involved in a work accident when he was emptying the waste tank. (T. at 18). He described the accident as he was dumping the waste tank, the "dumbbell" came apart and splashed his hand and leg and soaked through his pants. (T. at 18). He stated that following the accident he was nervous and immediately went to the washroom because the substance that splashed him was toxic waste. (*Id.*). The Petitioner testified that the day following the accident he felt dizzy and was nauseous. (T. at 19).

After experiencing these symptoms, the Petitioner went to Metro South Emergency Room where he was diagnosed with dehydration. According to the Petitioner, he appreciated red spots on his right hand, where he was splashed at work. (T. at 19). He further stated that

he followed up with Dr. Parikh on June 1, 2011 and was prescribed medication. (T. at 20). Once he returned to work on June 15, 2011, his symptoms were still persistent and included nausea, vomiting, diarrhea, and rash. (T. at 20). The rash was described as purple with different colors, including pink, and was very itchy. (T. at 21).

Following the increase in symptoms, the Petitioner sought treatment at Concentra Medical Center with Dr. Jucas, a dermatologist. (T. at 22). Dr. Jucas diagnosed the Petitioner with contact dermatitis on October 7, 2011. (T. at 23). On November 29, 2012 the Petitioner presented to Northwestern at the direction of Dr. Jucas for a patch test to be performed by Dr. Martini. The patch test revealed the Petitioner was allergic to cobalt, nickel, carbamates and thiuram. (T. at 25). The Petitioner was given work restrictions to wear heavy duty vinyl gloves upon returning to his normal job duties. (T. at 26). Following additional exposures, the Petitioner began having symptoms on his face and head. (T. at 27).

The Petitioner testified that he was exposed to carbon monoxide on June 9, 2013, after which he was kept off of work until July 1, 2013. (T. at 29- 30). Following additional exposures, the Petitioner was given work restrictions stating he needed to avoid cobalt, nickel, carbamates and thiuram. (T. at 31). The Petitioner further stated that he was unable to return to work due to these restrictions and the inability to work at Greyhound without coming into contact with these elements. (T. at 31-32).

The Petitioner testified he now does not seek treatment when having a reaction, but instead just tries to "deal with it" and use medications and creams. (T. at 34). The Petitioner further testified that he received maintenance benefits from Greyhound until October 15, 2015. (T. at 35). The Petitioner indicated he has not looked for alternative work due to being allergic

to so many things. (T. at 36). The Petitioner noted his highest level of education was high school and that he does not possess any special certifications that are currently valid. The Petitioner applied for Social Security disability after total temporary total disability benefits from the Respondent were terminated. (T. at 52).

On cross-examination, the Petitioner testified that Dr. Parikh has been his family physician for some time and also treats him for gastritis. (T. at 38). The Petitioner indicated he only saw Dr. Martini on one occasion, when he was diagnosed as being allergic to cobalt, nickel, thiuram and carbamates. (T. at 41). When questioned about allergic reaction in March of 2013, the Petitioner stated he did not seek medical treatment that time despite the fact that the rash was all over his body. (T. at 42). Instead, he applied ointment and took Benadryl. (T. at 43). The Petitioner further testified that he also sought treatment at Metro South for his allergic reactions. (T. at 44).

The Petitioner indicated he met with Mr. Pagella regarding his ability to return to work. (T. at 46). When asked about his ability to take Metra in terms of searching for a job, the Petitioner testified that he was able to take CTA and Metra. (T. at 47). He further testified that he does have a cell phone where prospective employers could contact him. (T. at 47). The Petitioner admitted no doctor has ever stated he could not work again. (T. at 48). The Petitioner acknowledged he has not looked for work since he stopped working for Greyhound. (T. at 48). The Petitioner also agreed he was examined by Dr. Scheman at the request of the Respondent, but was unaware of Dr. Scheman's opinions about his ability to return to work. (T. at 50).

The Respondent then presented Mr. David Ortega as a trial witness. Mr. Ortega stated he worked for Greyhound Lines in a senior management capacity in relation to the Petitioner. (T. at 141). He further testified being made aware of the Petitioner's restrictions and need for vinyl gloves. (T. at 142). He indicated the Respondent did procure these gloves and it was understood that the Petitioner would continue to wear them so long as he worked for Greyhound. On cross-examination, Mr. Ortega testified the Petitioner, after returning to work and using the recommended vinyl gloves, suffered subsequent reactions and exposures. (T. at 144).

The Petitioner's Medical Treatment

The Petitioner's family physician, Dr. Parikh, treated the Petitioner for dermatitis on several occasions and from several locations. (Petitioner's Exhibits 2 and 4). He eventually referred the Petitioner to Dr. K.A. Jucas, a dermatologist. (Petitioner's Exhibit (*hereinafter*, PX) 3). The Petitioner was first seen by Dr. Jucas on October 7, 2011. In the medical history, the Petitioner indicated he was seeking care for skin rash on the right hand and fingers. The doctor noted the Petitioner's left hand was clear at the time of that appointment. The doctor prescribed triamandone 1% cream to treat that condition. (PX 3). After completing care in December of 2011, the Petitioner did not return to Dr. Jucas until March 30, 2012. At that time, the Petitioner complained of right hand dermatitis with an area on the 5th finger of the left hand. (PX 3).The Petitioner returned to Dr. Jucas in May of 2012, reporting he was doing better. On July 20, 2012, the Petitioner complained of dermatitis on both hands. Dr. Jucas stressed that the Petitioner use hand protection at home as well. In September of 2012, the Petitioner advised Dr. Jucas that his symptoms improved when away from work. (*Id.*).

Vocational Expert Testimony

The Petitioner presented Mr. Ed Pagella as a trial witness and vocational expert. (T. at 55). Mr. Pagella testified he has been employed as a vocational expert for the Federal Government as well as Railroad Retirement Board for the past 25 years. (T. at 56). He further testified that he was hired to provide an evaluation of the Petitioner in this matter. (T. at 57). Mr. Pagella indicated his report was based on the medical records of Dr. Shirley Conibear and Dr. Parikh as well as a phone interview with the Petitioner and a review of standard allergens list. Mr. Pagella noted the Petitioner graduated from Fenger High School in 1980 and received on the job training with Xerox and belonged to the International Brotherhood of Electrical Workers, Local #134 from 1990 to 1995. (T. at 60).

Mr. Pagella stated he authored a second report including the records of Dr. Jucas in addition to an IME Report from Dr. Leikin. (T. at 62 and 64). Based on the review of these records, he understood the Petitioner to be suffering from contact dermatitis. The Petitioner advised Mr. Pagella that he had no idea what he would be capable of doing if he was to return to work based on his contact dermatitis. (T. at 65). Mr. Pagella opined the Petitioner would need to undergo vocational rehabilitation services, but even with this training, it wasn't 100% certain that he was going to be employable. (T. at 66). Mr. Pagella advised that employers may be wary of the Petitioner's limitation and, even with the gloves prescribed, it was not 100% certain the Petitioner would not experience additional breakouts. (T. at 66). Despite these concerns, it was Mr. Pagella's professional opinion that the Petitioner would benefit from vocational rehabilitation. (T. at 67).

Mr. Pagella then admitted that, despite the Petitioner having to avoid paint and printing inks, he still enjoyed and participated in painting and reading. (T. at 76). Mr. Pagella also did not perform a transferable skills analysis based on the Petitioner's prior employment as a maintenance worker. (T. at 81). He further opined there was no stable labor market for the Petitioner in his initial Report of December 1, 2015, based on the need to avoid all the allergens listed in the medical records. (T. at 81). Mr. Pagella acknowledged while he relied on the opinions of Dr. Conibear, he did not address the fact that Dr. Conibear returned the Petitioner to full duty with the use of protective personal gear in his December 2015 Report. (T. at 83). When queried concerning his statement that no employer would risk hiring someone who potentially would be off work for three weeks due to an allergic reaction, Mr. Pagella indicated his basis for this determination came from the Petitioner's own account of his allergic reactions and not from any provided medical records. (T. at 88-89). Mr. Pagella acknowledged he neither reviewed Dr. Scheman's medical records or Dr. Scheman's deposition testimony taken subsequent to the review of those records. (T. at 94). Mr. Pagella also affirmed he did not review the testimony of Dr. Scheman stating the allergies from which the Petitioner suffers as the most common workplace allergies Dr. Scheman deals with and that none of Dr. Scheman's other patients who suffer from this allergic reaction are unable to find employment. (T. at 98).

The Respondent presented Ms. Tytiana Brown as a trial witness and vocational expert. Ms. Brown indicated she reviewed the medical records for the Petitioner from Dr. Conibear as well as an IME Report of Dr. Andrew Scheman with the information necessary to form her opinion. (T. at 111). She stated she was not able to meet with the Petitioner despite scheduling multiple meetings because the attorney for the Petitioner would not set up a client meeting

due to some of the allergens existing in her office. (T. at 111). Ms. Brown testified on direct examination that, as a result of her review of the IME Report by Dr. Scheman and the medical records of Dr. Conibear, the Petitioner would be able to return to work with the use of vinyl gloves and steel-toed boots according to Dr. Scheman, and with the use of appropriate protective equipment according to Dr. Conibear. (T. at 113). Ms. Brown concluded the Petitioner would be able to return to work so long as he wore protective equipment, vinyl gloves and boots when necessary. (T. at 114). She further identified, through a transferrable skills analysis, that the Petitioner would be able to perform a range of jobs including dispatcher, receptionist, telephone solicitor, and repair order clerk. (T. at 115). The only necessary precaution would be for the Petitioner to avoid exposure to metals which include nickel and cobalt in addition to rubber which may contain carbamates or thiuram. (T. at 116). Ms. Brown further opined that the Petitioner would not need professional vocational assistance in order to acquire one of these positions. (T. at 116, 117). She also noted information made available to her indicated the Petitioner had not engaged in a job search since leaving Greyhound. (T. at 120).

Ms. Brown acknowledged she did not have a personal interview with the Petitioner, despite her efforts to schedule such a meeting. (T. at 121-123). She further testified that she did not reach out to any potential employers and could not verify which employment environments would contain cobalt, nickel, carbamates or thiuram. (T. at 133, 134). Ms. Brown also agreed the Petitioner could benefit from vocational rehabilitation programming to assist in finding employment within his restrictions. (T. at 134).

Ms. Brown further testified that the Petitioner refused to meet with her because was too anxious or nervous to meet with her. (T. at 137). She also indicated her review of the Petitioner's medical records led her to conclude that no doctor limited the Petitioner only to work environments free of the allergens in question. (T. at 137). Instead, she testified her understanding of the Petitioner's medical situation merely called upon him to avoid direct contact with the allergens. (*Id.*). Ms. Brown further opined it would be difficult for the Petitioner in his daily life to be in an environment that was completely free of the allergens listed. (T. at 138).

Medical Expert Testimony

The Petitioner sought the expert medical opinion of Dr. Shirley Conibear, who testified as to the existence of a causal connection between the Petitioner's contact dermatitis and the work accident. (PX 11). Dr. Conibear is board certified in occupational medicine. (PX 11 at 9). While Dr. Conibear testified to the existence of a causal relationship, she acknowledged that the chemicals to which the Petitioner is now allergic were explicitly not found in the chemicals used in the waste tank. (PX 11 at 24 and 44). She also had no information that the gloves the Petitioner wore contained thiuram or carbamates. (PX 11 at 24). She testified that the thiuram and carbamate "could have been" in the rubber gloves worn by the Petitioner during the incident. (PX 11 at 45). Dr. Conibear acknowledged the Petitioner suffered from dental infections for years, per his treatment records. (PX 11 at 24). She further acknowledged that cobalt can be used in dental appliances. (PX 11 at 30). Dr. Conibear admitted cell phones contain nickel, but also advised she was unaware of the scope of the Petitioner's cell phone usage preceding his work accident. (PX 11 at 32).

Dr. Conibear further testified as to the protective measures the Petitioner could implement to avoid contact with those substances to which he is allergic. For each of the substances to which the Petitioner is allergic, measures were identified that could be taken to avoid exposure. (PX 11 at Exhibit 2). Dr. Conibear testified she would not expect the Petitioner to be exposed to all of the same substances in every workplace as those he encountered while working for the Respondent. (PX 11 at 36). The doctor also opined that it was quite possible that the Petitioner suffered from dermatitis while employed with the Respondent based on exposures that did not involve his gloved hands. (PX 11 at 38).

The Respondent sought the expert medical opinion of Dr. Andrew Scheman, who testified there was no proof of a causal relationship between the work injury and the Petitioner's condition of contact dermatitis. (Respondent's Exhibit 1). Dr. Scheman, a board certified dermatologist, is an associate professor of clinical dermatology at Northwestern Memorial Hospital and previously served on the faculty of Loyola University Medical Center and Johns Hopkins Hospital. (Respondent's Exhibit (*hereinafter*, RX) 1 at 5). His CV outlined his research efforts and contributions to medical education. (RX 1 at Exhibit 1). Dr. Scheman specifically cited his authoring of one of the chapters in the current edition of the textbook "Fisher's Contact Dermatitis". (RX 1 at 6). Dr. Scheman testified that he has treated "hundreds and hundreds" of patients who are allergic to the same substances as those to which the Petitioner is allergic. (RX 1 at 20).

Dr. Scheman conducted a physical examination of the Petitioner on September 16, 2015. (RX 1 at7). The Petitioner provided a history of being exposed to chemicals and human waste when cleaning the toilet on a Greyhound bus on May 29, 2011. He indicated he was

wearing latex gloves but that the chemicals got underneath the gloves. (RX 1 at 9). The Petitioner attributed subsequent symptoms of severe swelling on the tops of his hands and fingers to that exposure. (RX1 at 9).

Dr. Scheman noted the Petitioner's dermatitis was not active on the date of the exam and the Petitioner showed only "very mild hyperpigmentation" on a few sites on the tops of his hands. (RX 1 at 20). Dr. Scheman found no areas of hyperpigmentation on other parts of the Petitioner's body. (RX 1 at 20). The Petitioner was using a 1 percent hydrocortisone cream, which is the weakest of the topical corticosteroids dermatologists use to treat dermatitis. (RX 1 at 21). The use of this cream suggested to Dr. Scheman that the rashes the Petitioner experienced were "really mild." (RX 1 at 21).

Dr. Scheman also reviewed extensive medical records outlining medical care received by the Petitioner. In rendering his opinions, Dr. Scheman reviewed the records of Dr. Majmudar, Dr. Parikh, Dr. Jucas, Dr. Goldsberry, Dr. Martini, Dr. Yount, Dr. Vadali and Dr. Bahmananbeigi. (RX 1 at 12-13). The doctor acknowledged the Petitioner is allergic to carbamates, thiuram, nickel and cobalt. (RX 1 at 17-18).

Dr. Scheman discussed the records of Dr. Martini, one of the Petitioner's treating physicians and a respected dermatologist. (RX 1 at 14). He reviewed Dr. Martini's patch testing of the Petitioner that identified positive reactions to carbamates, thiuram, nickel sulfate and cobalt chloride. (RX 1 at 14-15). Dr. Scheman discussed Dr. Martini's concerns regarding the Petitioner's work gloves as being relevant to his allergy to rubber accelerators. (RX 1 at 17). He also noted, however, that these substances are found in pesticides, to which the Petitioner was also exposed at work. (RX 1 at 16). Dr. Martini therefore recommended the Petitioner wear

only vinyl gloves at work. (RX 1 at 16). Dr. Scheman then opined that while the Petitioner worked for the Respondent following the accident, the rubber gloves were likely the major source of exposure. (RX 1 at 17).

Dr. Scheman noted the Petitioner had multiple episodes where he experienced eczema, or red scaly skin, and pigmentation on the tops of his hands and fingers. (RX 1 at 11). The Petitioner had complaints pertaining to dermatitis on a part of his body other than his hands on only a few occasions, which Dr. Scheman outlined in his report. (RX 1 at 38). There were only two office visits in which the treating physician documented involvement beyond the Petitioner's hands. (RX 1 at 38). One of these instances involving inflammation of the scalp occurred four months after the date of accident. (RX 1 at 11). The second event involving the left arm and left calf occurred on November 29, 2012, 19 months after the date of accident. (RX 1 at 11).

Dr. Scheman indicated that the severity of contact dermatitis can range from a milder red scaly rash to a severe blistering reaction. (RX 1 at 18). Dr. Scheman found no evidence in any of the records he reviewed that the Petitioner suffered from the severe reaction. (RX 1 at 18). He further found no evidence in the medical records of boils being present all over the Petitioner's body. (RX 1 at 19). Dr. Scheman defined boils as being abscesses or infections and opined a boil would never be an allergic response. (RX 1 at 19).

Dr. Scheman noted that the allergies from which the Petitioner suffers are the most common workplace allergies. (RX 1 at 20). Dr. Scheman opined that the records suggested the Petitioner's dermatitis results from exposure to cobalt, nickel, thiuram and carbamates. (RX 1 at 22). He further testified there is no way to medically identify the cause of any specific

outbreak as related to exposure to these substances versus irritation or dryness. (RX 1 at 22-23). Dr. Scheman acknowledged that the "one episode" the Petitioner experienced initially may have been attributable to the work accident, but the doctor noted the Petitioner was already wearing rubber gloves at that time. (RX 1 at 23).

The doctor found the causal element for all of the Petitioner's subsequent episodes to be unclear. (RX 1 at 24). He noted that the subsequent episodes could be "eczema due to anything". (RX 1 at 24). Specifically, he noted that there is no mention in the medical histories of an exposure to thiuram, carbamate, nickel or cobalt as precipitating these specific outbreaks. (RX 1 at 25). The doctor acknowledged that if the first outbreak occurred after the exposure, that factor could be significant. (RX 1 at 24). However, the doctor further opined individuals handle rubber and metal objects at home as well and, thus, there is no way to determine whether the Petitioner's ongoing dermatitis is work-related or not. (RX 1 at 25).

The only restrictions Dr. Scheman would impose on the Petitioner's work activities is the wearing of vinyl gloves to avoid handling rubber or metal objects with his bare hands. (RX 1 at 26). He also suggested the Petitioner should not be a tool and die maker or work in a rubber factory. (RX 1 at 27). The doctor concluded: "there are common allergies that people deal with all the time, they continue to be productive." (RX 1 at 27). Dr. Scheman rendered this opinion despite his knowledge that these substances of nickel, cobalt, thiuram and carbamate are "ubiquitous" in all environments. (*Id.*). The doctor anticipated the Petitioner would have recurrent outbreaks but noted these episodes are not life-threatening. (RX 1 at 28). These outbreaks are not disabling, in the doctor's opinion and based on his treatment of hundreds of patients. (RX 1 at 29).

The Respondent also presented medical reports from Dr. Jerrold Leikin, who listed his medical specialty as toxicology. (RX 12). Dr. Leikin similarly reported that there was no causal connection between the work incident and the Petitioner's current condition of ill-being. (RX 12.)

CONCLUSIONS OF LAW

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

The Petitioner was unquestionably exposed to fluids and waste on May 29, 2011. There is also no question that the Petitioner is now allergic to thiuram, carbamates, nickel and cobalt. Finally, there is no question that the Petitioner reacted to some substances while working for the Respondent after May 29, 2011. However, the presence of a reaction while at work is not proof that the work accident caused the physical injury of contact dermatitis. No physician has definitively identified carbamate, thiuram, nickel and cobalt as being components of the exposure occurring on May 29, 2011. To the contrary, the medical records show the Petitioner is exposed to these substances throughout his non-work environments. As Dr. Scheman stated, there is thus no definitive proof that the current condition of contact dermatitis is causally related to the work accident. (RX 1 at 23). In the absence of definitive medical evidence establishing a causal connection, the Petitioner has failed to meet his burden of proof.

The Petitioner carries the burden of proving every element of his claim by a preponderance of the credible evidence. The burden is on a claimant to prove that an injury is causally related to the employment. *Newgard v. Industrial Com. 58 Ill.2d 164 (1974).* Where the causal relationship is not clearly apparent, testimony of medical experts is necessary.

In the cause at bar, the only doctor to testify affirmatively as to the existence of a causal relationship between the Petitioner's current allergies and the work accident is Dr. Shirley Conibear. (*See* PX 9 and PX 11). Dr. Martini noted that the Petitioner reacted due to the presence of chemicals at work but did not relate the origin of the contact dermatitis to the incident of May 29, 2011. (*See* PX 1). Furthermore, Dr. Conibear is not a treating physician, but is a retained medical expert, whose specialty is occupational health medicine. (PX 11 at 9.) Additionally, she merely reviewed the Petitioner's medical records and did not actually examine the Petitioner himself. (PX 11 at 21). Nonetheless, she testified that she treats several patients per year for contact dermatitis. (PX 11 at 40).

Dr. Conibear admitted none of the allergens to which the Petitioner is now apparently allergic were contained in the materials that splashed onto the Petitioner on the date of accident. (PX 11 at 44). The doctor opined that the reaction could have come from the other gloves or from other locations in the employment area. (PX 11 at 45). In short, Dr. Conibear could not specifically identify the chemicals used in the waste tank as the source of the contact dermatitis. In fact, as her testimony progressed, she also hypothesized the Petitioner's exposure could be attributable to tubing used on the buses and to rubber dust and cobalt from the bus tires. (PX 11 at 45).

Furthermore, Dr. Conibear admitted other sources for the Petitioner's allergens were present outside of his workplace for the Respondent. These sources included cobalt in dental appliances (PX 11 at 30), cobalt in oil-based paints (PX 11 at 30), and nickel in cell phones (PX 11 at 32). Dr. Conibear testified she was unaware as to whether the Petitioner used a cell phone in the years preceding her evaluation of his case. (PX 11 at 32).

The Respondent presented the testimony of Dr. Andrew Scheman, a board certified dermatologist. Dr. Scheman testified he has treated hundreds of patients for contact dermatitis. He further testified that the allergies from which the Petitioner suffers are the most common workplace allergies which he sees in his practice. (RX 1, p.20) In his report, he stated that "it is impossible to absolutely determine whether these contact allergies were caused by the exposure on 5/29/11." (RX 1 at Exhibit 2). The Petitioner gave Dr. Scheman a history of onset of symptoms within a few days of the event. (RX 1 at Exhibit 2). Dr. Scheman testified that an initial onset similar to what the Petitioner described is a factor to consider based on the fact that "he was exposed to those chemicals." (RX 1 at 24). As Dr. Conibear opined, however, the Petitioner was not exposed to cobalt and nickel during the work incident. (*See* PX 11 at 44). Furthermore, she provided no explanation as to how the Petitioner became allergic to substances that were not shown to be present on the date of accident. (*See generally,* PX 11).

The records of the Petitioner's medical treatment also suggest that the Petitioner's ongoing contact dermatitis is not causally related to the work accident. The Petitioner sought treatment following the accident on June 1, 2011, at MetroSouth, at which time he complained of body aches, diarrhea, and was found to have a scattered rash only on his right hand. (PX 2). However, less than two weeks later, on June 7, 2011, he returned to MetroSouth complaining of gastrointestinal symptoms but lacking any skin lesions. (PX 2 at 4). Thereafter, his dermatitis was consistently present on his right hand and occasionally bilateral hands. Yet the list of items containing the allergens to which the Petitioner reacts includes innumerable daily

household items. Despite the ubiquitousness of these allergens, the Petitioner almost never experienced an outbreak on a part of his body other than his hands.

As both Dr. Scheman and Dr. Conibear noted, the Petitioner's medical records showed frequent dental infections. (*See generally* Rx 1 and PX 11). These infections predated the accident and continued thereafter, including a July 20, 2012 incident for which the Petitioner again sought treatment on MetroSouth Medical Center. (PX 2). Dr. Conibear acknowledged that many dental appliances may contain cobalt. (PX 11 at 30). Accordingly, it is just as probable that the Petitioner developed sensitivity to cobalt from his dental work as it is from one exposure to a liquid chemical compound that did not even contain cobalt.

The Petitioner also testified to a hobby of painting. (T. at 46-47). Dr. Conibear also acknowledged that cobalt could be found in paints. (PX 11 at 30). As such, it therefore is probable that the Petitioner had multiple non-work related exposures to cobalt that caused his allergic sensitization, especially because the waste tank liquid involved in his May 29, 2011, work incident lacked the presence of cobalt itself.

Additionally, the Petitioner's treatment for dermatitis is increasingly infrequent. The Petitioner treated with Dr. Jucas in September of 2014, and has not seen him since that date. (T. at 45). Dr. Jucas' records show a lack of a causal connection between the Petitioner's current condition of ill-being and the original work incident. The Petitioner was seen for a new condition of seborrhea dermatitis on September 14, 2014. (PX 3). It was noted this new condition had been present for more than one month and had started in the left nasal crease. (PX 3). Dr. Jucas then provided the Petitioner with medical literature regarding this new condition.

In December of 2014, the Petitioner did treat for an abscess at MetroSouth Medical. (*See* PX 2). However, the doctor diagnosed an "infected hair follicle to the left face." Additional "skin symptoms" were noted as "negative except as documented in HPI (history of present illness)". In short, no rash or dermatitis was found. Health Status notes on the report from that visit showed the following: "Allergies: Allergic Reactions (Selected) No Known Allergies." (PX 2).

Similarly, the Petitioner attributed his complaints on July 31, 2015 to his contact dermatitis. However, the treating physicians at the emergency room noted a "macula, circular, inflamed, red, **consistent with bug bites**, also noted on the Rt axilla are multiple abscesses." In the category of "Health Status", the physician noted "Allergic Reactions (selected) unknown, Rubber – No reactions were documented. Stainless steel – No reactions were documented." (PX 2).

The Petitioner's medical records only indicate one treatment session for contact dermatitis since November of 2013, and that was due to an exposure to insecticide. Dr. Leikin opined that after the initial exposure, the Petitioner's dermatitis was no longer related to the work incident. (RX 12). Dr. Scheman testified at length to the lack of evidence as to the origin or nature of the Petitioner's current infrequent episodes of dermatitis. (RX 1). The Petitioner's current condition of ill-being is not causally related to the work incident.

The lack of a causal connection between the Petitioner's current condition of ill-being and the original work incident if further demonstrated by the records of Dr. Jucas. (*See* PX 3). The Petitioner was seen for a new condition of seborrhea dermatitis on September 14, 2014. Dr. Jucas' records indicate the Petitioner was given a brochure on this new condition. The condition had been present for more than one month and had started in the left nasal crease.

In light of the foregoing, the Arbitrator finds no causal connection between the Petitioner's May 29, 2011 accident (11 WC 41652) and his current condition of ill-being.

Furthermore, the Arbitrator finds no proof in the medical records that the Petitioner was exposed to carbon monoxide in June of 2012, the alleged second accident (13 WC 23566). The Arbitrator finds no causal connection between that alleged work injury and any current condition of ill-being.

ISSUES J & K: PAST MEDICAL EXPENSES & PROSPECTIVE MEDICAL CARE

Based on the finding that no causal relationship exists between the work accident and the Petitioner's current condition of contact dermatitis, the Arbitrator finds the Respondent not liable for the costs of medical care.

Additionally, the Arbitrator notes many of the medical bills are not supported by the medical evidence. With respect to the bills from Quest Diagnostics (PX 8) and Emergency Care (PX 6), no medical records were offered into evidence demonstrating that the services billed for are causally connected to the work accident. Additionally, the Arbitrator notes the objections to costs of care raised by the Respondent as to the lack of records for various dates of service and finds the Respondent not liable for those charges.

The records of Cigna show the diagnoses assigned to the office visit by the Petitioner's various physicians. (*See* RX 4). These physicians, including Dr. Parikh, treated the Petitioner for multiple conditions and utilized various tests unrelated to the work exposure.

The MetroSouth emergency room treatment dated June 10, 2013, was treatment for a headache, resulting in the administration of belladonna and lidocaine. There is no evidence this charge is causally related to the incident of May 29, 2011. Similarly, treatment at MetroSouth on April 19, 2013, was for arthritis and resulted in the administration of belladonna again as well as the use of an EKG. Again, there are no medical records that demonstrate the causal relationship between this treatment and the incident of May 29, 2011. Certainly the colonoscopy performed at MetroSouth in January of 2014 is unrelated to the work incident. (*See* PX 2). The Respondent is not liable for those charges that are unrelated any allergy or dermatitis on the additional grounds that these conditions under treatment have no medical records to support the existence of a causal connection to the work incident.

Furthermore, the Respondent shall receive credit for all costs of medical care paid for by Cigna, the Respondent's group insurance provider. (RX 4).

ISSUE L: WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

As will be discussed in greater detail below, the Arbitrator finds the Petitioner is not entitled to vocational rehabilitation. The record (RX 3) shows the Petitioner was paid benefits by the Respondent from November of 2013 through November of 2015, providing ample opportunity for the Petitioner to obtain alternative employment. No further maintenance benefits are due.

ISSUE M: SHOULD PENALTIES OR FEES BE IMPOSED UPON RESPONDENT?

As noted above, the Arbitrator found no causal connection to the work accident and the Petitioner's condition of contact dermatitis. Additionally, the Arbitrator finds the Petitioner is not entitled to ongoing maintenance benefits and vocational rehabilitation, as will be discussed below. The Respondent terminated benefits based on the report of its expert, Dr. Andrew Scheman. Dr. Scheman not only raised substantial questions regarding the causal connection between the work accident and the Petitioner's current condition of contact dermatitis, but also confirmed the opinions of Dr. Martini, expressed in 2012, that the Petitioner need only wear gloves in order to return to work. (RX 1).

Penalties are awarded under Section 19k of the Act only when a respondent engages in vexatious or unreasonable conduct. Similarly, penalties are awarded under Section 19l of the Act only when a respondent denies payments without good and just cause. In the cause at bar, Dr. Martini, Dr. Conibear and Dr. Scheman all found the Petitioner able to return to work wearing vinyl gloves. The Petitioner never attempted to return to employment. Based on the report of Dr. Scheman, the Respondent presented credible legal and factual issues regarding its liability for costs of medical care and maintenance benefits. As such, and based on these legitimate justiciable issues, the Petition for Penalties is denied.

ISSUE O: VOCATIONAL REHABILITATION

Dr. Martini, Dr. Conibear and Dr. Scheman all testified the Petitioner is not required to utilize any protective measures other than the use of heavy vinyl gloves in order to return to work. The Arbitrator has reviewed all of the evidence in this case and finds that the Petitioner

has failed to prove that he only is able to work in an environment utterly free of nickel, cobalt, carbamates and thiuram as a result of the work accident of May 29, 2011. The Arbitrator instead credits the opinions of Dr. Scheman, the Respondent's Section 12 examiner, who opined that the only work environments in which the Petitioner cannot be employed are metal manufacturing plants or production of rubber plants. (RX 1). Furthermore, the medical records of Dr. Martini, the Petitioner's treating physician, state that the Petitioner is able to return to work with the use of vinyl gloves. (PX 1). This position also is supported by the Petitioner's expert, Dr. Conibear, who testified that the Petitioner requires only vinyl gloves and possibly protective sleeves and boots in order to avoid contact with the allergens. (PX 11).

The Petitioner failed to present any credible evidence that he requires vocational assistance in order to return to gainful employment. In so ruling, the Arbitrator finds the testimony of the Petitioner's vocational expert to be wholly lacking in credibility and not supported by the evidence.

In his first report, Mr. Pagella relied on the records of Dr. Parikh and Dr. Conibear. (PX 12). Notably, he did not mention or reference either of the treating dermatologists, Dr. Jucas and Dr. Martini, even once. While Mr. Pagella testified that he did review the records of Dr. Jucas and Dr. Martini from the outset and merely failed to mention them, the Arbitrator finds this testimony to be rebutted not only by the clear terms of the report but by the statements of the Petitioner's own attorney. In discussing his second report (PX 13), counsel for the Petitioner admitted that "additional medical records" were sent to Mr. Pagella, and Pagella acknowledged reviewing those records in authoring that report. (T. at 63). Not until the second report, after receiving "additional medical records" did Mr. Pagella actually rely on

the opinions of the treating dermatologists. Mr. Pagella discussed his change in opinions regarding the existence of a reasonably stable labor market and admitted that his opinions changed after "reviewing all the medical that was forwarded to me..." after the issuance of his first report. (T. at 78-79).

The Arbitrator also finds the opinions of Mr. Pagella to be unsupported by the facts as Mr. Pagella relied on the Petitioner's statements that he also suffers from gastroenteritis as a result of the work exposure. (T. at 61). As noted above, the Petitioner's own examining doctor, Dr. Conibear, explicitly found the condition of gastroenteritis to be unrelated to the work injury. (PX 9 and 11). Nonetheless Mr. Pagella utilized all of the Petitioner's medical criteria because, according to his own testimony, what medical conditions are or are not causally related to the work injury are irrelevant to his vocational assessment. (T. at 74). Thus, Mr. Pagella's opinions are based, at least in part, on a disability that is not properly a part of the Petitioner's claim under the Act.

Moreover, even if the opinions of Mr. Pagella were credible, the Petitioner failed to prove he qualifies for vocational services under the standards of *National Tea v. Illinois Industrial Commission*, 97 Ill.2d 424, 454 N.E.2d 672 (1983). Initially, the Arbitrator notes that not all of the elements of *National Tea* are relevant where, as here, the issue is job placement assistance rather than the retraining/education services in dispute in *National Tea*. The standards set forth by the Court in *National Tea* include: a reduction in earning capacity; evidence that rehabilitation will increase earning capacity; potential loss of job security; the likelihood of employment after training; unsuccessful similar training in the past; a status of "untrainable" based on age, education, training and occupation; current skills; the costs and

18IWCC0229

benefits from the program; life expectancy; and ability and motivation to undertake the program. *National Tea v. Illinois Industrial Commission*, 97 Ill.2d at 432.

A thorough review of these criteria demonstrates the Petitioner is not entitled to vocational rehabilitation services. First, the Petitioner has suffered no loss in earning capacity. The Petitioner earned just over $400.00 per week, and minimum wage in the City of Chicago is now equivalent to that wage. (T. at 100). Notably, Mr. Pagella makes no mention of a loss of earning capacity and there is no evidence in the record to show a loss of earning capacity. Since there was no loss of earning capacity, the question of whether rehabilitation would restore that capacity is moot.

The Petitioner did suffer a loss of job security. However, there is no evidence in the record that rehabilitation will restore job security given that Mr. Pagella initially found there was no reasonably stable labor market for the Petitioner in his first report. Because training has not been recommended, the factor of likelihood of employment after training is inapplicable. Even if that factor were to be considered, the credible evidence does not show vocational assistance will increase that likelihood.

Mr. Pagella testified the Petitioner required vocational assistance to increase the likelihood of obtaining employment. However, as noted above, Mr. Pagella's testimony lacked credibility. Ms. Brown, the Respondent's vocational expert, testified the Petitioner would be able to find employment, in her professional opinion, without the assistance of a vocational counselor. (T. at 116-117).

The factors of "unsuccessful training" in the past and being "untrainable" are similarly inapplicable as no vocational expert has identified a training program for the Petitioner. While

Mr. Pagella initially found the Petitioner to be unemployable based on his age, education and restrictions (PX 12), the Petitioner now is requesting that vocational services be provided, apparently conceding that the Petitioner is not, in fact, "untrainable". While Mr. Pagella dismissed the Petitioner's current skills (T. at 81), Ms. Brown identified multiple areas of employment available to the Petitioner based on the skills acquired in his past work history. (RX 8).

A critical factor in this case, per the Court in *National Tea*, is the Petitioner's ability and motivation to undertake a vocational program. The facts of this case demonstrate the Petitioner not only has no motivation to undertake such a program, but that the Petitioner actively believes he cannot participate in such a program as he believes himself to be totally disabled. While the Petitioner testified he did not apply for Social Security Disability benefits until after his TTD and maintenance benefits were terminated (T. at 52), he told Mr. Pagella that he had, in fact, applied for those benefits. (T. at 100). The Petitioner was released to return to work by Dr. Martini in December of 2012 with the sole restriction of wearing vinyl gloves. The Petitioner stopped working for the Respondent in November of 2013. In the 28 months from the date the Petitioner last worked for the Respondent until the date of hearing, the Petitioner did not look for one job. In fact, the Petitioner considers himself to be so disabled that he would not appear in his own attorney's office to meet with Mr. Pagella. The Petitioner similarly refused to meet with Ms. Brown at his attorney's office or any other location due to his fear of being in an allergy-inducing environment. Mr. Pagella endorsed this catastrophic view of the Petitioner's potential exposure in his initial report.

This extreme view held by the Petitioner is not corroborated by his medical records or the opinions of either Dr. Conibear or Dr. Scheman. The medical records show the Petitioner treated sporadically, at best, for contact dermatitis once he terminated his employment with the Respondent. The records further show a very mild degree of injury attributable to the contact dermatitis. Yet the Petitioner advised Mr. Pagella that he is incapacitated for weeks at a time when he suffers an episodic flare of his condition, including situations where boils cover his entire body. (PX 12).

In summary, none of the elements set forth in *National Tea* weighs strongly in favor of an award of vocational rehabilitation in this case. The critical factor of the Petitioner's ability and motivation to pursue a vocational program, however, weighs very strongly against an award of vocational rehabilitation. Ms. Brown testified he Petitioner is able to find employment without assistance. The Arbitrator finds, based on a weighing of all of the elements of *National Tea*, that the Petitioner is able to pursue future employment, if he desire to return to the workplace, without professional vocational assistance.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Henry Yau,

Petitioner,

vs.

NO: 13 WC 10819

18IWCC0230

City of Chicago - Department of Water Management,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 28, 2016, is hereby affirmed and adopted.

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

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

18IWCC0230

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: APR 13 2018
TJT:yl
o 4/3/18
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

YAU, HENRY
Employee/Petitioner

Case# **13WC010819**

CITY OF CHICAGO
Employer/Respondent

18IWCC0230

On 3/28/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.44% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4564 ARGIONIS & ASSOCIATES LLC
LOUKAS N KALLIANTASIS
180 N LASALLE ST SUITE 2105
CHICAGO, IL 60601

0113 CITY OF CHICAGO
NANCY SHEPARD
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

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STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Henry Yau
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **13** WC **10819**

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

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **3/11/16**. 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 **2/19/13**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

For the reasons set forth in the attached decision, the Arbitrator finds that Petitioner established causation as to the rotator cuff and labral pathology demonstrated on the MR arthrogram.

In the year preceding the injury, Petitioner earned **$90,341.40**; the average weekly wage was **$1734.00**.

On the date of accident, Petitioner was **38** years of age, ***married*** with **1** dependent child.

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

Respondent is entitled to credit for the medical payments reflected in RX 3.

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $1156/week for 15 5/7 weeks, commencing 2/21/13 through 6/10/13, as provided in Section 8(b) of the Act.

Petitioner is awarded the following reasonable and necessary medical expenses, subject to the fee schedule and with Respondent receiving credit for the payments reflected in RX 3: 1) Hinsdale Orthopaedics, $2,544.00 (MR arthrogram); and 2) Accelerated Rehabilitation Centers, $4,531.00 (therapy, 11/20/13 – 12/27/13).

Respondent shall pay Petitioner permanent partial disability benefits of $712.55/week for 50 weeks, because the injuries sustained caused the 10% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Molly C Mason

Signature of Arbitrator

3/28/16
Date

MAR 28 2016

Henry Yau v. City of Chicago
13 WC 10819

Summary of Disputed Issues

Petitioner, a longtime lineman for Respondent's Department of Transportation, claims a right shoulder injury of February 19, 2013. Respondent disputes accident, causal connection, medical expenses, temporary total disability and nature and extent. Arb Exh 1.

Arbitrator's Findings of Fact

Petitioner was born on January 29, 1975. He testified he has worked for Respondent for almost 20 years. He has spent 19 years as a lineman, or electrician, running conduit and wire for traffic lights.

Petitioner acknowledged straining his right shoulder at work approximately 10 to 12 years before the hearing. He underwent treatment for this sprain but did not undergo any physical therapy. He was able to resume full duty without any difficulty. He testified he continued performing full duty thereafter until his accident of February 19, 2013. On that date, he reported to work at 7 AM. At about 9 AM or 10 AM, he was up in the bucket of a bucket truck, running temporary wire from a power source to poles that were spaced about 100 feet apart. He felt a sharp pain behind his right shoulder while performing this work. After the accident, his right arm felt weak and he had difficulty doing anything overhead. He had never before experienced similar shoulder symptoms. He reported the accident to his foreman [notice is not in dispute].

Petitioner testified he first underwent treatment on February 20, 2013. On that date, he saw Dr. Ali at MercyWorks. The doctor's history reflects that Petitioner reported injuring his right shoulder while up in a bucket, stringing wire from pole to pole. The history also reflects that Petitioner reported straining the same shoulder approximately ten years earlier.

The MercyWorks records include a patient information sheet setting forth the following description of the accident: "working in the bucket truck stringing triplex from pole to pole – hurt right shoulder pulling wire tight to the insulator."

On right shoulder examination, Dr. Ali noted mild tenderness over the AC joint and posterior aspect of the shoulder, limited abduction and internal rotation, negative impingement testing and mildly positive "empty can" testing.

Dr. Ali obtained right shoulder X-rays. He interpreted the films as negative for fracture or dislocation. He diagnosed a right shoulder strain. He recommended ice/moist heat applications and prescribed Motrin and Flexeril. He released Petitioner to light duty with no use of the right arm. PX 1.

Petitioner testified he remained off work after February 20, 2013 because Respondent was not able to accommodate his restrictions.

Petitioner returned to MercyWorks on February 25, 2013. On this occasion, he saw Dr. Diadula. On examination, the doctor noted limited abduction and forward elevation and mildly positive supraspinatus testing. He recommended a right shoulder MRI along with medication. He continued the previous work restrictions. PX 1.

The MRI, performed without contrast on March 15, 2013, showed advanced degenerative changes at the glenohumeral joint, severe cartilage loss of the posterior labrum, irregularity of the anterior labrum, a small SLAP tear, fraying and tendinopathy of the supraspinatus tendon without a well-defined discrete tear and a thin interstitial tear of the distal infraspinatus tendon. PX 1.

On March 19, 2013, Dr. Diadula reviewed the MRI results, diagnosed SLAP and rotator cuff tears and referred Petitioner to Dr. Heller. He took Petitioner off work and indicated Petitioner's case should be closed "per COF [Committee on Finance] policy." PX 1.

Petitioner first saw Dr. Heller, an orthopedic surgeon, on March 22, 2013. Dr. Heller's records (PX 2) include a patient history form signed by Petitioner. The form sets forth the following description of the accident:

> "I was in the bucket pulling triplex wire from pole to pole to string power to a traffic corner. Around the 3rd span I pulled up slack tight over & behind my head and felt a sudden pain in shoulder."

In his note, Dr. Heller acknowledged Dr. Diadula's referral. He indicated that Petitioner reported experiencing a sharp pain in the anterior aspect of his shoulder on February 19, 2013 while pulling cable as a Respondent electrician. He also indicated that Petitioner reported sustaining a mild contusion to the same shoulder ten years earlier. He described Petitioner as right-handed.

On initial right shoulder examination, Dr. Heller noted no acute deformities, significant edema of the right upper arm, intact motion, positive Hawkins' and reverse Hawkins', no evidence of instability and mild pain with O'Brien's testing.

Dr. Heller interpreted the MRI films as showing severe glenohumeral joint osteoarthrosis, a relatively large humeral head osteophyte, tendinopathy of the rotator cuff without any large discrete tears and degenerative fraying of the labrum.

Dr. Heller indicated he told Petitioner that the degenerative changes in his shoulder were "well beyond what would be expected for his age [which was then 38] and activity level." He found these changes "somewhat difficult to explain [in] the absence of any prior injury." He

indicated this condition had "clearly been present for years." He did not view the condition as causing the symptoms Petitioner had experienced a month earlier. He opined that Petitioner sustained a "strain with ensuing tendinitis and bursitis that have contributed to his current symptoms and disability." He felt confident he would be able to restore Petitioner to his pre-accident level of function with conservative measures. He administered an injection of Depomedrol and local anesthetic into the right subacromial space and prescribed four weeks of physical therapy. He released Petitioner to work with no use of the right arm. PX 2.

Petitioner testified he did not undergo the therapy that Dr. Heller prescribed because Respondent did not authorize it. He remained off work because Respondent could not accommodate his restrictions.

Petitioner returned to Dr. Heller on April 22, 2013. Dr. Heller noted that Petitioner had not undergone the recommended therapy due to lack of authorization. He also noted that Petitioner reported some improvement secondary to the injection but that his right shoulder was still painful. On re-examination, he noted relatively well preserved motion and positive evocative maneuvers for rotator cuff weakness, labral pathology and glenohumeral joint tenderness.

Dr. Heller indicated that Petitioner "will eventually require an arthroplasty" but that he was very reluctant to recommend this due to Petitioner's young age, right hand dominance and activity level. He stated that the "most appropriate first procedure would be an arthroscopy with debridement." He indicated that Petitioner remained of work due to his symptoms. PX 2.

On May 6, 2013, Dr. Heller noted that therapy authorization was still pending and that Petitioner had undergone no therapy to date. He described his examination findings as unchanged. He indicated Petitioner would likely require an arthroscopy and a total shoulder replacement but that he wanted to try to avoid these surgeries "at this point." He recommended four weeks of therapy and directed Petitioner to remain off work. PX 2.

Petitioner returned to Dr. Heller on June 10, 2013 and reported he never underwent any therapy due to lack of authorization. Dr. Heller noted Petitioner described his right shoulder as "not painful today." On re-examination, he indicated Petitioner did not seem to have pain against resisted external rotation or abduction. He allowed Petitioner to resume full duty but directed him to return in one month. PX 2.

Petitioner testified he resumed full duty after June 10, 2013 because he had to support his family. His shoulder did not feel better at that point. He was able to perform his job duties but he experienced pain while so doing. He tried to deal with the pain by using his non-dominant left hand more.

Petitioner returned to Dr. Heller on July 19, 2013. The doctor indicated that Petitioner was still experiencing right shoulder soreness but was able to tolerate it and perform his job.

He released Petitioner from care but indicated Petitioner could return periodically for injections if his symptoms worsened. He allowed Petitioner to continue full duty. PX 2.

Petitioner testified he continued performing full duty thereafter.

On November 7, 2013, Petitioner consulted Dr. Domb at Hinsdale Orthopaedics. The doctor's note of that date sets forth a consistent history of the work accident and subsequent care. The doctor noted that Petitioner complained of posterior pain and weakness, aggravated by overhead activities. The doctor noted positive Neer's, Hawkin's, O'Brien's and Jobe testing on right shoulder examination. He also noted 4+/5 infraspinatus strength with pain. He interpreted the MRI as showing degenerative changes and possible tearing of the rotator cuff and labrum. He ordered an MR arthrogram and physical therapy. PX 3.

Petitioner underwent an initial physical therapy evaluation at Accelerated Rehabilitation on November 20, 2013. The evaluating therapist noted a history of the work accident and subsequent care. She indicated that Petitioner's primary complaint was reaching overhead, "as is required for 67% of his job tasks." On November 26, 2013, the therapist noted that Petitioner reported improvement but was still waking nightly due to pain. PX 3.

The MR arthrogram, performed on December 9, 2013, showed no full-thickness retracted rotator cuff tear, infraspinatus tendinosis and articular surface fraying and partial thickness tearing, mild acromioclavicular joint degenerative changes, a SLAP tear propagating to the mid-posterior labrum and moderate glenohumeral joint osteoarthritis. PX 3.

A therapy note dated December 27, 2013 reflects that Petitioner told the therapist his doctor wanted him to come in for a cortisone shot but he did not want to do this. The note also reflects that Petitioner reported improvement but was still experiencing pain and difficulty with sudden movements due to remaining weakness. The therapist recommended two more weeks of therapy. PX 5.

An Accelerated Rehabilitation discharge summary dated February 25, 2014 reflects that Petitioner completed ten therapy sessions and had been discharged by his physician "at last visit." The only note in evidence from Dr. Domb is the initial note of November 7, 2013.

Petitioner testified that the therapy helped him increase his range of motion but did not reduce his pain. He continued working while undergoing therapy.

Petitioner denied reinjuring his right shoulder at any point after the February 19, 2013 work accident.

Petitioner testified his right arm still feels weak. His range of motion is nowhere near what it used to be. His injury has affected his ability to perform certain tasks. He asks co-workers for help with those tasks.

Petitioner testified he received no benefits while he was off work after the accident. He claims an outstanding MR arthrogram bill (PX 4) and a physical therapy bill (PX 6).

Under cross-examination, Petitioner testified that, at the time of the accident, his right arm was overhead while he was pulling wire. The wire was about ½ inch around. He described the accident to the doctors at MercyWorks and Dr. Heller. He does not recall telling Dr. Heller in July 2013 that he was experiencing only occasional tolerable symptoms. He does not recall Dr. Heller telling him he could return thereafter if he continued having problems. He did not return to Dr. Heller. He continued performing full duty. He saw Dr. Domb in November 2013 because he was experiencing the same complaints and wanted a second opinion. At Dr. Domb's recommendation, he underwent an MR arthrogram and ten therapy sessions. Initially, he recalled returning to Hinsdale Orthopaedics and seeing someone other than Dr. Domb after the initial visit but he subsequently recalled having no follow-up visit after the MR arthrogram. He is continuing to perform full duty. He currently takes no medication for his shoulder. He believes he underwent acupuncture after his earlier shoulder strain, which occurred in about 2002. At the time of his February 19, 2013 accident, he felt pain right behind the top of his right shoulder, not in the area of his shoulder blade.

On redirect, Petitioner testified he did not experience upper back pain after the accident. He told Dr. Heller about his ongoing complaints in July 2013. The only care he underwent after his 2002 shoulder strain was acupuncture. He resumed full duty after that strain.

No witnesses testified on behalf of Respondent. Respondent offered into evidence documents showing payments it made toward the claimed MR arthrogram and physical therapy bills. RX 1, 2. Respondent also offered into evidence a payment report reflecting payments it made to MercyWorks, Midland Orthopaedics, Hinsdale Orthopaedics, Accelerated Rehabilitation, OCM, Radiological Physicians and First Script. RX 3.

Arbitrator's Credibility Assessment

Petitioner was calm and articulate. He did not exaggerate his complaints. His lengthy tenure with Respondent weighs in his favor, credibility-wise.

Arbitrator's Conclusions of Law

<u>Did Petitioner sustain an accident arising out of and in the course of his employment on February 19, 2013?</u>

The Arbitrator finds that Petitioner met his burden of proof on the issue of accident. In so finding, the Arbitrator relies on Petitioner's credible testimony concerning the duties he was performing at the time of the accident along with the corroborating histories in the records of MercyWorks, Dr. Heller and Dr. Domb. Petitioner testified he was performing a typical task, i.e., pulling wire between one pole and another, during a regular workday at the time of the

accident. The Arbitrator finds that the accident arose out of and in the course of Petitioner's employment.

Did Petitioner establish a causal connection between his February 19, 2013 work accident and his current condition of ill-being?

The Arbitrator finds that Petitioner established a causal connection between his February 19, 2013 accident and the rotator cuff and labral pathology demonstrated on the MR arthrogram. In so finding, the Arbitrator relies on the following: 1) Petitioner's credible testimony concerning the innocuous nature of the right shoulder strain he sustained at work in approximately 2002; 2) Petitioner's credible testimony that he successfully performed full duty between the time he recovered from that strain and his February 19, 2013 accident; 3) Petitioner's credible testimony concerning the mechanism of the February 19, 2013 accident; 4) the corroborating histories in the treatment records; 5) the MR arthrogram results; and 6) Petitioner's credible denial of any post-accident re-injuries.

The Arbitrator acknowledges that Dr. Heller viewed the accident as causing merely a shoulder strain "with ensuing tendinitis and bursitis." However, Dr. Heller reviewed only the MRI, not the subsequent MR arthrogram. Moreover, Dr. Diadula of Mercyworks, the physician who referred Petitioner to Dr. Heller, apparently did not agree with Dr. Heller's MRI interpretation, since he described the MRI as showing rotator cuff and labral tears.

While it is very plausible that Petitioner's relatively advanced osteoarthritis stems from or was aggravated by his work and/or the accident, given that Petitioner has been employed as a lineman for 19 years and that much of his work is performed overhead, Petitioner did not offer any medical opinion to this effect.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claims unpaid medical bills from Hinsdale Orthopaedics ($2,544.00, MR arthrogram)) and Accelerated Rehabilltation Centers ($4,531.00, physical therapy, 11/20/13 – 12/27/13). Petitioner did not offer a fee schedule analysis. Respondent disputed this claim, based on its accident and causation defenses. Respondent also asserted it paid the bills in question. Respondent offered into evidence print-outs showing payments toward the claimed amounts. RX 3.

The Arbitrator has already found in Petitioner's favor on the issues of accident and causation. The Arbitrator views the MR arthrogram and physical therapy prescribed by Dr. Domb to be reasonable and necessary. Dr. Heller, a referral from a Respondent-selected provider, had previously recommended therapy, with Respondent declining to authorize same. The Arbitrator awards the claimed bills, subject to the fee schedule and with Respondent receiving credit for the payments it has made.

Is Petitioner entitled to temporary total disability benefits?

Petitioner claims he was temporarily totally disabled from February 20, 2013 (the day after the accident) through June 10, 2013 (the day Dr. Heller released him to full duty). Respondent disputes this claim, based on its accident and causation defenses.

The Arbitrator has already found in Petitioner's favor on the issues of accident and causation. The Arbitrator finds that Petitioner was temporarily totally disabled from February 20, 2013 through June 10, 2013. In so finding, the Arbitrator relies on the records from MercyWorks and Dr. Heller along with Petitioner's credible testimony that Respondent was not able to accommodate his restrictions.

What is the nature and extent of the injury?

This is a post-amendatory case, since Petitioner's accident occurred after September 1, 2011. Accordingly, the Arbitrator looks to Section 8.1b of the Act for guidance in determining permanency. That section sets forth several factors to be considered in assessing the nature and extent of an injury. No one factor is to be given more weight than any other.

With respect to the first factor, any AMA impairment rating, the Arbitrator notes that neither party offered a rating into evidence. As for the second and third factors, occupation and age at the time of the accident, the Arbitrator notes Petitioner has worked as a lineman since approximately 1997 and was only 38 as of his accident. The Arbitrator views Petitioner as a younger worker who has devoted his adult years to one career. The Arbitrator further notes that, according to the therapy evaluation performed in November 2013, that career requires a significant amount of overhead work. With respect to the fourth factor, the Arbitrator finds no evidence that the accident affected Petitioner's future earning capacity. Petitioner testified he resumed his regular job in late 2013. He did not claim any wage diminution. As for the fifth factor, "evidence of disability corroborated by the treating medical records," the Arbitrator notes the MRI and MR arthrogram results.

Having considered the foregoing, along with Petitioner's right hand dominance and credible testimony as to his ongoing complaints, the Arbitrator finds that Petitioner is permanently partially disabled to the extent of 10% loss of use of the person as a whole under Section 8(d)2, equivalent to 50 weeks of permanent partial disability benefits.

STATE OF ILLINOIS)
) SS.
COUNTY OF Champaign)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Courtney Withers,
Petitioner,

vs.

NO: 11WC 16349

Viscofan USA, INC.,
Respondent,

18IWCC0231

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 28, 2016 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $22,500.00. 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: APR 13 2018

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

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CJD/rlc
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WITHERS, COURTNEY L
Employee/Petitioner

Case# **11WC046349**

VISCOFAN
Employer/Respondent

18IWCC0231

On 11/28/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.60% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1551 STOKES LAW OFFICES
JACOB R JACKSON
200 N GILBERT
DANVILLE, IL 61832

1893 LAW OFFICE PAUL LARIMORE
RANDEE SCHMITTDIEL
530 MARYVILLE CTR DR SUITE 315
ST LOUIS, MO 63141

18IWCC0231

STATE OF ILLINOIS)
)SS.
COUNTY OF Champaign)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Courtney L. Withers
Employee/Petitioner

v.

Viscofan
Employer/Respondent

Case # 11 WC 46349

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Urbana**, on **September 20, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

18IWCC0231

On **August 2, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being in his left knee *is* causally related to the accident. Petitioner's current condition of ill-being in his low back *is not* causally related to the accident

In the year preceding the injury, Petitioner earned ~~$54,279.16; the average weekly wage was~~ $1,043.83.

On the date of accident, Petitioner was **42** 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.

Petitioner *was* temporarily totally disabled from **August 3, 2011** through **October 7, 2011,** a period of **9 3/7 weeks.**

Respondent shall be given a credit of **$6,561.25** for TTD, **$0** for TPD, **$0** for maintenance, for a total credit of **$6,561.25**. The parties further stipulated that Respondent should be given a general credit for any non-occupational disability benefits or other benefits.

Respondent is entitled to a general credit for any medical bills paid by its group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of **$626.30/week** for **10.75 weeks**, because the injuries sustained caused the **5% loss of the left leg,** as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$626.30/week** for **25** weeks, because the injuries sustained caused the **5% loss of the person as a whole**, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of **$695.89/week** for **9 3/7th weeks**, commencing **8/3/11** through **10/7/11**, as provided in Section 8(b) of the Act. Respondent shall be given a credit for temporary total disability benefits previously paid. The parties also stipulated to a credit under Section 8(j) for non-occupational disability benefits paid to Petitioner. Therefore, Respondent is awarded this credit, if applicable, as it appears those benefits were not paid while he was off from August 3, 2011 through October 7, 2011.

Respondent shall pay to Petitioner compensation that has accrued between August 2, 2011 and September 20, 2016 and shall pay the remainder of the award, if any, in weekly installments.

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

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

Signature of Arbitrator

November 19, 2016
Date

NOV 28 2016

FINDINGS OF FACT AND CONCLUSIONS OF LAW

THE ARBITRATOR FINDS:

Petitioner has been employed for the past thirteen years as an extrusion operator for Respondent, a manufacturer of cellulose meat casings for the meat packing industry.

On August 2, 2011 Petitioner was opening up a B tank door. As he descended a three step pitching stand, the bottom step gave way causing him to lose his balance. Petitioner twisted his left knee and stumbled backwards hitting his back on the machine. He denied falling to the ground. Petitioner felt an immediate onset of pain in his left knee and back. He reported the accident to Respondent and an Accident Report was filled out. (PX 1) Petitioner's accident is undisputed. (AX 1)

Petitioner was taken to the emergency department at Provena United Samaritans Medical Center that same day. Petitioner gave a history of having injured his left knee and low back when the last rung of a ladder gave way. Petitioner, at the time, mainly complained of pain to his left knee. A pain drawing showed tenderness in the low back but no suggestion of any radicular complaints. Petitioner was diagnosed with an injury to his left knee and low back. X-rays of his back and knee were normal. (PX 4) He was given pain medications, a knee brace and crutches. Petitioner was instructed to follow-up with Dr. DeBoer at Carle Clinic Family Practice. (PX3)

Respondent sent Petitioner to Carle Occupational Medicine on August 4, 2011 where he was examined by Nurse Virginia Brown and a consistent history of the accident was noted. She diagnosed a left knee strain, low back strain and right upper arm contusion. She recommended that Petitioner stay off work for the day, prescribed medications, ice, and stretches and told Petitioner to continue to wear his knee brace. (PX 5)

Petitioner followed-up with Dr. Jones at Carle Occupational Medicine on August 11, 2011. At that time, he still has some low back and right arm complaints, but his main problem was his left knee. Dr. Jones ordered physical therapy and referred Petitioner to Dr. Plattner, an orthopedist, for his left knee. (PX 5)

Petitioner saw Dr. Plattner at the Carle Clinic Department of Orthopedics on August 22, 2011. His exam was limited to Petitioner's left knee complaints, although his back complaints were noted. During his examination, Dr. Plattner found no evidence of swelling or instability. Subjectively, Petitioner was tender in the medial joint line. The doctor suspected the possibility of internal derangement. Dr. Plattner ordered a MRI and also recommended physical therapy for his strains. (PX 6)

Petitioner started therapy for his knee and back on August 24, 2011 per the order of Dr. Johnson. (PX 7)

Petitioner's left knee MRI was performed on August 26, 2011. It showed a severe medial collateral ligament strain and grade II medial chondromalacia of the patella. (PX 8)

Petitioner returned to see Dr. Plattner on September 1, 2011. Based on the MRI findings, Dr. Plattner ordered more aggressive therapy and told Petitioner to wear his knee brace whenever he was active. He did not want him to use his crutches anymore. Petitioner remained off work as Respondent could not accommodate his restrictions. Dr. Plattner didn't see anything on the MRI suggesting a need for surgery as he felt Petitioner would respond with physical therapy and a steroid injection. (PX 6)

Petitioner then saw Dr. Jones at Carle Occ. Med. on September 9, 2011 for his strains. Petitioner reported that he was continuing to have pain and problems in his left knee. He presented with a significantly elevated blood pressure which the doctor wasn't sure was due to pain or ineffective medication. Petitioner was encouraged to get some assistance from Dr. DeBoer, his primary care physician. Petitioner was noted to be in physical therapy and expressed openness to the idea of trying a brace which was provided to him. Dr. Jones also checked out Petitioner's back noting everything seemed stable although Petitioner had a slightly provocative straight leg raise in a seated and supine position on the left side. Petitioner was released to transitional work with restrictions and was to wear the splints as recommended for his knee and crutches as needed. He was to continue with Advil and Tylenol and return in two weeks. (PX 5)

Petitioner last attended therapy on September 22, 2011. Not all therapeutic goals were met. (PX 7)

Petitioner saw Dr. Jones at the Occupational Medicine Department on September 23, 2011. Petitioner complained about his left knee during this visit noting he was having pain and buckling with walking or kneeling. He was waiting for an injection per Dr. Plattner. He was wearing his knee brace, as needed, and had been using a cane on occasion. Restrictions remained in effect. Dr. Jones wanted him to follow-up with Dr. Plattner. He was to return in two to three weeks. (PX 5)

Petitioner saw Dr. Plattner on September 30, 2011, reporting he was improving, undergoing therapy, and noting some residual soreness in his knee with certain activities. Petitioner wished to try an injection and that was provided. Dr. Plattner discontinued therapy and told Petitioner that if he felt better in a couple of days he would allow him to return to work full duty. He was to follow up with Dr. Jones on October 10, 2011. (PX 6)

Petitioner was re-evaluated by Dr. Sutter on October 7, 2011 at the Occupational Medicine Department. Petitioner stated that he wished to be released. Dr. Sutter noted, "He says his back and knee are fine, done with therapy." Dr. Sutter noted good range of motion of his back with no tenderness or paravertebral spasm. He had full range of motion of his knee and no instability, tenderness, or swelling. Petitioner could stand on his toes and heels and do a squat. Dr. Sutter released Petitioner to full duty and discharged him from treatment, noting his strains were healing satisfactorily. (PX 9)

Petitioner returned to full duty work October 8, 2011. The parties stipulated that Petitioner received temporary total disability while he was off of work from August 3, 2011 to October 7, 2011. (AX 1)

Petitioner returned to Dr. Plattner's office on November 8, 2011, where he was seen by nurse practitioner Jan Ostiguy. Petitioner was complaining of pain in his left knee and low back. Petitioner reported seeing Dr. Sutter in October and being released to return to work but upon returning to activities of stooping, pushing, pulling, and climbing ladders he was noting the return of back pain and knee pain just as when he had fallen. Petitioner also reported using Ibuprofen sporadically. The doctor increased his dosage. He was also advised as to good body mechanics when working. While his exam was relatively normal, Dr. Plattner noted that at the end of the work day Petitioner felt his back and knee hurt a lot. Petitioner was referred back to Occupational Medicine for his case to be re-opened. Dr. Plattner determined that Petitioner did not need any specific orthopedic treatment and referred him back to Occupational Medicine. Dr. Jones agreed to see him again. He was, otherwise, released to return as needed. (PX 6)

Petitioner failed to follow-up with Dr. Jones.

On November 29, 2011 Petitioner signed his Application for Adjustment of Claim herein. (AX 2)

Thereafter, there was a gap in Petitioner's treatment for nine months. During that time, Petitioner continued to work full duty as an extrusion operator for Respondent.

On August 5, 2012, Petitioner called Carle Occupational Medicine and asked to be seen again for complaints allegedly from his 2011 work accident. He was instructed to contact his employer for authorization to treat under workers' compensation. (PX 14)

On August 10, 2012 Petitioner saw Dr. Johnson, on his own referral, at the Carle Clinic Spine Institute for evaluation of back pain. Petitioner told Dr. Johnson about the August 2, 2011 accident, noting his back pain began then and improved somewhat and was "tolerable," but never completely went away. He added that "about a week ago, his pain worsened." He could recall no particular event or injury associated with the worsening of his discomfort. Petitioner also reported isolated left knee pain but no radicular symptoms. His back pain was rated at "8-9/10." Dr. Johnson noted the exacerbating factors were bending and standing. X-rays taken August 10, 2012 revealed slight disc space narrowing at L5-S1. According to the history, Petitioner had been off for a day and a half and then returned to work which involved a lot of bending and steps. On examination Petitioner's forward flexion was mildly restricted. His lower extremity exam was normal. Dr. Johnson diagnosed Petitioner with lumbar spondylosis without radiculopathy. Dr. Johnson noted that she "explained to the patient that he has degenerative disc disease, which is thought to be hereditary. It is poorly understood." Dr. Johnson recommended physical therapy and she referred him back to his family physician for a narcotic analgesic if he so desired one. (PX10)

On August 11, 2012 Petitioner underwent a lumbar spine x-ray per the order of Dr. Johnson. It was read as normal. (PX 11)

Petitioner attended physical therapy four times between August 27, 2012 and September 14, 2012. At his initial visit, Petitioner gave a history of his back injury in 2011, noting he eventually went back to work for two weeks but then his back pain returned. He reported continuing to struggle at work and finally calling his doctor. He also reported ongoing knee pain but not to the degree of his back. Petitioner was noted to be performing his job but was a lot slower and he hadn't missed much work. He was working 12 -14 hours per day with at least 20 hours of overtime per week. Bending was reportedly painful. In the August 30, 2012 PT Daily Note, the therapist again noted Petitioner's history of back complaints going back to 2011 and his return to work. Petitioner also advised the therapist he told the people at work about his ongoing back pain. (PX 12)

Petitioner was examined by Dr. DeBoer, his primary care physician, on September 25, 2012. According to the office note, "He is here on a workman's compensation to recheck an injury. Yesterday at Viscofan a door fell off its hinges and struck him on the head." Petitioner suffered no loss of consciousness but had been woozy since then along with neck pain. A CT of his head taken at the ER was negative. His eyes hurt, he had photophobia, and his neck was stiff. His blurry vision was improved and he was feeling a little motion sickness. Petitioner also reported having low back pain for a while longer, having been to physical therapy for a couple of weeks but finding it of little benefit. Petitioner reported sudden pains or spasms one or two times a week in his low back. Petitioner also reported some previous left knee pain from his injury but added that it was resolving and he didn't think it was much of a problem. Petitioner was diagnosed with post-concussive syndrome and neck pain. He was advised to rest and use heat on his neck. (PX 13)

Petitioner was discharged from therapy on September 26, 2012. According to the September 26, 2012 therapy note, Petitioner abandoned therapy after September 14, 2012 despite attempts made by his therapist to schedule more sessions. (PX 12)

Petitioner underwent no further treatment for almost a year. He worked full-time.

On August 5, 2013 Petitioner telephoned Nurse Practitioner Ginny Brown at Dover Occupational Medicine reporting he was still having problems from his work-related injury "in 2012." When asked if he had notified work, he replied "no" and was advised to go and do so so it could be determined if any paperwork needed to be completed on his behalf to be covered under workers' compensation. Petitioner stated he would speak with his employer and have it call Occ. Med. back. (PX 14)

On August 19, 2013 Petitioner was seen by PA Mathews at Carle Clinic Occupational Medicine for low back pain regarding an injury date of August 2, 2011. According to the office note, Petitioner had chronic right lower back pain which was worse at the end of his shift. He further reported being seen at Occ Med the year before and released to work in 2012. He had undergone physical therapy but the pain, by Petitioner's report, never really completely left him. He was using over-the-counter anti-inflammatories and working without restrictions. Tenderness was noted over the paralumbar muscles. Straight leg raise testing was negative. He was diagnosed with chronic back pain. Petitioner denied ever undergoing an MRI so one was ordered. P.A. Mathews noted an epidural pain injection or spine consultation might be needed.

Physical therapy and work restrictions were imposed. He was to return in two weeks. A copy of the office visit was sent to Respondent's workers' compensation unit. An Illness/Injury Report was completed and the injury date was noted to be "8/4/11." (PX 15)

On August 21, 2013 Petitioner began a course of physical therapy for his back, per the order of P.A. Mathews. According to the history Petitioner originally injured his back and knee falling off a step and had continued to have pain ever since but since "March" it had worsened. (PX 16)

Petitioner underwent a lumbar spine MRI on August 27, 2013 which revealed a small right central disc protrusion at L5-S1 abutting the right S1 nerve root. (PX 17)

On September 5, 2013 Petitioner was re-examined by P.A. Mathews in regard to an injury date of September 24, 2012[1]. The examination focused on Petitioner's back pain which Petitioner reported was about the same and definitely worse with forward bending and any twisting. They reviewed Petitioner's MRI which showed a central lumbar disc protrusion with degeneration of the disc at L5-S1 and protrusion on the nerve root at L5-S1 consistent with his symptoms. Petitioner was diagnosed with a lumbar disc protrusion with degenerative disc disease and an epidural pain shot was recommended. In the interim, work restrictions were imposed. An Illness/Injury Report for an injury date of September 24, 2012 was completed. (PX 15)

Petitioner continued with therapy through September 10, 2013. (PX 16)

Petitioner was seen by nurse Reith at the Carle Dep't of Family Practice on September 25, 2013 for evaluation of lower back pain complaints. Petitioner reported that he was "quite ill recently, hurt at work." He had been seeing Wayne Mathews at Occupational Medicine and "It was determined that his back pain was not secondary to workmen's comp, so he is here for continued evaluation." Petitioner was in the process of getting epidural steroid injections and needed FMLA papers filled out along with a work excuse. Petitioner's complaints included low back pain radiating down into his leg and foot. He had some mild tenderness to palpation in his lower lumbar area. He was referred to the spine Institute for evaluation and for an injection. He was given a one week work excuse. (PX 18)

On October 8, 2013 Petitioner followed up with Dr. Johnson at Carle Clinic Spine. Petitioner reported unchanged back pain since a year earlier. Dr. Johnson noted it had worsened in November of 2012 and again in February of 2013. Petitioner reported primarily back pain but some significant leg pain as well. Petitioner and the doctor reviewed his lumbar spine MRI of August 27, 2013 and she noted disc desiccation and a small disc bulge to the right posterolaterally and to the left laterally. Straight leg raise was negative bilaterally and there was no tenderness in his lumbar paraspinals. Her diagnosis was the same as it was the year before, lumbar spondylosis. (PX 10) Dr. Johnson felt Petitioner would benefit from some chiropractic treatment and she referred him to Dr. Robinson. She also noted that if his symptoms didn't improve an epidural injection could be considered but that would only help his intermittent leg pain. (PX 10)

[1] Petitioner reported a door falling and hitting Petitioner in the head. He saw Dr. DeBoer on 9/26/12. (PX 13)

On October 8, 2013 Petitioner again saw N.P. Reith at Carle Dep't of Family Medicine for continued follow-up of his lumbosacral spondylosis with "left leg radicular pain." Petitioner had last been seen three weeks earlier at which time an MRI was performed followed by a referral to the Spine Center. Petitioner had seen Dr. Johnson at the Spine Center who felt that injections would not been very effective; rather, she recommended physical therapy and a referral to a chiropractor. Petitioner still complained of lower back pain and intermittent pain radiating down his left leg to the level of his knee. No tenderness to palpation of the paraspinal muscles was noted but he did have some decreased range of motion of his lower back secondary to pain. Muscle strength was 5/5 bilaterally, (PX 18)

Petitioner then presented to Dr. Gabany at Robinson Chiropractic, Ltd. On October 14, 2013 regarding lower back problems which Petitioner described as being localized to his entire lower back and constant in nature. Petitioner reported having lower back pain since a work-related injury in August of 2011 and that it was aggravated by bending, lifting, sitting, standing, and walking and wasn't going away. He denied any back pain prior to the work injury. Chiropractic treatment was provided. (PX 19)

Petitioner returned to Dr. Gabany on October 15 and 16, 2013. At the visit on the 16th Petitioner reported doing slightly worse. (PX 19)

Petitioner returned to see N.P. Reith on October 21, 2013 and reported following up with a chiropractor for four visits, with minimal improvement and the inability to afford continued care. Petitioner wished to return to work and see what would happen with his back pain. He was still complaining of intermittent back pain and radiation into his left leg. He was given a return to work slip and told to use Tylenol as need for back pain and return if his symptoms worsened. (PX 18)

Petitioner underwent no treatment between October 21, 2013 and December 19, 2014. During that time, Petitioner continued to work full duty as an extrusion operator for Respondent.

On December 19, 2014 Petitioner saw Dr. Rana, at Carle Clinic in Hoopeston for several different problems, including worsening right knee pain and low back pain. Dr. Rana noted that Petitioner worked at a factory doing labor work and had noticed that when he stood at work his right knee ached. With regard to his low back, Petitioner noted that it has been a chronic issue after having fallen off a three step stool approximately one year earlier. Petitioner had undergone a right knee x-ray in September which showed some minimal spurring in the tibial spine. With regard to his back, Petitioner was advised to consult Carle therapy services. Petitioner was offered an injection for his right knee. (PX 20)

Petitioner underwent physical therapy for his low back per Dr. Rana beginning on January 19, 2015. Petitioner was to be seen two times a week for four weeks. (PX 21)

Petitioner returned to see Dr. Rana on March 31, 2015 reporting chronic low back pain, which had recently become slightly worse. Petitioner was experiencing an "aching sensation" in his right lower back area but no radiation. Petitioner reported having back pain ever since his work accident where he slipped off a step. Therapy was giving mild relief. Use of a TENS unit

helped temporarily. Petitioner expressed interest in an epidural injection. His right knee had improved drastically after his steroid injection in January of 2015. Petitioner had some right lower lumbar spine tenderness on exam. Dr. Rana referred him to the Spine Institute for evaluation of an epidural injection. (PX 20)

Petitioner's final physical therapy visit was in mid-April of 2015. (PX 21)

Petitioner next saw Dr. Tipirneni at the Carle Spine Institute on April 7, 2015. Petitioner gave a history of his work injury in 2011 and reported ongoing pain since then with no further accidents or traumas. Dr. Tipirneni diagnosed lumbar spondylosis, lumbago and a disc protrusion per the MRI. Dr. Tipirneni noted that Petitioner denied any new work-related injury and that a lot of his symptoms seemed very much like degenerative disease and facet arthropathy but he did complain of some pain into the right buttock area so they discussed an injection at L5-S1. She could not explain his left leg symptoms and they discussed his prior attempts at physical therapy and chiropractic care. She saw nothing on the MRI warranting surgery but if the injections didn't help she recommended an updated MRI. She felt a lot of his issue was "majority age related type wear and tear arthritis. I am not seeing anything acute from his fall at work in 2011 to cause much of the symptoms. I feel the majority is muscular, possibly could be irritation of the nerve." (PX 22)

Petitioner underwent a right-sided L5-S1 transforaminal epidural steroid injection on April 22, 2015 for lumbar degenerative disc disease and lumbar radiculopathy. (PX 22)

Petitioner presented to Dr. Rana on May 19, 2015 reporting very little relief in his right leg symptoms after the injection. He denied any new onset of weakness and no recent trauma, fall or work-related injury. Petitioner wished to undergo a right S1 nerve root block and was to return in three weeks thereafter. Petitioner expressed no interest in any surgery. The injection was given on July 6, 2015. (PX 22)

Petitioner returned to see Dr. Tipirneni on July 21, 2015 reporting 75% relief in his right leg symptoms. He was again referred for physical therapy to work on lumbar stabilization and he was then to return to see the doctor. (PX 22)

Petitioner returned on September 1, 2015 reporting significant relief from the block. He had been doing a little bit more work with his job and didn't have time to go to physical therapy. However, he had been doing exercises on his own and wanted formal therapy deferred. He denied any leg symptoms. Petitioner was advised he could return for a nerve root block if his pain returned. He also asked about pain medication and was told he should try Tylenol or Gabapentin, Neurontin, or Lyrica. He was to return as needed. (PX 22)

Petitioner returned to Carle in Hoopeston on October 7, 2015 where he was examined by P.A. Thompson. In addition to hypertension concerns, Petitioner wished to discuss his chronic back pain. He reported having gone to the Spine Institute and was in the process of receiving steroid injections which were helping but he didn't want to continue them because of how uncomfortable the procedure was. Petitioner reported his back was a little bit worse than normal as he was starting 12 hour shifts at work again and had to do a lot of bending, twisting, and

lifting for his job. Petitioner was seeking pain medication for the constant ache in his lower back which was occasionally accompanied by intermittent pain and tingling down his right leg. He was started on Gabapentin to be taken at night. He was to return in one month. (PX 20)

Petitioner's case proceeded to arbitration on September 20, 2016. Petitioner was the only witness testifying. Respondent tendered no exhibits.

Petitioner testified that he works an 8 hour shift five days a week with a thirty minute lunch break and two fifteen minute breaks. He is on his feet the entire time he is working, standing on metal and plastic gratings. Petitioner can lift up to thirty pounds of dies and modules while working. He also has to bend and twist at the waist and climb stairs and ladders.

Petitioner testified that when he was climbing down the ladder the bottom step gave out, his leg twisted, and his back hit the corner of the machine. He felt a lot of pain and his left knee was swollen. Petitioner testified that he went to the emergency room and then Respondent sent him to Carle Occupational Medicine where he was given work restrictions. Those restrictions could not be accommodated and he was taken off work. Petitioner testified that during the time he was off work (August to October of 2011) he thought both his left knee and low back were getting better. Petitioner further testified he wished to return to work in October of 2011 because he wanted to see if he was in good enough shape to work.

Petitioner further testified that once he returned to work in October of 2011 his back and left knee started hurting again and he so informed his supervisor and H.R. Petitioner further testified that HR contacted the doctor's office and sent him back to see the doctor.

Petitioner denied any injuries to his left knee or problems with his left knee or low back prior to his work accident. He also testified that he sustained no new injuries or accidents to his left knee or lower back between October of 2011 and August of 2012. While he worked, he remained symptomatic. During this time frame Petitioner also had a death in his family.[2]

Petitioner testified that he returned to Carle Occupational Medicine in August of 2013 because his back was hurting "pretty bad." Petitioner explained that his pain never went away but, rather, got to a point where he couldn't bear it anymore. He denied any new accident to his left knee or low back between August of 2012 and August of 2013.

Petitioner testified that his average pain is a "4/10" and, on his worst day, it goes up to a "10." He has more average days than "worse" days. Petitioner testified that he takes Aleve at least twice a day and he's undergone some injections with Dr. Tipineri and Dr. Rana. He also uses ice and heat for both his knee and back. Petitioner testified that he purchased a TENS unit for his back. When asked if the pain medication, ice, heat, and TENS unit, provide any relief, he replied "not much."

[2] There's a little disconnect in the testimony regarding treatment in 2012 and 2013. Initially, Petitioner addressed questions about the gap between 2011 and 2012. His attorney the switched gears and asked him about 2012 and 2013. Exactly when the personal issue came up isn't very clear.

On cross-examination Petitioner acknowledged that he initially treated with Dr. Jones for his back and with Dr. Plattner for his knee. When asked if he told Dr. Sutter on October 7, 2011 that his back and knee were fine and he wanted to go back to work, he replied, "No." and further indicated that he would disagree with the records if they so stated that. He agreed that when he returned to see Dr. Plattner in November of 2011 that the doctor made arrangements for him to go back to see Dr. Jones but he didn't go. He also agreed that thereafter he didn't seek any further medical treatment until August 10, 2012. Petitioner did not recall Dr. Johnson telling him he had degenerative disc disease which was hereditary. He also could not recall for certain if he only attended four physical therapy sessions before abandoning it but he would not disagree with that if the notes so stated it. He also agreed that he underwent no treatment between September of 2012 and August of 2013 and that he was working full-time at his regular job during that time as well as after returning to work in October of 2011. He further agreed that after treating between August and October of 2013 he didn't resume any further treatment until August of 2014 at which point he began treating with Dr. Rana, his new primary care physician.

Petitioner agreed that when he began treating with Dr. Rana he had right knee complaints and that he didn't injure his right knee in the accident. When asked if he recalled seeing Dr. Tipineri in April of 2015 at which time she told him he suffered from degenerative disc disease that was age-related wear and tear and that she saw nothing acute from his 2011 fall, he replied "No." When asked about it being in the records and whether or not he just didn't remember being told that, he replied that he wasn't sure.

Petitioner also testified that he believed both Drs. Rana and Tipirneni causally related his back pain to the August 2, 2011 accident. He further testified that the MRI results showed he had problems from the fall. He also acknowledged that he is only claiming low back and left knee/leg injuries as a result of his accident. He recalled hitting his elbow but he thought the hearing was only for his knee and back.

Petitioner testified that the medical bills incurred after October of 2011 were submitted by his group insurance/health carrier. He is claiming $475.00 in out-of-pocket expenses which he thought was from the chiropractor. He didn't bring any checks or receipts to document the expenses, however.

Petitioner was asked if he had been back to a doctor since September of 2015 and he testified that he has. He also acknowledged working for Respondent as an extrusion operator full duty. His shifts are changing and he now works 36 hours one week and 40-48 hours the next week.

On redirect examination Petitioner testified that he notices low back pain and left knee pain while working. He stopped physical therapy because it wasn't helping. Petitioner also acknowledged that when he spoke with his supervisor and HR regarding going back to the doctor he was told his case had been closed and he couldn't return to the doctor. Petitioner also identified some co-pays in the medical bills.

Petitioner's medical bills are found in PX 23 – 26.

Petitioner's Exhibit 23 consists of itemized billings from Carle Physician Group. The Arbitrator notes that some of the entries have been "blacked out" and, therefore, she reasonably infers Petitioner is not seeking their award. The remaining billings total $6200.00 and included in that amount are co-pays totaling $125.00. Insurance has made some payments on the bills.

Petitioner's Exhibit 24 consists of itemized billings from Carle Hospital totaling $9,632.00 and included in that amount are co-pays of $100.00. Insurance has made some payments on the bills.

Petitioner's Exhibit 25 is the chiropractic bill from Robinson Chiropractic. Office visits total $185.00. Petitioner has made payments of $100.00.

Petitioner's Exhibit 26 is the bill from Hoopeston Regional Health Center in the amount of $145.00. While there are three pages of bills contained in the exhibit, the bills appear to be duplicative. Petitioner made a payment of $25.00; insurance paid the remainder.

THE ARBITRATOR CONCLUDES:

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

Petitioner's current condition of ill-being in his left knee is causally related to his accident of August 2, 2011. Petitioner failed to prove that his current condition of ill-being in his low back is causally related to his accident of August 2, 2011. The Arbitrator finds that that Petitioner achieved medical maximum improvement from his work injuries as of November 8, 2011 for his left knee and September 25, 2012 for his back. Petitioner failed to prove any current condition of ill-being in his upper right arm was causally related to the accident of August 2, 2011. In support of her causation determination, the Arbitrator notes the absence of any medical expert opinions and significant gaps in treatment followed by a change in the nature of Petitioner's low back complaints.

With regard to his left knee, Petitioner was diagnosed with a knee strain and severe medial collateral ligament strain with grade II chondromalacia of the patella. When seen by Dr. Plattner, the knee specialist, on September 30, 2011 Petitioner reported residual soreness in his knee with certain activities. He received an injection to his knee. Thereafter, on October 7, 2011 Petitioner represented to Dr. Sutter that his knee was fine. Petitioner returned to work. Approximately one month later Petitioner returned to see Dr. Plattner (November 8, 2011) reporting that, after returning to work, he noticed knee pain with certain work activities. Petitioner's Ibuprofen dosage was increased. Dr. Plattner did not feel Petitioner needed any specific orthopedic treatment and his examination was relatively normal. Petitioner was referred back to Dr. Jones but Petitioner failed to do so. After seeing Dr. Plattner on November 8, 2011 Petitioner underwent no further treatment until August 10, 2012, nine months later. In the interim, he worked full duty. When seen by Dr. Johnson on August 10, 2012 Petitioner reported "isolated left knee pain." Dr. Johnson's examination focused primarily on Petitioner's low back pain and she made no treatment recommendations or examination findings regarding Petitioner's left knee. When Petitioner presented to his primary care physician, Dr. DeBoer, on September 25, 2012 he reported some "previous left

knee pain from his injury but added that it was resolving and he didn't think it was much of a problem." (PX 13) Dr. DeBoer did not examine Petitioner's left knee or make any treatment recommendations. While the medical records show that Petitioner continued to treat with doctors after the September 25, 2012 visit with Dr. DeBoer none of the treatment concerned Petitioner's left knee. There are references to left leg radicular pain but those complaints and references are associated with Petitioner's low back complaints and contain no mention of specific left knee symptoms or problems. Petitioner reached maximum medical improvement for his left knee as of November 8, 2011. While Petitioner periodically voiced left knee complaints associated with certain activities at work, he received no further treatment for his left knee after November 8, 2011. He also has had no further injuries to his left knee since his work accident herein. Therefore, the Arbitrator feels his periodic complaints after that date are more relevant to permanency, than causation, and that his current condition of ill-being in his knee is causally related to the accident herein.

With regard to Petitioner's low back pain, the Arbitrator notes that when Petitioner was initially seen at Provena, his primary complaint was left knee pain. He did, however, mention some low back pain and the pain drawing denoted tenderness in that region. There were no radicular complaints. Petitioner's back treatment was largely conservative during this time with primary focus being on his left knee. As of October 7, 2011 Petitioner reported to Dr. Sutter, that his back was fine. His back examination at that time was good and he was released to return to work for his strain which was "healing satisfactorily." (PX 9) At the time of this visit with Dr. Sutter, Petitioner had not yet tried returning to full duty work. He then did so and upon returning to Dr. Plattner on November 8, 2011, he mentioned low back pain upon returning to work and they discussed increasing his medication (Ibuprofen) and good body mechanics. Dr. Plattner referred Petitioner back to Occupational Medicine and Dr. Jones. However, Petitioner failed to follow up. Petitioner provided no explanation at the arbitration hearing as to why he failed to do so.

Thereafter, Petitioner continued working full duty with no further medical treatment for nine months. Petitioner tried to resume treatment for what he felt was a work-related problem but coverage/authorization was denied. Petitioner elected to pursue treatment on his own and presented to Dr. Johnson on August 10, 2012 for his back pain. By his history to Dr. Johnson, Petitioner's back pain had begun on August 2, 2011 was improved and tolerable but not completely resolved. Petitioner then added that "about a week earlier," it had worsened. He provided no details. Dr. Johnson explained to Petitioner that he had degenerative disc disease. She did not express a causation opinion regarding Petitioner's condition and his injury. While Petitioner testified that she did, the doctor was not deposed to corroborate Petitioner's testimony. Petitioner was then seen by Dr. DeBoer in September of 2012 for an accident occurring the day before at work. In conjunction with the examination Petitioner mentioned having low back pain prior to the September 24, 2012 accident consisting of sudden pains or spasms. Petitioner also reported having tried physical therapy but finding it of no avail. Dr. DeBoer provided no causation opinion regarding Petitioner's back nor did he provide any treatment or recommendations for Petitioner's back. Petitioner underwent no further treatment for almost a year and worked full-time in the interim. Upon re-initiating treatment in August of 2013 Petitioner also began giving inconsistent histories regarding his back pain and when it began and the nature of his complaints began to change to include

radicular leg pain and more extensive lower back pain. Neither Dr. Rana nor Dr. Tipirneni were deposed or provided causation opinions in their records. The Arbitrator also finds significant the fact that Petitioner's complaints changed in 2014 when he began treating with Dr. Rana and, eventually, Dr. Tipirneni. Petitioner also had right knee complaints which he agreed were unrelated to his accident of 2011. He also was experiencing more right-sided lower back complaints which were new and different than his original complaints post-accident and for a reasonable time thereafter (for ex. his 10/8/13 history).

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?

O. Other Issues – Out-of-Pocket Expenses.

Consistent with her causation determination the Arbitrator has found Petitioner reached maximum medical improvement for his knee on November 8, 2011 and for his back on September 25, 2012. The Arbitrator notes that the medical bills, including out-of-pocket expenses that Petitioner seeks to have awarded (PX 23 -26), are for services rendered after Petitioner reached maximum medical improvement. Therefore, the Arbitrator declines to award any medical bills or reimbursements to Petitioner. These expenses were incurred after 10/7/2011 and therefore, are denied.

K. What temporary benefits (TTD) are in dispute?

Petitioner is awarded TTD benefits from August 3, 2011 through October 7, 2011 a period of 9 3/7 weeks. The parties stipulated to this period. Consistent with her causation determination set forth above, Petitioner failed to prove he was entitled to any further TTD benefits. Respondent shall receive credit in the amount of $6,561.25 for TTD previously paid. The parties also stipulated to a credit under Section 8(j) for non-occupational disability benefits paid to Petitioner. Therefore, Respondent is awarded this credit, if applicable, as it appears those benefits were not paid while he was off from August 3, 2011 through October 7, 2011.

L. What is the nature and extent of the injury?

Petitioner sustained permanent partial disability of 5% of his left leg pursuant to Section 8(e)(12) of the Act and Petitioner sustained permanent partial disability of 5% of his person as a whole pursuant to Section 8(d)(2) of the Act. Petitioner failed to prove any permanent partial disability with regard to his right arm contusion as it appears to have resolved and Petitioner did not testify regarding any ongoing problems with it.

Petitioner sustained a low back strain and left knee strain as a result of the August 2, 2011 accident. He received appropriate conservative treatment and was at maximum medical improvement as of November 8, 2011 for his left knee and September 25, 2012 for his low back. Petitioner 10/7/2011. Petitioner did not miss a great deal of time from work and returned to full duty work. With regard to his knee, he has undergone no surgery nor has any

been recommended. Petitioner has, however, consistently noted knee pain with certain activities at work since being released by Dr. Plattner.

While Petitioner testified that he continues to have back pain that interferes with his ability to work and personal activities, he failed to provide corroborating medical evidence that his ongoing back pain is causally related to or a consequence of the work accident. The treating spine specialists opined that his back problem was age-related degenerative disc disease.

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STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Manuel Olea Diaz,

Petitioner,

vs. NO: 16WC 11784

Food Evolution,

Respondent,

18IWCC0232

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 13, 2016 is hereby affirmed and adopted.

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

18IWCC0232

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 13 2018

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CJD/rlc
049

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

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

DIAZ, MANUEL OLEA
Employee/Petitioner

Case# **16WC011784**

FOOD EVOLUTION
Employer/Respondent

18IWCC0232

On 10/13/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.49% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1920 BRISKMAN BRISKMAN GREENBERG
RICHARD VICTOR
351 W HUBBARD ST SUITE 810
CHICAGO, IL 60654

1454 THOMAS & PORTELA
KELLY JOHNSON
500 W MADISON ST SUITE 2900
CHICAGO, IL 60661

18IWCC0232

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Manuel Olea Diaz
Employee/Petitioner

Case # 16 WC 011784

v.

Food Evolution
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **9/26/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **3/21/16**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$21,632.00**; the average weekly wage was **$416.00**.

On the date of accident, Petitioner was **65** years of age, ***married*** with **0** dependent children.

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

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

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

ORDER

An accident did not occur, therefore, all benefits are denied.

Respondent shall be given credit for $815.77 for medical benefits to Premier Therapy, LLC.

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.

David A. Kane
Signature of Arbitrator

October 13, 2016
Date

ICArbDec19(b)

OCT 13 2016

----------e--------STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MANUEL OLEA DIAZ,
Petitioner,

vs. No. 16 WC 11738

RT WHOLESALE D/B/A
FOOD EVOLUTION,
Respondent.

STATEMENT OF FACTS

Testimony of Petitioner

The Petitioner's testimony at trial was relayed by a Spanish interpreter. He testified that he had been employed by the Respondent for 10 years. He had different jobs in the time that he was employed for them. Specifically, he was a driver, a warehouse worker and a production worker. He was a driver until February of 2016, at which time he was moved to the warehouse for daily work. He testified that he had to open cardboard boxes, take the containers out, put them in plastic bags on a dolly and then place the bags on the shelves. He indicated the cardboard boxes were on the higher shelves.

He testified that Rufino worked in the warehouse. He testified that

Rufino instructed him as to his job duties. He testified that various things needed to be lowered off the top shelves and "you had to use a ladder" to do it. He testified that he would get the ladder and lean it against the shelving where he was working.

He testified that on March 21, 2016 he was doing this job when the accident happened. The petitioner testified that he went to get the ladder and found it 10 meters away. He used the ladder and placed it up against the shelf. He testified that he had gone up about seven feet in the air when the ladder slipped out. He testified the ladder was more or less seven feet tall. He testified that when the ladder slipped out, it slipped out straight with the top of the ladder landing at the base of the shelves and the bottom of the ladder away from the shelving. He testified that when he fell, he hit his left knee on the ladder and then on the floor. He testified that he worked the rest of the day and did not tell anyone of the incident. He testified that the alleged accident occurred at approximately noon and he worked until 5:00 p.m. that day. He went to work the next day and did not report an accident. He testified that on the second day after the accident, he told his coworker, Rufino, at the warehouse. He indicated that no one else was present and that they spoke Spanish. No accident report was filled out. He testified that Cesar was the supervisor for the warehouse.

He testified that he first sought medical treatment on April, 9, 2016. He was referred to Dr. Sompalli by his attorney. An application for adjustment of claim was filed on April 2, 2016.

On April 9, 2016, the history provided to Dr. Sompalli was that of a left knee injury after falling off a ladder at work. (Pet. Exh. 1 and 2) He was sent for x-rays and an MRI on April 12, 2016. On April16, 2016, Dr. Sompalli's diagnosis was an aggravation of pre-existing arthritis and a meniscal tear which was related to the history of falling off a ladder at work. (Pet. Exh. 1 and 2)

The Petitioner went back to Dr. Sompalli on April 23, 2016, at which time he was referred to physical therapy and a left knee arthroscopy was recommended. The petitioner did a course of physical therapy from May 2, 2016 to May 19, 2016. (Pet. Exh. 1 and 2)

The petitioner was seen by Dr. Sompalli on July 30, 2016 for an exam. No changes were noted in his condition at that time. (Pet. Exh. 1 and 2)

The petitioner cancelled his last appointment with Dr. Sompalli on September 20, 2016.

He was given a light duty restriction from April 21, 2016 to the hearing date. He has been working for the Respondent since the alleged date of

accident. He has had no lost time. He has worked on the production line since the Respondent was given the modified duty restrictions from Dr. Sompalli.

He testified he had no accidents to his knee since the March 21, 2016 date of accident.

He testified that he had private health insurance through Land of Lincoln. This insurance was not accepted by his chosen doctor, Dr. Sompalli. He testified that he would need to get a referral to another physician through his primary care physician and he did not have the money to pay for a primary care office visit. He also testified that he would not be able to maintain his health insurance because it was too expensive.

The Petitioner testified that he was required every Friday to fill out a form indicating whether he had an accident or had witnessed an accident prior to picking up his check. The Petitioner testified that he had filled out the form for the week of 3/18/16 – 3/24/16. (Resp. Exh. B) He testified that he indicated on the form, he had not had an accident and he had not witnessed an accident. (Resp. Exh. B) He signed the printed his name and signed form. (Resp. Exh. B) He testified that he didn't realize what the form was saying, that he had marked the questions in the same place he did every week. He testified that the form was in Spanish.

He testified that he had treatment on his left knee in 2015 at an Elmhurst Clinic that he saw in the newspaper. He testified that he had pain in his knee and had exams and injections. He had five injections. He did not have physical therapy or an MRI. He testified that he had felt ok after the treatment. He did not complain of swelling or pain. He testified that he had continued to work as a truck driver. He did not have any treatment between his last visit and the alleged date of accident on March 21, 2016.

Additional details regarding this treatment were laid out in the records from Osteo Relief Institute. (Resp. Exh. D) Prior to his alleged work injury, the Petitioner sought treatment for his left knee at Osteo Relief Institute. He was initially seen on April 14, 2015. (Resp. Exh. D, pg. 30) He reported dull aching and stiffness. His pain had started gradually and persisted for one year. He was complaining of increasing pain in the prior six months. X-rays were performed of the left knee which showed degenerative joint space narrowing with varus deformity. A loss of cartilage and joint space narrowing was noted causing ligamentous laxity and instability. (Resp. Exh. D, pg. 31) It was noted the petitioner had failed conservative therapy over the prior six months, including NSAIDs, steroid injections, and physical therapy. (Resp. Exh. D, pg. 31) The Petitioner reported he did not want surgery at the time of that examination. (Resp. Exh. D, pg. 31) A series of

viscosupplementation was recommended as well as physical therapy. (Resp. Exh. D, pg. 31) The Petitioner had his first Hyalgan injection on April 14, 2015. (Resp. Exh. D, pg. 28) He also began physical therapy that day. (Resp. Exh. D, pg. 26)

The Petitioner had a second Hyalgan injection and session of physical therapy on 4/21/15. (Resp. Exh. D, pg. 22-24) The Petitioner had a third Hyalgan injection and session of physical therapy on April 28, 2015. (Resp. Exh. D, pg. 17-19) The Petitioner had his fourth Hyalgan injection and session of physical therapy on May 5, 2015. (Resp. Exh. D, pg. 13-15) The Petitioner had his final (fifth) Hyalgan injection and session of physical therapy on May 12, 2015. (Resp. Exh. D, pg. 9-11)

The Petitioner was seen on May 22, 2015 in the emergency room at Stroger Hospital on May 22, 2015. At that time, the Petitioner was complaining of pain and swelling in his left knee. He was given ibuprofen and topical lidocaine. The diagnosis was that of pes anserine bursitis. He was referred back to Osteo Relief Institute.

The Petitioner returned to Osteo Relief Institute on June 11, 2015. H reported an increase in his left knee pain. He indicated the pain was 10/10 approximately 75-100% of his awake hours. (Resp. Exh. D, pg. 4) He noted no overall improvement with the viscosupplementation. (Resp. Exh.

D, pg. 4) It was noted the Petitioner had failed to respond to Hyalgan injections and alternative visco product like Orthovisc or Euflexxa was discussed. (Resp. Exh. D, pg. 5)

In his last office visit to the Osteo Relief Institute was on June 25, 2015, the petitioner reported a worsening of symptoms. At the time of that last visit, the Petitioner had reported pain 75%-100% of the day at a 9/10 on the pain scale. (Resp. Exh. D, pg. 2) He noted no overall improvement following viscosupplementation. (Resp. Exh. D, pg. 2-3)Given the lack of improvement following the Hyalgan injections, he was given the option of a cortisone injection or an alternate series of visco-Orthovisc injections. (Resp. Exh. D, pg. 3) The Petitioner did not return.

The Petitioner testified that currently his knee hurts when he is standing doing his job. He testified that he is not walking or using ladders at work. He testified that it hurts when he lifts at work. He testified it gets better after he has been home, but gets worse when he walks or uses the stairs. He does not have pain sitting down or getting up. He takes over the counter ibuprofen for pain.

On redirect by Petitioner's attorney, after the Respondent witnesses testified, the petitioner testified that there were two ladders and a shelf behind the stack of bagged containers in the forefront of the photograph.

(Resp. Exh. A)

Testimony of Diana Maldano

Ms. Maldano testified that she was employed as the Human Resources Director for the Respondent. She had been in that position for five years. She was working in this position on March 21, 2016. He indicated that the procedure for reporting an accident was to tell the supervisor of the accident. To ensure the timely report of accidents, they had each and every employee fill out a report indicating whether that employee had been in an accident or witnessed an accident every week. The form was filled out weekly at the time the employee retrieved their paycheck. She testified that he had been working as a driver since before she had started with the company. She testified that in February there had been an accident with another employee that caused the petitioner not to want to drive. She testified that to help him keep his mind off things they provided him with a warehouse position temporarily. She testified that he was not doing a specific job. She indicated that what he was doing was placing bags of plastic food containers onto shelves in the warehouse.

When asked about the way in which the boxes were brought into the warehouse, she testified that they came directly from Receiving. There were cardboard boxes with bags of plastic food containers inside. The

containers were meant for prepackaged food, like salads that would be generated in the production line. She testified that the boxes were unpacked directly from receiving and the bagged plastic containers were put on a dolly to be placed on the shelf for the following day's production line. When asked how many shelves there were for the placement of the containers, she indicated there were only two shelves. She testified that the warehouse was not that big and that the highest shelves were below eye level. Specifically, she testified she was about 5'6" and she estimated the highest shelf to be approximately 5 feet high. She testified that there was a ladder at the warehouse that was kept in the back. The ladder was about 4 feet high.

She testified that she was in and out of the warehouse all day long on a daily basis. She testified that she had not seen the petitioner using the ladder. She testified that a ladder would not be necessary to place the containers on the shelves.

She testified that Rufino was not the petitioner's supervisor. She indicated Cesar was the warehouse supervisor.

She testified that the photograph showing a movable shelf with containers on it was an accurate depiction of the items the petitioner would have been placing on the shelves on March 21, 2016. (Resp. Exh. A) She

testified that the bagged containers would already have been removed from the cardboard boxes. When asked to indicate on the photograph the top shelf the petitioner would have had to place containers on, she circled a shelf on the right side of the photo that was behind the stacked containers in the forefront of the photograph. (Resp. Exh. A)

She also testified that the petitioner had filled out a form for the week of 3/18/16 – 3/24/16, which indicated he had no accidents that week and had witnessed no accidents that week. (Resp. Exh. B)

She testified that the petitioner had not reported an accident to her and that no other employee had reported an accident to her for the week of 3/18/16 – 3/24/16. She further testified that there were no forms filled out by the petitioner or any other employee for that week, which indicated any accident had occurred.

She testified that the first time she was given notice of any alleged injury was about a month later when a clinic called asking for treatment authorization for a workers compensation case.

She testified that the petitioner did not miss any work following the alleged accident on March 21, 2016. He was still working the warehouse job until after they received a restriction notice. He was then placed on the production line as it met the doctor's restrictions as provided to them. She

testified that she did not at any time see the petitioner acting as if he had an injury, there was no indicator such as grimacing or limping. She testified that she saw him in the warehouse every day, but could not quantify the time she saw him, as it changed from day to day.

Testimony of Ceasar Ramirez

Mr. Ramirez testified that he had worked as the Plant Manager for approximately thirteen years. He was working on March 21, 2016. He was Mr. Diaz' supervisor at the time of the alleged accident. He did not personally train the petitioner in his job duties as other employees were in charge of that.

He testified the petitioner was stacking bags of containers on the shelves in the warehouse. He testified that there were only two shelves on which to place the containers and the highest shelf was about 5 feet high and 7 feet long. He testified that there were racks/shelves behind the stacked containers in the forefront of the photograph. He testified that the ladder was a folding step ladder with two sides coming to the middle. He testified that the ladder was approximately 4 feet tall.

He testified that the petitioner would not have had to unpack the bagged containers from the cardboard boxes. That would not have been part of his job.

He testified that he did not see the petitioner fall off a ladder and he did not see the petitioner use a ladder on March 21, 2016. He testified he did not see a ladder on the floor on March 21, 2016. He testified that a ladder was not necessary to perform the job the petitioner was doing.

He testified that he did not see the petitioner showing any signs of an injury, including grimacing, limping, etc.

He testified that the petitioner did not tell him he had an accident and that no one else told him that there had been an accident on March 21, 2016.

ISSUES IN DISPUTE

In support of the Arbitrator's decision relating to (C), Did an accident occur that arose out of and in the course of the Petitioner's employment by Respondent?, the Arbitrator finds the following facts:

In order to determine whether an accident occurred, the Arbitrator has utilized the testimony of the Petitioner, Diana Maldonado, and Caesar Ramirez. He also notes photographic evidence, the accident report form and the medical records to determine the likelihood of an incident on March 21, 2016.

The petitioner gave a history of an injury to his left knee while at work on March 21, 2016. Specifically, he testified he was near the top of a

seven (7) foot leaning ladder, when the ladder slipped out across the floor behind him, causing him to fall on his left knee. There are numerous disputes with regard to the set up of the warehouse and the way the injury could have happened. One or two inconsistencies may be overlooked, however, the sheer number of issues calls into question the veracity of the Petitioner's testimony.

The Petitioner was the only person to testify to twelve (12) foot high shelving and a seven (7) foot leaning ladder. Both Respondent witnesses testified credibly that there was a ladder in the warehouse, however, both testified that the ladder was approximately four (4) feet high and was an A-frame folding ladder, like a step ladder. Both Respondent witnesses also testified that a ladder would not have been necessary to reach the rack/shelf where the plastic containers needed to be placed. They both testified that the highest shelf the petitioner would need to place the containers was approximately five feet high.

Both Respondent witnesses testified that they never saw the Petitioner using a ladder, they never saw him on a ladder that day, and there was no evidence that the Petitioner had fallen off a ladder that day. The Petitioner did not tell anyone he had an accident. The Petitioner did not request medical assistance after the alleged seven foot fall. In fact, he

finished five more hours of work that day, which according to his description of his job duties would have including climbing ladders. He lost no time from work and showed no signs of having sustained an injury, such as facial grimacing or limping. The Petitioner continued his warehouse position until after he was given restrictions nearly a month later. He made no reference to any problem completing his claimed duties of climbing ladders and carrying down cardboard boxes of plastic containers.

The timing and method of reporting of the alleged accident was also of note. The Petitioner had a prior workers compensation accident with this Respondent that was reported and settled previously. Therefore, he would have been aware of the procedure to report his injury. The Petitioner did not report the alleged accident to his supervisor or to human resources which is on site, adjacent to the warehouse. Furthermore, Ms. Maldando testified that the company has a procedure in place to avoid any issues with the reporting of accidents. Each employee is asked to indicate on a weekly basis whether an injury had occurred during the prior week. This is done on a simple form with two questions 1) Whether the employee sustained an accident that week and 2) Whether the employee witnessed an accident that week. The form signed by the Petitioner for the week of the alleged accident. (Resp. Exh. B) The questions are written in Spanish,

so the Petitioner would have been able to understand the simple questions. The Petitioner had clearly indicated that he sustained no accident and witnessed no accident for the week of 3/18/16 – 3/24/16. (Resp. Exh. B) The Petitioner's testimony that he just marked in the same place he always did does not make sense, especially if he had already told his co-worker, Rufino, of the accident. It is also of note that no other employee, including Rufino, reported the knowledge of an accident either to the manger or HR director verbally, or in written form on the weekly report.

There is no evidence of any medical trauma on March 21, 2016, until nearly three weeks after the alleged seven foot fall. The Petitioner had health insurance. If an accident had occurred, he could have either reported it as a workers compensation accident or sought treatment through his private group insurance. However, he did not seek treatment. He did not show any evidence of a traumatic injury. He did not miss any work.

The Petitioner alleges the fall resulted in him falling directly onto his left knee. This was the same knee that he had prior medical treatment for in 2015. (Resp. Exh. D, page 2) The Petitioner's complaints at that time included pain for a year prior to treatment. The treatment had included five (5) injections to the Petitioner's left knee. Petitioner testified that his knee

had resolved after the visco injections. However, at the time of his last office visit on June 25, 2015, the office note indicates that the petitioner had reported a worsening of symptoms. At the time of that last visit, the Petitioner had reported pain 75%-100% of the day at a 9/10 on the pain scale. (Resp. Exh. D, pg. 2) He noted no overall improvement following viscosupplementation. (Resp. Exh. D, pg. 2-3) Given the lack of improvement following the injections, he was given the option of a cortisone injection or an alternate series of visco-Orthovisc injections. The petitioner did not return. During his testimony, the Petitioner noted financial difficulty in maintaining his group insurance, he also indicated that the treatment that had been recommended would not be authorized by his insurance.

As previously indicated, one or two of these inconsistencies might be able to be explained away. However, the sheer number of inconsistencies causes this Arbitrator to question the credibility of the Petitioner. Given the known financial difficulties surrounding medical treatment through his group insurance, the lack reporting and inconsistent details of the alleged accident, the Petitioner has failed to prove an accident occurred on March 21, 2016 which resulted in an injury to his left knee. Therefore, all benefits are denied.

In support of the Arbitrator's decision relating to (F), Is the Petitioner's current condition of ill-being causally related to the injury?, the Arbitrator finds the following facts:

There has been a finding of no accident, therefore, the issue of causal connection is moot.

In support of the Arbitrator's decision relating to (J), Were the medical services that were provided to the Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?, the Arbitrator finds the following facts:

There has been a finding of no accident, therefore, the issue of reasonable and necessary medical treatment is moot.

In support of the Arbitrator's decision relating to (K), Is the Petitioner entitled to any prospective medical care?, the Arbitrator finds the following facts:

There has been a finding of no accident, therefore, the issue of prospective medical care is moot.

CONCLUSION

The Arbitrator does not find the Petitioner's testimony to be credible regarding accident. The Petitioner's description of the ladder and shelving is inconsistent with the Respondent's description of the ladder and shelving housed within the warehouse. The Petitioner did not report any accident on the day that it occurred, despite his claim of falling nearly seven feet. The Petitioner had worked for the Respondent for ten years. He knew

Cesar Ramirez was the supervisor of the warehouse. He had ample opportunity to report an accident to Cesar, but did not. Furthermore, he indicated to the Respondent in writing that no accident had occurred the week of 3/18/16 – 3/24/16. The Petitioner did not seek any medical care for three weeks after the alleged accident and after he had consulted with an attorney. The Petitioner had preexisting left knee complaints and additional treatment had been recommended prior to his alleged date of accident. The Petitioner testified that he could not afford the premium and co-payments from his private group insurance.

Based upon all of these factors, the Arbitrator does not find an accident to have occurred on March 21, 2016. As the Petitioner was unable to prove an accident occurred, medical benefits, past and prospective are denied. All other issues are moot.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ANTONIO THOMAS,

Petitioner,

vs. NO: 12 WC 007955

CEASEFIRE/THE WOODLAWN ORGANIZATION,

Respondent.

ORDER

Respondent, through Counsel, filed a Motion to Vacate or For Other Relief, with the Commission on January 28, 2016, seeking to vacate a Commission Order entered on July 26, 2012. Pursuant to Respondent's Motion, a hearing was held on October 19, 2017, before Commissioner Kevin W. Lamborn. The Commission, having the opportunity to review the transcript of the hearing, including the tendered exhibits, and after being advised of the facts and law, grants Respondent's Motion.

The July 26, 2012, Order was the result of a hearing presided over by Commissioner Lamborn on May 17, 2012, and made findings of fact and conclusions of law that an employer-employee relationship existed between Respondent and Petitioner and also that Petitioner's sustained accidental injuries that arose out of and in the course of his employment on January 17, 2012. Respondent maintained in its Motion and again before Commissioner Lamborn on October 19, 2017, that it had not received notice of the May 17, 2012, hearing.

The July 26, 2012, Order makes reference to both parties being represented by counsel. Respondent contests this assertion, claiming that no attorney had entered an appearance on its behalf prior to September 9, 2015. The Commission's database corroborates this.

No transcript was taken of the May 17, 2012, proceedings. The only explanation for the July 26, 2012, Order making reference to both parties being represented by counsel is that said reference was the result of a scrivener's error.

Respondent maintains it had no agent at the time of the May 17, 2012, hearing who would have received notice and also that no officer within the organization received notice of the hearing. To that end, Respondent provided Commissioner Lamborn with an affidavit on October 19, 2017, signed by Georgette L. Greenlee, Respondent's former Executive Director.

It is noted that the May 17, 2012, hearing was the continuation of a hearing that occurred on April 19, 2012. Notice of the April 19, 2012, hearing was sent to Respondent by Petitioner, via Certified Mail, to 6040 S. Harper Avenue, #2, Chicago, Illinois 60637. Respondent's affidavit states that address was and is not its mailing address and, furthermore, that the Certified Mail received at 6040 S. Harper Avenue, #2, Chicago, Illinois 60637, was not received by anyone within the organization or anyone authorized by the organization to receive the same. The Commission cannot find any evidence that Respondent was made aware of the continuation of the April 19, 2012, hearing until May 17, 2012.

Petitioner tendered into evidence a copy of a voucher addressed to him and purportedly provided to him by Respondent. The voucher indicates Respondent is located at 6040 S. Harper Avenue, Chicago, Illinois 60637. The Commission notes the address on the voucher does not include a unit number. The Commission cannot presume despite the voucher and the Certified Mail being mailed to the same street address that Respondent received any mail addressed to Unit 2 at that address and, therefore, would have been aware of the pending proceedings.

The lack of any evidence to the contrary compels the Commission to conclude Respondent received no notice of the April 19, 2012, hearing or the subsequent May 17, 2012, hearing and, therefore, was not provided with the opportunity to address Petitioner's claims.

IT IS THEREFORE ORDERED BY THE COMMISSION that the May 17, 2012, Order of the Commission is hereby vacated and has no legal effect.

IT IS FURTHER ORDERED BY THE COMMISSION that a Preliminary Hearing Pursuant to Section 4(d) shall be held at time and date convenient to the Commission and both parties; absent any such agreement as to the time and date for the hearing, either party can file the appropriate motion with the Commission set forth a time and date for the hearing.

No bond for removal of this cause to the Circuit Court by Respondent is required as the Commission has entered not award for the payment of money has been entered. 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.

APR 17 2018

DATED:
KWL/mav
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Geralyn Niwranski,

Petitioner,

vs.

NO: 14 WC 14870

Grand Prairie Transit,

Respondent.

18IWCC0233

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 6, 2017, is hereby affirmed and adopted.

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

18IWCC0233

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

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

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

DATED: APR 17 2018
TJT:yl
o 2/20/18
51

Kevin W. Lamborn

Michael J. Brennan

DISSENT

I respectfully dissent from the opinion of the majority and would reverse the Arbitrator's Decision in part. After considering the totality of the evidence, I believe Petitioner met her burden of proving by a preponderance of the evidence that her current condition of ill-being is causally related to the March 12, 2014, work accident.

Petitioner was a 44-year-old school bus driver on the date of accident. The parties stipulated that a work accident arising out of and in the course of Petitioner's employment occurred on March 12, 2014. It is undisputed that a vehicle hit the school bus while Petitioner sat in the driver's seat. Petitioner testified that she was holding onto the bus steering wheel with her left hand at the moment of impact. Petitioner also testified that her seatbelt "locked" and her body jerked forward and backward due to the impact. There is no evidence disputing Petitioner's testimony regarding her mechanism of injury. Likewise, the described mechanism of injury certainly can account for Petitioner's ongoing cervical and left shoulder complaints.

"'A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury.'" *Shafer v. Ill. Workers' Comp. Comm'n*, 2011 IL App (4th) 100505WC, 38 (quoting *Int'l Harvester v. Indus. Comm'n*, 93 Ill. 2d 59, 63-64 (1982)). Here, Petitioner testified that prior to the work accident she never

18IWCC0233

experienced any issues with her left shoulder or cervical spine. Respondent notably did not submit any evidence of prior complaints or treatment for those body parts. The medical records corroborate Petitioner's testimony regarding her complaints following the work accident. In fact, the medical records reveal Petitioner complained of left shoulder pain on the date of accident.

The Arbitrator relies partly on the opinions of Dr. Atluri, Respondent's Section 12 examiner, when determining causation. However, Dr. Atluri's conclusion that Petitioner did not suffer an injury as a result of the work accident is clearly contradicted by the medical records. While Dr. Atluri opined a low-speed impact (his understanding of the accident) would not cause Petitioner's complaints, Dr. Atluri failed to address the fact that Petitioner reported the impact of the crash caused her body to jerk forward and back and caused her seatbelt to "lock." It appears Dr. Atluri did not have a complete and accurate understanding of the motor vehicle accident. Dr. Atluri opined that there were no objective findings correlating with Petitioner's subjective complaints. However, the doctor also noted that he did not identify any inconsistencies during the examination and Petitioner was fully cooperative throughout the exam. There is no suggestion that Petitioner is malingering or engaging in symptom magnification. Finally, Dr. Atluri fails to provide any possible alternative explanation for Petitioner's left shoulder complaints given Petitioner's lack of any prior injuries or treatment and her complaints of left shoulder pain on the date of accident. For these reasons, I believe Dr. Atluri's opinions lack credibility.

Additionally, the Arbitrator attempted to discredit Petitioner by focusing on alleged inconsistencies in her testimony. Notably, the Arbitrator concluded that Petitioner gave an inconsistent history "of the contact between the Mercedes Benz and the [b]us." The Arbitrator greatly mischaracterizes Petitioner's testimony regarding this issue. Respondent's counsel unsuccessfully tried to impeach Petitioner using statements in an inadmissible police report. Petitioner testified that she never read the identified portion of the police report and did not recall ever telling the police officer that the impact was gentle and there was no visible damage to the bus. Respondent did not present the police officer as a witness. Thus, the only evidence is Petitioner's testimony that she does not recall making those statements to the officer. The Arbitrator had no basis to determine Petitioner testified inconsistently regarding the statements in an inadmissible police report and to place prominent weight on this alleged inconsistency.

Any inconsistencies found in Petitioner's testimony concerned issues relating to her work capabilities and her decision to relocate downstate. Her testimony regarding those issues has no bearing on the discrete question of causation, particularly when the medical records corroborate Petitioner's testimony regarding the work accident and her resulting symptoms. Instead, any inconsistent testimony regarding her relocation and work capabilities goes to the question of whether Petitioner met her burden of proving an entitlement to any temporary disability benefits. I agree that Petitioner failed to meet her burden of proving an entitlement to temporary disability benefits. I also agree that Respondent's actions were not vexatious or unreasonable. Thus, the Arbitrator properly denied the request for penalties and fees.

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For the forgoing reasons, I would reverse the Arbitrator's Decision in part and find Petitioner's current condition of ill-being is causally related to the March 12, 2014, work accident.

Thomas J. Tyrrell

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

NIWRANSKI, GERALYN
Employee/Petitioner

Case# **14WC014870**

GRAND PRAIRIE TRANSIT
Employer/Respondent

18IWCC0233

On 1/6/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.63% 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:

1920 BRISKMAN BRISKMAN & GREENBERG
SUSA E FRANSEN
351 W HUBBARD ST SUITE 810
CHICAGO, IL 60654

0530 TUCKER ROBIN & MERKER
BONNIE BIJAK
30 N LASALLE ST SUITE 2736
CHICAGO, IL 60602

18IWCC0233

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b) & 8(A)

Geralyn Niwranski
Employee/Petitioner

v.

Grand Prairie Transit
Employer/Respondent

Case # **14** WC **014870**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **November 14, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **March 12, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$5,938.08**; the average weekly wage was **$247.42**.

On the date of accident, Petitioner was **44** years of age, *single* with **0** dependent children.

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

ORDER

Petitioner's current condition of ill-being is not causally related to the work incident of March 12, 2014.

Respondent has paid all appropriate charges for reasonable and necessary medical services as result of the incident of March 12, 2014.

Petitioner is not entitled to prospective medical care pursuant to Section 8(a) of the Act.

No TTD benefits are due and owed in this claim.

As a result of the above, no penalties are warranted in this matter.

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

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

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

Signature of Arbitrator

12-30-16
Date

ICArbDec19(b)

JAN 6 - 2017

GERALYN NIWRANSKI VS. GRAND PRAIRIE TRANSIT

14 WC 014870

STATEMENT OF FACTS

On March 12, 2014, the Petitioner claimed that she sustained an injury to her left shoulder while working for the Respondent. (Application). The Petitioner testified that before March 12, 2014, she had never had any type of problems with her left shoulder or arm. (TX. P 7). She had been working for the Respondent as a part time bus driver for less than six months or since September 2013 (TX. PP 8-9, RX EX 4 P1).

On the date of the incident, she was covering a "fill in" route at a school in Willow Springs. (TX. P 9). She was stopped picking up three little girls from the school and while the teacher assistant was strapping the children down in the bus and talking to them, the bus was hit. (TX. PP 10-11). The Petitioner testified that while she had her hand on the steering wheel, she was watching through "the angel mirror" to see when the aide was going to sign for the children when the bus was struck by a vehicle. (TX. PP 10-11). It was a hit and run but they found out the name of the driver of the Mercedes Benz that made contact with the bus. (TX P 12). The Petitioner testified that the impact forced her to move forward and backward locking her seat belt. (TX P 11).

The bus company's procedure for a driver after an accident, was to contact dispatch regarding the incident, although first she asked the teacher's aide if she and the children were okay. (TX P. 13). The teacher's aide responded that everyone was fine and upon being reassured of that the Petitioner picked up the CB and contacted dispatch at the Bus Company (TX. P 13). She advised the dispatcher that the person drove off but she had gotten the license plate number. (TX P14).

The Petitioner testified that after the incident she had a conversation with Towanda White who was one of the managers of the bus company and she believed that Towanda was the one that dispatched the police to the school. (TX PP 14-15). The Police came to the school to take a report (TX. P. 15). On cross examination, the Petitioner denied telling the police that a black Mercedes Benz with an Illinois registration of N, as in Nancy 97368 gently struck the left rear and side of the bus with the front end of the Mercedes Benz leaving no scratches or visible damage to the bus (TX. P39, P42).

The Petitioner drove herself back to the home base and filled out an incident report for the bus company. (TX. P 44, RX EX 8). The incident report indicated that no one was transported by ambulance from the scene. (RX. EX. 8, P. 3).

She further testified that she after completing her afternoon route she told her supervisor Towanda that she believed that she was injured and she was sent to Concentra Health Centers of Illinois (TX P 17). The doctor examined her left shoulder, took an x-ray, a urine test and they spoke. (TX P 17). She returned to Concentra the next day, March 13, 2014 and was released to full duty. (TX. P 18).

Concentra records indicate that the Petitioner appeared at their facility in Darien during the early evening of March 12, 2014 (PX EX 1, P 15). The treatment was authorized by Towanda White, the Safety & Compliance officer at Grand Prairie Transit (PX EX 1, P 14). An x-ray of her left shoulder showed no fracture, malalignment or focal osseous abnormality. (PX. EX 1, P 15). She provided them a history of being parked at a curb when the bus was hit in the back end left corner, and she was now having problems with her left shoulder hurting down to her elbow. (PX EX 1, P13). During the physical examination the Doctor noted that there was no deformity, ecchymosis, erythema, and swelling and there was mild tenderness to palpation of the anterior shoulder, posterior shoulder and deltoid muscle. (PX EX 1, P6). She had full range of motion of her left shoulder, in all directions, full grip strength and sensory was intact to light and sharp touch. (PX EX 1, P6), Patient was instructed to ice the area and was prescribed ibuprofen and Tylenol. (PX. EX. 1, PP 7/11). The diagnosis was a shoulder strain. (PX. EX 1, P6).

She returned to the clinic the next day and advised them that the medication helped and she was working regular duty. (PX. 1 P1). She was advised to return if her condition worsened (PX. 2).

The Petitioner testified that the pain was getting worse, and described it as traveling across her shoulders, down the center of her back and across her neck, but she continued to work (emphasis added). (TX. P18). She went to see Dr. Barbara Heller, her primary care physician on March 28, 2014. (TX. P19). Dr. Heller's records indicate that her job told her to obtain a lawyer who allegedly recommended Dr. Heller as a treating doctor. (PX. EX 3, Page 3). At that visit the doctor's note indicates that she continued working full duty as a school bus driver without difficulty. (PX EX 3, P 3). The diagnosis was left rotator cuff strain and it was recommended that she undergo physical therapy, take mobic, and continue working full duty. (PX3, P. 5).

She was referred to physical therapy at Accelerated Rehabilitation and attended sixteen physical therapy sessions in Darien Illinois from April 8, 2014 through June 9, 2014. (TX. P20; PX. EX 6 PP 1-2). The Petitioner testified at the hearing that Dr. Heller prescribed some pain pills and gave her a couple of shots of cortisone in the back of her shoulder; however, the Arbitrator notes that there are no records that were submitted supporting that Dr. Heller provided cortisone shots (TX. P21).

At the initial PT evaluation at Accelerated in Darien Illinois on April 8, 2014 (nearly a month after the alleged incident), the petitioner advised them that she is unable to steer with her left arm and it was difficult for her to pop the hood of the school bus and make left arm hand turns. (PX. EX 7, P1). The Petitioner is right hand dominant. (TX P 12).

The Petitioner saw Dr. Heller a second time on April 18, 2014. (PX. EX. 2, P.1). At the second visit on April 18th the doctor noted that PT was improving her shoulder and it was recommended that she continue working full duty. (PX. EX 1) The assessment was "Improving Shoulder pain" and continue therapy (PX EX 3, P 1). In a physical therapy

appointment on Aril 28, 2014, the Petitioner advised the therapist that her shoulder has been achy lately "especially since the change in weather. (PX 7, P 8).

On May 14, 2014 the Petitioner completed a refresher school bus training program, and was presented with a certification by the DuPage Regional Office of Education. (TX PP 50-51; RX EX 10). While she did not have to go through any physical efforts to secure the certificate the Arbitrator takes note that she made the effort to update her requirements for driving a bus, which appears to be contrary to her testimony that she was having ongoing pain and could not work. (TX. PP 57-58).

On May 16, 2014 the Petitioner filled out a form for the respondent indicating that she would be available for summer work, but did not know if she would be available in the fall because she was going to be moving to Southern Illinois (TX. PP 47-48; RX EX 9). In her interrogatory answers, in the pending Third Party Claim, the Petitioner indicates that she was unable to work starting in August 2014 to the present (RX. EX 7, P4). The Arbitrator also notes that on that same date, the Petitioner executed a HIPAA Authorization for Dr. Heller to release her records to her attorneys Briskman, Briskman & Greenberg. (PX. EX. 3).

On June 6, 2014 at the request of Gallagher Bassett, the Petitioner saw Dr. Atluri, a hand and shoulder doctor. (TX 38). The petitioner testified that she only spent five to ten minutes with Dr. Atluri and that he only asked her one question about where her pain was. (TX. PP 58-59). Dr. Atluri noted in his report that the Petitioner was a restrained driver of a school bus, parked at a curb, while children were boarding the bus. (RX. EX. 2, P1). He further noted that she indicated that her left hand was gripping the steering wheel and her arm was positioned at her side, when the bus was rear ended. (RX. EX. 2, P1). Dr. Atluri noted that the petitioner did not initially feel pain, but a half hour later she felt pain at the left side of her neck and the superior aspect of her left shoulder. (RX. EX. 2, P1).

Dr. Atluri performed a physical examination of the petitioner. (RX. EX. 2 P 2) Dr. Atluri opined that there were no objective findings correlating with her subjective complaints and he felt that a low velocity collision, was not a plausible mechanism of injury. (RX. EX 2 P 3). He further opined that any problem with her left shoulder is not related to any work injury. (RX. EX 2 P 4). Dr. Atluri further indicated that she can continue to work without any restrictions (RX. EX. 2, P4) Dr. Atluri added that further treatment for her left shoulder may be appropriate but the additional treatment is not related to a work injury. (RX. EX 2, P4). Based upon Dr. Atluri's report no further treatment for the alleged incident of March 12, 2014 was authorized by Gallagher Bassett. (PX EX 7, P28; PX. EX 9, P86).

On July 1, 2014, the Petitioner started treating with Dr. Tony Chami of Chicagoland Advanced Pain Specialists. (TX. 21). On cross examination, at the 8(a) hearing, the petitioner testified that she went to see Dr. Chami at the recommendation of her attorneys. (TX. P46) During that first visit, Dr. Chami indicated that her chief complaint was "arm pain" but then went on to diagnose cervical spondylosis without myelopathy. (PX. EX 9 P. 1). He indicated that the patient had undergone left shoulder steroid and anesthetic injections; and the Petitioner testified that she had some but the Arbitrator notes that the only records for injections in the records provided were done by Dr. Chami, after the fact, so that appears to be another inaccurate history

(TX P 21, PX EX 9, P. 1). Dr. Chami recommended a trial of diagnostic and therapeutic facet joint injections at C3-4, C4-5, and C5-6 on the left side. (PX. EX 9, P1). The Petitioner was prescribed Mobic 7.5 along with ranitidine as a gastric protective agent and Ultram. (PX EX 9, P 1). Dr. Chami further recommended continued PT. (PX. EX 9, P2). The Arbitrator notes that the history provided to Dr. Chami was that on March 13, 2014 (sic) the petitioner was sitting in a school bus when an SUV struck the bus from behind and she experienced the immediate (emphasis added) onset of neck pain and left shoulder pain. (PX EX 9, P 2).

On July 2, 2014, a facsimile was sent to Anne Carlson of Gallagher Bassett requesting additional therapy authorization and it was denied based upon Dr. Atluri's IME report. (PX EX 7, P 28). On July 3, 2014, the Petitioner was provided a "no restrictions on driving note, per the patient request" by Chicagoland Advanced Pain Specialist (Dr. Chami), and the Arbitrator notes that an MRI was ordered for the left shoulder and cervical spine (TX P 52; RX EX 11; PX EX 9, P 20).

Dr. Chami started treating the Petitioner for her neck and upper back but the Petitioner did not recall when her neck started bothering her. (TX. P. 22). Dr. Chami referred her for MRI'S which were done on July 12, 2014. (TX. P22). The MRI of her cervical region showed spondylotic changes with straightening of the normal cervical lordosis and disc protrusions from C3-C4. (PX EX 5, P 2). The MRI of the left shoulder showed mild changes of acromiloclavicular arthropathy. (PX EX 5, P3).

In a follow up visit of July 18, 2014, Dr. Chami indicates that the patient advised him that she was compelled to return to work to avoid financial hardship after workers' compensation denied her claim. (PX EX. 8, P 21). The Arbitrator notes that this is inconsistent with the testimony that the petitioner stated indicating that she presented two light duty notes to the respondent. The petitioner underwent a cervical injection facet injection by Dr. Chami on August 14, 2014. (PX. EX 9, PP 32-33). The Arbitrator also notes that this is inconsistent with the petitioner advising her employer that she might be moving and not available to drive in the fall. (RX. EX 9, P1)

The petitioner saw Dr. Chami again on October 7, 2014 and his records indicate that she has had a difficult time obtaining treatment because of the distance she has to travel, which seems to confirm that at that point she had in fact moved out of the area. (PX. EX 9, P 41). He performed another left sided cervical epidural injection. (PX. EX 9, P -52). Dr. Chami also prepared an off work note for the petitioner (PX. EX 9, P 53). When she returned to see Dr. Chami on November 25, 2014, the petitioner indicated that she had a flare up of the left neck symptoms because of the recent dramatic weather changes and his records further indicate that she is employed. (PX. EX 9, P 55-57). An ESI Cervical/Thoracic Trigger point injection was done on that date. (PX EX. 9, P60-61).

The Petitioner started a second Physical therapy regime from December 10, 2014 through January 16, 2015 at Accelerated in Decatur Illinois, which was closer to her new home in Latham Illinois. (TX. P23). In the initial interview with that therapist on December 10, 2014, the petitioner talks about the incident where her body was "jarred" forward in a motor vehicle

accident. (PX EX 7, P31) She also advised them at that appointment that her condition was getting better (PX EX 7, P 34). In a therapy appointment on December 17, 2014, she told the therapist that she has been carrying her grandchild more lately. (PX. EX. 7, P 37). In a therapy appointment on January 6, 2015, at accelerated in Decatur, the Petitioner advised the therapist that she had a pinching pain on the left side of her neck and shoulder while she was folding laundry today and continued to report symptoms. (PX EX 7, P42). At the next visit on January 9, 2015 she advised the therapist that she "may be doing too much at home". (PX EX 7, P 43). In an Accelerated therapy note dated January 15, 2015, the therapist notes that the petitioner said she does not think she needs therapy anymore, that she has little pain, her arm is moving better and she can do most things around the house. (PX. EX 7, P 45-46). The Arbitrator takes note that the latter therapy that occurred in Decatur Illinois lists the Insurance as "Attorney Payer". (PX. EX 7, PP 31-48).

On March 6, 2015, at the recommendation of Dr. Chami the petitioner underwent an EMG. (TX. P 25). The last time the Petitioner treated with Dr. Chami was April 23, 2015 and he provided a prescription for more Physical therapy. (TX. PX 25). The patient allegedly was unable to work because of aggravations of her symptoms, particularly when she wears a seatbelt. (PX EX 9, PP 71-72). The Arbitrator notes that this appears to be inconsistent with information that the Petitioner testified to in saying that she has looked for jobs, and information she shared with therapists regarding activities of daily living at home such as carrying her granddaughter and doing laundry.

Dr. Chami indicated that there was sensory loss in the left upper extremity "consistent with the history" and documented by the EMG/NCV. (PX EX 9, P 71). The Arbitrator notes that since the "history of the work incident/accident" seems to be at the heart of this Petitioner's initial complaints, that the inconsistent histories are critical in this claim. The impressions that are listed in the EMG/NCV report indicate that the evidence is most consistent with a C6-C7 radiculopathy on the left, and mild carpal tunnel bilaterally, (PX. EX. 9, PP 81-85).

In a report dated May 26, 2016 and authored by Dr. Chami, at the request of the Petitioner's attorney, with an eye towards this litigation, Dr. Chami opined that during his initial examination of March 12 **(sic)** she revealed signs consistent with facet mediated pain. (PX EX 12, P1). (The Arbitrator takes note that the Petitioner did not see Dr. Chami until July 1, 2014 and that the date of the alleged incident was March 12, 2014). Dr. Chami's report of May 26, 2016 concurs that he had not seen the petitioner since April 23, 2015 and has no "further" information as to her current condition and disposition. (PX. EX 9, PP 81-85).

Dr. Chami's May 26, 2016 report further indicated that the MRI study that was done on July 12, 2014 evaluating her cervical spine and left shoulder showed bulging at C3-C4 and C4-C5 and mild acromioclavicular arthropathy changes of the left shoulder. (PX. EX 12, P1).

The petitioner testified that at some point, Dr. Chami put her on light duty restrictions, 25 pound limitation, occasionally maybe 50 and limited driving. (TX P 27). She stated that she presented a light duty note to Towanda (White) and that she should do no lifting. (TX. P 28). Ms. White testified that the only work notes she was ever given were from Concentra. (TX. P

65). The Petitioner testified that the copy of the note that she presented to her employer was at her home in Lathom, Illinois (TX. P 51). The Arbitrator finds it telling that no such notes were contained in the Accelerated Records nor in Dr. Chami Records.

The Petitioner testified that she moved out of the area in 2015 to Latham Illinois and testified that while she has never been released by a doctor, she has looked for work (TX PP 33-34). That appears to be contrary to the therapy records indicating that she was attending therapy closer to her new home in December 2014. (PX. EX 7, PP 31-46) The Petitioner testified that she has looked for work in grocery stores, convenience stores, and retail stores in the area, which would tend to lead the Arbitrator to believe that she is more than capable of working. (TX P 35).

The petitioner testified that she still has daily pain in her left shoulder and it goes from the neck to the elbow and left shoulder. (TX P 36). She receives prescription medication from her primary care physician Dr. Tracy Mizeur in Lincoln Illinois (TX P 37), who has prescribed meloxicam or mobic, an arthritic medication. No such records were submitted at the 8(a) hearing on November 14, 2016.

The petitioner confirmed in her testimony that she never requested additional care from anyone at Grand Prairie Transit (TX P 55). She did testify that she had conversations with both Towanda (White) and Terry (Boxel) about how to get her bills paid. (TX P 56).

Therese Boxel, the operations manager for Grand Prairie Transit testified on behalf of the respondent. She first became aware of the incident with the petitioner on March 12, 2014. (TX. P 61). She recalls that they went out to examine the bus after the Petitioner returned to the shop, which was their practice (TX PP 62-63). The Petitioner did not make any complaints of injury (TX. P. 64).

Ms. Boxel identified the form that was used by the respondent for the Petitioner's personnel status change. (TX. P 64, RX EX 12). The petitioner's form was filled out in May 2015, and her last date work was 8/1/14. (RX. EX 12). According to the form the Petitioner was eligible for rehire. (RX. EX 12). Ms. Boxel testified that she did not know why the petitioner left the employment of Grand Prairie Transit, other than the form that she filled out saying she may be moving. (TX P 65; RX EX 9).

Ms. Boxel testified that whatever they received from Concentra was the only information she had regarding a light duty work slip. (TX P 65). Concentra, which is the clinic that the bus company used for employees who might be injured on the job, sent the petitioner back and said she was clear to drive (TX P 66). She does not recall Ms. Niwranski ever asking for authorization to go to another doctor. (TX P 66). If she had asked Ms. Boxel for authorization, Ms. Boxel would have referred her to Gallagher Bassett for approval. (TX P 67). She does not recall ever referring Ms. Niwranski to Gallagher Bassett. (TX P 71). There is no light duty for bus drivers (TX. P 70). The Petitioner continued to work after the accident as is evidenced by her timesheets. (RX EX 5, PP 1-25) Terry Boxel further testified that she wanted the Petitioner to return to work. (TX. P 65).

The respondent also called Ms. Towanda White who is the safety and compliance officer for Grand Prairie Transit to testify at the hearing. (TX. P 72). Part of her responsibilities in addition to taking care of incidents or accidents is to make sure that employees are in compliance with DOT regulations and that they are medically and physically able to do their job. (TX. P 73).

According to the form that the Petitioner filled out the incident occurred at 11:30 a.m. (TX. P 75; RX EX 8, P 1). Ms. Niwranski did not complain about any physical injury until after her afternoon route. (TX P 76). Ms. White had to confirm that it was all right to send the Petitioner to Concentra because it was already after the incident. (TX. P 76). The care was approved and Ms. White gave her the paperwork, and the Petitioner drove herself to the clinic. (TX. P 76). The Petitioner did come back to her after she was released by Concentra and was complaining of pain and said she was going to sue the lady. (TX PP 77-78). Ms. Niwranski continued to work throughout the summer of 2014. (TX P 78).

Ms. White attempted to call her about returning to her employment at Grand Prairie (TX. P 78). They usually attempt to contact the employee at least three times by phone to see if they plan on coming back (TX PP 78-79). When they could not get in touch with her they terminated her, but that was not until May 2015. (TX P 80; RX EX 12). When asked if she knew why the Petitioner did not return to work, Ms. White testified that she remembered the petitioner saying she had to take care of someone and that she was moving out of state. (TX P 80). The Petitioner never told Ms. White that she did not return to Grand Prairie Transit because of injuries she alleges from the incident of March 12, 2014. (TX. P 80).

Ms. White testified that she did not recall if she actually reached Ms. Niwranski's voicemail between August 2014 and May 2015 when the termination was entered. (TX EX 83). Upon being asked on cross examination if Ms. Niwranski told her she could not afford her medical bills, Ms. White testified that Ms. Niwranski never told her that about the bills and further testified that she never told the Petitioner to get a lawyer. (TX. P 83). Ms. White confirmed that there is no light duty available for bus drivers. (TX. P 84).

The Petitioner was called as a rebuttal witness and testified that she had provided Ms. White with at least two light duty notes. (TX. 87) The Arbitrator notes that a July 3, 2014, work status light duty note listed in the medical records indicates no restrictions pursuant to the Patient's request. (RX. EX. 11 P. 1; PX EX 9, P 20) There is a work status note dated July 1, 2014 in Dr. Chami's records but the box for return to work is not checked, and it lists no carrying/lifting/pulling/pushing greater than 25 pounds, no driving and no lifting above the shoulder (PX EX 9 P 16).

When asked about the note that indicated that she might not be able to return to work because she was moving, the petitioner indicated that after her summer route was over, she knew she was not going to be able to drive a bus anymore or financially be able to live here. (TX. 88) The Arbitrator notes that the form advising the Respondent that the Petitioner may not return in the fall because she may be moving south, was filled out on May 16, 2014. (RX. EX. 9 P.1).

The Petitioner further testified on rebuttal that she said she never received any voicemail messages from Grand Prairie Transit regarding her job and she had the same number that she has had for 14 years. (TX. PP 88-89).

Further on rebuttal the petitioner testified that the light duty slips were in her file at home in Latham Illinois; however, those slips were from after the dates that she saw Doctor Chami. (TX. PP 89-90).

In order to procure an updated report dated January 26, 2016, the respondent had Dr. Atluri review additional materials which included the clinical notes of Dr. Chami, electrodiagnostic study dated 3/6/15, the MRI reports of the left shoulder and cervical spine of 7/12/14 and Accelerated therapy notes. (RX EX 3, P1). Dr. Atluri stood firm in his opinion that there is no evidence that the Petitioner sustained a work injury on March 12, 2014.

THE ARBITRATOR ADOPTS THE ABOVE FINDINGS OF MATERIAL FACTS IN SUPPORT OF THE FOLLOWING CONCLUSIONS OF LAW:

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

The Arbitrator reiterates his findings of facts and incorporates same relative to this issue.

While the Petitioner may have required some care to her left shoulder, the Arbitrator finds
Dr. Atluri's June 6, 2014 and January 25, 2016 reports more persuasive that said care is not related to whatever work incident occurred on March 12, 2014.

The Petitioner's inconsistent histories of the contact between the Mercedes Benz and the Bus, the fact that the Bus personnel were not aware that the Petitioner continued treatment, the form that the Petitioner filled out indicating that she was not sure that she would return to the bus company in the fall due to the fact that she might be moving, the fact that she continued working until August 1, 2014, despite the fact that the doctor that her attorneys referred her to said not to work, the comments she made to physical therapists in Decatur once she moved down there, are all factors that lead this Arbitrator to believe that the Petitioner's current condition is not related to a work injury that occurred on March 12, 2014.

The Arbitrator finds that based upon the testimony of the Petitioner, the witnesses and the exhibits presented that the Petitioner's current condition is not causally related to the incident of March 12, 2014.

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

The Arbitrator reiterates his findings of facts and incorporates same relative to this issue.

The Arbitrator finds that the Respondent has paid all appropriate charges for all reasonable and necessary services, for care through June 6, 2014. In support of this, the Arbitrator takes note of the Respondent's payment list which indicates that payments were made to certain providers during the time frame through the date of Dr. Atluri's June 6, 2014 report.

The Arbitrator finds that any medical services rendered and bills are related to any alleged work incident.

K. Is Petitioner entitled to any prospective medical care?

The Arbitrator reiterates his findings of facts and incorporates same relative to this issue.

According to her testimony and the report of Dr. Chami, the petitioner has not treated for this injury since April 2015. Since she has testified that she has a physician in the area where she now resides, the reasons for no treatment seem to conflict with her ability to find a job.

The Arbitrator finds that the petitioner is not entitled to any prospective medical care.

L. What temporary benefits are in dispute?

The Arbitrator reiterates his findings of facts and incorporates same relative to this issue.

The Petitioner was released to return to work, full duty as of March 13, 2014. The Petitioner continued to work after the date of loss, until August 1, 2014, and did not return to employment at the bus company.

In the stipulation sheet, the Petitioner is claiming that she is owed TTD benefits from August 18, 2014 through the date of the hearing. (Arb. Ex 1). There is no explanation for that date of onset. The Arbitrator also notes that contrary to the testimony indicating that two light duty notes had been presented to the Petitioner's employer, no such notes are contained in the records.

The Arbitrator finds that no TTD benefits are due and owed in this claim.

M. Should penalties or fees be imposed upon Respondent?

The Arbitrator reiterates his findings of facts and incorporates same relative to this issue.

It is clear that based upon Dr. Atluri's reports and opinions, the testimony of the witnesses, including the Petitioner, that the respondent had a legitimate reason to believe that the petitioner's shoulder condition was not related to the incident that occurred on March 12, 2014. The fact that Dr. Chami, was treating her for a cervical problem, lends even more credence that the Respondent's actions were not vexatious nor unreasonable. To date, the Petitioner has not claimed a neck injury on her application for adjustment of claim before the Illinois Workers' Compensation Commission. In his purported causal connection report of May 26, 2016 to the Petitioner's attorney he did not even have the correct date of care.

In all likelihood, bus companies do not allow a driver who is in pain, on medication and cannot perform their duties to drive special needs children. Part of Ms. White's job duties was to confirm that drivers were medically able to fulfill their duties.

Penalties should be imposed where the denial or delay of benefit payments are in bad faith or for an "improper purpose." In the case at hand, not only was the Petitioner not able to show that further treatment was requested, she could not produce the light duty slips that she claimed she submitted to her employer. She advised her employer that she did not know if she would be able to return to her employment in the fall of 2014, because she might be moving, which she in fact did. The entire claim appears to be solely fueled by litigation, instead of a legitimate injury.

Accordingly, the Arbitrator determines that this is not an appropriate claim for fees or Penalties and relies about U.S. Holland, Inc., vs. The Industrial Commission et al (Lawrence Baker, Appellee) 829 N.E. 2d 810 (2005; 357 Ill.App. 3d 798; 293 Ill.Dec. 885.

Accordingly, the Arbitrator does not find that Penalties and Attorney's fees as requested from Sections 16, 16 (a), 19 (b), 19 (k) and 19 (l) are appropriate in this case and said request is denied.

STATE OF ILLINOIS)
)
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Andre Hudson,
Petitioner,

vs. No. 14 WC 23775

Metro Industrial Tire,
Respondent.

18IWCC0234

DECISION AND OPINION ON REVIEW

Respondent has timely filed a Petition for Review of the August 18, 2016 Decision of the Arbitrator, issued following hearing held under Section 19(b) on September 25, 2015 and February 25, 2016. Notice has been given to all parties. The Commission, after considering the issues of accident, causal connection, medical expenses including prospective care, and temporary total disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below. In particular, the Commission finds that Petitioner reached maximum medical improvement no later than three months post-accident, and accordingly modifies the Arbitrator's award of benefits as it concerns temporary total disability and medical expenses. The Commission otherwise affirms and adopts the Decision of the Arbitrator, a copy of which is attached hereto and made a part hereof.

The Commission remands this case to the Arbitrator for proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327 (1980).

18IWCC0234

I. BACKGROUND

A. Petitioner's Accident and Treatment

Petitioner, 30 years old at the time, alleged injury to his low and mid-back incurred on June 19, 2014. He was employed as a tire technician for Respondent, Metro Industrial Tire. The company sells and services industrial tires for forklifts and other slow-moving equipment used in factories, warehouses, and airports. Petitioner's duties up through his termination included mounting and dismounting these specialty tires, as well as general cleaning of the shop premises (sweeping, emptying wastebaskets, and the like).

The asserted date of accident, June 19, 2014, was a Thursday. Petitioner began his day with his cleaning tasks in the morning. Then, in the afternoon, he serviced tires that were brought in for changing, or dismounting and mounting. This work was being done for a regular customer, whose tire delivery had been expected that day. (Tr. 2/25/16 at 121-124). These tires were used on airport "tugs" (tractors that pull baggage carts). In servicing the tires, Petitioner was first required to lift the tire, with its metal rim, a distance between 12 to 18 inches off the ground and place it onto a tire press machine. According to Petitioner, each tire weighed 30 to 70 pounds. It took about 10 or 15 minutes to dismount the old tire from its rim and mount the new tire, and he could change 3 or 4 tires in this manner in an hour. Petitioner estimated that he dismounted and mounted 20 tires that afternoon. (Tr. 9/25/15 at 92-99). For Petitioner, this was just a "regular" day. (Tr. 9/25/15 at 18).

Petitioner finished the tires and left work around 5 p.m. As he testified, he "felt fine" and was not in pain. He went home, had dinner, played a video game, and went to bed, experiencing nothing out of the ordinary all the while. Then, the next morning, June 20, 2014, he woke up with severe low back pain. Petitioner eventually attributed this pain to his work activities from the previous afternoon, as that was the most recent physical activity he could remember.[1] (Tr. 9/25/15 at 18-21, 120-121; Tr. 2/25/16 at 131). When asked what he thought when he woke up about the cause of his pain, he stated, "At the moment … it didn't really dawn on me. And then as I thought back to, you know, as far as anything I had done, I hadn't done anything except for work that day." (Tr. 9/25/15 at 21).

Petitioner was not at work for 3 days (Friday through Sunday), over the course of which the pain did not subside.[2] On Monday, June 23, 2014, Petitioner returned to work at Respondent's shop and requested approval to be treated at Concentra Occupational Health Centers, the company clinic. According to Petitioner, Respondent's owner, Kevin Clarke, did not grant approval until the next day,

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[1] As well, the medical records are consistent in noting that Petitioner woke up on the morning of June 20, 2014 with back pain. The records do mention that he reported lifting and working with tires the previous afternoon, and there is no express mention that that he had any immediate onset of pain upon lifting, twisting, etc.

[2] Petitioner had previously requested that Friday off to attend a funeral; he testified that he was in pain throughout the two-hour service and had to alternate between sitting and standing. The shop was closed on Saturday and Sunday. Petitioner testified that on those days as well his pain was still "excruciating" and the "same." (Tr. 9/25/15 at 21-22; Tr. 2/25/16 at 126-127).

June 24, 2014. (Tr. 9/25/15 at 24-32). Petitioner immediately left the shop and went to the Concentra clinic. There, he was examined by Dr. Nina Taylor, who wrote:

> "Patient states that on 6/19 he was repeatedly lifting heavy metal cages to place them onto tires. On 6/20 woke up with low back pain and stiffness. Said he rested over the weekend and felt better yesterday and worked his regular shift. This morning he again woke with low back pain and stiffness as well as with some tightness in his mid-back. He complains of constant pain across his low back that he rates a 7-8. Pain is exacerbated by bending and prolonged sitting. Pain does not radiate. Denies any associated numbness or tingling of his lower extremities."

(PX 4 at 6/24/14). The assessment was lumbar strain, with impairments correlating with localized inflammation. Twice-weekly physical therapy at the clinic was prescribed. He underwent his first therapy session that afternoon. He was also placed on work restrictions, including a 20-pound lifting restriction. (PX 4). Pursuant to the restrictions issued by Concentra, Petitioner did light-duty tasks the following day, Wednesday, June 25, 2014. (Tr. 2/25/16 at 34-35). The next day, Thursday, June 26, 2014 – one week after the asserted accident -- Petitioner was terminated from employment at Respondent.[3] Petitioner attended his second (and last) physical therapy session at Concentra that afternoon. (PX 4 at 6/26/14).

Soon thereafter, Petitioner began what would turn out to be an enduring and active relationship with Advanced Physical Medicine Associates, S.C., beginning on July 2, 2014, when he presented to physiatrist Dr. John Sarantopoulos, D.O., for initial evaluation and treatment. Dr. Sarantopoulos wrote:

> "[Petitioner] performed [a] movement of lifting [a metal cage used to install tires weighing 100 pounds] 20 times at work on [June 19, 2014] and then the next day after being home from work he felt severe low back pain. He reported his injury to his work on or about the 22nd of June… His pain mainly involves his mid back and his low back. He rates his pain as 8/10 and describes it as constant and sharp. He states he does get radiating pain down both lower extremities. He also complains of pain with movements of the low back."

(PX 6 at 7/2/14). Regarding his assessment, Dr. Sarantopoulos wrote: "thoracic strain with associated myofascial pain, lumbar strain with associated myofascial pain, bilateral lumbar radicular symptoms, cannot rule out lumbar intervertebral disc derangement, status post work related injury of 6/19/2014." (PX 6). That day, Dr. Sarantopoulos performed "OMT [Osteo Manipulative Therapy] to the cervical,

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[3] Petitioner suggests that his termination was in retaliation for asserting a work-related injury under the Act or otherwise wrongful. Respondent disputes this assertion. The circumstances of Petitioner's termination are not material to the Commission's conclusions in this proceeding.

18IWCC0234

thoracic and lumbar spine with activator technique;"[4] prescribed Mobic and Norco; wrote an off-work slip; and promptly referred Petitioner to physical therapy at Advanced Physical Medicine. (PX 6).

As well, thoracic and lumbar MRIs were ordered. These MRIs (done on July 16, 2014) would disclose nothing remarkable as to the thoracic spine and lumbar spine, save for the radiologist's finding of "subligamentous, posterior broad-based disk herniations at the L4-L5 and L5-S1 levels with extruded nuclei pulposi measuring approximately 5-6 mm and 4-5 mm." (PX 3).

Regarding the physical therapy prescribed by Dr. Sarantopoulos, this treatment is notable for its high frequency -- first three sessions weekly, then twice weekly[5] -- and its failure to render lasting improvement of Petitioner's subjective symptoms, even after more than a year. The physical therapy consisted of, *inter alia*, electrical stimulation, hydro-massage, ultrasound, and hot and cold packs. The therapy notes indicate that Petitioner described, in general and rather modest terms, pain in his low back and occasional pain travelling down his legs. For example: "LBP [lower back pain] increases after prolonged sitting" (1/30/15); "Low back feels really sore after shoveling snow last Monday" (2/24/15); "Occasional stiffness of low back" (2/6/15); "Left side of my low back feels sore and achy since I woke up." (2/25/15); "My low back hurts really bad. I do feel occasional numbness and tingling down both legs" (3/27/15); "I wake up in the middle of night because of low back pain and stiffness" (4/10/15); "Both of my legs feel sore after exercises" (5/22/15); "My low back feels stiff in the morning" (6/19/15); "Some days I do not have any low back pain and some days my low back hurts a lot" (7/8/15); "My back hurts a lot. I have difficulty sitting for longer duration." (8/10/15); "Can I ride bike every day to improve my leg strength? Do you think it will hurt my back a lot?" (8/14/15).

In addition, Petitioner also made about twice-monthly office visits to Dr. Sarantopoulos, who continued to administer the "osteopathic manipulation with activator technique" to Petitioner's entire spine (cervical, thoracic, and lumbar, even though Petitioner never asserted injury to the cervical spine) during these visits. The last office visit note in the evidentiary record is dated October 9, 2015. On that day, Petitioner's pain was noted to be 6/10 in the mid-back and 8/10 in the low back. (PX 3). In other words, after receiving 32 sessions of chiropractic treatment from Dr. Sarantopoulos (and at least 100 sessions of physical therapy) up to this point, Petitioner had made virtually no progress with respect to his subjective complaints of pain.

Petitioner's current assessments from Advanced Pain Medicine include lumbar disc herniation, left lumbar radiculopathy, low back pain, and lumbar myofascial pain. Petitioner is currently being prescribed Norco, Mobil, Flexeril and Gabapentin. At hearing, Petitioner described his condition as "a constant pain in my lower back. My left leg is numb with pain up and down. My mid-back is a little sore.

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[4] This "OMT with activator technique" apparently refers to a chiropractic treatment utilizing a small handheld electronic instrument which delivers a controlled impulse of mechanical force to the spine.

[5] Petitioner testified that, after several months, his physical therapy was cut back from three times to twice per week, as even Dr. Sarantopoulos thought it was "ridiculous" to go so often when it appeared to be having not much effect. (Tr. 9/25/15 at 66).

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Sitting, standing too long hurts." (Tr. 9/25/15 at 84). Among the prospective treatment sought by Petitioner in this workers' compensation proceeding are epidural steroid injections recommended by Dr. Sarantopoulos in the fall of 2014.[6] Dr. Sarantopoulos has continued to recommend these injections as well as ongoing physical therapy.

B. Section 12 Examination

Petitioner, on April 13, 2015, was seen for an independent medical examination by Dr. Julie Wehner, who authored a written report and sat for evidence deposition on December 11, 2015. (RX 1; RX 3). In pertinent part, Dr. Wehner's opinion was that, at most, Petitioner suffered a lumbar strain that was expected to have resolved within 3 months of his asserted accident -- that is, by September 19, 2014. (RX 3 at 26-27). Regarding his ongoing complaints of pain (related to be in the mid- and low back and intermittent pain down the back of both legs to his proximal calf), Dr. Wehner opined that there was no causal relationship to any work accident insofar as there were no objective findings to support these complaints. And, most certainly, Petitioner's treatment to date had been grossly excessive. (RX 3 at 23-24). Dr. Wehner commented that 113 sessions of physical therapy were the most she had ever seen anyone -- even patients with a life-threatening injury -- undergo. (RX 3 at 28-29).

Dr. Wehner read the lumbar MRI films of July 2014 as disclosing a minimal amount of disc bulging at L4-5. (RX 3 at 16-17). She strongly disagreed with the MRI radiologist's impression of lumbar herniation, calling this finding a "gross exaggeration." (RX 3 at 15-16). She allowed that the lumbar MRI did show "some non-specific abnormalities" but that these were not clinically significant as they did not correlate with Petitioner's subjective complaints. (RX 3 at 17). Dr. Wehner noted that Petitioner had a normal clinical examination, including normal neurological testing and a negative result upon the straight leg raising test – a test used to detect the presence of disc herniation. This negative straight leg raise result was consistently found as well by Dr. Sarantapolous over the course of his more than 30 office visits. (RX 1).

Dr. Sarantopoulos expressed no causation opinions in his medical records, nor did he provide one via evidence deposition or otherwise.

II. DISCUSSION

The Arbitrator found that Petitioner sustained a work-related accident and that his current condition of ill-being was related thereto. The Arbitrator awarded temporary total disability up through the last day of hearing (February 25, 2016). The Arbitrator was dismissive of Dr. Wehner's testimony and seemed to base his favorable decision for Petitioner on the radiologist's impression from the July 2014 lumbar MRI report indicating that Petitioner has "subligamentous, posterior broad-based disk herniations at the L4-L5 and L5-S1 levels with extruded nuclei pulposi measuring approximately 5-6 mm and 4-5

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[6] Dr. Sarantopoulos' office note of September 12, 2014 indicate that he referred Petitioner to pain specialist Dr. Eugene Lipov for evaluation for epidural steroid injections; however, the insurance carrier would not authorize the injections. (PX 5 at 9/12/14; Tr. 9/25/15 at 60-66).

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mm." (Arbitrator's decision at 15-16). The Arbitrator does not explain how this one impression supports Petitioner's claim of current, disabling ill-being.

As for medical benefits, the Arbitrator awarded medical expenses covering Dr. Sarantapoulos' office visits up through January 13, 2016 -- the date of the last office visit preceding the last day of hearing – as well as prospective care in the form of the epidural steroid injections pursuant to this treating doctor's recommendation. (Arbitrator's decision at 18).

However, as to the physical therapy treatment, the Arbitrator wrote that the number of sessions provided "became an inordinate number, especially since Petitioner failed to meet the short-term and long-term goals." (Arbitrator's decision at 18). The Arbitrator found Respondent liable for the physical therapy only up through April 13, 2015, after which date the treatment became "unreasonable and unnecessary medical care" (notwithstanding that ongoing physical therapy was also being recommended by Dr. Sarantopoulos). (Arbitrator's decision at 18). The date of April 13, 2015 was when Petitioner was examined by Dr. Wehner, who, as the Arbitrator noted, indicated that the physical therapy treatment was excessive.

The Commission finds that Petitioner has carried his burden by a preponderance of the evidence that he suffered a work-related injury on June 19, 2014. The Commission further finds that the injury suffered was no more than a lumbar strain and that he reached maximum medical improvement by September 19, 2014; the Commission finds Dr. Wehner's opinions persuasive in that regard. Petitioner's account of ongoing ill-being and disability beyond that date is not credible. (As noted above, the physical therapy records indicate that Petitioner can shovel snow and ride his bike.)

Lastly, Petitioner's petition for penalties and fees is denied.

Accordingly, the Commission modifies the Arbitrator's award of temporary total disability and medical expenses.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on August 18, 2016, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $ 360.41 per week commencing June 28, 2014 through September 19, 2014, as provided under Section 8(b).

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the reasonable and necessary medical expenses incurred for treatment only up through September 19, 2014, as provided under Section 8(a) of the Act and subject to the medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of prospective medical care is vacated.

18IWCC0234

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

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $ 10,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 17 2018

o-02/28/18
jdl/ac
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Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

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

HUDSON, ANDRE
Employee/Petitioner

Case# **14WC023775**

METRO INDUSTRIAL TIRE
Employer/Respondent

18IWCC0234

On 8/18/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.44% 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:

0592 POMPER & GOODMAN
CAROLINE WATSON
111 W WASHINGTON ST SUITE 1000
CHICAGO, IL 60602

1680 CASSANO & ASSOCIATES
LAWRENCE C CASSANO
1240 IROQUOIS AVE SUITE 210
NAPERVILLE, IL 60563

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPAGE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Andre Hudson
Employee/Petitioner

v.

Case # 14 WC 23775

Metro Industrial Tire
Employer/Respondent

18IWCC0234

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brian Cronin**, Arbitrator of the Commission, in the cities of **Wheaton** and **Chicago**, on **9/25/2015** and **2/25/2016**, respectively. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, 06/19/2014, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did* 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 an average weekly wage was $540.62.

On the date of accident, Petitioner was 30 years of age, *married* with 2 dependent children.

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

Respondent shall be given a credit of $7,000.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $7,000.00.

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

ORDER

Respondent shall pay the charges for the reasonable, necessary and related medical services rendered to Petitioner by Advanced Physical Medicine Associates, S.C., for physical therapy treatment, as well as for the office visits to Dr. Sarantopoulos, through April 13, 2015, as provided in Section 8(a) and subject to Section 8.2 of the Act. Respondent shall also pay the charges for the reasonable, necessary and related medical services that consist of office visits to Dr. Sarantopoulos from April 14, 2015 through January 13, 2016, the last office visit, in accordance with Section 8(a) and subject to Section 8.2 of the Act.

Respondent shall pay Petitioner $360.41/week for 86-6/7 weeks, from 6/28/2014 through 2/25/2016, because Petitioner was temporarily totally disabled during this period, in accordance with Section 8(b) of the Act.

Petitioner's petitions for penalties and attorney's fees are denied.

Respondent shall authorize and pay the reasonable cost of epidural steroid injections, as prescribed by Dr. Sarantopoulos, in accordance with Section 8(a) and subject to Section 8.2.

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

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

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

Signature of Arbitrator

August 17, 2016
Date

ICArbDec19(b)

AUG 18 2016

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ANDRE HUDSON, Petitioner, v. METRO NORTH INDUSTRIAL TIRE, INC. Respondent.	)	No. 14 WC 23775

18IWCC0234

DECISION OF ARBITRATOR

An Application for Adjustment of Claim was filed in this matter and notice of hearing mailed to each party. The matter was bifurcated. The first portion of this matter was heard September 25, 2015 by an Arbitrator designated by the Commission in the City of Wheaton, County of DuPage, and State of Illinois. The second portion of the matter was heard February 25, 2016 in the City of Chicago, County of Cook, and State of Illinois. After hearing the proofs and allegations of the parties and having made careful inquiry into this matter, the Arbitrator concludes as follows:

The parties stipulated that on June 19, 2014, Respondent METRO NORTH INDUSTRIAL TIRE, INC. ("Respondent"), was operating under and subject to the provisions of the Illinois Workers' Compensation Act; the relationship of employer and employee existed between Petitioner ANDRE HUDSON ("Petitioner") and said Respondent; timely notice of accident was given; and at the time of the injury Petitioner was 29 years of age, married, with 2 dependent children under 18 years of age. Yet, the medical records indicate DOB 5/16/84

The parties disagree as to the issues of accident, causation, average weekly wage, medical and prospective medical benefits, TTD benefits, and penalties and fees.

18IWCC0234

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDING OF FACTS:

Petitioner was a tire technician employed on the date of accident by Respondent. Respondent is in the business of servicing and selling industrial tires for forklifts, material handling equipment and various slow-moving equipment used in plants and warehouses. The servicing component of Respondent's business includes installing forklift tires and tires for "tugs." Tugs are machines used to carry baggage carts between airplanes at airports.

Petitioner was hired in June 2011. His job duties included installing, mounting and dismounting industrial tires, as well as accepting deliveries and cleaning the premises.

In the course of Petitioner's employment, Mr. Clarke testified, he attempted to have Petitioner certified or "badged" to work at O'Hare Airport by the Transportation Safety Administration (TSA). Mr. Clarke testified his employees would need to be badged by the TSA in order to drive on the airstrip at O'Hare and pick up tires. Petitioner was sent for badging and was denied, but the TSA did not give an explanation as to the reason for denial.

Mr. Clarke testified that on June 19, 2014, Respondent had a walk-in customer who needed 10 new tug tires installed. The customer, Sage, was a weekly customer. Petitioner testified he was assigned by his supervisor, Mike Murphy, to dismount the old tug tires and mount new tug tires using a tire press machine. He claimed the tires weighed 30 to 70 pounds. He also testified he was required to lift the tire and rim between 12 and 18 inches off the ground onto a tire press. Petitioner testified he waited for a co-worker to bring the old tires from the airport and then proceeded to mount and dismount them in the afternoon. Petitioner testified he dismounted and mounted an estimated 20 tires. He testified it took about 10-15 minutes to dismount the old tire and mount the new tire and that he could probably 3-4 tires in an hour. Petitioner did not experience any unusual pain, and left work after completing his usual shift.

Mr. Clarke testified that Respondent's protocol for reporting work accidents was to immediately report the accident to a supervisor. He testified that on June 19, 2014, Petitioner worked his normal shift, left at the normal time, and did not report to him, or anyone else at Metro North, that he sustained a work accident or injury on that day. Petitioner corroborated Mr. Clarke's testimony – he testified he did not notice any pain while he performed the job on June 19. He testified that he completed the job and felt fine afterwards. He went home at the usual time and had dinner, played a video game, and went to bed.

Petitioner testified he previously requested time off work on June 20, 2014 to attend a funeral. Respondent gave him that day off.

Petitioner testified that on June 20, 2014, he woke up and "could barely move" and "couldn't even get out of bed." He did not know why he was in pain, just that he was in pain. Two days later on June 22, 2014, Petitioner sent a text message to Mr. Murphy and reported he had been feeling bad since June 20, 2014, that he wanted to wait and see if his condition would resolve over the weekend, that his condition did not resolve, and that he wanted to be sent to the doctor. Petitioner testified he specifically told Mr. Murphy he hurt his back on Thursday [June 19, 2014], though no record of that conversation or text message was ever produced or admitted into evidence at trial by Petitioner. Although Mr. Murphy did not respond, he informed Mr. Clarke on June 23, 2014 that Petitioner texted him and reported his back was sore and that he needed to go to the company clinic, Concentra. Petitioner testified he wanted to go to Concentra because other people who were injured had been sent there. Petitioner also testified he repeatedly asked Mr. Murphy if he could go to Concentra, but did not receive an answer.

Petitioner testified that after he texted Mike Murphy on Sunday, he spoke with Mr. Clarke on Monday, June 23, 2014, over the telephone regarding the accident and that he believed he hurt himself during the job for Sage because that was the last job he did.

Mr. Clarke denied that such telephone conversation ever took place. Mr. Clarke testified he was out in the field on June 23, 2014. Petitioner was scheduled to work that day. Mr. Clarke testified that Mike Murphy told him that day that Petitioner claimed he injured himself the previous Thursday.

On June 24, 2014, Mr. Clarke had a conversation with Petitioner. Petitioner told Mr. Clark he hurt his back and wanted to go to Concentra. When Mr. Clarke asked when he hurt his back, Petitioner replied it "must have been the previous week" because when he was off over the weekend he awoke and his back was sore. Petitioner never said the accident happened on June 19, 2014. Mr. Clarke suggested Petitioner seek medical treatment from his own physician. Following a conversation with his wife, Petitioner spoke with Mr. Clarke once again and renewed his request to go to Concentra. Mr. Clarke authorized the visit and Petitioner presented to with chief complaints of low back pain.

The Concentra records reflect Petitioner's pain did not radiate and he denied any associated numbness or tingling of his lower extremities. X-rays were negative. He was diagnosed merely with a lumbar strain and given light-duty restrictions consisting of no lifting over 20 pounds and no pushing or pulling over 20 pounds of force. The records reflect he presented for an initial physical therapy evaluation, and complained of lower thoracic pain in the middle of his back. He also reported paresthesia of his hands and arms. Upon examination by the physician, Nina L. Taylor, D.O, found, *inter alia*, that Petitioner's reflexes were normal and equal bilaterally, that the straight leg raising test from a seated position in a seated position was

negative bilaterally and that Petitioner was in no apparent distress. She assessed a lumbar strain, prescribed medication and a course of physical therapy, and limited her to lifting/pushing/pulling of no more than 20 pounds.

Petitioner spoke with Mr. Clarke by phone after he left Concentra and advised of his diagnosis and work restrictions. Mr. Clarke told Petitioner he did not have any light-duty work to assign because he was not at the office and would not be there to assign such work. Ultimately, Mr. Clarke recommended Petitioner go home and come back in the morning. On June 25, 2014, Petitioner met with Mr. Clarke and was given a list of light-duty assignments that did not involve lifting. Petitioner worked a full day and was paid his regular wage of $16.00/hour.

On June 26, 2014, Petitioner reported for work wearing shorts and a T-shirt. As a tire technician, he was required to wear a uniform. Petitioner testified that because he knew he would be working in the office that day, he did not think it was necessary for him to wear his uniform. Mr. Clarke testified he asked Petitioner to change into his uniform because it was a business. While Petitioner was changing, Mr. Clarke received a call from the company's repair facility, indicating a truck was ready for pick up. When Petitioner came out of the locker room, Mr. Clarke asked if he would be able to drive. Mr. Clarke testified Petitioner responded belligerently and confronted him in an aggressive manner. Mr. Clarke testified he told Petitioner to calm down and go home and they would talk again the next day. Petitioner responded, "Good, that's what I wanted you to say." Petitioner went back to the locker room and changed back into his street clothes. He reappeared and a verbal altercation ensued between Petitioner and Mr. Murphy. The police were called and arrived at Metro North shortly thereafter.

Following the altercation, Mr. Clarke terminated Petitioner's employment for insubordination. However, Mr. Clarke testified he told Petitioner he could continue receiving

medical treatment. Petitioner returned to Concentra for a re-check of his lumbar strain on June 26, 2014. He complained of low back and mid back pain, which he rated at 8/10. He denied any radiation of pain. He also denied any numbness or tingling of his lower extremities. On examination, he was in no apparent distress, had a negative Straight Leg Raising (SLR) test bilaterally in the seated position, pain with palpation at the L4-L5 paraspinous area bilaterally, had decreased lumbar range of motion (ROM) to all planes (per Petitioner's report). He also had positive Waddell's tests for axial compression and over reaction. He was diagnosed with a lumbar strain, thoracic spine pain, and symptom magnification.

Mr. Clarke denied telling Concentra to stop medical treatment for Petitioner because he was no longer employed by the company. Mr. Clarke merely contacted his workers' compensation insurance carrier and advised Petitioner was no longer employed. Mr. Clarke testified Petitioner was offered COBRA, but he did not want to accept that coverage.

On July 2, 2014, Petitioner presented to John C. Sarantopoulos, D.O. Dr. Sarantopoulos specializes in physiatry. Petitioner gave a history of a work accident on June 19, 2014, stating he was lifting a cage that weighed about 100 pounds, which was used to help change tires for forklifts. He reported mid back and low back pain, which he rated as constant and sharp. He stated the pain radiated down both lower extremities. On examination, he was in no acute distress, had non-tender claves, negative seated SLR bilaterally, bilateral thoracic tenderness, bilateral lumbar tenderness, decreased lumbar flexion, decreased lumbar extension, and a non-antalgic gait. Dr. Sarantopoulos diagnosed (1) a thoracic strain with associated myofascial pain, (2) lumbar strain with associated myofascial pain, (3) bilateral lumbar radicular symptoms, and lumbar intervertebral disc derangement could not be ruled out. Petitioner was given medication for pain. He was also given an off work note that indicated he was to remain off work "until

further notice." He has not returned to work since he was terminated. He was referred for physiotherapy for his thoracic spine and lumbar spine.

On July 16, 2014, Petitioner underwent an MRI of the lumbar spine. Radiologist George G. Kuritza, M.D., provided the following interpretation:

CLINICAL HISTORY: Work-related lifting injury with back pain.

FINDINGS: MRI of the lumbar spine was performed utilizing standard pulse sequences in the coronal, sagittal, and axial imaging planes with multiecho and multipulse sequencing.

There is normal lumbar curvature. There are no fractures or significant subluxations.

Bone marrow signal intensity appeared homogeneous and unremarkable.

At the L4-L5 and L5-S1 levels, subligamentous posterior broad-based disk herniations with extruded nuclei pulposi are seen measuring approximately 5-6 mm. and 4-5 mm. respectively with mild spinal stenosis and bilateral neuroforaminal narrowing.

The rest of the lumbar intervertebral disks appeared unremarkable. The paravertebral soft tissues appeared normal. Posterior elements appeared intact. The conus medullaris was identified and appeared unremarkable. The visualized portions of the lower lumbar spinal cord and thecal sac appeared unremarkable.

IMPRESSION:

1. At the L4-L5 and L5-S1 levels, subligamentous posterior broad-based disk herniations with extruded nuclei pulposi are seen measuring approximately 5-6 mm. and 4-5 mm. respectively with mild spinal stenosis and bilateral neuroforaminal narrowing.
2. The rest of the lumbar spine appears unremarkable. (PX 6)

On July 16, 2014, Petitioner underwent an MRI of the thoracic spine. Radiologist George G. Kuritza, M.D., provided the following interpretation:

CLINICAL HISTORY: Work-related lifting injury with back pain.

FINDINGS: MRI of the thoracic spine was performed utilizing multiecho and multipulse sequencing.

There is normal lumbar curvature. There are no fractures or significant subluxations.

The bone marrow signal intensity appeared homogeneous.

The visualized thoracic intervertebral disks appeared unremarkable. There are no significant disk bulges, protrusions or herniations seen at this time. There is no significant spinal stenosis or significant neuroforaminal narrowing.

The posterior elements appeared unremarkable.

The spinal cord and thecal sac were visualized and appeared grossly normal.

The paravertebral soft tissues appeared unremarkable.

IMPRESSION:

Unremarkable MRI of the thoracic spine (PX 6)

Petitioner has treated conservatively for more than 21 months in this case under the care of Dr. Sarantopoulos, without any improvement.

On April 13, 2015, Petitioner presented to an orthopedic surgeon, Dr. Julie Wehner, for a Section 12 examination. Dr. Wehner's evidence deposition was taken on December 11, 2015 and at that time Petitioner raised no objection to the admission of Dr. Wehner's Section 12 report. Dr. Wehner took a detailed history from Petitioner. Petitioner reported being an

industrial tire technician for Respondent since 2011, and reported a date of injury of June 19, 2014. Petitioner stated "he had to work on a quantity of thirty 712 tires that weighed over 100 pounds each," the report reads. Petitioner reported lifting them approximately 12-14 inches off the ground onto a tire press machine. The next morning, a Friday, he reported experiencing low and mid back pain; he was off that day for a funeral. He took ibuprofen and experienced relief. He worked the following Monday, performing limited activity. He went to Concentra that Tuesday and had an x-ray and examination. He was sent for PT, as he was told he had a strain. He was fired that Thursday and his treatment was halted at Concentra thereafter. After being evaluated by Dr. Sarantopoulos, he had PT three times per week for approximately eight months, but reports being overall the same. He complains of mid back pain at a level of 6-7/10 and in the low back 8/10. He stated that pain radiated down the back of both legs to the proximal calf area and did have associated numbness and tingling. He reported a prior motor vehicle accident in 2003 but did not seek medical management.

On examination, his gait pattern was normal. He could bend to toe level with his fingertips. Extension was 20 degrees. No paraspinal spasm or scoliosis was present. Mild pain with palpation on the right at T12 to L1 was noted. There was no pain with axial compression or axial rotation. Straight leg raise was negative. Knee and ankle reflexes were 2+. Motor strength was 5/5. He easily straightened his leg to take off his shoes.

Dr. Wehner reviewed MRI reports from July 16, 2014 and films. Dr. Wehner's review of the films indicated no herniation. She opined, "I strongly disagree with the findings of disc herniations and extruded fragments." In her review of records, Dr. Wehner catalogued numerous, regular visits to Dr. Sarantopoulos occurring throughout December 2014 through March 2015.

Despite 94 visits to Dr. Sarantopoulos since July 2014, "there does not appear to be any progression towards the goals listed in the therapy program," Dr. Wehner wrote. She further opined, Petitioner "has had MRIs which show some non-specific abnormalities that do not correlate with his subjective complaints." Dr. Wehner wrote that MRI findings "do not correlate with his present clinical examination including the negative straight leg raising, normal neurologic testing, and pain that goes to the proximal calf." She concluded, "If MRI findings do not correlate then they are considered an asymptomatic finding and not considered clinically significant."

As to the issue of causal relationship, Dr. Wehner opined Petitioner's "ongoing subjective complaints can no longer be explained based on the diagnosis of June 19, 2014. He has had an extended period of therapy and reports the same pain on a daily basis despite observations by his treating physician of being in no acute distress, having a normal gait pattern, and negative straight leg raising. Therefore, he has ongoing subjective complaints of pain that are no longer substantiated by a specific clinical finding or a specific radiographic finding. I have no reason to believe his ongoing complaints are specifically related to the June 19, 2014 date based on these findings."

Regarding subsequent medical treatment, Dr. Wehner opined that Petitioner "has had eight months of physical therapy and has no documented improvement in symptoms. This is not medically appropriate. A course of therapy for onset of low back pain would be 6-12 visits with assessment of progress and transition to a home exercise program. There has been no documented progress throughout these therapy notes but he continues to go." Dr. Wehner concluded, "Therefore, his ongoing treatment with Dr. Sarantopoulos can no longer be medically justified after the initial 12 visits."

Dr. Wehner recommended no additional treatment or testing related to the date of June 19, 2014, as no neurologic findings substantiated Petitioner's subjective complaints about the thoracic and lumbar spine. She opined that Petitioner was able to work full duty, had reached MMI, and should have been considered disabled only for a maximum of six weeks. "I have no medical reason why he needed to be off work completely during this time," she wrote. Further she opined that "the osteopathic manipulative treatment has not been documented to provide any benefit to the patient and there is no medical need to pursue this type of treatment for chronic back pain complaints unless there is specific documentation of improvement over time." Dr. Wehner opined that no further treatment was necessary.

Despite this, Petitioner continued to treat under Dr. Sarantopoulos. On July 1, 2015, he tested positive for marijuana as well as Hydrocodone, and Hydromorphone. He again tested positive for marijuana on August 26, 2015.

Petitioner testified that during the course of treatment for his back, he requested to treat with a specialist, but was told that it was not authorized.

Petitioner testified he was an avid bowler at the time of the accident, and participated in bowling leagues.

His last doctor visit was on October 9, 2015, when Petitioner presented for yet more physiotherapy. After receiving 132 sessions, he had made virtually no progress towards his short-term goal of decreasing pain by 2 levels.

Dr. Sarantopoulos has continued to prescribe epidural steroid injections to treat Petitioner's back pain, but Respondent has not authorized such injections. He has assessed Petitioner with lumbar disc herniation, left lumbar radiculopathy, low back pain, and lumbar myofascial pain. Petitioner has been taking Norco, Mobic, Flexeril and Gabapentin for pain.

THE ARBITRATOR HEREBY MAKES THE FOLLOWING CONCLUSIONS OF LAW:

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

Petitioner testified that on Thursday, June 19, 2014, at work, he did his standard cleaning in the morning, and in the afternoon, he mounted 20 tires. He further testified that he was okay, he was fine and he went home, had dinner, played a video game and went to bed. Petitioner testified that when he woke up the next morning, he could not move and had to be helped out of his bed. Petitioner testified: "It was extreme." He testified that he was in tremendous pain, but he needed to make it to a funeral that morning and he did, in fact, make it to the funeral.

One week earlier, Petitioner had requested from his boss that he be allowed to take Friday, June 20, 2014, off work. His request was granted.

With regard to how he was feeling on the morning of June 20, 2014, Petitioner testified to the following:

Q: Did you have any inkling what had happened and why you were feeling that way?

A: At the moment, no, I didn't - - it didn't really dawn on me. And then as I thought back to, you know, as far as anything I had done, I hadn't done anything except for work that day. (Tr. 21)

Petitioner testified that it was really uncomfortable and painful at the funeral. He needed to sit, but once he sat, he needed to stand. After the funeral, he went home and took Ibuprofen, and hoped that the pain would go away.

The next day was Saturday, June 21, 2014. Petitioner was not scheduled to work that day. Petitioner further testified that he was in excruciating pain on Saturday. Once he sat down,

he could not get up. Petitioner further testified that his legs were burning, his buttocks were hurting, and his tailbone was hurting.

On Sunday, June 22, 2014, Petitioner testified, he was still feeling bad and sent a text message to his manager, Mike Murphy, in which he stated he hurt himself at work the previous Thursday, hoped he would get better over the weekend but had not, and wondered if, when he came into work on Monday, Mike could send him for medical care. (Tr. 22-23)

At the arbitration hearing, Petitioner was unable to produce a copy of the text message. However, Petitioner's testimony with regard to the sending of the text message and the contents of such message stand unrebutted.

Petitioner returned to work on Monday and testified that he spoke on the telephone with Kevin Clarke as Clarke was out in the field that day. Petitioner testified that he asked Mr. Clarke if he could seek treatment at the company clinic, but that Clarke urged his to see his own doctor.

Kevin Clarke testified: "I *believe* that the first time I talked to [Petitioner] was on Tuesday," and then testified that Petitioner would be incorrect if he said that he talked to me on Monday.

Kevin Clarke testified that he had a conversation with Petitioner on Tuesday, June 24, 2014. Clarke said to Petitioner that he heard Petitioner told Mike that he hurt his back. Petitioner replied that he had hurt his back and that he wants to go to the clinic. Clarke asked Petitioner when he hurt his back, to which Petitioner replied that it must have been last week because when he got up, his back was sore. Hudson then asked Petitioner why he did not see his own doctor to which Petitioner replied that he really wants to go to the company clinic. That day, Kevin Clarke allowed Petitioner to seek treatment at Concentra, nka, Occupational Health Centers of Ill.

On June 24, 2014, Petitioner gave the following HISTORY OF PRESENT ILLNESS to the staff to Nina L. Taylor, D.O. at Occupational Health Centers of Ill.:

> Pt states that on 6/19 he was repeatedly lifting heavy metal cages to place them onto tires. On 6/20 he woke up with low back pain and stiffness. Said he rested over the week-end and felt better yesterday and worked his regular shift. This morning he gain (sic) awoke with low back pain and stiffness as well as with some tightness in his mid back. He c/o constant pain in his low back that he rates a "7-8." Pain is exacerbated by bending and prolonged sitting. Pain does not radiate. Denies any associated numbness or tingling of the lower extremities. Denies any abdominal pain or bowel or bladder dysfunction. Denies any other associated injuries.
>
> (PX 5)

Respondent disputes accident and argues that Petitioner gave conflicting testimony as to the weight and number of tires he was lifting on the date of accident. However, it is undisputed that Petitioner, with the title of Tire Technician, was lifting and mounting industrial tires on the afternoon of June 19, 2014.

Petitioner reported the accident to Mike Murphy via text message on Sunday, June 22, 2014, to Kevin Clarke the next day, and provided a consistent history to Dr. Nina Taylor on Tuesday, June 24, 2014.

The Arbitrator heard the Petitioner's testimony, assessed his demeanor and finds him to be credible.

Therefore, the Arbitrator finds that on June 19, 2014, Petitioner sustained an accident that arose out of and in the course of his employment by Respondent.

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

Dr. Sarantopoulos did not write a narrative report and was not deposed. He did not include a formal causal connection opinion in his treating records. On July 2, 2014, Dr. Sarantopoulos took a history in which Petitioner reported that on June 19, 2014, he was lifting a cage that weighed about 100 pounds about 20 times at work and the next day he felt severe back pain. In his January 7, 2015 chart note, Dr. Sarantopoulos wrote: "He is status post work related lifting injury of 6/19/2014." (PX 6)

On August 27, 2014, Dr. Sarantopoulos completed a Verification of Disability (Employment) form for the Illinois Department of Human Rights. In it, Dr. Sarantopoulos indicated that Petitioner has a "Back Disorder," that the date of injury was "6/19/2014," and that the doctor can confirm Petitioner has/had such condition on the relevant date identified. Dr. Sarantopoulos also indicated Petitioner's problem is physical, that it is not minor, that his condition is permanent and that he has a positive lumbar MRI of 7/16/2014. Lastly, Dr. Sarantopoulos indicated that during the last 2 years, he placed restrictions on Petitioner: OFF WORK. (PX 6)

Dr. Wehner, in her April 13, 2015 Section 12 report, opined as follows:

> His ongoing subjective complaints can no longer be explained based on the diagnosis of June 19, 2014. He has had an extended period of therapy and reports the same pain on a daily basis despite observations by his treating physician of being in no acute distress, having a normal gait pattern and negative straight leg raising. Therefore, he has ongoing subjective complaints of pain that are no longer substantiated by a specific clinical finding or a specific radiographic finding. I have no reason to believe his ongoing complaints are specifically related to the June 19, 2014 date based on these findings. (RX 1)

In referring to "no specific radiographic finding," Dr. Wehner dismisses the following impression of the July 16, 2014 MR images of Petitioner's lumbar spine by board-certified radiologist George G. Kuritza, M.D.:

> At the L4-L5 and L5-S1 levels, subligamentous posterior broad-based disk herniations with extruded nuclei pulposi are seen measuring approximately 5-6 mm. and 4-5 mm. respectively with mild spinal stenosis and bilateral neuroforaminal narrowing. (PX 6)

Moreover, although Dr. Wehner finds that such MRI has not been clinically correlated, she concedes that the MRI findings are abnormal. (RX 1)

Furthermore, Dr. Wehner states: "His current diagnosis is chronic back pain, that is pain of over six months' duration." (RX 1)

The Arbitrator finds Petitioner to be credible.

Petitioner was 30 years old on the date of accident.

There is no evidence that Petitioner's bowling activities contributed to his low back or mid back condition of ill-being.

Dr. Sarantopoulos has assessed Petitioner with lumbar disc herniation, left lumbar radiculopathy, low back pain, and lumbar myofascial pain. Petitioner has been taking Norco, Mobic, Flexeril and Gabapentin for pain.

The Arbitrator finds that Dr. Kuritza's impression of the July 16, 2014 MR images, the Petitioner's credibility, Dr. Sarantopoulos' opinions and the chain of events outweigh the opinions of Dr. Wehner.

A chain of events which demonstrates a previous condition of good health, an accident and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove

a causal nexus between the accident and the employee's injury. International Harvester v. Industrial Commission, 93 Ill. 2d 59, 63-64 (1982)

Based on the foregoing, the Arbitrator finds that Petitioner's current condition of ill-being of his low back and mid back are causally related to the accident of June 19, 2014.

G. What were Petitioner's earnings?

Based upon Petitioner's wage records, the Arbitrator finds that Petitioner earned $28,436.50 during the period beginning the week ending June 28, 2013 and ending on June 6, 2014, including overtime hours at the regular hourly rate. (RX 5) After subtracting the weeks and/or parts thereof missed, Petitioner's average weekly wage was $540.62, calculated in accordance with Section 10 of the Act.

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

Dr. Wehner indicated on April 13, 2015 that the physical therapy treatment Petitioner was receiving was excessive since Petitioner's condition was not improving. Petitioner even testified the treatment "wasn't going anywhere." He testified he would receive treatment and still be in the same amount of pain.

Dr. Sarantopoulos began prescribing epidural steroid injections for Petitioner's work-related back injury on October 20, 2014, and has continued to prescribe such injections. However, Respondent has refused to authorize this course of treatment.

Dr. Sarantopoulos continued to recommend physical therapy, and Advanced Physical Medicine Associates continued to provide such treatment. The number of sessions of physical therapy that Advanced Physical Medicine Associates provided became an inordinate number, especially since Petitioner failed to meet the short-term and long-term goals.

Therefore, the Arbitrator finds that the physical therapy provided by Advanced Physical Medicine Associates, S.C., after April 13, 2015 was unreasonable and unnecessary medical care. The Arbitrator finds that Respondent is liable for payment of the physical therapy provided by Advanced Physical Medicine Associates, S.C., as well as the office visits to Dr. Sarantopoulos, on or before April 13, 2015, in accordance with Section 8(a) and subject to Section 8.2 of the Act. The Arbitrator further finds that Respondent is also liable for the payment of Petitioner's office visits to Dr. Sarantopoulos from April 14, 2015 through January 13, 2016, which is the date of the last office visit (PX 3), in accordance with Section 8(a) and subject to Section 8.2 of the Act.

K. Is Petitioner entitled to any prospective medical care?

Dr. Sarantopoulos has continued to prescribed epidural steroid injections to treat Petitioner's back injury. Respondent has not approved such injections.

In her Section 12 report, Dr. Wehner wrote: "Injection treatment is not recommended based on the fact that his subjective complaints of pain in the mid thoracic area and pain in the lumbar area radiating to the proximal calves is not a radicular pattern of pain. He also has no neurologic findings to substantiate the neurologic process. Therefore, there is no medical basis to pursue injection treatment."

However, the Arbitrator finds Petitioner to be credible and notes that the July 16, 2014 lumbar MRI that shows Petitioner has subligamentous, posterior broad-based disk herniations at the L4-L5 and L5-S1 levels with extruded nuclei pulposi measuring approximately 5-6 mm. and 4-5 mm., respectively. (PX 6)

Therefore, the Arbitrator finds that Petitioner is entitled to prospective medical care in the form of epidural steroid injections, as prescribed by Dr. Sarantopoulos.

L. What temporary benefits are in dispute?

In Arbitrator's Exhibit #1, Petitioner claims that he has been temporarily totally disabled from June 28, 2014 through February 25, 2016. Respondent claims that no TTD benefits are owed.

On June 24, 2014, the Concentra physician restricted Petitioner to light-duty work.

On June 26, 2014, Respondent terminated Petitioner's employment for insubordination. Petitioner's version of the altercation that led to Petitioner's termination differs from Mr. Clarke's.

On July 2, 2014, Dr. Sarantopoulos took Petitioner completely off work, and has not released him to return to work. (PX 6)

On April 13, 2015, Dr. Wehner, Respondent's Section 12 physician, reviewed medical records, conducted an examination of Petitioner and issued a report. Dr. Wehner opined that Petitioner was capable of returning to full-duty work 6 weeks after the accident. (RX 4)

An employer's obligation to pay TTD benefits to an injured employee does not cease because the employee had been discharged--whether or not the discharge was for "cause." When an injured employee has been discharged by his employer, the determinative inquiry for deciding

entitlement to TTD benefits remains, as always, whether the claimant's condition has stabilized. If the injured employee is able to show that he continues to be temporarily totally disabled as a result of his work-related injury, the employee is entitled to TTD benefits. Interstate Scaffolding, Inc. v. Illinois Workers' Comp. Comm'n, 923 N.E.2d 266, 337 Ill. Dec. 707 (2010)

As the Arbitrator has found that Petitioner has proved accident and causation, he further finds Petitioner was temporarily totally disabled from June 28, 2014 through February 25, 2016. The Arbitrator relies on Petitioner's testimony, the off-work slips and the July 16, 2014 lumbar MRI that shows Petitioner has subligamentous, posterior broad-based disk herniations at the L4-L5 and L5-S1 levels with extruded nuclei pulposi measuring approximately 5-6 mm. and 4-5 mm., respectively.

M. Should penalties or fees be imposed upon Respondent?

As Respondent had a bona fide dispute with regard to the threshold issue of accident, the Arbitrator finds that neither penalties nor attorney's fees are warranted in this case. Moreover, Respondent paid Petitioner 2 checks that totaled $7,000.00 to be used for TTD benefits, or if he chooses, for medical benefits.

Brian Cronin

Arbitrator

8-17-2016

Date

STATE OF ILLINOIS)
)
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Andre Hudson,
Petitioner,

vs. No. 14 WC 23775

Metro Industrial Tire,
Respondent.

18IWCC0234

DECISION AND OPINION ON REVIEW

Respondent has timely filed a Petition for Review of the August 18, 2016 Decision of the Arbitrator, issued following hearing held under Section 19(b) on September 25, 2015 and February 25, 2016. Notice has been given to all parties. The Commission, after considering the issues of accident, causal connection, medical expenses including prospective care, and temporary total disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below. In particular, the Commission finds that Petitioner reached maximum medical improvement no later than three months post-accident, and accordingly modifies the Arbitrator's award of benefits as it concerns temporary total disability and medical expenses. The Commission otherwise affirms and adopts the Decision of the Arbitrator, a copy of which is attached hereto and made a part hereof.

The Commission remands this case to the Arbitrator for proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327 (1980).

18IWCC0234

I. BACKGROUND

A. Petitioner's Accident and Treatment

Petitioner, 30 years old at the time, alleged injury to his low and mid-back incurred on June 19, 2014. He was employed as a tire technician for Respondent, Metro Industrial Tire. The company sells and services industrial tires for forklifts and other slow-moving equipment used in factories, warehouses, and airports. Petitioner's duties up through his termination included mounting and dismounting these specialty tires, as well as general cleaning of the shop premises (sweeping, emptying wastebaskets, and the like).

The asserted date of accident, June 19, 2014, was a Thursday. Petitioner began his day with his cleaning tasks in the morning. Then, in the afternoon, he serviced tires that were brought in for changing, or dismounting and mounting. This work was being done for a regular customer, whose tire delivery had been expected that day. (Tr. 2/25/16 at 121-124). These tires were used on airport "tugs" (tractors that pull baggage carts). In servicing the tires, Petitioner was first required to lift the tire, with its metal rim, a distance between 12 to 18 inches off the ground and place it onto a tire press machine. According to Petitioner, each tire weighed 30 to 70 pounds. It took about 10 or 15 minutes to dismount the old tire from its rim and mount the new tire, and he could change 3 or 4 tires in this manner in an hour. Petitioner estimated that he dismounted and mounted 20 tires that afternoon. (Tr. 9/25/15 at 92-99). For Petitioner, this was just a "regular" day. (Tr. 9/25/15 at 18).

Petitioner finished the tires and left work around 5 p.m. As he testified, he "felt fine" and was not in pain. He went home, had dinner, played a video game, and went to bed, experiencing nothing out of the ordinary all the while. Then, the next morning, June 20, 2014, he woke up with severe low back pain. Petitioner eventually attributed this pain to his work activities from the previous afternoon, as that was the most recent physical activity he could remember.[1] (Tr. 9/25/15 at 18-21, 120-121; Tr. 2/25/16 at 131). When asked what he thought when he woke up about the cause of his pain, he stated, "At the moment … it didn't really dawn on me. And then as I thought back to, you know, as far as anything I had done, I hadn't done anything except for work that day." (Tr. 9/25/15 at 21).

Petitioner was not at work for 3 days (Friday through Sunday), over the course of which the pain did not subside.[2] On Monday, June 23, 2014, Petitioner returned to work at Respondent's shop and requested approval to be treated at Concentra Occupational Health Centers, the company clinic. According to Petitioner, Respondent's owner, Kevin Clarke, did not grant approval until the next day,

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[1] As well, the medical records are consistent in noting that Petitioner woke up on the morning of June 20, 2014 with back pain. The records do mention that he reported lifting and working with tires the previous afternoon, and there is no express mention that that he had any immediate onset of pain upon lifting, twisting, etc.

[2] Petitioner had previously requested that Friday off to attend a funeral; he testified that he was in pain throughout the two-hour service and had to alternate between sitting and standing. The shop was closed on Saturday and Sunday. Petitioner testified that on those days as well his pain was still "excruciating" and the "same." (Tr. 9/25/15 at 21-22; Tr. 2/25/16 at 126-127).

June 24, 2014. (Tr. 9/25/15 at 24-32). Petitioner immediately left the shop and went to the Concentra clinic. There, he was examined by Dr. Nina Taylor, who wrote:

> "Patient states that on 6/19 he was repeatedly lifting heavy metal cages to place them onto tires. On 6/20 woke up with low back pain and stiffness. Said he rested over the weekend and felt better yesterday and worked his regular shift. This morning he again woke with low back pain and stiffness as well as with some tightness in his mid-back. He complains of constant pain across his low back that he rates a 7-8. Pain is exacerbated by bending and prolonged sitting. Pain does not radiate. Denies any associated numbness or tingling of his lower extremities."

(PX 4 at 6/24/14). The assessment was lumbar strain, with impairments correlating with localized inflammation. Twice-weekly physical therapy at the clinic was prescribed. He underwent his first therapy session that afternoon. He was also placed on work restrictions, including a 20-pound lifting restriction. (PX 4). Pursuant to the restrictions issued by Concentra, Petitioner did light-duty tasks the following day, Wednesday, June 25, 2014. (Tr. 2/25/16 at 34-35). The next day, Thursday, June 26, 2014 – one week after the asserted accident -- Petitioner was terminated from employment at Respondent.[3] Petitioner attended his second (and last) physical therapy session at Concentra that afternoon. (PX 4 at 6/26/14).

Soon thereafter, Petitioner began what would turn out to be an enduring and active relationship with Advanced Physical Medicine Associates, S.C., beginning on July 2, 2014, when he presented to physiatrist Dr. John Sarantopoulos, D.O., for initial evaluation and treatment. Dr. Sarantopoulos wrote:

> "[Petitioner] performed [a] movement of lifting [a metal cage used to install tires weighing 100 pounds] 20 times at work on [June 19, 2014] and then the next day after being home from work he felt severe low back pain. He reported his injury to his work on or about the 22nd of June… His pain mainly involves his mid back and his low back. He rates his pain as 8/10 and describes it as constant and sharp. He states he does get radiating pain down both lower extremities. He also complains of pain with movements of the low back."

(PX 6 at 7/2/14). Regarding his assessment, Dr. Sarantopoulos wrote: "thoracic strain with associated myofascial pain, lumbar strain with associated myofascial pain, bilateral lumbar radicular symptoms, cannot rule out lumbar intervertebral disc derangement, status post work related injury of 6/19/2014." (PX 6). That day, Dr. Sarantopoulos performed "OMT [Osteo Manipulative Therapy] to the cervical,

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[3] Petitioner suggests that his termination was in retaliation for asserting a work-related injury under the Act or otherwise wrongful. Respondent disputes this assertion. The circumstances of Petitioner's termination are not material to the Commission's conclusions in this proceeding.

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thoracic and lumbar spine with activator technique;"[4] prescribed Mobic and Norco; wrote an off-work slip; and promptly referred Petitioner to physical therapy at Advanced Physical Medicine. (PX 6).

As well, thoracic and lumbar MRIs were ordered. These MRIs (done on July 16, 2014) would disclose nothing remarkable as to the thoracic spine and lumbar spine, save for the radiologist's finding of "subligamentous, posterior broad-based disk herniations at the L4-L5 and L5-S1 levels with extruded nuclei pulposi measuring approximately 5-6 mm and 4-5 mm." (PX 3).

Regarding the physical therapy prescribed by Dr. Sarantopoulos, this treatment is notable for its high frequency -- first three sessions weekly, then twice weekly[5] -- and its failure to render lasting improvement of Petitioner's subjective symptoms, even after more than a year. The physical therapy consisted of, *inter alia*, electrical stimulation, hydro-massage, ultrasound, and hot and cold packs. The therapy notes indicate that Petitioner described, in general and rather modest terms, pain in his low back and occasional pain travelling down his legs. For example: "LBP [lower back pain] increases after prolonged sitting" (1/30/15); "Low back feels really sore after shoveling snow last Monday" (2/24/15); "Occasional stiffness of low back" (2/6/15); "Left side of my low back feels sore and achy since I woke up." (2/25/15); "My low back hurts really bad. I do feel occasional numbness and tingling down both legs" (3/27/15); "I wake up in the middle of night because of low back pain and stiffness" (4/10/15); "Both of my legs feel sore after exercises" (5/22/15); "My low back feels stiff in the morning" (6/19/15); "Some days I do not have any low back pain and some days my low back hurts a lot" (7/8/15); "My back hurts a lot. I have difficulty sitting for longer duration." (8/10/15); "Can I ride bike every day to improve my leg strength? Do you think it will hurt my back a lot?" (8/14/15).

In addition, Petitioner also made about twice-monthly office visits to Dr. Sarantopoulos, who continued to administer the "osteopathic manipulation with activator technique" to Petitioner's entire spine (cervical, thoracic, and lumbar, even though Petitioner never asserted injury to the cervical spine) during these visits. The last office visit note in the evidentiary record is dated October 9, 2015. On that day, Petitioner's pain was noted to be 6/10 in the mid-back and 8/10 in the low back. (PX 3). In other words, after receiving 32 sessions of chiropractic treatment from Dr. Sarantopoulos (and at least 100 sessions of physical therapy) up to this point, Petitioner had made virtually no progress with respect to his subjective complaints of pain.

Petitioner's current assessments from Advanced Pain Medicine include lumbar disc herniation, left lumbar radiculopathy, low back pain, and lumbar myofascial pain. Petitioner is currently being prescribed Norco, Mobil, Flexeril and Gabapentin. At hearing, Petitioner described his condition as "a constant pain in my lower back. My left leg is numb with pain up and down. My mid-back is a little sore.

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[4] This "OMT with activator technique" apparently refers to a chiropractic treatment utilizing a small handheld electronic instrument which delivers a controlled impulse of mechanical force to the spine.

[5] Petitioner testified that, after several months, his physical therapy was cut back from three times to twice per week, as even Dr. Sarantopoulos thought it was "ridiculous" to go so often when it appeared to be having not much effect. (Tr. 9/25/15 at 66).

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Sitting, standing too long hurts." (Tr. 9/25/15 at 84). Among the prospective treatment sought by Petitioner in this workers' compensation proceeding are epidural steroid injections recommended by Dr. Sarantopoulos in the fall of 2014.[6] Dr. Sarantopoulos has continued to recommend these injections as well as ongoing physical therapy.

B. Section 12 Examination

Petitioner, on April 13, 2015, was seen for an independent medical examination by Dr. Julie Wehner, who authored a written report and sat for evidence deposition on December 11, 2015. (RX 1; RX 3). In pertinent part, Dr. Wehner's opinion was that, at most, Petitioner suffered a lumbar strain that was expected to have resolved within 3 months of his asserted accident -- that is, by September 19, 2014. (RX 3 at 26-27). Regarding his ongoing complaints of pain (related to be in the mid- and low back and intermittent pain down the back of both legs to his proximal calf), Dr. Wehner opined that there was no causal relationship to any work accident insofar as there were no objective findings to support these complaints. And, most certainly, Petitioner's treatment to date had been grossly excessive. (RX 3 at 23-24). Dr. Wehner commented that 113 sessions of physical therapy were the most she had ever seen anyone -- even patients with a life-threatening injury -- undergo. (RX 3 at 28-29).

Dr. Wehner read the lumbar MRI films of July 2014 as disclosing a minimal amount of disc bulging at L4-5. (RX 3 at 16-17). She strongly disagreed with the MRI radiologist's impression of lumbar herniation, calling this finding a "gross exaggeration." (RX 3 at 15-16). She allowed that the lumbar MRI did show "some non-specific abnormalities" but that these were not clinically significant as they did not correlate with Petitioner's subjective complaints. (RX 3 at 17). Dr. Wehner noted that Petitioner had a normal clinical examination, including normal neurological testing and a negative result upon the straight leg raising test – a test used to detect the presence of disc herniation. This negative straight leg raise result was consistently found as well by Dr. Sarantapolous over the course of his more than 30 office visits. (RX 1).

Dr. Sarantopoulos expressed no causation opinions in his medical records, nor did he provide one via evidence deposition or otherwise.

II. DISCUSSION

The Arbitrator found that Petitioner sustained a work-related accident and that his current condition of ill-being was related thereto. The Arbitrator awarded temporary total disability up through the last day of hearing (February 25, 2016). The Arbitrator was dismissive of Dr. Wehner's testimony and seemed to base his favorable decision for Petitioner on the radiologist's impression from the July 2014 lumbar MRI report indicating that Petitioner has "subligamentous, posterior broad-based disk herniations at the L4-L5 and L5-S1 levels with extruded nuclei pulposi measuring approximately 5-6 mm and 4-5

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[6] Dr. Sarantopoulos' office note of September 12, 2014 indicate that he referred Petitioner to pain specialist Dr. Eugene Lipov for evaluation for epidural steroid injections; however, the insurance carrier would not authorize the injections. (PX 5 at 9/12/14; Tr. 9/25/15 at 60-66).

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mm." (Arbitrator's decision at 15-16). The Arbitrator does not explain how this one impression supports Petitioner's claim of current, disabling ill-being.

As for medical benefits, the Arbitrator awarded medical expenses covering Dr. Sarantapoulos' office visits up through January 13, 2016 -- the date of the last office visit preceding the last day of hearing – as well as prospective care in the form of the epidural steroid injections pursuant to this treating doctor's recommendation. (Arbitrator's decision at 18).

However, as to the physical therapy treatment, the Arbitrator wrote that the number of sessions provided "became an inordinate number, especially since Petitioner failed to meet the short-term and long-term goals." (Arbitrator's decision at 18). The Arbitrator found Respondent liable for the physical therapy only up through April 13, 2015, after which date the treatment became "unreasonable and unnecessary medical care" (notwithstanding that ongoing physical therapy was also being recommended by Dr. Sarantopoulos). (Arbitrator's decision at 18). The date of April 13, 2015 was when Petitioner was examined by Dr. Wehner, who, as the Arbitrator noted, indicated that the physical therapy treatment was excessive.

The Commission finds that Petitioner has carried his burden by a preponderance of the evidence that he suffered a work-related injury on June 19, 2014. The Commission further finds that the injury suffered was no more than a lumbar strain and that he reached maximum medical improvement by September 19, 2014; the Commission finds Dr. Wehner's opinions persuasive in that regard. Petitioner's account of ongoing ill-being and disability beyond that date is not credible. (As noted above, the physical therapy records indicate that Petitioner can shovel snow and ride his bike.)

Lastly, Petitioner's petition for penalties and fees is denied.

Accordingly, the Commission modifies the Arbitrator's award of temporary total disability and medical expenses.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on August 18, 2016, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $ 360.41 per week commencing June 28, 2014 through September 19, 2014, as provided under Section 8(b).

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the reasonable and necessary medical expenses incurred for treatment only up through September 19, 2014, as provided under Section 8(a) of the Act and subject to the medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of prospective medical care is vacated.

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

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $ 10,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 17 2018

o-02/28/18
jdl/ac
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Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

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

HUDSON, ANDRE
Employee/Petitioner

Case# **14WC023775**

METRO INDUSTRIAL TIRE
Employer/Respondent

18IWCC0234

On 8/18/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.44% 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:

0592 POMPER & GOODMAN
CAROLINE WATSON
111 W WASHINGTON ST SUITE 1000
CHICAGO, IL 60602

1680 CASSANO & ASSOCIATES
LAWRENCE C CASSANO
1240 IROQUOIS AVE SUITE 210
NAPERVILLE, IL 60563

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPAGE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Andre Hudson
Employee/Petitioner

v.

Case # 14 WC 23775

Metro Industrial Tire
Employer/Respondent

18IWCC0234

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brian Cronin**, Arbitrator of the Commission, in the cities of **Wheaton** and **Chicago**, on **9/25/2015** and **2/25/2016**, respectively. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, 06/19/2014, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did* 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 an average weekly wage was $540.62.

On the date of accident, Petitioner was 30 years of age, *married* with 2 dependent children.

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

Respondent shall be given a credit of $7,000.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $7,000.00.

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

ORDER

Respondent shall pay the charges for the reasonable, necessary and related medical services rendered to Petitioner by Advanced Physical Medicine Associates, S.C., for physical therapy treatment, as well as for the office visits to Dr. Sarantopoulos, through April 13, 2015, as provided in Section 8(a) and subject to Section 8.2 of the Act. Respondent shall also pay the charges for the reasonable, necessary and related medical services that consist of office visits to Dr. Sarantopoulos from April 14, 2015 through January 13, 2016, the last office visit, in accordance with Section 8(a) and subject to Section 8.2 of the Act.

Respondent shall pay Petitioner $360.41/week for 86-6/7 weeks, from 6/28/2014 through 2/25/2016, because Petitioner was temporarily totally disabled during this period, in accordance with Section 8(b) of the Act.

Petitioner's petitions for penalties and attorney's fees are denied.

Respondent shall authorize and pay the reasonable cost of epidural steroid injections, as prescribed by Dr. Sarantopoulos, in accordance with Section 8(a) and subject to Section 8.2.

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

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

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

Signature of Arbitrator

August 17, 2016
Date

ICArbDec19(b)

AUG 18 2016

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ANDRE HUDSON, Petitioner, v. METRO NORTH INDUSTRIAL TIRE, INC. Respondent.	)	No. 14 WC 23775

18IWCC0234

DECISION OF ARBITRATOR

An Application for Adjustment of Claim was filed in this matter and notice of hearing mailed to each party. The matter was bifurcated. The first portion of this matter was heard September 25, 2015 by an Arbitrator designated by the Commission in the City of Wheaton, County of DuPage, and State of Illinois. The second portion of the matter was heard February 25, 2016 in the City of Chicago, County of Cook, and State of Illinois. After hearing the proofs and allegations of the parties and having made careful inquiry into this matter, the Arbitrator concludes as follows:

The parties stipulated that on June 19, 2014, Respondent METRO NORTH INDUSTRIAL TIRE, INC. ("Respondent"), was operating under and subject to the provisions of the Illinois Workers' Compensation Act; the relationship of employer and employee existed between Petitioner ANDRE HUDSON ("Petitioner") and said Respondent; timely notice of accident was given; and at the time of the injury Petitioner was 29 years of age, married, with 2 dependent children under 18 years of age. Yet, the medical records indicate DOB 5/16/84

The parties disagree as to the issues of accident, causation, average weekly wage, medical and prospective medical benefits, TTD benefits, and penalties and fees.

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THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDING OF FACTS:

Petitioner was a tire technician employed on the date of accident by Respondent. Respondent is in the business of servicing and selling industrial tires for forklifts, material handling equipment and various slow-moving equipment used in plants and warehouses. The servicing component of Respondent's business includes installing forklift tires and tires for "tugs." Tugs are machines used to carry baggage carts between airplanes at airports.

Petitioner was hired in June 2011. His job duties included installing, mounting and dismounting industrial tires, as well as accepting deliveries and cleaning the premises.

In the course of Petitioner's employment, Mr. Clarke testified, he attempted to have Petitioner certified or "badged" to work at O'Hare Airport by the Transportation Safety Administration (TSA). Mr. Clarke testified his employees would need to be badged by the TSA in order to drive on the airstrip at O'Hare and pick up tires. Petitioner was sent for badging and was denied, but the TSA did not give an explanation as to the reason for denial.

Mr. Clarke testified that on June 19, 2014, Respondent had a walk-in customer who needed 10 new tug tires installed. The customer, Sage, was a weekly customer. Petitioner testified he was assigned by his supervisor, Mike Murphy, to dismount the old tug tires and mount new tug tires using a tire press machine. He claimed the tires weighed 30 to 70 pounds. He also testified he was required to lift the tire and rim between 12 and 18 inches off the ground onto a tire press. Petitioner testified he waited for a co-worker to bring the old tires from the airport and then proceeded to mount and dismount them in the afternoon. Petitioner testified he dismounted and mounted an estimated 20 tires. He testified it took about 10-15 minutes to dismount the old tire and mount the new tire and that he could probably 3-4 tires in an hour. Petitioner did not experience any unusual pain, and left work after completing his usual shift.

Mr. Clarke testified that Respondent's protocol for reporting work accidents was to immediately report the accident to a supervisor. He testified that on June 19, 2014, Petitioner worked his normal shift, left at the normal time, and did not report to him, or anyone else at Metro North, that he sustained a work accident or injury on that day. Petitioner corroborated Mr. Clarke's testimony – he testified he did not notice any pain while he performed the job on June 19. He testified that he completed the job and felt fine afterwards. He went home at the usual time and had dinner, played a video game, and went to bed.

Petitioner testified he previously requested time off work on June 20, 2014 to attend a funeral. Respondent gave him that day off.

Petitioner testified that on June 20, 2014, he woke up and "could barely move" and "couldn't even get out of bed." He did not know why he was in pain, just that he was in pain. Two days later on June 22, 2014, Petitioner sent a text message to Mr. Murphy and reported he had been feeling bad since June 20, 2014, that he wanted to wait and see if his condition would resolve over the weekend, that his condition did not resolve, and that he wanted to be sent to the doctor. Petitioner testified he specifically told Mr. Murphy he hurt his back on Thursday [June 19, 2014], though no record of that conversation or text message was ever produced or admitted into evidence at trial by Petitioner. Although Mr. Murphy did not respond, he informed Mr. Clarke on June 23, 2014 that Petitioner texted him and reported his back was sore and that he needed to go to the company clinic, Concentra. Petitioner testified he wanted to go to Concentra because other people who were injured had been sent there. Petitioner also testified he repeatedly asked Mr. Murphy if he could go to Concentra, but did not receive an answer.

Petitioner testified that after he texted Mike Murphy on Sunday, he spoke with Mr. Clarke on Monday, June 23, 2014, over the telephone regarding the accident and that he believed he hurt himself during the job for Sage because that was the last job he did.

Mr. Clarke denied that such telephone conversation ever took place. Mr. Clarke testified he was out in the field on June 23, 2014. Petitioner was scheduled to work that day. Mr. Clarke testified that Mike Murphy told him that day that Petitioner claimed he injured himself the previous Thursday.

On June 24, 2014, Mr. Clarke had a conversation with Petitioner. Petitioner told Mr. Clark he hurt his back and wanted to go to Concentra. When Mr. Clarke asked when he hurt his back, Petitioner replied it "must have been the previous week" because when he was off over the weekend he awoke and his back was sore. Petitioner never said the accident happened on June 19, 2014. Mr. Clarke suggested Petitioner seek medical treatment from his own physician. Following a conversation with his wife, Petitioner spoke with Mr. Clarke once again and renewed his request to go to Concentra. Mr. Clarke authorized the visit and Petitioner presented to with chief complaints of low back pain.

The Concentra records reflect Petitioner's pain did not radiate and he denied any associated numbness or tingling of his lower extremities. X-rays were negative. He was diagnosed merely with a lumbar strain and given light-duty restrictions consisting of no lifting over 20 pounds and no pushing or pulling over 20 pounds of force. The records reflect he presented for an initial physical therapy evaluation, and complained of lower thoracic pain in the middle of his back. He also reported paresthesia of his hands and arms. Upon examination by the physician, Nina L. Taylor, D.O, found, *inter alia*, that Petitioner's reflexes were normal and equal bilaterally, that the straight leg raising test from a seated position in a seated position was

negative bilaterally and that Petitioner was in no apparent distress. She assessed a lumbar strain, prescribed medication and a course of physical therapy, and limited her to lifting/pushing/pulling of no more than 20 pounds.

Petitioner spoke with Mr. Clarke by phone after he left Concentra and advised of his diagnosis and work restrictions. Mr. Clarke told Petitioner he did not have any light-duty work to assign because he was not at the office and would not be there to assign such work. Ultimately, Mr. Clarke recommended Petitioner go home and come back in the morning. On June 25, 2014, Petitioner met with Mr. Clarke and was given a list of light-duty assignments that did not involve lifting. Petitioner worked a full day and was paid his regular wage of $16.00/hour.

On June 26, 2014, Petitioner reported for work wearing shorts and a T-shirt. As a tire technician, he was required to wear a uniform. Petitioner testified that because he knew he would be working in the office that day, he did not think it was necessary for him to wear his uniform. Mr. Clarke testified he asked Petitioner to change into his uniform because it was a business. While Petitioner was changing, Mr. Clarke received a call from the company's repair facility, indicating a truck was ready for pick up. When Petitioner came out of the locker room, Mr. Clarke asked if he would be able to drive. Mr. Clarke testified Petitioner responded belligerently and confronted him in an aggressive manner. Mr. Clarke testified he told Petitioner to calm down and go home and they would talk again the next day. Petitioner responded, "Good, that's what I wanted you to say." Petitioner went back to the locker room and changed back into his street clothes. He reappeared and a verbal altercation ensued between Petitioner and Mr. Murphy. The police were called and arrived at Metro North shortly thereafter.

Following the altercation, Mr. Clarke terminated Petitioner's employment for insubordination. However, Mr. Clarke testified he told Petitioner he could continue receiving

medical treatment. Petitioner returned to Concentra for a re-check of his lumbar strain on June 26, 2014. He complained of low back and mid back pain, which he rated at 8/10. He denied any radiation of pain. He also denied any numbness or tingling of his lower extremities. On examination, he was in no apparent distress, had a negative Straight Leg Raising (SLR) test bilaterally in the seated position, pain with palpation at the L4-L5 paraspinous area bilaterally, had decreased lumbar range of motion (ROM) to all planes (per Petitioner's report). He also had positive Waddell's tests for axial compression and over reaction. He was diagnosed with a lumbar strain, thoracic spine pain, and symptom magnification.

Mr. Clarke denied telling Concentra to stop medical treatment for Petitioner because he was no longer employed by the company. Mr. Clarke merely contacted his workers' compensation insurance carrier and advised Petitioner was no longer employed. Mr. Clarke testified Petitioner was offered COBRA, but he did not want to accept that coverage.

On July 2, 2014, Petitioner presented to John C. Sarantopoulos, D.O. Dr. Sarantopoulos specializes in physiatry. Petitioner gave a history of a work accident on June 19, 2014, stating he was lifting a cage that weighed about 100 pounds, which was used to help change tires for forklifts. He reported mid back and low back pain, which he rated as constant and sharp. He stated the pain radiated down both lower extremities. On examination, he was in no acute distress, had non-tender claves, negative seated SLR bilaterally, bilateral thoracic tenderness, bilateral lumbar tenderness, decreased lumbar flexion, decreased lumbar extension, and a non-antalgic gait. Dr. Sarantopoulos diagnosed (1) a thoracic strain with associated myofascial pain, (2) lumbar strain with associated myofascial pain, (3) bilateral lumbar radicular symptoms, and lumbar intervertebral disc derangement could not be ruled out. Petitioner was given medication for pain. He was also given an off work note that indicated he was to remain off work "until

further notice." He has not returned to work since he was terminated. He was referred for physiotherapy for his thoracic spine and lumbar spine.

On July 16, 2014, Petitioner underwent an MRI of the lumbar spine. Radiologist George G. Kuritza, M.D., provided the following interpretation:

CLINICAL HISTORY: Work-related lifting injury with back pain.

FINDINGS: MRI of the lumbar spine was performed utilizing standard pulse sequences in the coronal, sagittal, and axial imaging planes with multiecho and multipulse sequencing.

There is normal lumbar curvature. There are no fractures or significant subluxations.

Bone marrow signal intensity appeared homogeneous and unremarkable.

At the L4-L5 and L5-S1 levels, subligamentous posterior broad-based disk herniations with extruded nuclei pulposi are seen measuring approximately 5-6 mm. and 4-5 mm. respectively with mild spinal stenosis and bilateral neuroforaminal narrowing.

The rest of the lumbar intervertebral disks appeared unremarkable. The paravertebral soft tissues appeared normal. Posterior elements appeared intact. The conus medullaris was identified and appeared unremarkable. The visualized portions of the lower lumbar spinal cord and thecal sac appeared unremarkable.

IMPRESSION:

1. At the L4-L5 and L5-S1 levels, subligamentous posterior broad-based disk herniations with extruded nuclei pulposi are seen measuring approximately 5-6 mm. and 4-5 mm. respectively with mild spinal stenosis and bilateral neuroforaminal narrowing.
2. The rest of the lumbar spine appears unremarkable. (PX 6)

On July 16, 2014, Petitioner underwent an MRI of the thoracic spine. Radiologist George G. Kuritza, M.D., provided the following interpretation:

CLINICAL HISTORY: Work-related lifting injury with back pain.

FINDINGS: MRI of the thoracic spine was performed utilizing multiecho and multipulse sequencing.

There is normal lumbar curvature. There are no fractures or significant subluxations.

The bone marrow signal intensity appeared homogeneous.

The visualized thoracic intervertebral disks appeared unremarkable. There are no significant disk bulges, protrusions or herniations seen at this time. There is no significant spinal stenosis or significant neuroforaminal narrowing.

The posterior elements appeared unremarkable.

The spinal cord and thecal sac were visualized and appeared grossly normal.

The paravertebral soft tissues appeared unremarkable.

IMPRESSION:

Unremarkable MRI of the thoracic spine (PX 6)

Petitioner has treated conservatively for more than 21 months in this case under the care of Dr. Sarantopoulos, without any improvement.

On April 13, 2015, Petitioner presented to an orthopedic surgeon, Dr. Julie Wehner, for a Section 12 examination. Dr. Wehner's evidence deposition was taken on December 11, 2015 and at that time Petitioner raised no objection to the admission of Dr. Wehner's Section 12 report. Dr. Wehner took a detailed history from Petitioner. Petitioner reported being an

industrial tire technician for Respondent since 2011, and reported a date of injury of June 19, 2014. Petitioner stated "he had to work on a quantity of thirty 712 tires that weighed over 100 pounds each," the report reads. Petitioner reported lifting them approximately 12-14 inches off the ground onto a tire press machine. The next morning, a Friday, he reported experiencing low and mid back pain; he was off that day for a funeral. He took ibuprofen and experienced relief. He worked the following Monday, performing limited activity. He went to Concentra that Tuesday and had an x-ray and examination. He was sent for PT, as he was told he had a strain. He was fired that Thursday and his treatment was halted at Concentra thereafter. After being evaluated by Dr. Sarantopoulos, he had PT three times per week for approximately eight months, but reports being overall the same. He complains of mid back pain at a level of 6-7/10 and in the low back 8/10. He stated that pain radiated down the back of both legs to the proximal calf area and did have associated numbness and tingling. He reported a prior motor vehicle accident in 2003 but did not seek medical management.

On examination, his gait pattern was normal. He could bend to toe level with his fingertips. Extension was 20 degrees. No paraspinal spasm or scoliosis was present. Mild pain with palpation on the right at T12 to L1 was noted. There was no pain with axial compression or axial rotation. Straight leg raise was negative. Knee and ankle reflexes were 2+. Motor strength was 5/5. He easily straightened his leg to take off his shoes.

Dr. Wehner reviewed MRI reports from July 16, 2014 and films. Dr. Wehner's review of the films indicated no herniation. She opined, "I strongly disagree with the findings of disc herniations and extruded fragments." In her review of records, Dr. Wehner catalogued numerous, regular visits to Dr. Sarantopoulos occurring throughout December 2014 through March 2015.

Despite 94 visits to Dr. Sarantopoulos since July 2014, "there does not appear to be any progression towards the goals listed in the therapy program," Dr. Wehner wrote. She further opined, Petitioner "has had MRIs which show some non-specific abnormalities that do not correlate with his subjective complaints." Dr. Wehner wrote that MRI findings "do not correlate with his present clinical examination including the negative straight leg raising, normal neurologic testing, and pain that goes to the proximal calf." She concluded, "If MRI findings do not correlate then they are considered an asymptomatic finding and not considered clinically significant."

As to the issue of causal relationship, Dr. Wehner opined Petitioner's "ongoing subjective complaints can no longer be explained based on the diagnosis of June 19, 2014. He has had an extended period of therapy and reports the same pain on a daily basis despite observations by his treating physician of being in no acute distress, having a normal gait pattern, and negative straight leg raising. Therefore, he has ongoing subjective complaints of pain that are no longer substantiated by a specific clinical finding or a specific radiographic finding. I have no reason to believe his ongoing complaints are specifically related to the June 19, 2014 date based on these findings."

Regarding subsequent medical treatment, Dr. Wehner opined that Petitioner "has had eight months of physical therapy and has no documented improvement in symptoms. This is not medically appropriate. A course of therapy for onset of low back pain would be 6-12 visits with assessment of progress and transition to a home exercise program. There has been no documented progress throughout these therapy notes but he continues to go." Dr. Wehner concluded, "Therefore, his ongoing treatment with Dr. Sarantopoulos can no longer be medically justified after the initial 12 visits."

Dr. Wehner recommended no additional treatment or testing related to the date of June 19, 2014, as no neurologic findings substantiated Petitioner's subjective complaints about the thoracic and lumbar spine. She opined that Petitioner was able to work full duty, had reached MMI, and should have been considered disabled only for a maximum of six weeks. "I have no medical reason why he needed to be off work completely during this time," she wrote. Further she opined that "the osteopathic manipulative treatment has not been documented to provide any benefit to the patient and there is no medical need to pursue this type of treatment for chronic back pain complaints unless there is specific documentation of improvement over time." Dr. Wehner opined that no further treatment was necessary.

Despite this, Petitioner continued to treat under Dr. Sarantopoulos. On July 1, 2015, he tested positive for marijuana as well as Hydrocodone, and Hydromorphone. He again tested positive for marijuana on August 26, 2015.

Petitioner testified that during the course of treatment for his back, he requested to treat with a specialist, but was told that it was not authorized.

Petitioner testified he was an avid bowler at the time of the accident, and participated in bowling leagues.

His last doctor visit was on October 9, 2015, when Petitioner presented for yet more physiotherapy. After receiving 132 sessions, he had made virtually no progress towards his short-term goal of decreasing pain by 2 levels.

Dr. Sarantopoulos has continued to prescribe epidural steroid injections to treat Petitioner's back pain, but Respondent has not authorized such injections. He has assessed Petitioner with lumbar disc herniation, left lumbar radiculopathy, low back pain, and lumbar myofascial pain. Petitioner has been taking Norco, Mobic, Flexeril and Gabapentin for pain.

THE ARBITRATOR HEREBY MAKES THE FOLLOWING CONCLUSIONS OF LAW:

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

Petitioner testified that on Thursday, June 19, 2014, at work, he did his standard cleaning in the morning, and in the afternoon, he mounted 20 tires. He further testified that he was okay, he was fine and he went home, had dinner, played a video game and went to bed. Petitioner testified that when he woke up the next morning, he could not move and had to be helped out of his bed. Petitioner testified: "It was extreme." He testified that he was in tremendous pain, but he needed to make it to a funeral that morning and he did, in fact, make it to the funeral.

One week earlier, Petitioner had requested from his boss that he be allowed to take Friday, June 20, 2014, off work. His request was granted.

With regard to how he was feeling on the morning of June 20, 2014, Petitioner testified to the following:

Q: Did you have any inkling what had happened and why you were feeling that way?

A: At the moment, no, I didn't - - it didn't really dawn on me. And then as I thought back to, you know, as far as anything I had done, I hadn't done anything except for work that day. (Tr. 21)

Petitioner testified that it was really uncomfortable and painful at the funeral. He needed to sit, but once he sat, he needed to stand. After the funeral, he went home and took Ibuprofen, and hoped that the pain would go away.

The next day was Saturday, June 21, 2014. Petitioner was not scheduled to work that day. Petitioner further testified that he was in excruciating pain on Saturday. Once he sat down,

he could not get up. Petitioner further testified that his legs were burning, his buttocks were hurting, and his tailbone was hurting.

On Sunday, June 22, 2014, Petitioner testified, he was still feeling bad and sent a text message to his manager, Mike Murphy, in which he stated he hurt himself at work the previous Thursday, hoped he would get better over the weekend but had not, and wondered if, when he came into work on Monday, Mike could send him for medical care. (Tr. 22-23)

At the arbitration hearing, Petitioner was unable to produce a copy of the text message. However, Petitioner's testimony with regard to the sending of the text message and the contents of such message stand unrebutted.

Petitioner returned to work on Monday and testified that he spoke on the telephone with Kevin Clarke as Clarke was out in the field that day. Petitioner testified that he asked Mr. Clarke if he could seek treatment at the company clinic, but that Clarke urged his to see his own doctor.

Kevin Clarke testified: "I *believe* that the first time I talked to [Petitioner] was on Tuesday," and then testified that Petitioner would be incorrect if he said that he talked to me on Monday.

Kevin Clarke testified that he had a conversation with Petitioner on Tuesday, June 24, 2014. Clarke said to Petitioner that he heard Petitioner told Mike that he hurt his back. Petitioner replied that he had hurt his back and that he wants to go to the clinic. Clarke asked Petitioner when he hurt his back, to which Petitioner replied that it must have been last week because when he got up, his back was sore. Hudson then asked Petitioner why he did not see his own doctor to which Petitioner replied that he really wants to go to the company clinic. That day, Kevin Clarke allowed Petitioner to seek treatment at Concentra, nka, Occupational Health Centers of Ill.

On June 24, 2014, Petitioner gave the following HISTORY OF PRESENT ILLNESS to the staff to Nina L. Taylor, D.O. at Occupational Health Centers of Ill.:

> Pt states that on 6/19 he was repeatedly lifting heavy metal cages to place them onto tires. On 6/20 he woke up with low back pain and stiffness. Said he rested over the week-end and felt better yesterday and worked his regular shift. This morning he gain (sic) awoke with low back pain and stiffness as well as with some tightness in his mid back. He c/o constant pain in his low back that he rates a "7-8." Pain is exacerbated by bending and prolonged sitting. Pain does not radiate. Denies any associated numbness or tingling of the lower extremities. Denies any abdominal pain or bowel or bladder dysfunction. Denies any other associated injuries.
>
> (PX 5)

Respondent disputes accident and argues that Petitioner gave conflicting testimony as to the weight and number of tires he was lifting on the date of accident. However, it is undisputed that Petitioner, with the title of Tire Technician, was lifting and mounting industrial tires on the afternoon of June 19, 2014.

Petitioner reported the accident to Mike Murphy via text message on Sunday, June 22, 2014, to Kevin Clarke the next day, and provided a consistent history to Dr. Nina Taylor on Tuesday, June 24, 2014.

The Arbitrator heard the Petitioner's testimony, assessed his demeanor and finds him to be credible.

Therefore, the Arbitrator finds that on June 19, 2014, Petitioner sustained an accident that arose out of and in the course of his employment by Respondent.

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

Dr. Sarantopoulos did not write a narrative report and was not deposed. He did not include a formal causal connection opinion in his treating records. On July 2, 2014, Dr. Sarantopoulos took a history in which Petitioner reported that on June 19, 2014, he was lifting a cage that weighed about 100 pounds about 20 times at work and the next day he felt severe back pain. In his January 7, 2015 chart note, Dr. Sarantopoulos wrote: "He is status post work related lifting injury of 6/19/2014." (PX 6)

On August 27, 2014, Dr. Sarantopoulos completed a Verification of Disability (Employment) form for the Illinois Department of Human Rights. In it, Dr. Sarantopoulos indicated that Petitioner has a "Back Disorder," that the date of injury was "6/19/2014," and that the doctor can confirm Petitioner has/had such condition on the relevant date identified. Dr. Sarantopoulos also indicated Petitioner's problem is physical, that it is not minor, that his condition is permanent and that he has a positive lumbar MRI of 7/16/2014. Lastly, Dr. Sarantopoulos indicated that during the last 2 years, he placed restrictions on Petitioner: OFF WORK. (PX 6)

Dr. Wehner, in her April 13, 2015 Section 12 report, opined as follows:

> His ongoing subjective complaints can no longer be explained based on the diagnosis of June 19, 2014. He has had an extended period of therapy and reports the same pain on a daily basis despite observations by his treating physician of being in no acute distress, having a normal gait pattern and negative straight leg raising. Therefore, he has ongoing subjective complaints of pain that are no longer substantiated by a specific clinical finding or a specific radiographic finding. I have no reason to believe his ongoing complaints are specifically related to the June 19, 2014 date based on these findings. (RX 1)

In referring to "no specific radiographic finding," Dr. Wehner dismisses the following impression of the July 16, 2014 MR images of Petitioner's lumbar spine by board-certified radiologist George G. Kuritza, M.D.:

> At the L4-L5 and L5-S1 levels, subligamentous posterior broad-based disk herniations with extruded nuclei pulposi are seen measuring approximately 5-6 mm. and 4-5 mm. respectively with mild spinal stenosis and bilateral neuroforaminal narrowing. (PX 6)

Moreover, although Dr. Wehner finds that such MRI has not been clinically correlated, she concedes that the MRI findings are abnormal. (RX 1)

Furthermore, Dr. Wehner states: "His current diagnosis is chronic back pain, that is pain of over six months' duration." (RX 1)

The Arbitrator finds Petitioner to be credible.

Petitioner was 30 years old on the date of accident.

There is no evidence that Petitioner's bowling activities contributed to his low back or mid back condition of ill-being.

Dr. Sarantopoulos has assessed Petitioner with lumbar disc herniation, left lumbar radiculopathy, low back pain, and lumbar myofascial pain. Petitioner has been taking Norco, Mobic, Flexeril and Gabapentin for pain.

The Arbitrator finds that Dr. Kuritza's impression of the July 16, 2014 MR images, the Petitioner's credibility, Dr. Sarantopoulos' opinions and the chain of events outweigh the opinions of Dr. Wehner.

A chain of events which demonstrates a previous condition of good health, an accident and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove

a causal nexus between the accident and the employee's injury. International Harvester v. Industrial Commission, 93 Ill. 2d 59, 63-64 (1982)

Based on the foregoing, the Arbitrator finds that Petitioner's current condition of ill-being of his low back and mid back are causally related to the accident of June 19, 2014.

G. What were Petitioner's earnings?

Based upon Petitioner's wage records, the Arbitrator finds that Petitioner earned $28,436.50 during the period beginning the week ending June 28, 2013 and ending on June 6, 2014, including overtime hours at the regular hourly rate. (RX 5) After subtracting the weeks and/or parts thereof missed, Petitioner's average weekly wage was $540.62, calculated in accordance with Section 10 of the Act.

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

Dr. Wehner indicated on April 13, 2015 that the physical therapy treatment Petitioner was receiving was excessive since Petitioner's condition was not improving. Petitioner even testified the treatment "wasn't going anywhere." He testified he would receive treatment and still be in the same amount of pain.

Dr. Sarantopoulos began prescribing epidural steroid injections for Petitioner's work-related back injury on October 20, 2014, and has continued to prescribe such injections. However, Respondent has refused to authorize this course of treatment.

Dr. Sarantopoulos continued to recommend physical therapy, and Advanced Physical Medicine Associates continued to provide such treatment. The number of sessions of physical therapy that Advanced Physical Medicine Associates provided became an inordinate number, especially since Petitioner failed to meet the short-term and long-term goals.

Therefore, the Arbitrator finds that the physical therapy provided by Advanced Physical Medicine Associates, S.C., after April 13, 2015 was unreasonable and unnecessary medical care. The Arbitrator finds that Respondent is liable for payment of the physical therapy provided by Advanced Physical Medicine Associates, S.C., as well as the office visits to Dr. Sarantopoulos, on or before April 13, 2015, in accordance with Section 8(a) and subject to Section 8.2 of the Act. The Arbitrator further finds that Respondent is also liable for the payment of Petitioner's office visits to Dr. Sarantopoulos from April 14, 2015 through January 13, 2016, which is the date of the last office visit (PX 3), in accordance with Section 8(a) and subject to Section 8.2 of the Act.

K. Is Petitioner entitled to any prospective medical care?

Dr. Sarantopoulos has continued to prescribed epidural steroid injections to treat Petitioner's back injury. Respondent has not approved such injections.

In her Section 12 report, Dr. Wehner wrote: "Injection treatment is not recommended based on the fact that his subjective complaints of pain in the mid thoracic area and pain in the lumbar area radiating to the proximal calves is not a radicular pattern of pain. He also has no neurologic findings to substantiate the neurologic process. Therefore, there is no medical basis to pursue injection treatment."

However, the Arbitrator finds Petitioner to be credible and notes that the July 16, 2014 lumbar MRI that shows Petitioner has subligamentous, posterior broad-based disk herniations at the L4-L5 and L5-S1 levels with extruded nuclei pulposi measuring approximately 5-6 mm. and 4-5 mm., respectively. (PX 6)

Therefore, the Arbitrator finds that Petitioner is entitled to prospective medical care in the form of epidural steroid injections, as prescribed by Dr. Sarantopoulos.

L. What temporary benefits are in dispute?

In Arbitrator's Exhibit #1, Petitioner claims that he has been temporarily totally disabled from June 28, 2014 through February 25, 2016. Respondent claims that no TTD benefits are owed.

On June 24, 2014, the Concentra physician restricted Petitioner to light-duty work.

On June 26, 2014, Respondent terminated Petitioner's employment for insubordination. Petitioner's version of the altercation that led to Petitioner's termination differs from Mr. Clarke's.

On July 2, 2014, Dr. Sarantopoulos took Petitioner completely off work, and has not released him to return to work. (PX 6)

On April 13, 2015, Dr. Wehner, Respondent's Section 12 physician, reviewed medical records, conducted an examination of Petitioner and issued a report. Dr. Wehner opined that Petitioner was capable of returning to full-duty work 6 weeks after the accident. (RX 4)

An employer's obligation to pay TTD benefits to an injured employee does not cease because the employee had been discharged--whether or not the discharge was for "cause." When an injured employee has been discharged by his employer, the determinative inquiry for deciding

entitlement to TTD benefits remains, as always, whether the claimant's condition has stabilized. If the injured employee is able to show that he continues to be temporarily totally disabled as a result of his work-related injury, the employee is entitled to TTD benefits. Interstate Scaffolding, Inc. v. Illinois Workers' Comp. Comm'n, 923 N.E.2d 266, 337 Ill. Dec. 707 (2010)

As the Arbitrator has found that Petitioner has proved accident and causation, he further finds Petitioner was temporarily totally disabled from June 28, 2014 through February 25, 2016. The Arbitrator relies on Petitioner's testimony, the off-work slips and the July 16, 2014 lumbar MRI that shows Petitioner has subligamentous, posterior broad-based disk herniations at the L4-L5 and L5-S1 levels with extruded nuclei pulposi measuring approximately 5-6 mm. and 4-5 mm., respectively.

M. Should penalties or fees be imposed upon Respondent?

As Respondent had a bona fide dispute with regard to the threshold issue of accident, the Arbitrator finds that neither penalties nor attorney's fees are warranted in this case. Moreover, Respondent paid Petitioner 2 checks that totaled $7,000.00 to be used for TTD benefits, or if he chooses, for medical benefits.

Brian Cronin

Arbitrator

8-17-2016

Date

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

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Amelia Alvarez Carranza,
Petitioner,

vs. No. 11 WC 45619

West Suburban Nursing & Rehab,
Respondent.

18IWCC0235

DECISION AND OPINION ON REVIEW

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

Petitioner, a 44-year-old housekeeper, testified that on October 23, 2011 while mopping a resident's room she leaned over and felt pain in her back. Her floor manager sent her to Glen Oaks Hospital, where she was given a shot. She admitted her only complaint to the emergency room personnel was back pain. Her diagnosis there was back pain and back sprain. She returned to work three days later, and testified she was able to continue working thereafter.

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Petitioner testified her next treatment was with Dr. Barnabas, a physician to whom she was referred by her counsel. Petitioner claimed Dr. Barnabas took her off work, prescribed therapy and referred her to Dr. Ossama Hassan at Pro Clinic. Petitioner offered no records from Dr. Barnabas into evidence. She admitted her only complaint to Dr. Barnabas and his doctors and therapists was of back pain.

Petitioner treated with Dr. Hassan from November 2011 until June 2012. His records show that when he first saw Petitioner on November 23, 2011, her chief complaint was neck pain radiating to her thoracic midback. Although Petitioner also complained of low back pain radiating to her legs, she gave Dr. Hassan a history of having felt a strong shocking cramp on the back of her neck after turning and twisting at work. Dr. Hassan provided Petitioner with two rounds of cervical epidural steroid injections. In December 2011, he diagnosed her with cervical and lumbar radiculopathy and facet syndrome. In May 2012, Petitioner underwent a lumbar discogram, after which Dr. Hassan recommended and performed an L4-5 percutaneous discectomy.

Although at the arbitration hearing Petitioner testified her life has not been the same since her accident, she also admitted she was feeling fine at that hearing. She now occasionally works at a temporary office, and admitted that other than going to Stroger Hospital once in 2014, she has not seen any other doctors for her back since 2012. At arbitration, she had no pending appointments to see any doctors.

Respondent's Section 12 medical expert, Julie Wehner, MD, examined Petitioner on December 19, 2011. At her deposition, Dr. Wehner testified that Petitioner gave her a history of having experienced a sharp pain in her back on October 23, 2011 while mopping underneath a bed. Dr. Wehner reviewed Petitioner's records from DuPage Hospital, Alivio Therapy, Pro Clinic, and her MRI films. Those films showed mild degenerative changes in her spine but no herniations or other evidence of acute injury. Dr. Wehner found nothing either in Petitioner's MRI's or at her clinical examination which would explain Petitioner's claimed, non-anatomical arm numbness. Dr. Wehner found little in Dr. Barnabas' records to justify his diagnoses of a cervical strain, lumbar spine pain, lumbar radiculopathy and lumbar disc displacement. Dr. Weiner testified that the 10 steroid injections which Petitioner received in one day would not be effective for sprain/strain type injuries; were not medically supportable based upon her MRI which showed no nerve impingement, and would be too much steroids to give a patient in one day.

Dr. Wehner also gave these opinions: Petitioner's diagnosis was cervical, thoracic and lumbar pain consistent with soft tissue sprains; her recommended treatment for Petitioner would be 6-12 physical therapy or chiropractic sessions followed by 2-3 weeks of light duty restrictions; Petitioner should be MMI by January 2012; Petitioner's accident would not result in permanent injury; the compound medicines which were prescribed to Petitioner were not reasonable because her pain was not focal and had no specific underlying organic ideology; Petitioner's 4-level discogram wasn't necessary based upon her negative MRI findings, and Petitioner did not need percutaneous disc decompression surgery.

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Respondent also offered into evidence a Utilization Review report of Dr. Allan Brecher dated January 23, 2012. In that report, Dr. Brecher, who like Dr. Wehner is board certified in orthopedic surgery, believed that Petitioner's MRI scans, facet injections and trigger point injections were not indicated according to Official Disability Guidelines. He also reported that based upon Petitioner's injury and her records, only ten physical therapy visits were supported by the ODG, but that those should have included active treatment rather than the passive modalities Petitioner was given. Dr. Brecher also noted that no further treatment was medically necessary for Petitioner, whose records identified no findings consistent with any injury beyond a sprain, which should have been resolved.

The Arbitrator found Petitioner proved she sustained only a lumbar sprain/strain, but not the following conditions which Dr. Hassan diagnosed: cervical radiculopathy, cervical facet syndrome, lumbar radiculopathy, lumbar facet syndrome, degenerative disc disease and herniated disc. The Arbitrator found Dr. Wehner's opinions persuasive, Petitioner's credibility questionable, and Dr. Hassan's treatment not causally related.

The Commission agrees with the Arbitrator that Petitioner proved she sustained only a lumbar strain and sprain as a result of her work accident. Her discharge diagnosis at the Glen Oaks' emergency room on the day of her accident was "back pain" and "back sprain." The location of her pain was noted to be, "Right lumbar." The amount of radiating pain was noted to be, "none." After that emergency room visit, Petitioner testified she received no further treatment for almost a month, until she saw Dr. Barnabas. The next medical report in evidence, however, was Dr. Hussan's note dated November 23, 2011, in which he documented Petitioner's chief complaint to be a neck injury.

Petitioner offered no credible explanation why she seeks payment of a $1,124.27 Cadence Health bill; at the arbitration hearing she expressly denied being seen by that provider, and she failed to offer into evidence medical records which would show causally related treatment from that provider. Petitioner also failed to offer into evidence records from Dr. Barnabas, Alivio Therapy, Elite Physical Therapy, or Herron Medical Center – yet seeks payment of those bills, as well.

In finding Petitioner has not proven a causal relationship between her alleged injuries (other than a lumbar spine sprain and strain) and her October 23, 2011 accident, the Commission finds Dr. Wehner's opinions to be credible and persuasive. The Commission also notes the absence of a persuasive medical causation opinion. While Dr. Hassan did include a chart note that Petitioner was, "injured at work," it is unclear whether that was his opinion, or merely his report of what Petitioner told him. Even if Dr. Hassan's note is considered to be his opinion, the Commission finds it unpersuasive because he failed to give a basis for that opinion. Petitioner offered no other narrative reports or deposition testimony from any doctor which would credibly establish a causal relationship between her extensive treatment and her work accident.

The Commission, like the Arbitrator, finds Petitioner's credibility questionable. After denying neck pain following her accident to her initial provider, Petitioner told Dr. Hassan that her chief complaint was neck pain, stating she had experienced a, "Strong shocking cramp," on the back of her neck after turning and twisting at work. She initially testified Dr. Barnabas was her personal physician before admitting she had been sent to him by her attorney. Dr. Wehner found Petitioner's arm complaints to be non-anatomical. And despite Petitioner's complaints of ongoing pain, she admitted she felt fine at the arbitration hearing.

The Arbitrator found that Petitioner's lumbar sprain/strain had resolved by January 2012, and that the medical care which she received after that date was not medically necessary to relieve the effects of her work injury. The only medical expenses which the Arbitrator found reasonable were those incurred at: Glen Oaks Hospital; Alivio Physical Therapy; an October 25, 2011 visit at Cadence Occupational Health; Herron Medical Center, and Lakeshore Open MRI. The Arbitrator denied over $94,000.00 in bills from Pro Clinic and Dr. Hassan for treatment which included injections, discogram and a percutaneous disc decompression.

The Commission affirms the Arbitrator's denial of all bills from Pro Clinic and Dr. Hassan. That treatment was excessive and not proven reasonable, necessary or causally related to Petitioner's work injuries; based upon Dr. Wehner's opinions and the Utilization Review report.

Regarding the medical expenses which the Arbitrator awarded to Petitioner, the Commission makes some modifications. The Commission finds Petitioner attained maximum medical improvement for her injuries on January 31, 2012; all medical expenses incurred after that date are not reasonable or necessary. The Commission reverses the Arbitrator's award of medical expenses incurred after that date. Those bills include the following:

- $1,060.00 for three physical therapy sessions at Alivio Physical Therapy on 2/1/12, 4/12/12 and 4/16/12.
- $376.78 for a 4/12/12 visit at Herron Medical Center, and
- $1,801.46 for a 5/2/12 MRI at Lakeshore Open MRI.

Because the Commission agrees with the Arbitrator's finding that Petitioner's cervical problems and complaints were not causally related to her work accident, the Commission also reverses the Arbitrator's award of the November 23, 2011 bill in the amount of $1,806.92 from Lakeshore Open MRI. That bill was for a cervical MRI. The Commission also reverses the Arbitrator's award of $586.28 for Petitioner's alleged October 21, 2011 visit to Cadence Occupational Health. Not only did Petitioner fail to offer medical records showing treatment performed on that date, but she also testified she never was seen there. Petitioner has not proved that bill to be reasonable and related to her work injuries.

The Arbitrator awarded Petitioner 20 weeks of PPD, representing 4% loss of person-as-a-whole, after considering the 5 subsections of §8.1b of the Act. The Commission finds the Arbitrator's consideration of those factors to have been appropriate, and it affirms the Arbitrator's award of 4% loss of person-as-a-whole under §8(d)2 of the Act.

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The Commission also notes there was a clerical error in the award of the Arbitrator. On page 2 of the Arbitration decision, the Arbitrator incorrectly listed the amount of the Lakeshore Open MRI bill he was awarding Petitioner as, ***"$3,3608.38."*** The correct figure should have been, ***"$3,608.38."*** The Commission corrects that error in this decision.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 7, 2016, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of medical expenses awarded by the Arbitrator is modified as follows: Respondent shall pay only $568.36 to Alivio Physical Therapy and $833.15 to Herron Medical Center for treatment provided on and before Petitioner's MMI date of January 31, 2012, pursuant to §8(a) and the medical fee schedule as provided by §8.2 of the Act. All other medical bills are denied.

IT IS FURTHER ORDERED BY THE COMMISSION that the permanency award of the Arbitrator is affirmed, and Respondent shall pay to Petitioner the sum of $330.00 per week for a period of 20 weeks, as provided in §8(d)2 of the Act, for the reason that Petitioner's lumbar sprain/strain caused the four percent disability to the person-as-a-whole.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $8,600.00 The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 17 2018

o-02/28/18
jdl/mcp
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Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CARRANZA, AMELIA ALVAREZ
Employee/Petitioner

Case# **11WC045619**

WEST SUBURBAN NURSING & REHAB
Employer/Respondent

18IWCC0235

On 9/7/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.47% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0293 KATZ FRIEDMAN EAGLE ET AL
RYAN A PODGES
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STATE OF ILLINOIS)

)SS.

COUNTY OF DuPage

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Amelia Alvarez Carranza
Employee/Petitioner

v.

West Suburban Nursing & Rehab
Employer/Respondent

Case # **11** WC **45619**

18IWCC0235

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth**, Arbitrator of the Commission, in the city of **Wheaton**, on **7/28/2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **10/23/2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$17,680**; the average weekly wage was **$340.**

On the date of accident, Petitioner was **44** years of age, *married* with **5** dependent children.

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

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

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

Respondent is entitled to a credit of **$0** under §8(j) of the Act for long-term disability benefits paid for by the group disability carrier.

ORDER

Respondent shall pay reasonable and necessary medical expenses:$1,628.36 to Alivio Physical Therapy, $586.28 for Cadence Occupational Health, $3,3608.38 for Lakeshore Open MRI, and $1,209.23 for Herron Medical Center; pursuant to §8(a) and the medical fee schedule as provided by §8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$330.00** per week for **20** week, due to injuries which caused a **4%** loss of a person-as-a-whole.

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

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

Signature of Arbitrator

September 2, 2016
Date

SEP - 7 2016

Amelia Alvarez v. West Suburban Nursing and Rehab
11 WC 45619

INTRODUCTION

This matter proceeded to hearing on before Arbitrator Steven Fruth. The disputed issues were: ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; ***L:*** What is the nature and extent of the injury?

STATEMENT OF FACTS

Petitioner Amelia Alvarez testified that she was employed by Respondent West Suburban Nursing and Rehab in the Housekeeping Department of its nursing and rehabilitation facility. Her duties included mopping and cleaning the dining room and the patients' rooms. She indicated that the mop that she used weighed 17 lbs.

On October 23, 2011, she was mopping a patient's room. She leaned over to mop under a bed and could not straighten up because of pain in her low back. She reported the injury and was sent to Adventist Glen Oaks Hospital (PX #2) emergency room.

Petitioner complained of 8/10 mid back pain to the ER staff of Glen Oaks. She reported that she had twisted her back while mopping. Petitioner denied any radiating pain. The physical examination by Dr. Susan Jacob revealed normal range of motion and strength, normal alignment, mild tenderness in the right lumbar region, and positive straight-leg raise on the right at 0°. She was given pain and muscle relaxant medication and instructed to return to work with no heavy lifting. Petitioner testified that she returned to work 3 days later. She was also advised to follow up with Mahrukh Subhani.

On October 28, 2011 Petitioner returned to work for the Respondent.

Petitioner offered into evidence the subpoenaed records of Central DuPage Hospital (PX #4) where she had x-rays on October 25, 2011 for rib and thoracic back pain, ordered by Dr. Robin Robinson. There were no notes that an examination was performed. Other records from Central DuPage Hospital were for blood work performed prior to the date of the accident. Petitioner specifically denied being seen, treated, or tested at Central DuPage Hospital for her injury.

Petitioner testified that the next doctor that she saw was Dr. Ravi Barnabas on November 22, 2011. Dr. Barnabas took Petitioner off work. He ordered physical therapy, which consisted of electrotherapy, massages, exercises, and ointments. She testified that she got no relief from her therapy. In addition, Dr. Barnabas referred Petitioner to Dr. Ossama Abdellatif Hassan for pain management.

Petitioner first saw Dr. Hassan at ProClinics on November 23, 2011 (PX #4). She testified that Dr. Hassan administered a round of injections from which she felt no

improvement. A second set of injections was performed on December 14, 2011, but she only felt a little bit better. An MRI of the lumbar spine ordered by Dr. Barnabas was performed on November 23, 2011. The radiologist noted mild degenerative changes and disc bulging scattered along the lumbar spine without significant encroachment on the adjacent neuro elements. There was also disc desiccation at L5-S1. Petitioner also had a cervical MRI on November 23, also ordered by Dr. Barnabas, which showed minimal disc bulging and mild hypertrophy of the posterior elements with no significant spinal stenosis or cord displacement from C3 through C7. There was also mild scattered bilateral foraminal narrowing.

On November 23, 2011 Dr. Hassan noted Petitioner's complaints of neck pain radiating into the mid-back and low back pain radiating into the legs, with nonspecific tingling and numbness. Petitioner marked a body diagram indicating low back pain only. There were no markings indicating neck or mid-back or leg or arm pain. Dr. Hassan noted cervical radiculopathy in the upper arms. He noted Petitioner's complaints of 7/10 neck pain, 8-9/10 thoracic pain, and 6/10 lumbar pain.

Dr. Hassan performed multiple injections on November 30, 2011: C7-T1 depomedrol; bilateral facet blocks at C4-5, C5-6, and C6-7; trigger points in the trapezius oblique and rhomboid minor muscles. On December 14, 2011 the same injections as on November 30 were administered. On January 9, 2012 Dr. Hassan performed a radio frequency procedure at C7 and a depomedrol injection at C7-T1, as well as bilateral facet blocks at C5-6 and C6-7. Dr. Hassan also injected trigger points in the trapezius, rhomboid minor, and splenius cervicis muscles. Dr. Hassan performed a lumbar discogram on May 2, 2012, along with trigger point injections in the external abdominal oblique and gluteus medius muscles. His report noted the discogram caused concordant pain at L5-S1 and recommended percutaneous disc decompression. Dr. Hassan performed a percutaneous discectomy at L4-5 on May 14, 2012, along with more trigger point injections in the external abdominal oblique and gluteus medius muscles.

Dr. Hassan did not document the clinical indications for any of the procedures performed on November 30, 2011, December 14, 2011, January 9, 2012, May 2, 2012 or May 14, 2012.

Dr. Hassan originally diagnosed cervical radiculopathy, cervical facet syndrome, lumbar radiculopathy, and lumbar facet syndrome. At the discogram on May 2, 2012 Dr. Hassan diagnosed Petitioner with degenerative disc disease, "herniation disc", and "lumabr" [*sic*] radiculopathy. He did not note whether he believed the diagnoses were causally related to Petitioner's workplace accident on October 20, 2011. He did not note that his care was necessary to cure or relieve the effects of a workplace injury on October 20, 2011.

Dr. Hassan had also recommended physical therapy. Petitioner had nine sessions at Elite Physical Therapy from February 2 to March 21, 2012. Petitioner stated at trial that she had no improvement in her back pain from physical therapy.

Petitioner testified that she still has back pain. The pain is exacerbated by moving her body or by sitting or standing for extended periods. Despite some relief that was provided by her treatment, she testified that her pain persists and it can be difficult for her to stay comfortable. She also notices weakness her arms and difficulty with heavier lifting. However, Petitioner testified at the arbitration hearing that she felt fine.

On cross-examination, Petitioner acknowledged that she was sent to Dr. Barnabas by her attorneys. Drs. Barnabas and Hassan have offices in Chicago. At the time of the treatment, Petitioner lived in Hanover Park. She testified that a car was sent to pick her up and drive her to the doctors' offices and then take her back home again. She never paid for the transportation to and from these doctors' offices. She spent approximately 40 minutes on the expressway to get to the doctors. While treating with Dr. Barnabas and his other consultants and therapists, she complained only of her back.

Dr. Julie Wehner performed a §12 IME at the request of Respondent on December 19, 2011. Dr. Wehner testified at evidence deposition on July 18, 2014 (RX #1). She is a board-certified orthopedic surgeon, with approximately 90% of her practice related to spine-related problems. She reviewed medical records in additional the physical examination.

At the IME Petitioner gave a history of injuring her back at work on October 23, 2011 while mopping underneath a bed. Petitioner gave a history of her emergency room treatment at Glen Oaks Hospital and x-rays at Central DuPage Hospital. She had physical therapy at her workplace for two weeks while still working. Petitioner also reported her consultation with Dr. Ravi Barnabas at Alivio Physical Therapy and Chiropractic Center, who ordered MRIs of the neck, thoracic and lumbar spines. Dr. Barnabas provided therapy and referred Petitioner to Dr. Hassan at ProClinics. Dr. Hassan administered injections on November 30 and December 14, 2011. Petitioner reported some relief from the injections but was still stiff, complaining of 8/10 pain. She also complained of bilateral arm numbness, right worse than left. She had right leg pain which had resolved.

The physical examination revealed extremity strength 5/5; normal reflexes of the upper extremity; full range of motion of the shoulders; no lumbar spasms; tenderness in a diffuse pattern to the entire spine; pain with axial compression; pain with axial rotation; leg strength 5/5; no atrophy of the lower extremities; and mild decreased range of motion of the neck. Bending to the knees caused neck and back pain. Dr. Wehner noted nonorganic and subjective complaints. Petitioner's complaint of generalized numbness over the entire arm was nonanatomic. She found nothing in Petitioner's clinical exam to explain Petitioner's 8/10 pain complaints.

Dr. Wehner's review of the MRIs revealed mild degenerative changes throughout the lumbar, thoracic, and cervical spines, and no evidence of neural impingement to either the arms or legs. Dr. Wehner found Dr. Barnabas's clinical record did not support his diagnoses. Dr. Hassan's records noted that he gave her a combination of 10 different injections all on November 23, 2011: trigger points, epidural steroid, and bilateral facets

at four levels. Dr. Wehner testified that there was nothing on the MRIs or the physical examinations that would support the need for any injections. Moreover, administering 10 injections of steroids in one day is "way too much steroids." There is an increased risk of paralysis after being given such amounts of cervical epidural injections.

Dr. Wehner further testified that cervical spine injections should only be given when there are specific clinical findings on exam or MRI because of known risks. The MRIs did not show an impingement of a nerve root or the thecal sac. These injections have no effect for sprain/strain type of injury, which is what she diagnosed.

In Dr. Wehner's opinion there was no medical need to perform a discogram when the MRI is negative. There was no medical need to perform a percutaneous disc decompression. Dr. Wehner noted that type of procedure was largely abandoned 8 or 10 years ago because they were determined to be of no benefit.

Dr. Wehner felt that Petitioner sustained cervical, thoracic, and lumbar sprains. The recommended treatment would be decreased activity or light duty work for 2 to 3 weeks and then return to full duty work by 6 weeks. 6 to 12 sessions of therapy and chiropractic treatment would be advisable. Petitioner would be at MMI within 4 weeks of return to full duty work, January 2012. Dr. Wehner opined that Petitioner's injury would not result in any type of permanent disability.

Dr. Wehner also reviewed records from Chicagoland Pain and Headache Clinic. She opined that the administration of the topical analgesic gel medication was not reasonable in light of the nonorganic nature of Petitioner's presentation. Dr. Wehner further opined that discograms are not good predictors of surgical outcomes. Further, she testified that discograms have "fallen out of favor." Finally, Dr. Wehner opined that percutaneous disc decompressions have been largely abandoned. A presentation at a North American Spine Society 8 or 10 years ago noted there were no benefits from the procedure. Dr. Wehner opined that the percutaneous disc decompression was neither reasonable nor necessary.

A Utilization Review was performed on January 23, 2012 (RX #2), which found that the injections performed by Dr. Hassan were not medically necessary. This determination was based on no evidence of radicular pain. Injections should not be performed unless the problem continued after 3 months of conservative treatment. It was also determined that no more than 10 visits of physical therapy would have been necessary.

CONCLUSIONS OF LAW

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

The Arbitrator finds that Petitioner proved that she sustained a lumbar sprain/strain as a result of her workplace accident on October 23, 2011. The evidence

established that Petitioner's injury was short-lived and that she reached MMI by January 2012.

The Arbitrator finds that Petitioner's evidence failed to meet the required burden of proof that her ongoing and persistent complaints of low back pain were causally related to the work injury. The Arbitrator found the observations and opinions of Respondent's §12 examiner, Dr. Julie Wehner, persuasive. Dr. Wehner noted Petitioner's exaggerated subjective and nonanatomic complaints. Dr. Wehner's exam was essentially normal. She noted the Petitioner's complaints of numbness and tingling in her arms and legs did not conform to normal anatomy. The Arbitrator notes that Petitioner's MRIs showed mild, diffuse degenerative changes.

In addition, Dr. Hassan aggressively administered a wide variety of interventional injections, a radio frequency procedure, a discogram, and a percutaneous discectomy, all without documenting the clinical bases or necessity of any those procedures. The Arbitrator also notes the apparent inconsistency of Dr. Hassan finding concordant pain at L5-S1 on the discogram and performing the discectomy at L4-5. The lumbar MRI on November 23, 2011 only demonstrated disc desiccation at L5-S1 and no particular pathology at L4-5.

The Arbitrator further finds that Petitioner failed to prove that she sustained an injury to her neck in her workplace accident on October 23, 2011. There was no documentation that Petitioner complained of neck pain in the emergency room of Glen Oaks Hospital on October 23, 2011. When Petitioner's thoracic spine was x-rayed at Central DuPage Hospital on October 25, 2011 no x-rays were taken of her neck. The Arbitrator notes that in that setting, more likely than not, x-rays of the neck would have been ordered had Petitioner been complaining of neck pain.

Finally, the Arbitrator questioned Petitioner's credibility. Despite detailed testimony at trial about extensive continuing complaints she also testified that she felt "fine." The Arbitrator also questioned Petitioner's credibility when she reported nonanatomic symptoms to her doctors and Dr. Wehner and at trial.

Therefore, the Arbitrator finds that Petitioner only proved that she sustained a lumbar sprain/strain that resolved by January 2012. Petitioner failed to prove that she sustained cervical radiculopathy, cervical facet syndrome, lumbar radiculopathy, and lumbar facet syndrome or degenerative disc disease, disc herniation disc, and lumbar radiculopathy, as diagnosed by Dr. Hassan.

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

Petitioner underwent extensive medical care which the Arbitrator previously found was not medically necessary to cure or relieve the effects of her work injury. Petitioner was advised by Glen Oaks Hospital emergency room personnel to follow up

with Dr. Subhani. Rather than follow the advice of medical professionals Petitioner allowed her medical care to be directed by her attorney. This calls the necessity of her follow-up medical care into question.

Petitioner offered into evidence numerous medical bills comprising Petitioner's Group Exhibit #3.

Petitioner offered a bill from Advanced Lab Services in the amount of $2,351.00 for testing between December 2, 2011 and June 19, 2012. No evidence was offered as to what this testing was for or whether it was related to Petitioner's work-related injury. The records of Advanced Lab Services were not offered into evidence. Accordingly the request for payment of Advanced Lab Services is denied.

The records of Alivio Physical Therapy were for treatment between December 2, 2011 and April 16, 2012, totaling $1,628.36. Based on the opinion of Respondent's §12 medical examiner, Dr. Julie Wehner, 6–12 visits for physical therapy were medically necessary. Furthermore, the Utilization Review found 10 sessions of therapy were reasonable. The therapy sessions provided at Alivio fall within the range opined by Dr. Wehner. The Arbitrator orders Respondent to pay Alivio Physical Therapy in accord with §8(a) and §8.2 fee schedule.

Petitioner offered into evidence medical bills from Cadence Occupational Health for treatment between October 25, 2011 and November 11, 2011, totaling $1,124.27. The medical records offered into evidence reflect only a visit for October 21, 2011, with charges totaling $586.28. The Arbitrator finds this charge was reasonable and necessary orders Respondent pay the charges for the October 21, 2011 visit, in accord with §8(a) and §8.2 fee schedule.

Petitioner offered into evidence a bill from Elite Physical Therapy for multiple visits from February 7, 2012 through March 26, 2012, in the amount of $2,862. There was no testimony regarding what this treatment was for nor were the medical records of Elite Physical Therapy offered into evidence. In addition, the Arbitrator found that the evidence established that Petitioner was at MMI before this care was provided. Petitioner failed to prove the reasonableness and necessity of these charges and, therefore, request for payment of this bill is denied.

Petitioner introduced a bill from the Herron Medical Center in the amount of $1,209.93 for services from November 22, 2011 through April 12, 2012. The records of the Herron Medical Center were not offered into evidence. However, Petitioner testified about the medical care she received by Dr. Barnabas at Herron Medical Center. Petitioner did meet the modest burden of proof that the medical care at Herron was reasonable and necessary. The Arbitrator finds this charge was reasonable and necessary orders Respondent pay the charges of Herron Medical Center for $1,209.23, in accord with §8(a) and §8.2 fee schedule.

Petitioner offered into evidence a bill from Industrial Pharmacy Management in the amount of $1,290.62 for medication received between June 19 and June 25, 2012. There is no testimony, medical records, or other evidence showing what this medication

was for or who prescribed the medication. Petitioner failed to prove the reasonableness and necessity of these charges and, therefore, request for payment of this bill is denied.

Petitioner offered into evidence medical billing from Lakeshore Open MRI and CT for scans performed on November 23, 2011 and May 2, 2012. The bill is in the amount of $3,608.38. The Utilization Review noted that the MRIs were not medically necessary because there was no clear documentation of radiculopathy. However, Dr. Wehner did not criticize having MRIs of the cervical and lumbar spine in light of Petitioner's subjective complaints. The Arbitrator finds that, based on all the evidence, the scans were reasonable. Therefore, Respondent pay the charges of Lakeshore Open MRI for $3,608.38, in accord with §8(a) and the §8.2 fee schedule.

Petitioner offered into evidence a bill in the amount of $65,294.27 from Lakeshore Surgery Center for services performed between November 30, 2011 and May 14, 2012. This billing pertains to the spinal injections, a discogram, and a percutaneous disc decompression. The Arbitrator previously noted that Dr. Hassan did not document the medical bases or necessity for the care he provided at Lakeshore. The Arbitrator further notes that non-emergency transportation charges are included in the Lakeshore billing. There was no evidence that such transportation was medically necessary. Based on the opinions of Dr. Wehner and the conclusions set forth in the Utilization Review, the Arbitrator finds that Petitioner failed to prove these procedures were medically necessary. The Arbitrator finds Dr. Wehner's opinions and the determinations of the Utilization Review to be persuasive. Particularly, there was no evidence that the medical provider appealed the Utilization Review. Petitioner did not present evidence rebutting the conclusions of the Utilization Review. Petitioner's request for payment of this bill is denied.

Petitioner offered into evidence a medical bill from ProClinics in the amount of $29,284.42 for treatment provided by Dr. Hassan between November 23, 2011 and June 25, 2012. The Arbitrator previously noted that Dr. Hassan did not document the medical bases or necessity for the care he provided. Further, Dr. Wehner opined and the Utilization Review determined that epidural, facet and trigger point injections were not medically necessary, the MRIs showing nothing more than mild degenerative changes without disc herniation, disc bulging, or neural impingement. As above, Petitioner presented no evidence to rebut the Utilization Review. Petitioner's request for payment of this bill is denied.

Finally, Petitioner offered into evidence a bill from Western Touhy Anesthesia in the amount of $4,500 for services related to injections performed between November 30, 2011 and May 14, 2012. Dr. Wehner opined and it was concluded on the Utilization Review that the injections were not medically necessary, the MRIs showing nothing more than mild degenerative changes without disc herniation, disc bulging, or neural impingement. As above, Petitioner presented no evidence to rebut the Utilization Review. Petitioner's request for payment of this bill is denied.

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

The Arbitrator evaluated Petitioner's permanent partial disability in accord with § 8.1(b):

(i) No AMA impairment rating was admitted in evidence. The Arbitrator could not give any weight to this factor.

(ii) Petitioner works as a custodian. This occupation may from time to time require strains to the back, arms, and shoulders. The arbitrator gives moderate weight to this factor.

(iii) Petitioner was 34 years old at the time of her accident. She has a statistical life expectancy of 50 years and a statistical worklife expectancy of 16 years. Petitioner testified that she has occasional aches and pains she attributes to her injury. Due to her age, these periodic complaints may continue into later life. The Arbitrator gives this factor moderate weight.

(iv) There was no evidence that Petitioner's earning capacity has been affected by her injury. She has returned to full duty work. The Arbitrator gives this factor no weight.

(v) Petitioner sustained a lumbar strain/sprain injury as a result of the work injury. At the hearing Petitioner testified that currently she felt "fine." While Dr. Wehner did testify that there would be no permanent disability as a result of the work-related injury, she did opine that Petitioner would benefit from up to 12 weeks of therapy for her back strain. Pain from a back strain/sprain which requires therapy can and does cause disability. As noted above, the Arbitrator found that much of the medical care Petitioner received was not reasonable or necessary. The Arbitrator gives this factor great weight.

Therefore, the Arbitrator finds that Petitioner sustained a permanent partial disability as a result of the work-related injury to the extent of 4% of a person-as-a-whole, 20 weeks.

September 2, 2016

Steven J. Fruth, Arbitrator

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Pamela Collins,
Petitioner,

vs. No. 15 WC 1552

Catholic Charities,
Respondent.

18IWCC0236

DECISION AND OPINION ON REVIEW

Respondent has timely filed a Petition for Review of the July 25, 2016 Decision of the Arbitrator, issued following arbitration hearing held on June 28, 2016. Notice has been 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, modifies the Decision of the Arbitrator, as stated below. In particular, the Commission finds that the Arbitrator improperly awarded medical expenses covering epidural steroid injections to the cervical and lumbar spine and related care, and so modifies the award as to exclude those expenses. The Commission otherwise affirms and adopts the Decision of the Arbitrator, a copy of which is attached hereto and made a part hereof.

I. BACKGROUND

A. Petitioner's Accident and Treatment

Petitioner, 45 at the time, was employed as a part-time delivery driver for Respondent in its Meals on Wheels program, and alleges cervical and lumbar spine injury incurred while she was making deliveries on November 12, 2014. On that day, according to her testimony, she had gone to her car after finishing a meal delivery to a client. Her car was parked at a lot at 2885 Village Park in Waukegan. She got in the driver's seat, fastened the seat belt, and – while her car was still parked – a "small blue car" backed into her rear bumper. (The cars were parked with their back ends towards each other, with a short distance separating them). Petitioner claimed that her body was "jerked" on impact. The airbag did not deploy. (Tr. 16-19, 35-38; 55-56). Petitioner

18IWCC0236

was able to exit the car within seconds to view the scene; her back bumper was cracked and there was paint on it from the other car. The driver of the small blue car fled before Petitioner could exchange any insurance or other information. (Tr. 21-22).

Petitioner drove herself to the ER at Vista Medical Center East, where she related the accident and complained of low back pain and right-sided general pain and stiffness. The ER records describe the the motor vehicle collision as low-impact. She was noted to be upright and walking briskly without antalgic gait. X-rays of the lumbar spine were taken; the x-rays disclosed degenerative changes with no evidence of traumatic injury to the spine. Petitioner was diagnosed with lumbosacral sprain, prescribed pain medications, and advised to follow up with her family doctor, Dr. Lisa Fields of Intervention Arms Medical Center. (PX 1 at 8-10). Petitioner testified that she called her supervisor while at the ER, advising him of the accident. (Tr. 23). The next day, November 13, 2014, Petitioner made a police report of the accident at the desk of Waukegan Police Department. (RX 1).

On November 14, 2014, as follow-up to the ER visit, Petitioner went to Intervention Arms Medical Center, where she was seen by physician assistant Lisa Choi, MS, PA-C. Petitioner provided a history of the accident and the ER visit. She now also reported arm and neck pain at the time of the incident and that she continued to have pain in her neck and throughout her back, radiating down to her buttocks. Ms. Choi assessed cervicalgia and suspected muscle etiology. Ms. Choi noted that only lumbar spine X-rays had been done at the hospital, and she wrote that cervical spine X-rays would be ordered. (PX 3). On November 18, 2014, Petitioner presented again at Vista Medical Center East with diagnoses of cervicalgia and chest pain. Petitioner underwent a cervical spine X-ray and an electrocardiogram. Both studies were normal. (PX 1).

Two months after the accident, on January 14, 2015, Petitioner presented to Dr. Alexandr Goldvekht of Advanced Physical Medicine for an initial examination and evaluation.[1] She reported that, since the motor vehicle accident, she had been experiencing neck pain that radiated into the mid- and upper back and localized lower back pain, among other symptoms. Dr. Goldvekht assessed cervical and lumbar discogenic pain and upper extremity radiculopathy. Petitioner was placed off-work. Cervical and lumbar MRIs were done on January 21, 2015, disclosing degenerative changes and multi-level disc bulging.[2] Dr. Goldvekht's recommendations included a course of physical therapy consisting of 2 to 3 sessions per week for 4 weeks. Petitioner would end up attending about 18 sessions of physical therapy over 10 weeks (until late March 2015). This physical therapy was administered by Dr. Craig Oswald, a chiropractor at Advanced Physical Medicine. (PX 5).

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[1] Petitioner testified that her primary care physician had referred her to Advanced Physical Medicine. However, as noted by the Arbitrator, there is no notation in the records of Intervention Arms Medical Center or Advanced Physical Medicine of any such referral.

[2] Regarding the cervical MRI report, the radiologist's impressions were spondylosis with neural foraminal stenosis most severe towards the right side at C4-5; and 2 mm right paracentral herniation at C3-4. On the lumbar MRI report, the impressions were spondylosis with multi-level disc bulging contributing to neural foraminal narrowing at multiple levels; left neural foraminal protrusion at L3-4 with moderate left neural foraminal stenosis; and grade 1 anterolisthesis of L4 on L5. (PX 7).

18IWCC0236

Dr. Goldvekht's records indicate that what ultimately provided lasting relief for Petitioner was epidural steroid injections. Dr. Goldvekht referred Petitioner for injections in the cervical spine (bilateral C3-4, C4-5 and C5-6 facet joint injection) and then in the lumbar spine (bilateral L3-4 and L4-5 facet joint injection), which were administered, respectively, on February 9, 2015 and March 9, 2015. Petitioner reported improvement in her pain after both treatments. (PX 5). The injections were performed by Dr. Nareej Jain and billed through APM Surgical Group. Ltd. (PX 11). Dr. Jain also prescribed a vasopneumatic compression device (air compression sleeve), provided by Argus Medical Supply Company. (PX 14).

The lumbar injections in particular provided significant relief. On March 11, 2015, she reported to Dr. Goldvekht that her low back felt 80% better after the lumbar injection and that she now felt consistent relief in her neck. Dr. Goldvekht released her to return to work light duty effective March 16, 2015. On March 25, 2015, he discharged her from care at maximum medical improvement; his note of that last day reads: "Patient stated that once she had her second injection she felt relief. Patient reported she is able to move around without much pain. Patient stated her pain levels are minimal and can function on a daily basis without use of medication." She was cleared to work without restrictions as of March 30, 2015. (PX 5).

At the arbitration hearing of June 28, 2016, Petitioner testified that she currently feels "okay" and that she has pain "sometimes from time to time," for which takes over-the-counter pain medicine about once or twice per week. (Tr. 34).

B. Section 12 Examination

On April 8, 2015, Petitioner was examined at Respondent's request by Dr. Jay Levin pursuant to Section 12. Dr. Levin generated a written report documenting the examination and, upon receipt and review of the January 2015 MRIs and other medical records, authored a supplemental report on May 19, 2015, containing his conclusions. (RX 3).

Dr. Levin wrote that the MRIs showed degenerative changes of the cervical and lumbar spine without acute edema and that the findings were consistent with age-appropriate pathology. (RX 3, May 19, 2015 report at 5). He further wrote that the MRI findings "are of no clinical significance without any acute basis referable to a November 12, 2014 occurrence, that being longstanding degenerative changes." Dr. Levin's opinion was that Petitioner's condition of ill-being was "cervical and lumbar myofascial strain," or muscle strain in the neck and low back. He opined that this muscle strain was related to the November 12, 2014 incident, assuming that she had clinical symptoms to the spine following the asserted accident. As to treatment for this muscle strain, Dr. Levin opined that Petitioner had received appropriate and reasonable treatment consisting of physical therapy pursuant to the standards of ODG (Official Disability Guidelines), and that she required no further care. (As mentioned above, Petitioner underwent 10 weeks of physical therapy from Advanced Physical Medicine). (RX 3; May 19, 2015 report at 6).

Notably, regarding history of prior injuries and ill-being, Petitioner related to Dr. Levin an extensive account that included: a February 2012 fall on her back; a work-related motor vehicle accident in "December 2012 when she was rear-ended and she injured her left hand/arm and possibly the neck and low back;" an "ache in her low back prior to this work-related injury [for which she] did not have treatment," and another motor vehicle accident in 2013 for which she injured her arm and low back and received physical therapy at Accelerated

in Zion. (RX 3, April 8, 2015 report at 1). In contradiction to Dr. Goldvekht's medical records regarding her significant improvement following epidural injections, she related that she had a cervical epidural that helped reduce her pain but the lumbar epidural injection did not. (RX 3, April 8, 2015 report at 2).

II. DISCUSSION

In his Decision, the Arbitrator took note of multiple inconsistencies in Petitioner's hearing testimony and reporting to treaters concerning preexisting condition, prior back injury and treatment, details of the severity of the accident, and physical complaints.[3] (Arbitrator's decision at 7-8). However, ultimately, the Arbitrator found that Petitioner proved a work accident, resulting in sprain/strain injuries. The Arbitrator awarded temporary total disability benefits, medical expenses, and permanent partial disability benefits representing 4% loss of use of the person as a whole under Section 8(d)2.

As to the threshold issue of occurrence of accident, the Arbitrator found – and the Commission agrees -- that Petitioner proved it by a preponderance of the evidence. (Arbitrator's decision at 6). In support of this determination, the Arbitrator cited to the medical records that contained consistent accounts of a rear collision motor vehicle accident, as well as the police report that she made the following day. (Arbitrator's decision at 6). As to the nature of injury sustained, the Arbitrator determined it to be cervical and lumbar sprain/strains. (Arbitrator's decision at 8). The Arbitrator noted that the diagnoses of strains were supported by Dr. Levin's opinions, the ER records of Vista Medical Center East, and the notes of physician assistant Lisa Choi of Intervention Arms Medical Center. As to causation, the Arbitrator found Dr. Levin's opinions persuasive. (Arbitrator's decision at 8).

The Arbitrator correctly noted that, as Petitioner sustained sprain/strain injuries to the cervical and lumbar spine causally related to the accident, she would be entitled to medical benefits that are reasonable, necessary and causally connected to the injury. (Arbitrator's decision at 8-9). In his Decision, he addressed each of the medical bills for which Respondent's liability is claimed by Petitioner, discussing the reasoning behind his awarding payment against some and denying it against others. (Arbitrator's decision at 8).

Pertinent to the Commission's instant Decision and Opinion is the Arbitrator's award of expenses for the epidural steroid injections performed by Dr. Jain on February 9, 2015 and March 9, 2015 and related care – these expenses are reflected in the bills of Windy City Anesthesia (PX 10), APM Surgical Group (PX 12), and Argus Medical Supply (PX 14). The Arbitrator wrote, "Based upon the referral from Dr. Goldvehkt, and the improvement in Petitioner's symptoms reported as a result of the injections, which resulted in her full duty release on March 30, 2015, the Arbitrator finds this treatment reasonable, necessary and causally connected."

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[3] For significant example, Dr. Oswald's first record of Petitioner's physical therapy, dated January 16, 2015, indicated that she told him she had not experienced symptoms prior to the accident. Dr. Oswald also wrote that Petitioner "struck her head on the window during the impact," suggesting a more dramatic accident. (PX 5). At hearing, Petitioner appeared uncertain or flustered about this notation of her head striking the window (she is 5'1" and was restrained by a seatbelt), expressed confusion about the difference between the front windshield and the side window, and eventually attested that she either hit her head on the windshield or else on the driver's side window. (Tr. 38, 54-55).

This award is inconsistent with the Arbitrator's earlier finding regarding the nature of the injury Petitioner sustained as a result of the accident.[4] The Arbitrator asserted reliance on the opinions of Dr. Levin, who opined that Petitioner's ill-being relatable to the alleged accident was limited to neck and low back myofascial strains -- as opposed to spinal discogenic pain and upper extremity radiculopathy diagnosed and treated by Advanced Physical Medicine and its affiliates. Epidural steroid injections may be appropriate for discogenic pain and radiculopathy but are not treatment indicated for myofascial, or muscle, strain. Indeed, the operative reports of Dr. Jain expressly indicate that the spinal procedures were to address diagnoses of cervical and lumbar discogenic pain, facet syndrome, and radiculopathy.

In conclusion, the Commission finds that Petitioner proved the occurrence of a (minor) motor vehicle accident, causing -- at most -- muscle strain in the neck and low back, for which she incurred temporary total disability and medical expenses. The epidural steroid injections of February 9, 2015 and March 9, 2015 are excessive and neither necessary nor reasonable to treat her muscle strain injuries. The Commission modifies the Arbitrator's medical expenses award to exclude these expenses. All else (including award of expenses for office visits and physical therapy at Advanced Physical Medicine (PX 6) and for MRIs from American Diagnostic MRI (PX 8)) is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed on July 25, 2016, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of those medical expenses reflected in PX 10, PX 12 and PX 14 is vacated. The remainder of the medical expenses award is affirmed and shall be paid by Respondent.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $ 154.69 per week for the period commencing January 9, 2014 through February 11, 2014 for (11 and 4/7 weeks), under Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $ 154.69 per week for 20 weeks, under Section 8(d)(2) of the Act, as her accidental injury caused 4% loss of use of the person.

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

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

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[4] The Arbitrator also reasoned that "Dr. Levin's report does not document that he reviewed the medical notes of the injections or was aware they had been provided. His opinions do not address the reasonableness of this treatment ... There was no utilization review submitted as to whether this treatment or any component thereof was inappropriate." (Arbitrator's Decision at 9). This is not entirely correct -- Dr. Levin's April 2015 report at page 2 indicates that Petitioner apparently told him about the injections (she claimed limited relief from the cervical injection and none from the lumbar injection.)

18IWCC0236

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $-12,100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 17 2018

o-02/28/18
jdl/ac
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Joshua D. Luskin

Charles J. DeVriendt

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

COLLINS, PAMELA
Employee/Petitioner

Case# **15WC001552**

CATHOLIC CHARITIES
Employer/Respondent

18IWCC0236

On 7/25/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.43% 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:

5094 SKLARE LAW GROUP LTD
MICHAEL R TRYBALSKI
20 N CLARK ST SUITE 1450
CHICAGO, IL 60602

2623 McANDREWS & NORGLE PC
MICHAEL P LATZ
57 W JACKSON BLVD SUITE 315
CHICAGO, IL 6604

STATE OF ILLINOIS)
)SS.
COUNTY OF Lake)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Pamela Collins
Employee/Petitioner

v.

Catholic Charities
Employer/Respondent

Case # 15 WC 01552

18IWCC0236

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Waukegan**, on **June 28, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0236

FINDINGS

On **November 12, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$8,044.25**; the average weekly wage was **$154.69**.

On the date of accident, Petitioner was **45** years of age, *single* with **2** dependent children.

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

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

Respondent shall be given a credit of **$28.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$28.00**.

Respondent is entitled to a credit of **$521.43** under Section 8(j) of the Act.

ORDER

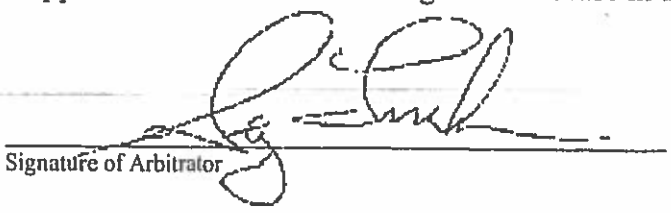
Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $4,234.00 to Advanced Physical Medicine, $3,400.00 to American Diagnostic MRI, $4,059.00 to Windy City Anesthesia, $18,450.00 to APM Surgical Group, Ltd., and $9,100.00 to Argus Medical Supply Company, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit of $521.43 for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner temporary partial disability benefits of $154.69/week for 11 4/7 weeks, commencing November 15, 2014 through November 19, 2014, and commencing January 14, 2015 through March 30, 2015 as provided in Section 8(a) of the Act. Respondent shall be given a credit of **$28.00** for TTD.

Respondent shall pay Petitioner permanent partial disability benefits of $154.69/week for 20 weeks, because the injuries sustained caused the 4% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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



Signature of Arbitrator

July 25, 2016
Date

ICArbDec p. 2

JUL 25 2016

Statement of Facts

Petitioner Pamela Collins testified that on November 12, 2014, she was employed by Respondent Catholic Charities. She had been employed by Respondent since 2008. She delivered Meals on Wheels for the senior program. She drove her own car, a 2004 Buick Century. She testified that she would make an average of 20 to 30 deliveries per day. She worked part time, less than four hours per day. She also had another part time job as a caretaker.

Petitioner testified she had a prior Workers Compensation claim involving her right knee in April, 2011. Petitioner initially denied any prior back or neck injuries or medical treatment. She then testified she had a December, 2011 auto accident injuring her back and arm. She testified she had no other injuries or medical treatment in 2012, 2013 or 2014 up to November 12, 2014. She testified she had no problem with her neck or back. Petitioner admitted she had treatment for her back at Illinois Bone & Joint Institute in September and October, 2014.

The records of Illinois Bone & Joint Institute were admitted as Respondent's Exhibit 4. The records include therapy for the 2011 right knee injury. The October 27, 2011 note states low back pain has increased from stairclimbing. Petitioner cancelled therapy on December 14, 2011 because she was in a car accident that day. Petitioner was treated by Dr. James A. Joseph DO at Interventional Arms Medical Center on August 13, 2014, August 22, 2014 and September 8, 2014 (PX 4). The September 24, 2014 Illinois Bone & Joint Institute discharge report notes referral from Dr. Lisa Fields for a diagnosis of lumbago. The evaluation was for low back pain. The goals stated were to allow prolonged sitting and driving for occupational activities, allow sleep without disruption, and allow standing and walking 2 hours per day for occupational activities. Petitioner was not seen because of insurance issues (RX 4).

Petitioner testified that on November 12, 2014, she was making her last two deliveries. She completed the first delivery and got back into her car to make the last delivery. She was in the parking lot at 2885 Village Park Drive in Waukegan. It was about 11:00 AM. She put on her seatbelt and started the car. Her car was in Park. She testified that a small blue car struck the back end of her car. The back end of the other car was also involved. The blue car was parked back to back with her. There was a very little distance away. She testified that she believes she hit her head on the window. She was jerked in her seat. She initially stated she hit the windshield, but later testified it was the driver's side window. There was no damage to the window. The airbag did not deploy. She exited her vehicle in a matter of seconds and viewed the damage. She testified that her back bumper was cracked. She testified that the other driver left without exchanging information. She went to the police department the next day to make a report. The report was admitted as Respondent's Exhibit 1.

Petitioner testified she left the second delivery and then called her supervisor Dave Himpelman to let them know she was in an accident. She drove herself to the ER at Vista Medical Center. Petitioner testified that she had x-rays to the back, neck and head. She testified that she was told to remain off work and see her primary care doctor. The records of Vista Medical Center were admitted as Petitioner's Exhibit 1. The records note Petitioner's arrival at 12:48 CST. She reported a low speed rear impact collision when she was backed into in a parking lot. She complained of low back pain (PX 1, p 6) and right sided general pain and stiffness (PX 1, p 13). Prior history was negative. Petitioner is noted to be 5' 1" tall and weighed 230 pounds. Risk factors are diabetes and morbid obesity. Petitioner had x-rays to the lumbar spine. Her physical examination noted she was walking briskly without antalgic gait. Her neurological exam was normal. Her low back had normal range of motion, no tenderness or swelling. She was diagnosed with a lumbar sprain/strain. She as given a

prescription for Norco and Ibuprofen and advised to see her family doctor. No notation of work status was made (PX 1, p 8-10).

Petitioner testified that she saw her primary physician at Interventional Arms a couple of days later. The records of Interventional Arms Medical Center were admitted as Petitioner's Exhibit 3. Petitioner saw Dr. Choi on November 14, 2014. She provided a history of the motor vehicle accident and her emergency room visit. She reported no loss of consciousness, and no head or neck injury. She reported neck and arm pain at the time of the incident. She was complaining of continued pain to her neck and throughout her back radiating down to her buttocks. The physical examination noted neck and trapezius tenderness with full range of motion. Strength and neurological examination was normal. The diagnosis was cervicalgia. Dr. Choi noted no cervical imaging was performed and ordered this. She notes that she suspects muscle etiology. Petitioner was taken off work through November 19, 2014. She was to return if symptoms did not improve (PX 3, p 4-10). Cervical x-rays taken November 18, 2014 were read as negative (PX 3, p 19). The prescription history records that Petitioner was prescribed hydrocodone on September 2, 2014 and Tramadol on November 14, 2014 (PX 3, p 5-6).

Petitioner testified that she next treated with Advanced Physical Medicine. She testified that she was referred by her primary care doctor. Petitioner testified she was given physical therapy for her pain in her back and neck. The records of Advanced Physical Medicine were admitted as Petitioner's Exhibit 5. Petitioner presented for an initial evaluation by Dr. Aleksandr Goldvehkt on January 14, 2015. She stated that she has been working part time and light duty. She complained of neck pain radiating into the upper and mid back and lower back pain. Dr. Goldvehkt's examination noted markedly restricted range of motion in the cervical and lumbar spine, loss of strength in the right upper and lower extremities and decreased sensation. Petitioner was diagnosed with cervical discogenic pain, lumbar discogenic pain, and UE radiculopathy. Dr. Goldvehkt instructed Petitioner to begin a course of physical therapy 2-3 times a week for a period of four weeks. He ordered cervical and lumbar MRI studies (PX 5, p 3). Petitioner was held off work through February 11, 2015 (PX 5, p 4).

On January 21, 2015, MRI imaging of Petitioner's lumbar and cervical spines was obtained at American Diagnostic (PX. 7). Petitioner's cervical MRI impression was cervical spondylosis with neural foraminal stenosis appearing most severe towards the right side at C4-5 and a 2 mm right paracentral herniation at C3-4. Petitioner's lumbar MRI impression was lumbar spondylosis with multilevel disc bulging contributing to neural foraminal narrowing at multiple levels, left neural foraminal protrusion at L3-4 with moderate left neural foraminal stenosis, and a Grade 1 anterolisthesis of L4 on L5 (PX 7, p 9-12).

Petitioner began a course of physical therapy with Dr. Oswald DC at Advanced Physical Medicine on January 16, 2015, completing a total of 18 sessions through March 23, 2015 (PX 5). On January 16, 2015, Dr. Oswald recorded that Petitioner denied any prior symptoms and was symptom free at the time of the accident. On January 28, 2015, Dr. Goldvehkt referred Petitioner for cervical injections (PX 5, p 12). Petitioner underwent a series of bilateral facet joint injections at C3-4, C4-5, and C5-6 with Dr. Neeraj Jain of APM Surgical Group on February 9, 2015 (PX 11, p 3-4). On February 11, 2015, Petitioner reported feeling better and an increased ability to move her neck and perform activities at the shoulder level. Dr. Goldvehkt stated that he would consider lumbar injection if Petitioner's back pain continued in a couple of weeks time. Petitioner was held off of work (PX 5, p 16- 17). On February 25, 2015, Petitioner noted less pain the neck, but constant pain in the low back region. Dr. Goldvehkt held Petitioner off work through March 11, 2015 and referred her for a lumbar

injection (PX 5, p 21-22). Petitioner underwent bilateral L3-4 and L4-5 facet joint injections with Dr. Jain on March 9, 2015 (PX 11, p 5-6).

Petitioner was seen by Dr. Shah at Interventional Arms Medical Center for a physical examination on March 10, 2015. The examination was not to address her neck or back complaints. The physical exam finds normal tone and muscle strength, normal movement of all extremities, normal gait and station (PX 3, P 25). Petitioner did note the pain shot received on March 9, 2015 and her follow up on March 11, 2015 (PX 3, p 27).

On March 11, 2015, Petitioner reported an 80% improvement in her low back pain and improvement in her neck pain. Dr. Goldvehkt noted a mild antalgic gait. He released Petitioner to return to work light duty as of March 16, 2015 with restrictions of no lifting, carrying, pushing or pulling over 5 pounds, and no stooping/bending/climbing (PX 5, p 26-27). Petitioner's final examination with Dr. Goldvehkt took place on March 25, 2015. Petitioner noted having experienced relief following completion of the lumbar injections. She described her pain level as minimal. She reported that she can function on a daily basis without the use of medication. Petitioner was released from care at maximum medical improvement. She was instructed to contact the doctor if she suffered any aggravation of her current complaints. She was to continue taking the previously-prescribed medications on an as-needed-basis for flare ups. Petitioner was released to return to work without restriction beginning March 30, 2015 (PX 5, p 35).

Petitioner did not return to work at that time. She attempted to return to Respondent. She was offered work on different terms, a different position and location. She did not take it. She did do a job at Bell Resources right after she was released to return to work. She is not currently working. She has not worked since 2015. Petitioner testified that she continues to experience low back and neck pain from time to time. She takes over-the-counter medication one to two times per week to manage those symptoms.

Petitioner testified her car was repossessed. She had driven the car until the date of repossession. She had not made a property damage claim to her insurance. She had not had the car repaired. It was minor damage.

Petitioner was examined by Dr. Jay Levin on April 8, 2015 at Respondent's request. Dr. Levin's reports were admitted as Respondent's Exhibit 3. Dr. Levin records the history of the November 12, 2014 accident. Petitioner reported a history of the prior right knee work injury, as well as a 2012 fall on her back, a 2012 motor vehicle accident, and a 2013 motor vehicle accident. Following receipt and review of the MRI films and additional medical records, Dr. Levin provided a May 19, 2015 supplement to his original examination report. Dr. Levin stated that he read the MRI studies as showing degenerative changes of the cervical and lumbar spine without acute edema and findings consistent with age appropriate pathology (RX 3).

He opines that based upon the history of prior neck and back injuries and treatment, there are pre existing complaints. The MRI findings are of no clinical significance and the findings are not causally related to the accident. Petitioner suffered a cervical and lumbar myofascial strains causally connected to the accident. He opines that ODG standards recommend a course of physical therapy with fading frequency of 10 visits. Petitioner has completed this treatment and no further care is required. Petitioner is at maximum medical improvement and capable of returning to her regular job. Dr. Levin notes Petitioner's subjective complaints do not correlate to the objective findings (RX 3).

18IWCC0236

Conclusions of Law

In support of the Arbitrator's decision with respect to (C) Accident, the Arbitrator finds as follows:

To obtain compensation under the Act, Petitioner must show, by a preponderance of the evidence, that she suffered a disabling injury that arose out of and in the course of her employment. An injury occurs "in the course of' employment when it occurs during employment and at a place where the claimant may reasonably perform employment duties, and while a claimant fulfills those duties or engages in some incidental employment duties. An injury "arises out of" one's employment if it originates from a risk connected with, or incidental to, the employment and involves a causal connection between the employment and the accidental injury.

Petitioner testified to being employed delivering meals to seniors. She delivered meals to seniors in the area using her own vehicle. As such Petitioner would be considered a traveling employee. A traveling employee is an employee whose job duties require him or her to travel away from the employer's premises. For a traveling employee, any act the employee is directed to perform by the employer, any act the employee has a common-law duty to perform, and any act that the employee can reasonably be expected to perform are all compensable.

Petitioner testified that while completing her deliveries on November 12, 2014, she was struck by another vehicle. Petitioner testified that she notified her supervisor on that date of the accident and the Respondent stipulated that Petitioner provided notice. Petitioner sought emergency room treatment that same day at Vista Medical Center, providing a consistent history of the motor vehicle accident complaining of injury to her back. Her subsequent medical histories remain consistent. Petitioner prepared a police report on November 13, 2014, again with a consistent history of the accident.

Based upon the record as a whole, the Arbitrator finds that Petitioner proved by a preponderance of the evidence that she sustained accidental injuries arising out of and in the course of her employment on November 12, 2014.

In support of the Arbitrator's decision with respect to (F) Causal Connection, the Arbitrator finds as follows:

Following the motor vehicle accident on November 12, 2014, Petitioner sought immediate care at Vista Medical Center. She reported a low rear impact collision when she was backed into in a parking lot. She complained of low back pain and right-sided general pain and stiffness. The Arbitrator notes that Petitioner's testimony concerning the accident is more dramatic, stating that she was jerked in the seat and struck her head. Petitioner testified she received x-rays of the head, neck and back, but the records document only lumbar x-rays, which were unremarkable. Petitioner testified she was told to stay off work, but no notation on work status in documented in the records.

Petitioner then was seen by Dr. Choi on November 14, 2014. She reported no loss of consciousness, no head or neck injury. This contradicts her testimony of striking her head on the window. She reported neck and arm pain at the time of the incident, although the Vista Medical Center records address only low back complaints.

She was complaining of continued pain to her neck and throughout her back radiating down to her buttocks. The physical examination noted neck and trapezius tenderness with full range of motion. Strength and neurological examination was normal. The diagnosis was cervicalgia. Dr. Choi suspects muscle etiology. She noted no cervical imaging was performed and ordered this. Cervical x-rays taken November 18, 2014 were normal.

Petitioner testified that Dr. Choi referred her to Advanced Physical Medicine, but there is no notation of a referral in Dr. Choi's records. The November 14, 2014 record reflects Petitioner was advised to return if symptoms did not improve. She began treatment with Advanced Physical Medicine after a two month gap in care beginning January 14, 2015. There is no notation in the Advanced Physical Medicine records to document the alleged referral.

The Arbitrator also notes the inconsistency in Petitioner's testimony and reporting of her pre existing condition, statements concerning the details of the accident and her physical complaints.

Petitioner's testimony initially denied any prior back or neck injuries or medical treatment. She did not report any relevant history at Vista Medical Center. On January 16, 2015, Dr. Oswald recorded that Petitioner denied any prior symptoms and was symptom free at the time of the accident. But she then testified that she had a December, 2011 auto accident injuring her back and arm. She gave Dr. Levin a history of a 2012 fall on her back, the motor vehicle accident testified to as well as a 2013 motor vehicle accident. Petitioner admitted she had treatment for her back at Illinois Bone & Joint Institute in September and October, 2014. The records of Illinois Bone & Joint Institute include an October 27, 2011 therapy note stating low back pain has increased from stairclimbing. Petitioner was treated by Dr. James A. Joseph DO at Interventional Arms Medical Center on August 13, 2014, August 22, 2014 and September 8. 2014. The prescription history records that Petitioner was prescribed hydrocodone on September 2, 2014. The Illinois Bone & Joint Institute September 24, 2014 discharge report notes referral from Dr. Lisa Fields for a diagnosis of lumbago. The evaluation was for low back pain.

Petitioner testified that she struck her head and was jerked at the time of the impact as well as testifying to damage to her car. But her Vista Medical history describes a low speed impact. This limited impact is supported by the close distance of the car striking her, the lack of air bag deployment, her immediate exit of the vehicle, and her failure to seek or obtain any repair to the vehicle. The Arbitrator finds Petitioner's testimony that she could not remember the date her car was repossessed disingenuous.

Petitioner was evaluated at Vista Medical Center on the day of the accident and was treated for a low back injury only. Only lumbar spine x-rays were taken. The diagnosis was lumbar sprain/strain. Petitioner did not advise them of her prior low back treatment. On November 14, 2014, Petitioner advised Dr. Choi that she did not have any head or neck injury. She reported immediate onset of neck and arm complaints, which were not noted at Vista Medical Center. She complained of pain in her neck and her back radiating to her buttocks. The examination notes full cervical range of motion, a normal gait and normal neurological testing. The diagnosis was cervicalgia, probably muscular.

On January 14, 2015, Petitioner complained of neck pain radiating into the upper and mid back and lower back pain. The only prior history noted is hypertension. Dr. Goldvehkt's examination noted markedly restricted range of motion in the cervical and lumbar spine, loss of strength in the right upper and lower extremities and decreased sensation. He diagnosed cervical discogenic pain, lumbar discogenic pain, and UE radiculopathy.

On January 16, 2015, Dr. Oswald recorded that Petitioner denied any prior symptoms and was symptom free at the time of the accident. He therefore stated that Petitioner's history has not contributed to her present condition. The Arbitrator notes Dr. Shah notation of normal gait and station on March 10, 2015 and Dr. Goldvehkt's finding of an antalgic gait on March 11, 2015. Dr. Levin states Petitioner's subjective complaints do not correlate to the objective finding

In light of these multiple inconsistencies, the Arbitrator finds that Petitioner's testimony, medical history and subjective presentation are suspect and discounts the credibility of this evidence.

The January 21, 2015 MRI imaging of Petitioner's lumbar and cervical spines were obtained. Petitioner's cervical MRI impression was evidence of cervical spondylosis with neural foraminal stenosis appearing most severe towards the right side at C4-5 and a 2 mm right paracentral herniation at C3-4. Petitioner's lumbar MRI impression was lumbar spondylosis with multilevel disc bulging contributing to neural foraminal narrowing at multiple levels, left neural foraminal protrusion at L3-4 with moderate left neural foraminal stenosis, and a Grade 1 anterolisthesis of L4 on L5.

Dr. Levin read the MRI studies as showing degenerative changes of the cervical and lumbar spine without acute edema and findings consistent with age appropriate pathology. He opines that based upon the history of prior neck and back injuries and treatment, there are pre existing complaints. The MRI findings are of no clinical significance and the findings are not causally related to the accident. He opines that Petitioner suffered a cervical and lumbar myofascial strains causally connected to the accident.

The Arbitrator finds the opinions of Dr. Levin, that as a result of the accident sustained on November 12, 2014, Petitioner suffered a cervical and lumbar sprain, supported by the diagnoses provided by both Vista Medical Center and Dr. Choi, persuasive. The Arbitrator also finds Dr. Levin's opinions on causal connection persuasive.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that, as a result of the accident on November 12, 2014, she sustained injuries to the cervical and lumbar spine consisting of a cervical and lumbar sprain/strains causally connected to the accident.

In support of the Arbitrator's decision with respect to (J) Medical, the Arbitrator finds as follows:

Based upon the Arbitrator's finding with respect to Causal Connection, the Petitioner sustained sprain/strain injuries to the cervical and lumbar spine causally connected to the accident sustained on November 12, 2014. Petitioner would be entitled medical that is reasonable, necessary and causally connected to this injury. Petitioner has submitted medical bills claimed as Petitioner's Exhibits 2, 4, 6, 8, 10, 12, and 14. With respect to these exhibits the Arbitrator has reviewed the bills and the supporting medical records and finds as follows:

PX 2 is the bill from Vista Medical Center. This treatment was reasonable, necessary and causally related to the accident on November 12, 2014. The bill shows payment by Medicaid of Illinois and no balance owing. The Arbitrator therefore does not award medical payment against this paid bill. Respondent shall hold Petitioner harmless for any claim by Medicaid of Illinois for the payments made.

PX 4 is a bill from Interventional Arms Medical Center for treatment provided before the date of accident. No charges are listed for the treatment rendered on November 14, 2014 which was reasonable, necessary and causally connected to the accident on November 12, 2014. The bill is therefore denied.

PX 6 and 8 are for the treatment rendered by Advanced Physical Medicine and the MRI studies Dr. Goldvehkt ordered. Dr. Levin opined that a course of physical therapy was appropriate per the ODG Guidelines attached to his report. The Guideline note treatment over 5 weeks, with chiropractic in severe cases with objective functional improvement of up to 18 visits over 6-8 weeks. Based upon opinions of Dr. Levin that physical therapy was appropriate care, the Arbitrator finds this treatment reasonable, necessary and causally connected to the accident on November 12, 2014 and awards the bills for these services.

PX 10, 12, and 14 are bills for the injections and related care performed by Dr. Jain on February 9, 2015 to the cervical spine and March 9, 2015 to the lumbar spine on referral from Dr. Goldvehkt. The Arbitrator notes that Dr. Levin's report does not document that he reviewed the medical notes of the injections or was aware they had been provided. His opinions to not address the reasonableness of this treatment other that citing the ODG Guidelines as to the duration of physical therapy in response to a question as to whether Petitioner is in need of further treatment as of the date of his examination. There was no utilization review submitted as whether this treatment or any component thereof was inappropriate. Based upon the referral from Dr. Goldvehkt, and the improvement in Petitioner's symptoms reported as a result of the injections, which resulted in her full duty release on March 30, 2015, the Arbitrator finds this treatment reasonable, necessary and causally connected, and awards the bills for these services with the exception that the Arbitrator does not find the charges for "unusual travel" billed by APM Surgical Group, Ltd. are reasonable or necessary and therefore denies these charges of $275.00 per visit.

Based upon the record as a whole, the Arbitrator finds that Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $4,234.00 to Advanced Physical Medicine, $3,400.00 to American Diagnostic MRI, $4,059.00 to Windy City Anesthesia, $18,450.00 to APM Surgical Group, Ltd., and $9,100.00 to Argus Medical Supply Company, as provided in Sections 8(a) and 8.2 of the Act.

The parties stipulated that Respondent paid $521.43 pursuant to a group medical plan for which credit may be allowed pursuant to Section 8(j) of the Act. The Arbitrator does not find any payments documented on the awarded bills for such payments, but Respondent shall be given a credit of $521.43 for medical benefits that may have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

In support of the Arbitrator's decision with respect to (K) Temporary Compensation, the Arbitrator finds as follows:

Based upon the Arbitrator's finding with respect to Causal Connection, the Petitioner sustained sprain/strain injuries to the cervical and lumbar spine causally connected to the accident sustained on November 12, 2014.

Petitioner was disabled by Dr. Choi from November 15, 2014 through November 19, 2014. Petitioner had no further medical disability slip until seen by Dr. Goldvehkt on January 14, 2015. She reported to him on that date that she had been working light duty. Dr. Goldvehkt disabled the Petitioner from January 14, 2015 through his release to maximum medical improvement and full duty work on March 30, 2015. Dr. Levin did not

see Petitioner until after her release from care. As noted in the Arbitrator's finding with respect to Medical, the ODG guidelines note reasonable care can extend for up to 8 weeks in severe cases with objective functional improvement. This period of lost time is not inconsistent with Dr. Levin's opinions.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that she was entitled to temporary total disability benefits for the periods commencing November 15, 2014 through November 19, 2014, and commencing January 14, 2015 through March 30, 2015, a period of 11 4/7 weeks.

In support of the Arbitrator's decision with respect to (L) Nature & Extent, the Arbitrator finds as follows:

Petitioner's date of accident was after September 1, 2011 and therefore the provisions of Section 8.1b of the Act are applicable to the assessment of partial permanent disability in this matter.

With regard to subsection (i) of §8.1b (b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a part time delivery driver for Respondent at the time of the accident and that she is able to return to work in this prior capacity as a result of said injury. The Arbitrator notes Petitioner found other employment following her release to regular work, but is not currently working. Because of these facts, the Arbitrator therefore gives no weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 45 years old at the time of the accident. Petitioner would not be considered a younger or older individual. Petitioner was working part time for Respondent at the time of the injury. Because of this, the Arbitrator therefore gives no weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner has been released to return to regular work. Respondent offered Petitioner employment with a different position and location which Petitioner refused. Petitioner testified that she did obtain employment after her release but has not worked since 2015. There was no evidence that she has been seeking employment. Because of these facts, the Arbitrator therefore gives no weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the questionable credibility of Petitioner's subjective complaints as more fully addressed in the Arbitrator's finding with respect to Causal Connection above. The Petitioner was diagnosed with cervical and lumbar sprain/strains. She has been released to unrestricted work, and has had no medical care for her neck or back since March, 2015. Despite the full duty release, Petitioner has not returned to work. The Arbitrator also notes the lack of objective findings in Dr. Levin's report and his opinion that Petitioner's subjective complaints do not correlate with the objective findings. Because of these facts, the Arbitrator therefore gives greater weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 4% loss of use of whole person pursuant to §8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

James A. Kleist,
Petitioner,

vs. NO: 16 WC 35395

18IWCC0237

Illinois State Police,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed and notice given to all parties, the Commission, after considering the sole issue of the nature and extent of Petitioner's permanent partial disability and being advised of the facts and law, modifies the Decision of the Arbitrator as noted below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The underlying facts of this claim were well laid out in the Arbitrator's Decision, which is incorporated herein, and the Arbitrator's findings of fact are adopted. The Commission further concurs with and adopts the Arbitrator's findings and conclusions as to the nature and extent of the injury as pertains to the left leg, which was the subject of the knee surgery the petitioner underwent. However, the Commission notes that while the claimant did describe some complaints in his right hip and there was an allegation of an altered gait which provoked symptoms on his right side, the claimant was released to full duty following surgery within weeks and was assessed at MMI less than two months following surgery. More significantly, the petitioner's treating surgeon, Dr. Sams, noted when he released the claimant to work following surgery that there was no altered gait and when he released the claimant at MMI, he noted that the petitioner was walking with a normal heel-toe gait. The record also shows no prescription or order for therapy directed to the right side and no physician made a diagnosis of any particular pathology as to the right leg or hip. Given this evidence, the Commission vacates the award of permanent partial disability as regards the right leg. All other findings are affirmed.

18IWCC0237

IT IS THEREFORE ORDERED BY THE COMMISSION the Decision of the Arbitrator filed October 26, 2017 is hereby modified as noted above and is otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $775.18 per week for a period of 48.375 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of use of the left leg to the extent of 22.5%.

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

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

DATED: APR 17 2018

Joshua D. Luskin

o-04/11/18
jdl/mcp
68

L. Elizabeth Coppoletti

Charles J DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KLEIST, JAMES A
Employee/Petitioner

Case# **16WC035395**

ILLINOIS STATE POLICE
Employer/Respondent

18IWCC0237

On 10/26/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.24% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2427 KANOSKI BRESNEY
KATHY A OLIVERO
2730 S MacARTHUR BLVD
SPRINGFIELD, IL 62704

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

0000 ASSISTANT ATTORNEY GENERAL
BRADLEY DEFREITAS
500 S SECOND ST
SPRINGFIELD, IL 62706

2202 ILLINOIS STATE POLICE
801 S 7TH ST
SPRINGFIELD, IL 62794

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

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62794-9255

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

OCT 26 2017

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Sangamon)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

James A. Kleist
Employee/Petitioner

v.

Illinois State Police
Employer/Respondent

Case # 16 WC 35395

Consolidated cases: N/A

18IWCC0237

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Springfield**, on **August 29, 2017**. By stipulation, the parties agree:

On the date of accident, **August 17, 2016**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$109,999.76+**, and the average weekly wage was **$2,115.38+**.

At the time of injury, Petitioner was **45** years of age, ***married,*** with **2** dependent children.

Necessary medical services and temporary compensation benefits have been provided by Respondent, and Respondent agrees to pay the outstanding bills found in Petitioner's Exhibit No. 8, subject to the Medical Fee Schedule.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**. Petitioner received his regular salary while off work.

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

ORDER

Respondent shall pay Petitioner the sum of $775.18/week for a further period of 53.75 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused **22.5% loss of use of the left leg and 2.5% loss of use of the right leg.**

Respondent shall pay Petitioner compensation that has accrued from **8/17/16** through **8/29/17**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

October 22, 2017
Date

OCT 26 2017

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

Petitioner has been employed by Respondent since May 5, 1997. On August 17, 2016 Petitioner held the position of Sergeant with Special Operations Command, commonly known as the SWAT team, where he was assigned to the Illinois State Fair. As a member of the SWAT team, Petitioner had to complete a physical fitness test on a quarterly basis which alternated between the departmental standard physical fitness test and the unit's own internal obstacle course, and maintain an overall 80% average on these tests. Petitioner's duties included being the squad leader of 6 individuals as well as running, jumping, propelling, swimming, climbing, kneeling, crawling, and performing every type of physical activity imaginable.

On August 17, 2016, Petitioner was at the Illinois State Fair Grandstand when a physical altercation occurred between two men that caused Petitioner to scale the wall and jump down between the men to stop the altercation and shortly thereafter, Petitioner noticed something wrong with his left knee and left ankle. Later that evening, Petitioner noticed his left knee and left ankle were swollen but Petitioner waited a few days before he sought medical treatment at Decatur Memorial Hospital Corporate Health (DMHCH).

The records of DMHCH indicate that Petitioner was seen on August 22, 2016 with the primary problem of pain in his left knee, described as a firm, tight, dull ache, and made worse by twisting (PX 1, p. 5). It was also reported the problem began on 8/17/16 when Petitioner was working at the state fair grandstand, climbed a 4 foot wall in an attempt to break up a fight, and hurt his left knee. On examination, there was pain on motion over the posterior knee, the popliteal fossa, and the medial knee joint line, pain to palpation over the medial knee joint line, bruising over the medial knee joint line, swelling, a positive Appley's test to the medial aspect of the knee, and effusion and swelling over the ankle (PX 1, p. 6). X-rays of Petitioner's left knee showed joint effusion, and X-rays of his left ankle showed soft tissue swelling without fracture (PX 2, pp. 2-4). Petitioner was diagnosed with a sprain of the left knee and effusion of the left ankle, given a knee sleeve, work restrictions, instructed to elevate the leg as often as possible, and to take Ibuprofen as needed for pain and swelling.

Petitioner returned to DMHCH on September 8, 2016, and reported his left ankle swelling had resolved and there was no pain in his ankle. However, Petitioner still had pain at times in his left knee, more with activity, and was able to walk, climb, get down steps, but unable to run/jog or walk fast as these activities cause discomfort and limping, the knee swelling was gone but there was pain on the medial, posterior, and behind the knee cap (PX 1, p. 18). On examination of the left knee, there was mild crepitation, pain on the medial part, pain on the posterior knee below the midline medially on palpation, pain on dorsiflexion of the foot, pain on lateral movement of the knee on the medial aspect, and it was observed Petitioner seemed to favor the left leg when walking. Petitioner was diagnosed with a left knee sprain, improving, and prescribed physical therapy (PX 1, pp. 18-19).

The initial physical therapy evaluation occurred on September 21, 2016. Petitioner reported that his pain was sometimes more severe than at other times, primarily when trying to jog or bend the knee, and his knee occasionally locked up on him and made loud popping sensations. Petitioner's pain was in the medial, lateral, and posterior portions of his knee (PX 1, pp. 23-24). On examination, the therapist found a positive McMurray's test with lateral joint line pain and clunking, tenderness to palpation of the center posterior knee joint, pain with resisted hamstring in neutral and external rotation, no pain with internal rotation and resisted flexion, tenderness along the medial and lateral joint lines, and Petitioner ambulated with a left antalgic gait. Petitioner received treatment on 9/26/16, 9/28/16, 9/30/16, 10/3/16, and 10/4/16, where it was reported Petitioner's left knee locked up on him, caused moderate pain, and his right hip was sore when he tried to run (PX 1, pp. 31, 33, 36-37, 43-44). Petitioner reported he experienced right hip pain due to the altered gait he had with respect to his left knee, and the physical therapy treatments were directed to his left knee and right hip, and with respect to the right hip, the treatment included strengthening exercises for stability.

Petitioner returned to DMHCH on October 6, 2016, and reported he was not improving much and while he could do most things, his knee would pop and catch, and there was an occasional burning pain on the medial aspect of the knee (PX 1, pp. 46-47). An MRI of the knee was ordered as well as continued physical therapy and restricted duty (PX 1, p. 48). The physical therapy records showed Petitioner was seen on 10/6/16, 10/7/16, 10/10/16, 10/12/16, 10/14/16, 10/17/16, 10/19/16, and 10/21/16, where it was reported Petitioner had increased pain with negotiating stairs, descending greater than ascending, moderate pain, noticeable swelling, stiffness, tightness, soreness, and occasional locking and clicking (PX 1, pp. 64-70, 72). The MRI of the left knee was performed on 10/28/16 at DMH and showed diffuse thinning of near 50% with fissuring and chondromalacia involving the articular cartilage along the lateral patellar facet, as well as mild intraosseous edema within the lateral patella, questionable near full thickness loss of the articular cartilage along the central trochlea, and prominence of the tibial tuberosity with mild edema involving the distal patellar tendon at its insertion on the tibial tuberosity, favored to represent a component of Osgood-Schlatter (PX 2, pp. 4-6). DMHCH subsequently referred Petitioner to Dr. Sams at Decatur Orthopedic Center.

The records of Decatur Orthopedic Center reported Petitioner was seen on November 4, 2016 for left knee pain after an injury with complaints of constant clicking, snapping, and popping of the left knee (PX 3, pp. 2-4). On examination of the left knee, there was medial joint line tenderness and a positive McMurray's test on the left. Dr. Sams noted that Petitioner had 2 sources of pain, including chondromalacia involving the patellofemoral joint and a medial meniscus tear, and he performed a diagnostic and therapeutic injection on the medial and lateral sides of the left knee to see how Petitioner's symptoms responded.

Petitioner returned to Dr. Sams on November 18, 2016 reporting the injection helped relieve the pain underneath the patella but he was continuing to have pain directly over the medial joint line and with any twisting motion, the pain was sharp and stabbing (PX 3, pp. 5-7). Dr. Sams recommended a left knee arthroscopy with partial medial meniscectomy as Petitioner's pain had been refractory to conservative measures.

Petitioner returned to Dr. Sams on 12/21/16, who reported Petitioner continued to have left knee pain and Dr. Sams again recommended Petitioner undergo a left knee arthroscopy with partial medial meniscectomy (PX 3, pp. 11-13).

On December 22, 2016, Dr. Sams performed a left knee arthroscopy with partial medial meniscectomy, removal of loose bodies – chondral fragments, and chondroplasty of the medial femoral condyle and trochlear groove at St. Mary's Hospital (PX 4, pp. 16-17). The operative report noted there were multiple loose bodies of cartilage fragmentation found in the suprapatellar pouch, medial gutter, and lateral gutter that were cleared out (PX 3, p. 17). It was also reported that on the medial meniscus, there was an area of the posteromedial body where the inner edge slightly overlapped and an area of deficit as if a piece of the medial meniscus had been fragmented off, and to make this a smoother transition, Dr. Sams performed a partial medial meniscectomy, anterior and posterior to this area, so this could not be a source of catching or further meniscal tear. Dr. Sams also found there was significant chondromalacia of grade 3-4 involving the trochlear groove area and debrided back the loose cartilaginous flaps to a stable base there. Finally, Dr. Sams found a loose cartilaginous flap with grade 2-3 chondromalacia on the more posterior aspect of the medial femoral condyle that was trimmed back to a stable base.

Petitioner returned to see Dr. Sams on January 6, 2017 reporting he had minimal pain although the last two weeks had been difficult Petitioner had been weight bearing as tolerated and noting his knee felt significantly better ("actually his knee feels better than it has in years.") He denied any sharp stabbing pain in his knee. (PX 3, pp. 17- 19). On examination, Dr. Sams found Petitioner ambulated with a normal heel toe gait, the portals were well-healed, mild swelling was noted, and range of motion was 0-120 degrees (PX 3, p. 17). Dr. Sams recommended Petitioner return to work on 1/9/17 without restrictions and return for re-evaluation in a month. The doctor further noted that given the level of cartilage wear, petitioner might have further degeneration in the future that would require treatment. He was to return in one month for re-evaluation at which point the doctor felt he would be at maximum medical improvement. (PX 3, p. 17)

Petitioner returned to see Dr. Sams on February 7, 2017 reporting minimal pain but a sensation of his tendon stretching at the posterior aspect of the knee and thigh when he was exercising, continued swelling, and continued right hip pain described as burning in the joint. Upon examination, Dr. Sams found Petitioner ambulated with a normal heel toe gait, the portals were well-healed, there was no swelling, and range of motion of the left knee was 0-120 degrees. Dr. Sams recommended Petitioner stay active and "live life." He prescribed Mobic for Petitioner's right hip and left knee, and instructed Petitioner to return as needed. (PX 3, pp. 25 -27)

Petitioner's case proceeded to arbitration on August 29, 2017. Petitioner was the sole witness testifying at the hearing which centered around the nature and extent of Petitioner's injury. (See AX 1) At the time of the hearing the attorneys waived the submission of an impairment rating report.

Petitioner testified regarding his accident and treatment both of which were consistent with the medical records herein.

As previously noted, on August 17, 2016 Petitioner held the position of Sergeant with Special Operations Command, commonly known as the SWAT team, where he was assigned to the Illinois State Fair. As a member of the SWAT team, Petitioner had to complete a physical fitness test on a quarterly basis which alternated between the departmental standard physical fitness test and the unit's own internal obstacle course, and maintain an overall 80% average on these tests. Petitioner's duties included being the squad leader of 6 individuals as well as running, jumping, propelling, swimming, climbing, kneeling, crawling, and performing every type of physical activity imaginable.

Petitioner further testified that he requested a change in his position with Respondent immediately after his left knee surgery but the change did not actually occur until mid-March of 2017. Petitioner testified that he requested the change because he was not physically able to sustain the activity required of him on the SWAT team in that there were too many aches and pains including his injuries to his left knee and right hip, as well as the statement the doctor made that he was a candidate for knee replacement in the future.

Petitioner is currently assigned to the logistical support staff for the three SWAT teams in Illinois which Petitioner described as an administrative role. In this position, Petitioner still has to complete the departmental standard physical fitness test, but the criteria is different as Petitioner only has to maintain an overall 40% average on this test. While Petitioner has to perform some physical activities such as running and climbing in his current position, he is able to set his own pace.

Petitioner estimated he averaged between 20 – 30 hours of overtime per month in certain months when he was on the SWAT team as this overtime was event related. In his position on the logistical support staff, Petitioner is not required to attend events and has earned only 4 hours of overtime since being in his current position.

Petitioner further testified that he no longer has the same knee as he did before the accident, as he has stiffness, soreness, occasional swelling, and occasional tenderness on the medial side for which he ices the knee every other day and takes anti-inflammatory medication depending on his activity level. Petitioner also reported he continues to have an arthritic feeling/burning sensation in his right hip on the lateral side.

On cross-examination Petitioner testified that when he was last examined by his surgeon, he was advised that he would be a candidate for a knee replacement in the future. He also testified that he no longer performs home or recreational activities as intensely and to the degree he used to, including running.

Petitioner's Exhibit 5 contained medical evaluation forms for Respondent completed by Dr. Sams on 11/22/16 and 1/11/17. Petitioner's Exhibit 6 was a Demands of the Job for Petitioner in the position of Sergeant/SWAT operator and reported Petitioner worked on or with moving machinery, lifted weights from 1-100 lbs., climbed stairs and ladders, walked, stood, sat, bended or stooped, reached above shoulder level, and used his hands for gross manipulation and fine manipulation. Petitioner's Exhibit 7 contained wage records for the pay periods R 17 2015 through S 16 2016 and showed Petitioner received $25.00 of overtime in each pay period from R 17 2015 through R 16 2016 and then received various amounts of overtime in each pay period thereafter in the amounts of $242.52, $929.66, $202.10, $808.40, $282.94, $1,212.60, $4,805.10, $210.75, $379.35, and $632.35 (PX 7, p. 1- 12, 13-17). Petitioner's Exhibit 8 contained medical bills from DMH Corporate Health, Decatur Radiology Physician Services, Decatur Orthopedic Center, Decatur Memorial Hospital, St. Mary's Hospital, Central Illinois Associates, and Clinical Radiologists, and showed the sum of $293.23 had been paid by workers' compensation on the bills of the providers noted.

Respondent's Exhibit 1 contained payment information on the medical bills of various providers, including a bill from Infinity Meds – LLP in the sum of $172.98, and the payments noted therein totaled the sum of $3,527.47. Respondent's Exhibit 2 contained various documents including the Employee's Notice of Injury dated 8/21/16, the Supervisor's Report of Injury dated 8/21/16, an email dated 8/18/16 from Petitioner regarding the accident of 8/17/16, and an email regarding the days Petitioner was off work and when Petitioner returned to work.

The Arbitrator concludes:

Regarding the nature and extent of Petitioner's injury –

Respondent stipulated to causal connection, including Petitioner's right hip condition. It did not have Petitioner undergo an examination by a doctor of its choosing.

Pursuant to Section 8.1b of the Act for accidental injuries that occur on or after 9/1/11, in determining the level of permanent partial disability, the Commission shall base its determination on several factors, including (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 injury, (iv) the employee's future earning capacity, and (v) the evidence of disability corroborated by the treating medical records, and further provides that no single enumerated factor shall be the sole determinant of disability.

With regard to Section 8.1b(i) of the Act, the parties stipulated this requirement was waived, so no weight is given to this factor.

With regard to Section 8.1b(ii) of the Act, Petitioner was a sergeant with the SWAT team at the time of the accident, which the undisputed evidence showed was a physically demanding job requiring Petitioner to perform high impact activities with his lower extremities including running, jumping, propelling, climbing, kneeling, crawling, swimming, and lifting significant weights. At the arbitration hearing, Petitioner held more of an administrative role with the logistical support staff for all the SWAT teams in Illinois, but still had to complete the departmental standard physical fitness test and maintain an overall 40% average on this test. While this test requires the ability to perform high impact activities with the lower extremities, it is not to the degree Petitioner previously had to maintain while on the SWAT team, so significant weight is given to this factor.

With regard to Section 8.1(b)(iii) of the Act, Petitioner was 45 years of age at the time of the accident, and has a longer period of time to experience residuals from his left knee and right hip than an older employee, but not as long as a younger employee, so some weight is given to this factor.

With regard to Section 8.1(b)(iv) of the Act, there was no evidence Petitioner sustained any reduction in his normal wages due to the position change he requested, but Petitioner did lose the ability to work any significant overtime with the logistical support staff, so some weight is given to this factor.

With regard to Section 8.1(b)(v) of the Act, the evidence showed Petitioner had 2 sources of pain in his left knee following this work accident, including chondromalacia involving the patellofemoral joint and a medial meniscus tear. Petitioner initially received conservative treatment for these injuries including physical therapy and an injection before Dr. Sams performed surgery on Petitioner's left knee on 12/21/16 to address both of these sources of pain. That surgery consisted of a left knee arthroscopy with partial medial meniscectomy, removal of loose bodies – chondral fragments, and chondroplasty of the medial femoral condyle and trochlear groove. While this surgery did reduce Petitioner's complaints of pain, Petitioner credibly reported increased pain and swelling in his left knee when he is more active, and credibly testified to a reduction in certain physical activities in terms of intensity and magnitude, and the use of home remedies for his complaints, including icing the knee every other day and taking the anti-inflammatory medication Dr. Sams prescribed. Petitioner's condition of ill-being in his right hip was diagnosed as right hip pain, for which Petitioner received physical therapy and a prescription for Mobic

as needed. Petitioner credibly testified to continued complaints of burning pain in the right hip on the lateral side, consistent with the complaints documented by the treating medical providers herein. Significant weight is given to this factor with respect to the conditions of ill-being in Petitioner's left leg/knee and right leg/hip.

The Arbitrator further notes that Petitioner was a credible witness. Medical records and the evidence as a whole corroborated Petitioner's credible complaints as to his level of pain, injury and ongoing limitations. She further notes that at the conclusion of the hearing, Petitioner stood up from the witness chair and in so doing hopped off his left knee putting more weight on his right knee.

Based upon the foregoing factors, the Arbitrator concludes that Petitioner is permanently, partially disabled to the extent of 22.5% loss of use of the left leg (for his knee) and 2.5% loss of use of the right leg (for his right hip).

****

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

Donald Herrin,
Petitioner,

vs. NO: 16 WC 05355

18IWCC0238

Olin Corp.,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review, under Section 19(b), having been filed by the Petitioner herein and notice given to all parties, the Commission, accident, temporary total disability, medical expenses, prospective medical expenses and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 21, 2017, is hereby affirmed and adopted.

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

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: APR 17 2018

Joshua D. Luskin

o-04/10/18
jdl/wj
68

L. Elizabeth Coppoletti

Charles J. DeVriendt

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

HERRIN, DON
Employee/Petitioner

Case# **16WC005355**

OLIN
Employer/Respondent

18IWCC0238

On 2/21/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.64% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4463 GALANTI LAW OFFICE
PATTI GIAMBATTISTA
PO BOX 99
E ALTON, IL 62024

0299 KEEFE & DePAULI PC
JAMES K KEEFE JR
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

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)

Don Herrin
Employee/Petitioner

v.

Olin
Employer/Respondent

Case # 16 WC 5355

Consolidated cases: N/A

18IWCC0238

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Collinsville**, on **December 20, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **January 29, 2016**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

Per the stipulation of the parties, in the year preceding the injury, Petitioner earned **$62,400.00**; the average weekly wage was **$1,200.00**.

On the date of accident, Petitioner was 47 years of age, ***single*** with 2 dependent children.

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

Respondent is entitled to a credit **for all benefits paid through group insurance** under Section 8(j) of the Act.

ORDER

Petitioner failed to prove that he sustained an accident that arose out of and in the course of his employment with Respondent, and that his current condition of ill-being is casually related to his alleged accident. All benefits are denied; the remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

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

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

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

Melinda M. Bowe-Gillivan

Signature of Arbitrator

2/13/17

Date

ICArbDec19(b)

FEB 21 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

Don Herrin
Employee/Petitioner

Case # 16 WC 5355

v.

Consolidated cases: N/A

Olin
Employer/Respondent

18IWCC0238

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he is currently 48 years of age and has worked at Olin for 27 years. He testified that he is currently a Scrap Disposal Operator, and that his jobs in the past have included Adjuster II which he performed for almost 25 years. He testified that his job duties of Adjuster II included lubrication, maintenance of machines, operating machines and gauging the product coming off of the machines. He testified that he had to gauge 6-8 shells off each head turn approximately every 10-15 minutes. He testified that the materials were dumped into a hopper and then into a quad reducer. He testified that there were four high speed head turns, and that material about every 30 minutes was dumped into a hopper and then went through a soaker into a quad reducer.

Petitioner testified that he would gauge 1,000-1,500 shells per day off of the four head turns and the quad reducer. He testified that he did this every day for the duration of his shift, which varied from 8 hour to up to 16 hours. He testified that he performed the gauging activity for 25 years. When asked if performing this activity caused hand symptoms, Petitioner responded that it caused some numbness and tingling but it was not anything he could not live with, but that towards the end it got more frequent.

Petitioner testified that he stopped working as an Adjuster at the end of 2015. He testified that he was placed in Primer in January where he performed the duties of a Charger. He testified that as a Charger, his job duties included taking powder mix, smearing it over a plate, scraping off the excess powder to the side of the plate and tapping the powder out. He testified that he was flexing and extending his wrists repeatedly. He testified that he never got qualified as a Charger, so he never had to work more than 8 hours per shift. He testified that he could not do the motion as it caused pain. He testified that he worked that position for three weeks and then disqualified himself off the position. He testified that as a trainee the first day he just watched and that on the second day, he jumped in and started learning how to do the job. He testified that the longest time he spent on the table charging was 20-30 minutes in the three weeks he worked the position. He testified that the pain was so bad that he had to leave.

Petitioner testified that he began experiencing symptoms while working as an Adjuster II. He testified that he moved to work as a Charger but disqualified himself from that position. He testified that his daily goal when pushing powder into the primer was that of 1,450 plates and that he was unable to meet that goal. He testified that a co-worker would take over as he was physically unable to do the motion for more than 20 minutes. He testified that he was off work for four months and that after a couple of months he felt better when he was off, but that the pain returned when he went back to work.

Petitioner testified that he first sought treatment at Olin's medical in the second or third week of January. He testified that he then followed up with his primary care physician, who ordered an EMG which was performed on January 29, 2016. He testified that he then followed up with Dr. Beatty. Petitioner testified that he reported to Dr. Beatty his job duties and that he diagnosed carpal tunnel syndrome. He testified that surgery has been recommended and that he wished to have it. He testified that he wakes up 6-7 times with a hand asleep and that he has some numbness and tingling during the day. He testified that it is virtually impossible to sleep.

Petitioner testified that he was sent to Dr. Rotman by Respondent. He testified that his appointment with Dr. Rotman was similar to his appointment with Dr. Beatty, that he asked him what he did and that he told him about the gauging and different job activities that he performed. He testified that he is back to work at Respondent, where he worked as a Scrap Disposal Operator. He testified that his hands hurt more now while he has been back to work as compared to when he was off work. He denied having any hobbies that caused hand pain or numbness.

On cross examination, Petitioner denied that his hands are always numb. He agreed that in the 25 years he spent as an Adjuster, he never sought treatment for numbness and tingling in his hands. He agreed that when he worked as an Adjuster, he never reported his hand condition as being work-related prior to January of 2016. He agreed that he sought treatment at Olin's medical around the second week of January 2016.

On cross examination, Petitioner denied having reviewed Respondent's Exhibit 2 which documented his hours worked in 2016. He agreed that he worked three weeks as a Primer in January of 2016. He agreed that he physically worked 6 days as a Charger in January of 2016 and that he took approximately 7-10 vacation days as well. He agreed that during the third week of January, he was laid off when he disqualified himself from the job. He agreed that he was laid off for about 4 months. He testified that he attempted to find employment but did not find any.

On cross examination, Petitioner testified that his hobbies consist of riding bikes (not motorcycles) with his girlfriend. He testified that he has not fished or hunted for 10-15 years. He agreed that he saw Dr. Beatty only the one time in March of 2016. He testified that the focus of description with Dr. Beatty was the Charger job.

On redirect examination, Petitioner agreed that his symptoms started before the Charger job, but it was the work activities of the Charger job that caused him to seek medical attention.

The medical records of Dr. Beatty were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The records reflect that Dr. Beatty authored a report directed to Petitioner's attorney on April 25, 2016. The report reflects that on March 14, 2016, Petitioner presented with symptoms of numbness and tingling in his left hand increasing in severity over the past several months. It was noted that Petitioner discussed "the job situation" that he was in that aggravated the problem that he was experiencing and explained about the job basically requiring rolling of the wrist to displace primer into a plate and that the repetitive flexion and extension upon downward pressure would increase the severity of the symptoms. It was noted that Petitioner's physical examination was consistent with bilateral carpal tunnel syndrome and ulnar compressive neuropathy in the ulnar tunnel of the hand on the left. It was noted that Dr. Beatty reviewed Petitioner's job description with him and found that the job activities would be consistent with the causative basis for his carpal tunnel issue and certainly the right hand as well since the nerve conduction EMG study was abnormal and reflected bilateral median sensory entrapment neuropathy consistent with carpal tunnel syndrome. (PX1).

The records of Dr. Beatty reflect that Petitioner was seen on March 14, 2016 at the referral of Dr. Harms for left carpal tunnel syndrome. It was noted that Petitioner had intermittent numbness and

tingling over 2-3 years and that it had increased in severity since January. It was noted that Petitioner had night pain with numbness and he noted that his last job really aggravated the symptoms. It was noted that Petitioner had been placed in the primer charger area which required rolling of the wrist to displace primer into a plate. It was noted that Petitioner reported repeated flexion and extension, pressure downward. It was noted that at the end of January, Petitioner took himself out of the job due to numbness and pain and reported that he knew of a woman with this particular job who had to have carpal tunnel in both hands. It was noted that Petitioner stated that he used hammers, punches, Allen wrenches, crescent wrenches and a socket wrench in a varied amount of time, 20 minutes to 6 hours. It was noted that the nerve conduction/EMG study obtained on January 29, 2016 was considered to be an abnormal study with left median motor and moderate bilateral sensory entrapment neuropathy at the carpal tunnel, and that he had ulnar entrapment neuropathy at Guyon's canal on the ulnar side of the palm side of the hand. It was noted that it was clear that Petitioner had bilateral carpal tunnel syndrome and ulnar tunnel neuropathy of the left hand. (PX1).

The EMG dated January 29, 2016 was entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The record reflects that Petitioner reported a history of numbness and tingling of hands, and that the study was ordered to evaluation of entrapment neuropathy. The impression was noted to be that of (1) mild left median motor and moderate bilateral median sensory entrapment neuropathy at the flexor retinaculum; (2) left ulnar entrapment neuropathy at Guyon's canal; the needle EMG did not show any ongoing denervation; clinical correlation is recommended. (PX2).

The transcript of the deposition of Dr. Michael Beatty was entered into evidence at the time of arbitration as Petitioner's Exhibit 3. Dr. Beatty testified that he is a plastic, reconstructive and hand surgeon. He testified that he evaluated Petitioner on March 14, 2016 for the possibility of a nerve compression in his upper extremity. He testified that Petitioner presented with symptoms of numbness and tingling in his left hand primarily and subsequently reported that he also had it in both hands, but more in the left than the right. He testified that along with numbness and tingling, Petitioner also reported pain. He testified that Petitioner reported intermittent numbness over the previous 2-3 years but had worsened prior to the time that he was seen and had become more permanent. He testified that Petitioner reported that it became more intense in January of 2016. (PX3).

Dr. Beatty testified that Petitioner stated that the issue that bothered him the most was when he was doing repetitive flexion and extension maneuvers with his hands, and that this surrounded rolling of the wrist in the primer and movement into the plate. He testified that Petitioner reported that in January of 2016, he took himself out of the job activity that he was doing to try to relieve the issue. He testified that his diagnosis was bilateral carpal tunnel syndrome and ulnar compressive neuropathy of the left hand. He testified that he found Petitioner's diagnosis to be causally related to his work activities, and that he recommended carpal tunnel and ulnar nerve release on the left and a carpal tunnel release on the right. (PX3).

When asked why he felt that Petitioner's carpal tunnel surgery was related to his work activities, Dr. Beatty testified that Petitioner related the fact that what got him to think was the fact that he discussed this with a former employee that worked in the same area and had carpal tunnel surgery after which her problems were resolved. When asked why it was significant that someone that worked a similar job experienced relief after getting treatment for carpal tunnel, Dr. Beatty responded that it would be the relationship that caused the basis of the problem. He testified that the EMG confirmed his diagnosis. He testified that Petitioner's subjective complaints were confirmed by objective data and clinical findings. (PX3).

Dr. Beatty testified that the IME report of Dr. Rotman did not affect his opinion. He testified that Petitioner was not diabetic from his point of view. He agreed that diabetes can replicate the symptoms of carpal tunnel but not necessarily cause carpal tunnel. He testified that there was some literature that

indicated that high blood pressure was or potentially could be related to the development of carpal tunnel syndrome. He testified that it was possible that high blood pressure may cause some swelling in or around the nerve, but he did not believe that was the situation in this case. He testified that Petitioner had normal blood pressure while taking medication, however, and he still had the symptoms. He testified that he did not feel that Petitioner's weight was a risk factor. He testified that Petitioner was overweight, but he was not morbidly obese where he thought it could be a problem and could cause or contribute to compressive neuropathy. He testified that obesity could mechanically cause carpal tunnel syndrome but was not applicable in this case, and that diabetes and high blood pressure would replicate the symptoms of carpal tunnel but not cause it but were not applicable in this case. (PX3).

Dr. Beatty testified that he disagreed with Dr. Rotman as to the Guyon tunnel release. He testified that both the carpal tunnel release and the ulnar tunnel release would both be performed through the same incision. (PX3).

On cross examination, Dr. Beatty agreed that he testified that in deciding on whether or not to recommend surgery for neuropathic conditions at the wrist was the history and physical exam. He agreed that when he examined Petitioner in March of 2016, there was a positive exam finding at the ulnar tunnel of the left wrist, and that the positive test finding along with his report of symptoms into the left fifth finger was the basis of his recommendation for surgery. He agreed that he has not seen Petitioner since March 14, 2016. (PX3).

On cross examination, Dr. Beatty testified that Dr. Rotman's report noted that Petitioner had a negative Tinel's over Guyon's canal and no discomfort with Guyon's canal compression testing, and that it told him that Dr. Rotman believed there was no problem with the ulnar nerve. He agreed that when he performs surgery on Petitioner on the left, he is going to go through the same incision to address both the median nerve and the ulnar nerve at the wrist. He testified that there was an additional charge for addressing the ulnar nerve at the same time as addressing the median nerve. (PX3).

On cross examination, Dr. Beatty agreed that the nerve conduction study that was performed referenced a slightly prolonged latency of the left ulnar motor nerve. He agreed that Petitioner reported that his fifth finger was numb to both him and Dr. Rotman. He agreed that Dr. Rotman's exam in July of 2016 noted that Petitioner had negative Tinel's and compression test at Guyon's canal. He agreed that before he would perform surgery, he would require an updated appointment and examination. (PX3).

On cross examination, Dr. Beatty testified that Petitioner reported he had been employed by Respondent for 20-25 years, but indicated that it was not recorded how long he had been performing the primer charger job. He agreed that Petitioner described a co-worker that had also performed the primer job who also was treated for carpal tunnel syndrome. He agreed that he had no specific information regarding that co-worker such as when she had the surgery, how long she worked for Olin, or for how long she worked the primer job. He testified that Petitioner reported that at the end of January of 2016 he took himself out of the job due to the numbness and pain, so he was not doing that job when he examined him in March of 2016. He testified that Petitioner did not relate to him whether there was any change in his symptoms between when he stopped the job in January of 2016 and when he was seen in March. (PX3).

On redirect examination, Dr. Beatty denied that at any point did he suspect Petitioner of malingering or symptom magnification. (PX3).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 4.

The transcript of the deposition of Dr. Mitchell Rotman was entered into evidence at the time of arbitration as Respondent's Exhibit 1. Dr. Rotman testified that he is an orthopedic surgeon with a subspecialty in hand surgery and is board-certified in orthopedic surgery. He testified that he has visited the plant for Respondent and was familiar with the general positions of Adjusters, Operators and Primers. (RX1).

Dr. Rotman testified that he performed an Independent Medical Examination on July 7, 2016. He testified that Petitioner had complaints of numbness and tingling in both of his hands, that on the left hand his entire hand would go numb, that on the right hand it was mainly his index and middle fingers, that the left was worse than right, that he was waking up at night and that a brace on his wrist helped. He testified that Petitioner provided him with a brief work history of the positions that he had held at Respondent over the years, that it was his understanding that for a number of years he held the position of Adjuster and that he was familiar with that position. He testified that it was his understanding that immediately before his alleged accident date of January 29, 2016, Petitioner worked in the Charger position and held that position for about three weeks before he mentioned anything about the symptoms in his hands. He testified that it was his understanding that Petitioner took himself off the Charger position and was off work for four months, and that while he was off work his symptoms did not improve at all. He testified that it was his understanding that when Petitioner returned to work at Olin he was not placed back in the Charger position, but was doing an easier job called a Scrap Disposal Operator. He testified that Petitioner reported no change in his symptoms while in his new position. (RX1).

Dr. Rotman testified that he reviewed the medical records of Dr. Beatty and the nerve conduction studies dated January 29, 2016, and that the concern based on the neurologist's report was that of compression of the ulnar nerve, carpal tunnel on the left wrist and then carpal tunnel on the right. He testified that he would not call it severe, but would say it was moderate on the left and milder on the right. He testified that the pertinent findings of the physical examination performed were that Petitioner was overweight, that he had treatment in the form of a previous fusion on the neck but was not having any problems from the neck, that his elbows showed a little bit of local irritability over the cubital tunnel but the numbness and tingling seemed to be more in the median nerve distribution when he was tested for cubital tunnel. He testified that Petitioner had "meaty" hands and had typical-looking hands for someone with carpal tunnel, and that he had positive findings for carpal tunnel. He testified that he could not find any problems with the ulnar nerve at the wrist. He testified that the diagnosis rendered was that of bilateral carpal tunnel, left greater than right. (RX1).

Dr. Rotman testified that he was of the opinion that Petitioner's work activities at Respondent did not cause or aggravate his carpal tunnel condition. He testified that surgery was a reasonable option for Petitioner but only the carpal tunnel releases, and that there was no reason to release his Guyon's canal. He testified that Petitioner's carpal tunnel had nothing to do with his work, that Petitioner had the symptoms for quite some time, that his work did not involve heavy, repetitive, forceful activities of the hand and that carpal tunnel was idiopathic. He testified that whether Petitioner worked or not he was going to have symptoms, that it had nothing to do with his work and that it had more to do with his body habitus and perhaps his pre-diabetic condition. (RX1).

On cross examination, Dr. Rotman agreed that he saw Petitioner only once regarding the bilateral carpal tunnel and Guyon's canal. He agreed that he had been to Respondent's plant in East Alton, and testified that it was many years ago (*i.e.*, 10-15 years) and that he went there a couple of times. He testified that he agreed with Dr. Beatty that Petitioner has carpal tunnel and that he also agreed with Dr. Beatty that he would benefit from a carpal tunnel release. He agreed that it was a fair statement that he and Dr. Beatty differed in their causation opinion, and that he would not perform a Guyon's canal release. (RX1).

On cross examination, Dr. Rotman agreed that one of the factors taken into consideration when determining the course of treatment included how a patient's symptoms affected their quality of lift or their ability to work, and that this was a decision only made between the treating physician and his/her patient. He agreed that he testified on direct examination that carpal tunnel in general was idiopathic meaning that the true cause was relatively unknown. He agreed that certain conditions either predispose or mimic the symptoms of carpal tunnel, including diabetes and obesity. (RX1).

On cross examination, Dr. Rotman testified that he has watched videos of Respondent's jobs "hundreds of times" but that he did not watch a video in this particular case. He testified that he watched videos of Adjusters in the past and that they basically monitored machines and pressed buttons. He testified that Petitioner stated that the most repetitive thing he did was gauging, and that gauging did not involve any significant forces at all. He agreed that Petitioner's job duties included charging plates, pushing primer, rolling the rubber handle, using a crescent and/or T-wrench, repairing the machine and gauging, but that he was doing charging for three weeks. He agreed that Petitioner mentioned that he had trouble with charging plates, and that he also mentioned trouble with pushing primer and rolling the rubber handle. He agreed that he indicated in his report that the work risk factors were not entirely obvious, and that he was basing that off of videos that he reviewed in the past and nothing he reviewed for this case. He agreed that he did not review a job duty analysis in this particular case. (RX1).

On cross examination, Dr. Rotman agreed that in his report he did not discuss which hand movements were required to perform various job duties including charging plates, pushing primer, etc. He agreed that he did not review any information regarding what types of forces were required to operate the machines. He agreed that he opined that gauging activities were light and would not be a risk factor for carpal tunnel. He agreed that he has never worked as an Adjuster at Olin and that Petitioner had worked at Olin since 1989. He agreed that Petitioner reported that he worked 8-16 hours a day and that he worked a 40-hour week. (RX1).

On cross examination, Dr. Rotman agreed that in his report he did not note whether he discussed repetitive flexion, extension or downward pressure. He agreed that he was only looking for repetitive heavy gripping. When asked if Petitioner's job activities included repetitive flexion, extension and downward pressure and whether that would affect his causation opinion, Dr. Rotman testified that it would have to be hyperextension or hyperflexion for prolonged periods of time. He testified that the downward pressure would not be of concern to him unless it involved heavy gripping. (RX1).

On cross examination, Dr. Rotman agreed that he did not see that Petitioner had any family history of carpal tunnel, but that he had noted he was pre-diabetic. He testified that pre-diabetics commonly could present with carpal tunnel syndrome because of higher sugar content in the body that caused thickening of the ligament, and that it could also cause peripheral neuropathy. He testified that Petitioner's pre-diabetic condition was a risk factor in carpal tunnel if he truly was pre-diabetic. He testified that he did not know whether the blood test was taken before or after eating and that he was aware that Petitioner had not been diagnosed with diabetes. He agreed that he was not a primary healthcare provider, but testified that as an orthopedic surgeon, he was concerned if an individual was diabetic. He testified that he could not say with any reasonable degree of medical certainty that diabetes was not a factor in Petitioner's carpal tunnel. He agreed that the only reason they were even discussing a diabetic condition was because diabetic patients were linked with higher incidences of carpal tunnel, but agreed that not everyone with diabetes had carpal tunnel. (RX1).

On cross examination, Dr. Rotman testified that carpal tunnel was compression of the median nerve secondary to the transverse carpal ligament causing pressure on the underlying nerve. He agreed that Guyon's canal would be the ulnar nerve that was being compressed in the Guyon's canal. He agreed that Petitioner's body mass index (hereinafter "BMI") was a risk factor in carpal tunnel. He agreed that causation was not the same as correlation. He agreed that the risk factors they discussed correlated with

higher incidences of carpal tunnel, but did not necessarily cause it. He agreed that it was fair to say that not everyone with a BMI over 30 would develop carpal tunnel. (RX1).

On cross examination, Dr. Rotman agreed that Petitioner's ulnar nerve was being compressed but disagreed that he needed surgery on the Guyon's canal because studies indicated that it may improve with a carpal tunnel release. When asked if there was no guarantee that it would get better, Dr. Rotman testified that he would guarantee it if he did Petitioner's carpal tunnel release because he did not have any symptoms from his carpal tunnel and he was very familiar with the anatomy of Guyon's canal and the research on it. He testified that he would not look at the ulnar nerve when he did a carpal tunnel release, so the only way you could look at it was if you released the whole thing and then made an incision. He agreed that he was familiar with Dr. Charles Goldfarb but admitted that he was not familiar with the June 2016 article by Dr. Goldfarb where he cited CPG findings reported by two moderate quality studies for a single high quality study showing assembly line work as having an increased risk of carpal tunnel. He testified that he would agree that, depending on the severity of the carpal tunnel, it did not matter what one did and that they were still going to have symptoms. He agreed that numbness and tingling were symptoms associated with carpal tunnel. (RX1).

On redirect, Dr. Rotman agreed that he had seen the machines and the departments at Olin both in person and on video. He agreed that Petitioner performed the Primer position with the rolling pin and the distribution of the primer for three weeks. (RX1).

On further cross examination, Dr. Rotman agreed that he did not review a job duties video in this case and that the last time that he was at Olin was 10-15 years ago. (RX1).

The 2016 Work Hours documentation was entered into evidence at the time of arbitration as Respondent's Exhibit 2.

CONCLUSIONS OF LAW

With respect to disputed issues (C) and (F), given the commonality of facts and evidence relative to both issues, the Arbitrator addresses those jointly.

The Arbitrator finds that Petitioner failed to prove that he sustained accidental injuries that arose out of and in the course of his employment with Respondent on January 29, 2016, and that his current condition of ill-being is causally related to his work activities.

In so concluding that Petitioner failed to prove that he sustained accidental injuries that arose out of and in the course of his employment with Respondent, the Arbitrator finds the opinions of Dr. Rotman to be more persuasive than the opinions provided by Dr. Beatty. The Arbitrator finds to be highly significant the fact that Dr. Rotman testified that he has visited the plant for Respondent and was familiar with the general positions of Adjusters, Operators and Primers, while Dr. Beatty proffered no testimony regarding his familiarity with Petitioner's job duties beyond those as discussed at the time of the sole office visit on March 14, 2016. (RX1; PX3).

The Arbitrator notes that Dr. Rotman testified that Petitioner's carpal tunnel had nothing to do with his work, that Petitioner had the symptoms for quite some time, that his work did not involve heavy, repetitive, forceful activities of the hand and that carpal tunnel was idiopathic. Dr. Rotman testified that whether Petitioner worked or not he was going to have symptoms, that it had nothing to do with his work and that it had more to do with his body habitus and perhaps his pre-diabetic condition. Furthermore, the Arbitrator finds to be significant in this case the testimony of Dr. Rotman that Petitioner stated that the most repetitive thing he did was gauging and that gauging did not involve any significant forces at all, and

that Petitioner's job duties included charging plates, pushing primer, rolling the rubber handle, using a crescent and/or T-wrench, repairing the machine and gauging, but that Petitioner was doing charging for only three weeks. (RX1). This testimony, when coupled with Petitioner's admissions on cross examination that in the 25 years he spent as an Adjuster he never sought treatment for numbness and tingling in his hands, that when he worked as an Adjuster he never reported his hand condition as being work-related prior to January of 2016, that he worked three weeks as a Primer in January of 2016 and that he physically worked 6 days as a Charger in January of 2016, causes the Arbitrator to find that Petitioner performed the Primer job for such a short duration that it did not contribute to or aggravate the bilateral carpal tunnel condition. As such, the Arbitrator finds that Petitioner failed to prove that he sustained accidental injuries that arose out of and in the course of his employment with Respondent.

Based upon the foregoing and the record as a whole, the Arbitrator concludes that Petitioner has failed to prove that he sustained accidental injuries that arose out of and in the course of his employment with Respondent on January 29, 2016, and that his current condition of ill-being is causally related to his work activities. All benefits are denied. The remaining issues of medical bills and prospective medical treatment are moot, and the Arbitrator makes no conclusions as to those issues.

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

James McCormack,
Petitioner,

vs. NO: 10 WC 07846

York & Sons, LLC,,
Respondent.

18IWCC0239

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 28, 2016, is hereby affirmed and adopted.

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $5,600.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 17 2018

Joshua D. Luskin

o-04/10/18
jdl/wj
68

L. Elizabeth Coppoletti

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

McCORMACK, JAMES M
Employee/Petitioner

Case# 10WC007846

YORK & SONS LLC
Employer/Respondent

18IWCC0239

On 11/28/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.60% 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:

3650 MEINDERS LAW LLC
BLAKE G MEINDERS
10 S JACKSON ST SUITE 300
BELLEVILLE, IL 62220

0445 RODDY LAW LTD
RICHARD S ZENZ
303 W MADISON ST SUITE 1900
CHICAGO, IL 60606

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

JAMES M. MCCORMACK
Employee/Petitioner

v.

YORK & SONS, LLC
Employer/Respondent

Case # **10** WC **07846**

Consolidated cases: _____

18IWCC0239

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Collinsville**, on **July 19, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **April 10, 2007**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being *was* causally related to the accident, but is no longer causally related.

In the year preceding the injury, Petitioner earned **$Unknown**; the average weekly wage was **$460.00**.

On the date of accident, Petitioner was **23** years of age, ***single*** with **0** dependent children.

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

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

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

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

ORDER

The Arbitrator finds that the Petitioner's condition of ill-being, while initially related to the April 10, 2007 accident, was no longer causally related after May 14, 2008. At that time, the Petitioner reached maximum medical improvement with regard to the April 10, 2007 accident. As such, all benefits incurred subsequent to that date are denied.

Respondent shall pay causally related reasonable and necessary medical services which were incurred by the Petitioner prior to May 15, 2008, as provided in Section 8(a) of the Act. Respondent shall be given a credit for any awarded medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit.

Respondent shall pay Petitioner permanent partial disability benefits of **$276.00 per week** for **20 weeks**, because the injuries sustained caused the **4% loss of the person as a whole**, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner compensation that has accrued from **April 10, 2007** through **July 19, 2016**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

November 16, 2016
Date

ICArbDec p. 2

NOV 2 8 2016

STATEMENT OF FACTS

On 4/10/07, the Petitioner was working for the Respondent as a commercial and residential painter. While working at an animal clinic, the Respondent's scaffolding had been taken down and the Petitioner had to use another contractor's scaffold. The wood decking on the scaffold was rotted, he stepped in a hole, it broke and he testified that he fell about 15-20' onto concrete. He testified that his back landed on a paint can, and he struck his head on the concrete. He testified that he was knocked out, reported it when he woke up, and the Respondent's owner advised him to go to get treatment.

The Petitioner testified he went to his doctor, Dr. Maret, who was close by, and that he had pain and bruising all over. He testified that Maret advised him to go to the emergency room right away, so he went to Barnes-Jewish Hospital. The Arbitrator notes that the records of Dr. Maret were not offered into evidence.

Petitioner testified that he had pain in his low back, neck, upper back, leg and right arm, and that he also complained of numbness. The 4/10/07 records from Barnes-Jewish Hospital indicate the Petitioner reported falling 7' off of scaffolding, landing on his back with his head striking a concrete wall. A separate note indicated a history of Petitioner's foot went through a wood scaffold deck, he fell backwards, hot the wall and fell 6 to 10 feet to the floor, with a numb/dead feeling in the right arm and leg. He denied loss of consciousness. He noted complaints of right back and leg pain. One note indicated Petitioner had upper to mid back pain, and was awaiting consultation regarding a feeling of numbness/fullness in the right upper and lower extremities. (Px1).

An orthopedic consult note indicates Petitioner "does have past history of similar pain (after) MVC (with) herniated disc per report, but pain today much more severe." History was noted of a herniated lumbar disc and spina bifida per Petitioner "on prior CT (no) neurologic deficit in past."

It noted he had prior injuries to his spine. He had right arm abrasions. There were no neurological deficits. A CT scan of the head was normal. Lumbar films reflected L5/S1 and S1/2 herniated discs, but no fractures or other soft tissue abnormalities. One note stated that the CT scans of the head, upper, mid and lower spine all were within normal limits. Given Petitioner's complaints, he was referred by the ER for a neurologic consult, but a lack of objective findings was also noted. The radiology reports for these CT scans noted no fracture or subluxation, lumbarized S1 vertebra with disc herniations at L5/S1, resulting in right neuroforaminal narrowing and mild compression of the thecal sac at the L5 nerve root / displacement of posterior S1 root, and at S1/2 to the left. Cervical (with and without flex/extension) and thoracic x-rays were normal, and lumbar x-rays (with and without flex/extension) reflected the transitional disc below S1, noting the herniated S1/2 disc was not

profiled here despite the indication on CT. The diagnoses were cervical and lumbosacral strains, closed head injury and right arm contusion. The Petitioner was discharged and advised to follow up with the orthopedic department. (Px1). He testified that he was put into a cervical collar, which he wore for a month or two, and was to follow up with his family doctor.

Petitioner testified he followed up with Dr. Maret, but that since then Dr. Maret retired and his current family doctor is Dr. Vaid. Again, the records of Dr. Maret are not in evidence, but the Petitioner testified he was prescribed therapy and, at some point, Percocet, and that he took Percocet after that for "a couple years." However, he also testified that he still takes this medication, but at a third of the original dose.

The first post-accident note from the primary provider, Dr. Wolff, in evidence is dated 5/9/07. Petitioner reported falling backward off scaffolding, hitting his head against the wall and falling on his back and head about 7' from the scaffolding. The visit to Barnes is noted. Dr. Wolff states: "He is back to work and feeling pretty well in regard to his back, head and neck." He denied any distal paresthesias, but he did have some tender lumps on the right ankle, which Wolff believed were hematomas from the trauma, and advised it could take a few weeks to resolve. On 6/12/07 Petitioner returned noting the hematomas were resolving, but that when he extends his head and neck for any amount of time for overhead work, he feels burning, shooting pain down the cervicothoracic spine to about T6 level. He had occasional left chest wall discomfort radiating to the T5/6 area. Examination was essentially normal. Diagnosis was neuritic-type pain in the cervicothoracic pain with full and prolonged extension of the head and neck, as well as occasional left intercostal myospasms. He was to perform activities as tolerated and avoid prolonged extension of the head and neck. If symptoms didn't resolve, cervicothoracic imaging was recommended. He was to follow up in 2-3 weeks. (Px3).

Petitioner next followed up for back pain on 8/21/07, after being a no show on 8/14. Petitioner reported the same symptoms and that he had gotten a little worse, again noting overhead work as an aggravating factor. Over the counter medications hadn't helped. Chronic back pain with T5/6 radiculopathy was diagnosed, and MRIs were requested. Petitioner requested chiropractic services, but was advised he would have to self-refer for that. He was advised to continue to work unrestricted duty. (Px3). On 5/14/08, Petitioner reported chronic left chest pain to Dr. Wolff, especially with overhead work. He also reported that his chest and arms get mottled and purplish when he is doing that work, resolving when he puts his arms down and rests. He never got the MRI to rule out suspected T5/6 radiculopathy, but is "open to getting this now". He reported paresthesias about the neck and arms at times, so cervical films were also recommended. Diagnosis was left chest wall pain, which was likely thoracic radiculopathy versus costochondritis. Unrestricted activity was continued. (Px3). The last visit to Dr. Wolff was on 11/14/08, mainly for hand itching likely due to medication for a tooth abscess, but he also noted he was working as a painter. (Px3).

The Petitioner testified that he thereafter had multiple emergency room visits, and that he always had the same complaints: head, back and neck pain with numbness and tingling in the arms and legs, with most of the latter being right-sided. He had PT and, eventually, pain meds, Percocet, which he took for a couple years, and he still does but at a much lower dose. He testified that these facilities had recommended different treatments, including physical therapy, chiropractic treatment and a home exercise program. He testified that he had therapy via Belleville Family Medicine (Px3) for about 8-12 weeks, which included a TENS unit (home and in-house), stretching, massage, traction table. He testified the treatment only gave temporary relief. There are no records of the therapy treatment in the submitted records from Belleville, and a bill that was submitted includes therapy from 2003, but only two or three therapy visits after the accident, and it is unclear from the bill itself if those were for therapy or just general visits. (Px3).

He saw chiropractor Dr. Schmidt (Px8) for 1-2 months, but testified that he didn't think it helped other than temporarily, and sometimes it made him feel worse. The records in evidence have very few actual records or reports of Dr. Schmidt, other than one handwritten note. Petitioner testified he had aquatherapy some time after this, but couldn't recall where or when. The Arbitrator could not locate any records of this treatment in the presented evidence.

Petitioner went to the St. Elizabeth's Hospital emergency room (ER) on 3/6/09 after being struck in the face with a tennis racket. The intake form indicated he was an employee of the Respondent. He returned on 5/7/09 with "classic thoracic outlet syndrome symptoms." This included left arm numbness with activity, color changes ("left arm turns purple when use it"), pain (arm, upper back, chest and abdomen) and weakness. He reported 3 to 6 months of symptoms, and that it "maybe" related to an injury. An MR angiogram was prescribed, and it was reported to be normal. Petitioner noted a prior left clavicle surgery. On 6/14/09 Petitioner went to the St. Elizabeth ER with a toothache (Px2).

Petitioner went to the St. Elizabeth ER on 11/7/09 complaining or left knee and back pain after wrecking a motor bike at 25 mph. A separate note indicated he fell off the bike. IT was noted he had been drinking and smelled of alcohol. The diagnosis was left elbow and shoulder pain with left elbow and knee abrasions. (Px2).

On 7/22/10, the Petitioner went to the Memorial Hospital emergency room reporting that he had a bulging disc in his back, had back pain and was out of medication. He gave a history of spina bifida, chronic low back pain, and was out of pain medication with no insurance or medical provider. Multiple medications were prescribed, and he was advised to follow up with Southwest Illinois Healthcare in Belleville. (Px5).

Petitioner returned to the Memorial Hospital ER on 11/12/10. An intake form noted he was there for back pain, but the triage note indicates complaints of burning neck pain and intermittent left arm pain and tingling. He also noted pain in the back that radiated to the chest, and that he had been told a year and a half before that he might have a blood clot in his left arm that he never followed up on. Cervical and thoracic x-rays were normal. He was prescribed Norco, Motrin and Flexeril and advised to follow up with his primary care providers. (Px5).

On 12/3/10, Petitioner went to the Anderson Hospital ER complaining of left arm pain and numbness, shortness of breath and feeling like he was having a heart attack. He reported his left arm "gets 'splotchy' then left face hot red & neck." Diagnoses were possible thoracic outlet syndrome, anxiety and chronic back pain. He was prescribed hydrocodone, tramadol and lorazepam. (Px4).

On 12/2/10, a Dr. Hipskind, MD PhD, indicated the Petitioner could work with restrictions of "minimal hands working above head level as much as possible". (Px1). It is unclear who this physician was or what his specialty as, as no other records were submitted from this provider. On 12/15/10, chiropractor Dr. Schmidt indicated in a handwritten note that the Petitioner presented on 11/30/10 with complaints of neck and arm pain. Diagnosis was cervical IVD syndrome, TOS, myalgia (myositis & cervicalgia), "all caused by his accident in March". He was treated with traction, chiropractic adjustments and "neuromuscular skeletal reeducation." He was treated through 12/15/10, didn't improve and then never came back in. (Px1). A bill was submitted as part of Dr. Vaid's records indicating treatment by Schmidt Chiropractic from 11/30/10 to 12/15/10, but the records for this treatment were not part of the exhibit. (Px8).

Petitioner testified that he sought treatment with Dr. Gornet, and complained: "The tightness in my right hand, the tingling and numbness going down my right leg, upper back pain, lower back pain and neck and at that time I was having tightness on the top of my head."

Petitioner initially saw Dr. Gornet on 11/8/12 with complaints of neck pain, headaches, pain into both shoulders right greater than left, radiating into the right trapezius and into the right arm and hand, with numbness and weakness that occasionally went into the left side. He also reported low back pain into both buttocks and legs to the feet, again right greater than left. The Petitioner stated that his current symptoms began on 4/17/07 when he "apparently fell 18 feet", landing on a bucket. He had returned to work two weeks after the accident but had persistent pain. He did not recall any prior problems or treatment of any significance. The Petitioner noted his conservative treatment, and that he felt the only gap in treatment was due to the Respondent's failure to authorize further treatment, and "he states he was told to see a specialist and at this point, he felt that he had approval to come here today." Petitioner reported constant pain worse with walking, stairs and prolonged sitting or standing. (Px7).

Neurological examination indicated normal reflexes and sensation, with decreased motor signs in the right bicep and ankle. Dr. Gornet reviewed x-rays, noting Petitioner reported a history of scoliosis but films did not reflect this. Noting it was "by history and assuming that it is factually correct", Dr. Gornet opined that Petitioner's current symptoms were related to the 4/17/07 accident. He requested Petitioner's prior medical records and scans, noting that while there were no bony injuries, he could have a disc injury related to structural back pain. He was released to return to full duties. (Px7).

While no records of his treatment were submitted into evidence, Dr. Vaid issued a 5/28/13 note indicating the Petitioner was allowed to return to restricted work duties with no lifting over 10 pounds and no bending. (Px8).

On 5/31/13, the Petitioner again went to the Anderson ER, again complaining of left arm pain and shortness of breath. He also reported neck and back pain, tingling in both arms and his face gets red and hot. He reported that he might have thoracic outlet syndrome per his primary doctor, that he was being worked up for this, that this was a workman's compensation case and he was to have MRI and blood work done. He was diagnosed with anxiety, chronic pain and backache. Ibuprofen, tramadol and flexeril were prescribed. (Px4).

Petitioner then did not return to Dr. Gornet until 6/17/13. He returned with his records of treatment following the 4/17/07 accident. Dr. Gornet noted: "There is clear documentation of multiple treatments after this injury." Petitioner complained of neck pain, headaches, bilateral shoulder pain, right greater than left, radiating into the right trapezius and arm with numbness and weakness. He also complained of low back pain into the legs, right greater than left. Dr. Gornet recommended updated MRIs. Indicating it didn't appear Petitioner's symptoms resolved, he was never released to full duty, and that there were no intervening injuries, he opined the ongoing condition remained related to the accident. (Px7).

Petitioner next saw Dr. Gornet on 2/12/14, and returned for MRIs. Lumbar MRI reportedly showed L4/5 and L5/S1 disc degeneration "with what I feel is a central left disc protrusion at L5/S1 as well as central disc protrusion/annular tear at L5/S1 left and central right L4/5". He opined that his low back pain was consistent with discogenic pain due to structural disc inflammation, not so much due to a nerve issue. For this, he recommended conservative treatment, and if that failed, surgery. As to the cervical spine, Dr. Gornet noted subtle multi-level disc protrusions with no herniations. It was possible there was a foraminal C6/7 herniation, but this was not consistent with Petitioner's symptoms. Dr. Gornet expressed significant concern about Petitioner's Oxycodone usage, and referred him to Dr. Boutwell to wean off of the medication. Dr. Gornet stated: "If he can demonstrate that he can be off of all narcotics for a prolonged period of time, then at that point we will work him up and potentially treating him, but he understands for right now until he can demonstrate that he can be off of all narcotics, there is really no reason to proceed with any further treatment beyond weaning him." He was advised to follow up in two months. (Px7).

The 2/12/14 lumbar MRI report noted disc desiccation at L4/5 and L5/S1 with accompanying annular tears and herniations resulting in right greater than left L4/5 and left greater than right L5/S1 foraminal encroachment with mild central canal stenosis at L5/S1. Probable mass effect was noted on the traversing left L5 and S1 nerve roots. Cervical films were within normal limits. (Px6).

On 2/13/14, Dr. Gornet noted Petitioner had failed to appear to see Dr. Boutwell, despite an offer of free treatment to wean from narcotics. Dr. Gornet stated: "At this point, clearly has narcotic issues. Whether there is anything we can do to help him given these clear issues with narcotic dependence remains to be seen." (Px7). The Petitioner testified that he did not want to have surgery because he was afraid, and he remains afraid.

The Petitioner did end up seeing Dr. Boutwell on 2/20/14. Petitioner reported his current narcotic use was the result of his 2007 accident. He reported being on narcotics for a short time after the accident, was off the medications for about 2 years after that, and then pursued pain management in 2009 and resumed the use of narcotics. These included multiple medications: Indocet, tramadol, hydrocodone, oxycodone, Percocet, Tylenol 3 and Vicodin. He also had multiple other modalities (injections, physical therapy and hydrotherapy), and neither these nor the medications had provided any lasting relief. The Petitioner reported 5 out of 10 to 9 out of 10 pain. A history of 2007 hernia surgery was noted. He reported working in auto sales the past 6 years. His hobbies included basketball and fishing. Dr. Boutwell outlined a plan to wean off of the medications, as well as the use of substitute medications, and Petitioner was advised to follow up in a month. (Px6). The Petitioner testified that he believed he received injections from Dr. Boutwell, which only helped temporarily. Px6 did not include any records indicating such injections were performed.

The Petitioner was examined at the Respondent's request by physical medicine and rehabilitation specialist Dr. Cantrell on 3/30/15. (Rx1). The Petitioner gave a consistent history of the 4/10/07 work accident and provided a vague history of his treatment to date. He reported that Dr. Gornet had recommended surgery and that he did not want to proceed with this. He returned to work and had some difficulties, particularly with prolonged activities in an overhead position. He had ongoing thoracolumbar pain radiating into both legs, right greater than left, with numbness in the heels. He denied any prior history of thoracolumbar pain or injury. He was continuing to take Oxycodone daily, obtaining medications through Dr. Vaid, but reported that his pain was an 8 or 9 on a 10-point scale. Relevant examination findings included limited lumbar range of motion and some loss of strength in the lower right leg. (Rx1).

Dr. Cantrell thoroughly reviewed and reported his review of all of the medical records in this case. The Arbitrator notes that some of the noted records were not submitted into evidence, including a 4/10/12 note of Dr. Lattimore indicating the Petitioner was taking 12 Percocets a day and wanted to get off of it, but would get withdrawal symptoms when he tried. He also reported radicular symptoms into the legs and was prescribed Methadone. Dr. Cantrell also noted the records were lacking with regard to the providers who were prescribing medications to the Petitioner, and that is also the case with the medical submitted into evidence here. (Rx1).

Dr. Cantrell noted the prior records were not consistent with Petitioner's report of no prior thoracolumbar pain, as they noted chronic low back pain, including symptoms radiating into the legs, multiple vehicle accidents. Noting the Petitioner was presenting with thoracolumbar back pain that intermittently radiated to the legs, but had no neck or upper extremity complaints, Dr. Cantrell opined that as to the 4/10/07 accident, the Petitioner's ongoing complaints were not causally related, he was at maximum medical improvement and he was capable of full duty work. The diagnosis "could best be described as chronic thoracolumbar back pain complaints." (Rx1).

With regard to pre-accident records, the records of St. Elizabeth Hospital note a 6/5/96 visit where he complained of intermittent low back pain, often over the bilateral quadratus lumborum muscles. He reported

this began 3 months prior after sleeping on a futon. Petitioner's mother reported a prior finding of 5% to 10% scoliosis. Neurological exam was normal, but straight leg raise was decreased bilaterally secondary to decreased hamstring length. The diagnosis was lumbar strain and scoliosis, with an indication that x-ray showed "normal lumbar and sacral compensations for right lumbar scoliosis." He was discharged shortly thereafter when he stopped going to therapy and reported no pain. On 9/8/98, Petitioner returned complaining of the right knee after falling off a 4 wheeler. (Px2).

Px1 contains an indication of a 10/3/01 head trauma with nausea, vomiting and headache. A 10/30/01 lumbar x-ray and a 10/31/01 head CT-sean were both read as essentially normal. (Px1).

An 8/8/03 lumbar MRI was obtained from Petitioner at the request of Dr. Schwarze. Unfortunately, no other records were included with this, so it is unclear why it was performed or what Petitioner's symptoms were. The impression was moderate right sided focal L4/5 disc protrusion, where L4 neural impingement could not be ruled out, and a moderate left L5/S1 disc protrusion without stenosis. On 10/23/03, Petitioner reported to his primary doctor, Dr. Wolff (Belleville Family Medical), that he had fallen down 15 stairs and had left rib pain with brief loss of consciousness. Diagnosis included costochondritis and possible concussion. He returned on 12/15/03 with "chronic low back pain, status post MVA (motor vehicle accident)". It was noted that an MRI performed in the last few months reportedly showed disc bulging. The report states: "He has had 4 car accidents in the last couple of years, resulting in chronic back pain." The low back pain radiated into both legs. He was working with his father in landscaping/snow plowing. Neurologic exam was normal. (Px3; Rx3). On 2/17/04, Dr. Wolff noted the 8/8/03 MRI report was reviewed. Petitioner reported right greater than left low back pain with radiation into the bilateral legs, noting this did impair his ability to work at times. He denied numbness. The pain was chronic following several motor vehicle accidents. Diagnosis was mechanical low back pain with suggestion of bilateral sciatica at times. Physical therapy was prescribed. (Rx3).

On 6/6/05 he returned to St. Elizabeth Hospital ER with complaints of back pain and bulging disc, and the neck. A TENS unit was prescribed and provided. On 8/15/05, Petitioner returned to St. Elizabeth with complaints of mid-back pain after work. Thoracic x-rays were obtained that showed a questionable T1 over T2 listhesis, which was noted to possibly be film artifact. (Px2). On or about 11/16/05, the Petitioner complained of chest pains with the sensation of a block in his chest, but a CT scan of the entire trunk was normal, other than possible acid reflux. No spinal findings were indicated. (Px1).

Medical expenses were submitted into evidence within multiple presented exhibits. The Respondent submitted evidence of the medical expenses paid prior to hearing as Respondent's Exhibit 2.

The Petitioner testified that he was involved in 3 motor vehicle accidents between 2003 and 2007, but didn't recall getting any treatment related to them, and he had no pain leading up to this work accident ("not really, no"). His job generally involved painting, mudding, taping, drywall. A lot of the work is overhead, and some on scaffolding. He was not having any problems doing that work until after the accident. He was unable to continue to do that work, and left the painting business around 2008. He now works as a car salesman.

He testified that he used to golf, play basketball, fishing and dirt bikes. He tries to do these things now, but he can no longer swing a golf club like he used to. He gets back pain and tightness by the 3rd or 4th hole. He tries to play basketball as best he can, but ends up having tightness and pain. It's the same with riding dirt bikes.

The Petitioner testified that currently: "Right now I'm constantly leaning over like this trying to stretch my back out because my right side and my lower back is very tight and the pain and tightness goes down my right leg, behind my kneecap and down my leg. I don't paint anymore but any time I do anything over my head or if I'm

picking my daughter up over my head my neck starts to tingle and tightens and I get tightness down my arm and into my fingers a little bit and also in between my shoulder blades." He testified he also still has numbness in the right arm and right leg. He does do daily exercises, which helps somewhat. He still sees Dr. Vaid once a month, and gets his medications there. He is taking only pain medications now, noting that muscle relaxers made him sleepy. He testified that he only started taking the medication because that is all he could afford or that his insurance would cover.

On cross examination, the Petitioner testified that he did not recall undergoing a 2003 MRI, and denied having back pain after 2003. He then testified that his symptoms lasted into 2005, and that he was then okay for a couple of years. He denied having complaints of pain radiating into his legs before 2007. He did have a TENS unit, but couldn't recall when or how long he used it, noting that Dr. Heffner didn't ring a bell with him. He was not aware that a 2005 lumbar MRI showed disc problems, but didn't have a dispute if the medical records indicated this to be the cases. He doesn't remember the 2003/2005 MRI. He didn't recall complaining of neck pain in 2005. The chiropractic care from Dr. Schmidt didn't really help him, and sometimes made him worse.

CONCLUSIONS OF LAW

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

The Arbitrator finds that the Petitioner sustained injuries to his head, neck and back as a result of the 4/10/07 accident. However, the Arbitrator further finds that the evidence supports a finding that the causal relationship of this accident to any condition of ill-being ended as of 5/14/08.

The Arbitrator initially notes that the evidence clearly reflects that the Petitioner had a preexisting condition with similar symptoms prior to the accident. He admitted, as reflected by several of the pre-2007 records in evidence, that he had been involved in several motor vehicle accidents. He initially complained of low back pain, per the records, in 1996 after sleeping on a futon. He also fell down 15 stairs in 2003. However, despite the records clearly reflecting back, and to a lesser extent neck, complaints, the Petitioner inexplicably denied having prior neck and back problems, and didn't recall getting treatment following his motor vehicle accidents. The 2003 lumbar MRI showed preexisting disc problems at L4/5 and L5/S1, and other prior records indicated a history of spina bifida and a lumbarized spinal level at the sacrum. The records reflect diagnoses of chronic low back pain, and complaints of symptoms radiating into the legs, with Dr. Wolff diagnosing suggestion of bilateral sciatica in 2004. In 2005 he was prescribed a TENS unit after noting complaints of back and neck pain. A 2001 report noted a head trauma with headache, nausea and vomiting. At the initial ER visit on 4/10/07, the Petitioner reported that he had prior back problems, and that while it was more severe after the fall, he had a history of similar pain.

The Arbitrator notes that the records of several providers in this case are either missing entirely from the evidentiary record, or include very incomplete records. This includes Dr. Maret, Dr. Schmidt, Dr. Hipskind, Dr. Lattimore, Dr. Vaid and Dr. Boutwell, as well as records of alleged physical therapy and aquatherapy. The Petitioner testified he initially went to Dr. Maret on the date of accident, was told to go to the ER, and followed up with Dr. Maret. No record of this was submitted into evidence. Despite the Petitioner testifying to weeks of chiropractic treatment with Dr. Schmidt, no records regarding this treatment were in evidence. One work restriction note of Dr. Hipskind was submitted, but no progress note was included to support what the Petitioner complained of, what treatment he received and what the basis of the restrictions were. Petitioner testified that he

underwent injections with Dr. Boutwell: the only records of Boutwell in evidence reflected a single visit with a purpose of getting the Petitioner weaned from narcotic medication. The Petitioner testified that he has been receiving medications from Dr. Vaid on an ongoing basis for several years, yet, other than a few notes, the records of Dr. Vaid were not in evidence.

There are discrepancies in the evidence with regard to how far the Petitioner fell from the scaffolding. The initial ER records indicated 7' and 6' to 10', while later records reference a fall from up to 20'.

While he had multiple visits to ERs complaining of upper back/neck pain into the arm or arms, there were virtually no low back complaints after the date of accident. There was one note indicating back pain and a bulging lumbar disc on 7/22/10, but the key issue appeared to be that Petitioner was out of medication and needed more. The Arbitrator is in full agreement with Dr. Gornet that there appears to be strong evidence of a narcotic problem that was driving much of the Petitioner's behavior. Dr. Gornet also noted that the cervical findings in this case did not correlate with the Petitioner's symptoms.

Dr. Cantrell, Respondent's examining physician, appears to be the only doctor in this case who reviewed all of the Petitioner's available medical records. As noted above, it appears he even reviewed more records than were submitted into evidence, including a report of a Dr. Lattimore which noted the Petitioner in 2012 was taking 12 Percocet's per day. The Arbitrator finds that his opinion is most persuasive in this case in terms of the findings that the Petitioner had reached maximum medical improvement as a result of the accident, and was capable of full duty work. The evidence reflects that the Petitioner continued to work as a painter for the Respondent for at least a year or two after this accident. In fact, on 5/9/07, the Petitioner told Dr. Wolff that he was back to work and feeling pretty good with regard to his back, head and neck.

The greater weight of the evidence supports the Arbitrator's finding that the Petitioner reached maximum medical improvement regarding the injuries sustained as a result of the 4/10/07 accident as of 5/14/08. As such, any ongoing complaints after that date are determined by the Arbitrator as being not causally related.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the finding that the Petitioner reached maximum medical improvement as of 5/15/08, the Respondent shall pay the causally related reasonable and necessary medical expenses incurred by the Petitioner as a result of the April 10, 2007 accident which were incurred through 5/14/08. The Respondent is not liable for the expenses incurred from 5/15/08 to the present. The Respondent is entitled to credit for the awarded medical expenses that were paid prior to the 7/19/16 hearing.

WITH RESPECT TO ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

This accident predates the addition of Section 8.1b to the Act, and thus there is no requirement to specifically analyze the permanency in this case per the 5 noted factors.

Based on a review of the case, as noted above, the Arbitrator finds that the Petitioner reached a state of maximum medical improvement as of 5/14/08. As of that time, it appears that the Petitioner sustained strains of

his low back and neck, as well as a closed head injury. There simply is no evidence indicating he sustained anything more than that.

The Petitioner obtained minimal treatment subsequent to this accident, with very large gaps in treatment, particularly between 5/14/08 and 3/6/09. There are multiple providers, that the Petitioner either testified he saw or which were referenced in other medical records, for which the Arbitrator received no documentation of complaints, history or treatment.

Dr. Gornet diagnosed a lumbar problem and recommended a possible surgery, opining that this would be related to the accident. First, he indicated this opinion was based on the Petitioner's history being factually correct, which was not the case. Secondly, he indicated that surgery was not appropriate so long as Petitioner had a narcotic problem. Third, he referred Petitioner to Dr. Boutwell for treatment to wean from the medications, free of charge, but despite the Petitioner's testimony that he received injections from Boutwell, only one report of Dr. Boutwell was included in the evidentiary record, and it reflects nothing other than a plan to wean from the medications.

The Petitioner's testimony was disjointed, and at times plainly false. Whether this was purposeful or not is unclear, but either way it leaves the Arbitrator with way too many gaps in the facts of this case. Ultimately, it appears to the Arbitrator that the Petitioner temporarily aggravated his preexisting lumbar and cervical problems, and that he returned to his baseline condition by 5/14/08. There are notes indicating a possible thoracic outlet syndrome, but there is really nothing significant in evidence to either confirm this diagnosis or to indicate, if it existed, whether it would be causally related to the 4/10/07 accident. Thus, the Arbitrator finds that the Petitioner sustained a closed head injury with no evidence of ongoing sequelae, lumbar and cervical strains which subsequently resolved with the Petitioner returning to his pre-accident condition, and a possible thoracic outlet syndrome that could be related to the accident based on a chain of events analysis, but which remains questionable in its existence and relationship to the accident given the evidence.

The Arbitrator finds that the Petitioner sustained a 4% loss of use of the person as a whole, pursuant to Section 8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

REGINALD WILLIAMS,

Petitioner,

vs.

NO: 13 WC 02370

CITY OF CHICAGO,

18IWCC0240

Respondent.

DECISION AND OPINION ON REVIEW

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

Petitioner bears the burden of proving all the elements of the claim by a preponderance of the credible evidence in the record.

The Commission finds the Petitioner's testimony not to be credible. Petitioner was in a motor vehicle accident on January 7, 2013, as a restrained passenger, when the truck in which he was riding collided with a viaduct. Petitioner reported the accident to his supervisor and sought medical treatment the following day. Petitioner was diagnosed with a contusion of his mid-back, right upper back and lower back. (Px1) Petitioner had ongoing complaints of pain and continued treatment, which also included physical therapy and epidural steroid injections. Petitioner was kept off work. Diagnostic imaging performed within a couple of months of the accident showed that Petitioner was suffering from degenerative disc disease. Petitioner presented to multiple emergency departments and treating physicians in both the St. Louis, Missouri and Chicagoland areas. Petitioner appeared to exaggerate

the severity of his symptoms as they did not correlate to clinical findings, and Petitioner appeared to be seeking pain medication and trying to bolster his workers' compensation claim. In fact, on February 3, 2015, Petitioner presented to an emergency department for the second time in one day, and complaining of chronic pain. Petitioner clearly stated that he has back pain from a work injury and needs surgery, but work comp's denying it. He stated, "he needs a lot of Dr's visits to improve claim." (Rx7) In June of 2014, Petitioner's treater, Dr. Zabela, diagnosed Petitioner with axial low back pain and degenerative disc disease and opined that he could not make Petitioner's pain better with surgery. (Px4) By August of 2014, Dr. Zabela's partner, Dr. LaBore, noted that Petitioner was at maximum medical improvement (MMI) from the standpoint of non-operative care. Petitioner presented for an independent medical examination in December 2014, wherein Dr. Levin opined that Petitioner would have reached MMI at four to six weeks post-injury referable to the diagnosis of lumbar strain, and that Petitioner had currently reached MMI. The Commission finds Petitioner reached MMI at the time he saw Dr. Levin on December 16, 2014. Prospective medical treatment in the form of surgical intervention and post-operative care is denied.

The Commission further finds that even had Petitioner proven causal connection, any medical expenses incurred, or treatment recommended to be performed by Dr. Slack, Dr. Fisher, and/or Illinois Bone & Joint is denied. Petitioner exceeded the permissible choice of physicians. Petitioner initially sought treatment with Drs. Zabela and LaBore, his first choice of physicians. Petitioner next chose to treat with Dr. Taylor as his second choice. Drs. Slack and Fisher were Petitioner's third choice of physician. As Drs. Slack and Fisher exceed the two-physician rule, under §8(a), medical expenses related to their care and treatment are denied. Petitioner additional presented to a variety of Emergency Rooms in both St. Louis, Missouri, and the Chicagoland area approximately twenty times following his January 7, 2013, accident. These visits displayed pain seeking behavior and included complaints to body parts in addition to Petitioner's low back. Further there was no evidence these visits constituted *bona fide* medical emergencies. See *Wolfe v. Industrial Commission of Illinois*, 138 Ill App 3d 680, 689 (1985). The Commission finds the Emergency Room visits were neither reasonable nor necessary.

The Commission finds Petitioner failed to meet his burden of proof, and hereby reverses the Arbitrator's decision on the issue of causation. The Petitioner failed to prove that his current condition of ill-being is causally connected to the work accident of January 7, 2013, and finds that the Petitioner reached maximum medical improvement as of December 16, 2014 and therefore temporary total disability should be terminated as of that date. Further, Petitioner sought treatment from multiple providers, and the Commission finds that the treatment of Drs. Slack and Dr. Fisher as exceeding the number of permissible providers under the Act, and therefore those medical expenses are not awarded. Furthermore, prospective medical treatment is denied based on causation.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $901.59 per week for a period of 101 1/7 weeks, commencing January 8, 2013 through December 16, 2014, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $26541.00: 1) Washington University Physicians - $196.00, 2) Professional Imaging -

18IWCC0240

$22,623.00, 3) St. Louis Ortho - $1,655.00, and 4) Town & Country Ortho - $2,067.00, for medical expenses under §8(a) of the Act subject to the fee schedule in §8.2 of the Act.

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

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

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

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: APR 18 2018

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

CJD/dmm
O: 032118
049

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

WILLIAMS, REGINALD
Employee/Petitioner

Case# **13WC002370**

CITY OF CHICAGO
Employer/Respondent

18IWCC0240

On 8/8/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4564 ARGIONIS & ASSOCIATES LLC
AL KORITSARIS
180 N LASALLE ST SUITE 2105
CHICAGO, IL 60601

0010 CITY OF CHICAGO-CORP COUNSEL
NANCY J SHEPARD
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

18IWCC0240

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Reginald Wiliams
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # 13 WC 2370

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **George Andros**, Arbitrator of the Commission, in the city of **Chicago**, on **4/28/16 and 5/17/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **1/7/13**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$70,324.80**; the average weekly wage was **$1,352.40**.

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

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

Respondent shall be given a credit of **$97,120.57** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**.

ORDER

Temporary Total Disability
Respondent shall pay Petitioner temporary total disability benefits of $901.59/week for 172 2/7 weeks, commencing January 8, 2013 through April 28, 2016 as provided in Section 8(b) of the Act and shall continue weekly until Petitioner's work status changes or until the Respondent has a valid reason under The Act to terminate benefits in the future. Respondent shall receive a credit for any TTD already paid.

Medical benefits
Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of 1) Washington University Physicians - $196.00, 2) Professional Imaging - $22,623.00, 3) St. Louis Ortho - $1,655.00, 4)Town & Country Ortho - $2,067.00, 5) Illinois Bone & Joint - $878.00, as provided in Sections 8(a) and 8.2 of the Act.

The prospective medical treatment ordered by Dr. Taylor, Dr. Slack, and Dr. Fisher shall be the responsibility of the Respondent, including but not limited to surgical intervention and post-operative care. Respondent shall pay for all medical services associated with said treatment pursuant to the medical fee schedule as provided in Sections 8(a) of the Act.

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

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

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

#001 G. Andros
Signature of Arbitrator

8-7-16
Date

AUG 8 - 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

REGINALD WILLIAMS,	)	
	)	
Employee/Petitioner,	)	
	)	
v.	)	13 WC 2370
	)	Chicago
CITY OF CHICAGO ,	)	
	)	
Employer/Respondent.	)	

ARBITRATOR'S FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator makes the following Findings of Facts:

It is undisputed that on January 7, 2013, Petitioner Reginald Williams suffered a lower back injury that arose out of and in the course of his employment with the City of Chicago, Department of Transportation. Petitioner testified that on January 7, 2013, he was injured when he was involved in a trucking accident on the way to a job-site. Petitioner testified that he was seated as a front passenger in a City owned 18 wheeler when the driver misjudged the viaduct height and collided with it at a speed of approximately 40 miles per hour. Petitioner testified that that he was restrained at the time of the incident. Petitioner testified his entire body was jolted forward and backward during the collision and that he felt immediate pain in his lower back. She further testified that he reported the incident and injury to his supervisor. He testified that he was sent to MercyWorks clinic the next day by the City of Chicago to treat his injury.

On January 8, 2013, Mr. Williams treated with Homer Diadula, M.D., at MercyWorks on Ashland. (Petitioner's Exhibit 1, p. 1, hereinafter "Pet Ex." 1). He testified that he provided a history to the doctor and complained of lower back pain. He was taken off work related to his back injury and was given an x-ray of his spine. *Id.* He was also prescribed Norco for his pain

and was instructed to follow-up in one week. *Id.* On January 15, 2013, he followed-up with the clinic. (Pet. Ex. 2, p. 2). His symptoms remained the same, he was kept off work and was prescribed physical therapy. *Id.* He followed up with MercyWorks on January 29, 2013, complaining of lower back pain and was kept off work. *Id.* Petitioner testified that he began physical therapy and that the therapy did not improve his symptoms. He also testified that he began receiving disability benefits from the City of Chicago. On February 28, 2013, he returned to MercyWorks complaining of lower back pain with numbness and tingling in his left leg. *Id.* He was kept of work at the time and prescribed Ultram as well as an MRI of the lower back. *Id.* Petitioner underwent a lumbar spine MRI at Chicago Ridge Radiology per order by MercyWorks. Pet Ex. 1, p. 4. The MRI showed a herniated disc at L5-S1 with contact on the L5 ganglion, as well as L4-5 stenosis with contact on the L4 ganglia. *Id.*

On March 22, 2013, he returned to MercyWorks for a follow-up visit and continued to complain of lower back pain with numbness and tingling into his right leg. Pet. Ex. 1, p. 3. He was prescribed work hardening, kept off work and instructed to follow-up in one month. *Id.* Petitioner testified he began work hardening. On April 18, 2013, he returned to MercyWorks with a summary of the work hardening he had done, which showed his physical capabilities. *Id.* He informed the doctors that he went to the emergency room at Barnes Jewish due to increased pain in his low back. *Id.* He was kept off work and instructed to finish off nine more sessions of Work Hardening and then to return. *Id.* He returned on May 9, 2013, after finishing work hardening. *Id.* At this time, he complained of lower back pain with numbness and tingling. *Id.* On exam, he had a positive straight leg raise test on the right. *Id.* He was kept off work and was instructed to follow-up with a specialist. Petitioner testified that during the past 4 months while under the care of MercyWorks, he did go to the emergency room a number of times due to

unbearable low back pain.

On June 3, 2014, he began treating with Adam LaBore, M.D., out of Washington University Physicians, in St. Louis, Missouri. Pet. Ex. 4, p. 2. He testified he was referred to the doctor by a family member. He testified that he has a residence in St. Louis and Chicago and that he was traveling back and forth at the time. He testified that he was off work per doctors' orders so he did not need to be in Chicago for work. Further, he testified that when he was working full duty prior to the incident, he was living in Chicago full time. He complained of lower back pain with right leg numbness and tingling. *Id.* He was examined by the doctor and was kept off work. *Id.* Further, Dr. LaBore diagnosed discogenic injury vs. right hip joint pain and ordered a diagnostic right hip injection. Pet. Ex. 4, p. 2. Mr. Williams testified he had the injection with no relief. On August 13, 2014, he returned to see Dr. LaBore complaining of lower back pain with numbness and tingling down the right leg. Pet. Ex. 4, p. 4. On examination, Mr. Williams had a positive straight leg raise test on the right side. *Id.* He was kept off work and an MRI was ordered. *Id.* An MRI was performed which Dr. LaBore interpreted and showed a right L4/5 disc herniation which he recorded correlates with his right side symptoms. Pet. Ex. 4, p. 5. A right L4/5 steroid epidural injection was ordered at this time.

On October 14, 2013, Mr. Williams underwent a fluoroscopically guided right L4/5 transforaminal steroid epidural injection, performed by Dr. LaBore. Pet. Ex. 4, p. 6. The Petitioner testified that he went to the emergency room the next day due to increased pain following the procedure. The record shows that Mr. Williams contacted Dr. LaBore the next day to inform him that he went to the emergency room. Pet. Ex. 4, p. 7. On November 26, 2013, Mr. Williams returned to see Dr. LaBore for a visit following the injection. Mr. Williams complained that the injection provided mild temporary relief but that the symptoms returned

completely. Physical therapy was ordered along with another injection at L4-S1 foramen on the right. Pet. Ex. 4, p. 9. Petitioner testified that he began therapy again and that the symptoms persisted. On December 24, 2013, Mr. Williams underwent a fluoroscopically guided L5-S1 transforaminal injection performed by Dr. LaBore. Pet. Ex. 4, p. 12. On January 12, 2014, he returned following the injection, and he stated his pain improved temporarily and that the symptoms returned. Pet. Ex. 4, p. 14 Further, the record notes that Mr. Williams informed Dr. LaBore that he went to the emergency room at DePaul when his symptoms became unbearable. *Id.* At this time he was kept off work, he was instructed to continue therapy and a repeat MRI was ordered. *Id.*

Reginald Williams underwent the MRI at Professional Imaging on January 29, 2014 per order from Dr. LaBore. Pet. Ex. 5, p. 2. The MRI showed stenosis with herniation at L4-5 and disc herniation at L5-S1 which was essentially unchanged since prior MRI study. *Id.* On March 11, 2014, he returned for a follow-up with Dr. LaBore, complaining of low back pain with radicular symptoms into the right leg. Pet. Ex. 4, p. 18. He was kept off work and Dr. Labore stated that there were no more non-operative treatment recommendations. *Id.* After review of the MRI film, he recommended that Mr. Williams undergo a surgical consult. Pet. Ex. 4, p. 21.

On April 14, 2014, he had an initial consultation with orthopedic surgeon Lukas Zebala, M.D. at Washington University Hospital in St. Louis. Pet. Ex. 4, p. 25. Mr. Williams testified that he provided Dr. Zebala with a history regarding his treatment and injury. He complained of right sided back pain with radicular symptoms into the right leg. *Id.* He informed Dr. Zebala that he was in such severe pain the day before, that he went to the emergency room in Libertyville, Illinois. *Id.* He even brought Dr. Zebala the paperwork from the emergency room which showed his lower back complaints. *Id.* Dr. Zebala reviewed the MRI films that were

brought to the visit. Pet. Ex. 4, p. 26. Dr. Zebala then recommended an L4-5 fusion with pedicle screw implementation. Pet. Ex. 4, p. 27. Mr. Williams testified that he was aware of the recommendation for surgery following the visit. The injury was causally connected to the injury sustained by Mr. Williams. *Id.* He returns to see Dr. Zebala again on June 2, 2014 for a follow-up visit. Pet. Ex. 4, p. 30. After being evaluated again, Dr. Zebala states that non-operative treatment has not offered any significant improvement in his pain. *Id.* He opines that he unsure if surgery would help solve the problem and recommends that Mr. Williams seek a second opinion as to whether surgery should be undertaken. *Id.* Mr. Williams testified that he followed Dr. Zebala's recommendation and sought a second opinion regarding necessity of surgery.

On September 23, 2014, Mr. Williams presented to Brett Taylor, M.D., orthopedic surgeon, for a second opinion regarding surgery. Pet. Ex. 6, p. 1. Mr. Williams provided a detailed history of the event causing him injury to his lower back as well as all of the treatment that he underwent conservatively. *Id.* He complained of lower back pain that has been constant since his injury. *Id.* Dr. Taylor reviewed all of his diagnostic films at the visit an confirmed the diagnostic pathology of damage to the L4-5 and L5-S1 discs. Pet. Ex. 6, p. 2. Dr. Taylor causally relates the lower back injury to the work related even from January 7, 2013 and states he would like to review Dr. LaBore's prior records prior to giving a surgical opinion. *Id.* On October 21, 2014, Mr. Williams returned to see Dr. Taylor for a follow-up visit. Pet. Ex. 6, p. 8. He complains of lower back pain with intermittent numbness and tingling down the right lower extremity. *Id.* Lower back evaluation showed a reduced range of motion of the lower back with lateral bending. *Id.* Dr. Taylor also reviewed all of the prior medical record visits with Dr. LaBore which he summarizes in his note. Pet. Ex. 6, p. 9-10. At this point Dr. Taylor states that he would be a candidate for anterior posterior fusion but that Mr. Williams would first have to

undergo additional testing. Pet. Ex. 6, p. 11. The testing included a repeat MRI, psychological testing and a discogram. On November 11, 2014, Mr. Williams returned, following the repeat MRI and having undergone the psychological testing. Pet. Ex. 6, p. 12. Review of the updated MRI, showed L4/5 pathology of herniation. Pet. Ex. 6, p. 13. Further, the record notes that they offered Mr. Williams surgery in the month of December of 2014, but that he wanted him to do a discogram first. *Id.*

On December 3, 2014, Mr. Williams saw Jay Levin, M.D., at the request of the respondent for a Section 12 examination. Mr. Williams testified that he provided Dr. Levin with a history of the occurrence and his injury and that he brought his diagnostic films for his review. Dr. Levin answers a number of questions posed to him by the respondent regarding his lower back injury. Res. Ex. 1. Dr. Levin does not document any physical examination that he performed on Mr. Williams in his report. *Id.* Dr. Levin does summarize all of the treatment records that he reviewed in his report. *Id.* Dr. Levin concedes that Mr. Williams did suffer an injury to his lumbar spine in the January 7, 2013 incident. *Id.* His review of the MRI fil taken August 23, 2013 states there is a L4-5 herniated disc with annular bulging towards the right. *Id.* He also states that Mr. Williams does not need surgery of the lumbar spine related to an occurrence of January 7, 2013. *Id.*

Mr. Williams testified that he stopped receiving medical benefits after his Section 12 evaluation by Dr. Levin. Further, he testified that this time he came back and spent most of his time in Chicago. Mr. Williams testified that he did not return to work at this time since his treating doctors had him on an off work restriction. Further, he testified that he started seeing another doctor's group in Illinois named Illinois Bone and Joint. He testified he was referred to Dr. Charles Slack by a previous doctor that he had seen for a prior knee injury. He testified that

he was required to turn in updated off work slips every three months in order to keep his job with the City of Chicago. He testified that since he was back in Illinois for the most part it was much more convenient to be following-up with doctors in Illinois.

On April 5, 2015, he treated with orthopedic surgeon Charles Slack, M.D., at Illinois Bone and Joint. Pet. Ex. 8, p. 2. He testified that he provided a history of his injury and treatment to Dr. Slack on that day. He brought in several MRI and CT scans for Dr. Slack's review. *Id.* Dr. Slack reviewed the MRI films and confirmed the disc pathology seen at L4-5 and L5-S1. Pet. Ex. 8, p. 3. Dr. Slack diagnosed Mr. Williams with an L4-5 disc herniation with nerve compression and lumbar radiculopathy. Pet. Ex. 8, p. 4. Dr. Slack opined that Mr. Williams is a candidate for surgical intervention of L4-5 fusion with decompression. *Id.* Dr. Slack referred Mr. Williams to his partner Dr. Fisher who performs these types of procedures. *Id.* Mr. Williams also testified that he was kept off work at this time. The records also show that Mr. Williams was kept off work at this time. *Id.* On August 3, 2015, Mr. Williams followed-up with Dr. Theodore Fisher. Pet. Ex. 8, p. 6. He provided a history of the work related injury as well as the treatment history. *Id.* He complained of low back pain with numbness into the right leg. *Id.* Dr. Fisher reviewed the MRI studies during the visit and rendered the same diagnosis as his partner Dr. Slack. Pet. Ex. 8, p. 7. Dr. Fisher agreed that Mr. Williams requires surgery of L4-5 discectomy with posterior lumbar interbody fusion (PLIF). *Id.* Mr. Williams testified that he was kept off work at this time.

Mr. Williams testified that since August 3, 2015 he continued to see Dr. Fisher every three months and that he has kept him off work until the present time. Mr. Williams testified that her lower back pain continues to exist with numbness down his right leg. Mr. Williams testified that he never injured his lower back prior to the work related incident of January 7,

2013. There are no records submitted by Resondent that discuss any injuries or pain in the lower back prior to January 7, 2013. Mr. Williams testified that prior to January 7, 2013, he did not have any issues performing his job. Further, he testified that he was working full duty up until January 7, 2013, when he sustained the subject injury.

The Arbitrator makes the following Conclusions of Law:

In support of the Arbitrator's decision relating to (F), whether the petitioner's present condition of ill-being is causally related to the injury, the Arbitrator finds the following facts:

The Arbitrator finds Petitioner's current condition of ill-being is causally related to his work injury of January 7, 2013. Accordingly, based on the credible testimony of the petitioner as well as the medical records and opinions of Dr. Diadula, Dr. Labore, Dr. Zebala, Dr. Taylor, Dr. Slack, and Dr. Fisher, which includes the MRI results of the lumbar spine, the Arbitrator finds that the petitioner has affirmatively demonstrated a causal relationship between his work related injury on January 7, 2013 and is current condition of ill-being. All of the above referenced physicians attribute the lower back injury to be related to the January 7, 2013 work related incident. Prior to his injury, Petitioner did not have any issues with his lower back. The injury caused an immediate disability to Petitioner's lower back. The Petitioner complained lower back pain during each and every visit and immediately following the incident. No evidence was presented that Petitioner suffered any injury other than the work related injury he suffered on January 7, 2013. Therefore, there is no evidence that would lead the Arbitrator to determine that the Petitioner's current condition to his lower back was caused by anything but the January 7, 2013, work related injury.

On December 3, 2014, Mr. Williams was sent for a Section 12 Examination with Dr. Jay Levin regarding his lower back injury. Mr. Williams testified that the insurance company for the

respondent sent him a notice of the visit and asked that he attend. Mr. Williams testified that Dr. Levin examined him during the visit. However, Dr. Levin's report does not document a physical examination that he performed. Instead, he discusses review of the prior treating doctor's records extensively and then answers a list of questions provided to him by the Respondent. Mr. Williams testrified that he brought in the MRI films of his lower back for his review. Dr. Levin's evaluation of the MRI is the same as the other physicians and he agrees that the pathology on film revealed two disc herniations one of which is to the right side. This is consistent with the right sided radicular complaints. However, Dr. Levin fails to note this consistency. Instead, Dr. Levin states that it is a degenerative condition unrelated to the incident. Dr. Levin agreed that Mr. Williams sustained a work related injury but disagreed that he requires surgery as a result of the incident. Interestingly, Dr. Levin states that Mr. Williams does not need surgery related to the January 7, 2013 incident. However, Dr. Levin does not state unequivocally in his report that Mr. Williams does not need surgery on his lower back. That statement is somewhat cryptic and it is unclear whether Dr. Levin believes Mr. Williams does not surgery but that the need for surgery is unrelated to the incident.

It is well settled that employers take their employees as they find them. Therefore, even though an employee may have a pre-existing condition which may make him more susceptible to an injury, compensation for the injury will not be denied as long as it can be shown that the employment was also a causative factor. *Caterpillar Tractor Co., v. Industrial Comm'n*, 92 Ill. 2d 30, 36, 440 N.E.2d 861 (1982). Furthermore, an accidental injury need not be the sole causative factor, or even the primary causative factor as long as it was a causative factor in the resulting condition of ill-being. *Rock Road Construction Co., v. Industrial Comm'n*, 37 Ill. 2d 123, 127, 227 N.E.2d 65 (1967). Although this is well settled law in the state of Illinois, the

petitioner's work related injury was the primary causative factor in the resulting condition of ill-being. If a pre-existing condition was asymptomatic prior to the injury and then became symptomatic as a result of the injury, aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. *Id* at 67-68.

Upon close examination of the medical records, this Arbitrator finds no inconsistent history, nor any evidence of any intervening cause for the petitioner's current condition. The respondent's doctor did not dispute that the petitioner sustained a work related injury. Additionally, Dr. Levin's opinion lacks credibility due to the many factors described above. Dr. Levin disagrees with four well qualified physicians as it relates to the injuries sustained. He states that Mr. Williams sustained a myofascial lumbar sprain yet his review of the MRI films opines that there are 2 disc herniations at L4-5 and L5-S1. He does not mention that at all in his report under the section asking for an opinion on what injuries were sustained in this incident. Therefore, this suggests that the herniations were pre-existing in his opinion. However, there is no evidence of any pre-existing injury to the lower back or any symptoms of low back pain. Under the law, even if this assessment were in fact true, the condition would still be related and compensable as an asymptomatic degenerative condition that became symptomatic as a result of the incident. Clearly, after reviewing the records of Dr. LaBore, Dr. Zebala, Dr. Taylor, Dr. Slack, and Dr. Fisher as well as the diagnostic film reports, Mr. Williams' work related injury caused injuries his lower back and he continues to need treatment. Therefore, the Arbitrator concludes that the petitioner's current condition of ill-being is causally related to the petitioner's accident of January 7, 2013.

In support of the Arbitrator's decision relating to (J), were the medical services that were provided to petitioner reasonable and necessary, the Arbitrator finds the following facts:

On June 3, 2014 the Petitioner began treating at Dr. Adam LaBore's office and treated there for roughly one year through August 8, 2014. The Arbitrator finds that the treatment rendered by the medical staff and doctor was reasonable and necessary to treat Mr. Williams for the work-related injury he sustained on January 7, 2013. The Arbitrator also finds that since the Petitioner's condition of ill-being was causally related to his injury on January 7, 2013, the respondent is responsible for the aforementioned medical charges and that such charges were generated as a result of treatment that was reasonable and necessary as well as usual and customary. The Arbitrator finds that the related bills on Petitioner's Exhibit 9, totaling $196.00 are to be paid by Respondent according to the medical fee schedule.

On June 24, 2013, January 29, 2014 and October 17, 2014 the Petitioner went in for diagnostic testing at Professional Imaging in St. Louis Missouri. At the time of the hearing on April 28, 2016, the petitioner presented medical bills from Professional Imaging. (Pet. Ex. 6). The Arbitrator finds that the treatment rendered by Professional Imaging was reasonable and necessary to treat Mr. Williams for the work-related injury he sustained on January 7, 2013. The Arbitrator also finds that since the Petitioner's condition of ill-being was causally related to his injury on January 7, 2013 the respondent is responsible for the aforementioned medical charges and that such charges were generated as a result of treatment that was reasonable and necessary as well as usual and customary. The Arbitrator finds that the related bills on Petitioner's Exhibit 10, totaling $22,623.00 are to be paid by Respondent according to the medical fee schedule.

On October 16, 2014 the Petitioner went for an EMG test at St. Louis Orthopedics. At the time of the hearing on April 28, 2016, the petitioner presented medical bills from St. Louis

Orthopedics. (Pet. Ex. 11). The Arbitrator finds that the treatment rendered by the doctor was reasonable and necessary to treat Mr. Williams for the work-related injury he sustained on January 7, 2013. The Arbitrator also finds that since the Petitioner's condition of ill-being was causally related to his injury on January 7, 2013, the respondent is responsible for the aforementioned medical charges and that such charges were generated as a result of treatment that was reasonable and necessary as well as usual and customary. The Arbitrator finds that the related bill on Petitioner's Exhibit 11, totaling $1,655.00 is to be paid by Respondent according to the medical fee schedule.

On September 23, 2014 the Petitioner began treating at Town and Country Orthopedics. At the time of the hearing on April 28, 2014, the petitioner presented medical bills from Town and Country Orthopedics (Pet. Ex. 12). The Arbitrator finds that the treatment rendered by the medical staff and doctors was reasonable and necessary to treat Mr. Williams for the work-related injury he sustained on January 7, 2013. The Arbitrator also finds that since the Petitioner's condition of ill-being was causally related to his injury on January 7, 2013, the respondent is responsible for the aforementioned medical charges and that such charges were generated as a result of treatment that was reasonable and necessary as well as usual and customary. The Arbitrator finds that the related bills on Petitioner's Exhibit 12, totaling $2,067.00 are to be paid by Respondent according to the medical fee schedule.

On April 5, 2015 the Petitioner began treating at Illinois Bone and Joint Institute. At the time of the hearing on April 28, 2014, the petitioner presented medical bills from Illinois Bone and Joint Institute (Pet. Ex. 13). The Arbitrator finds that the treatment rendered by the medical staff and doctors was reasonable and necessary to treat Mr. Williams for the work-related injury he sustained on January 7, 2013. The Arbitrator also finds that since the Petitioner's condition of

ill-being was causally related to is injury on January 7, 2013, the respondent is responsible for the aforementioned medical charges and that such charges were generated as a result of treatment that was reasonable and necessary as well as usual and customary. The Arbitrator finds that the related bills on Petitioner's Exhibit 13, totaling $878.00 are to be paid by Respondent according to the medical fee schedule.

In support of the Arbitrator's decision relating to (K), is the Petitioner entitled to any prospective medical treatment, the Arbitrator finds the following facts:

The Arbitrator finds that the Petitioner requires additional medical treatment and is entitled to prospective medical treatment. The Arbitrator finds that the respondent is responsible for the additional treatment consistent with petitioner's treating physician's instructions. The MRI's taken of the Petitioner's lumbar spine clearly shows herniated discs at L4-5 and L5-S1 with nerve root impingement and stenosis. Pet. Ex. 1, p. 4, Pet. Ex 10. Further, the records from Dr. LaBore, Dr. Zebala, Dr. Taylor, Dr. Slack, and Dr. Fisher as well as the Petitioner's credible testimony show that the injuries were causally related and that additional treatment is needed. Pet Ex. 1-8. The medical records submitted from the aforementioned doctors' show that Mr. Williams has undergone extensive conservative treatment to no avail. The Arbitrator finds that the respondent must authorize the remaining treatment, including the lower back L4-5 posterior lumbar interbody fusion surgery as well as post-operative care. The Arbitrator finds that payment for the aforementioned treatment is also the responsibility of the respondent. Once the current recommended treatment regimen decided by the Petitioner's treating physician is rendered and complete, the petitioner's condition will be re-evaluated in order to ascertain whether additional treatment is necessary.

In support of the Arbitrator's decision relating to (L), is the Petitioner entitled to any TTD benefits, the Arbitrator finds the following facts:

Having found an accident that arose out of an in the course of Petitioner's employment, and that Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator awards temporary total disability benefits to Mr. Williams. The medical records show that Mr. Williams has been kept off of work since his injury on January 7, 2013. Pet. Ex. 1-8. Mr. Williams testified that he has been kept on an off work restriction by Dr. Fisher to the present date. The Arbitrator finds that Mr. Williams is owed temporary total disability benefits from January 8, 2014 through April 28, 2016, for a total of 172 and 2/7 weeks. Further the Arbitrator awards that TTD should continue until Mr. Williams is released to return to work by her treating physicians or until work status becomes validly disputed in the future. The Respondent is awarded a credit for TTD paid in the amount of $97,120.57 for TTD paid from January 8, 2013 through January 13, 2015.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Richard Furco Jr.,

Petitioner,

vs. NO: 10 WC 28708

City of Chicago/Transportation,

18IWCC0241

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice provided to all parties, the Commission, after considering the sole issue of nature and extent of permanent disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission notes there were no TTD or maintenance benefits awarded. On the Request for Hearing form, the parties stipulated Petitioner was temporarily totally disabled from July 8, 2010 through September 12, 2010 and from October 1, 2010 through April 15, 2016, a total period of 298-5/7 weeks. The parties also stipulated Petitioner was entitled to maintenance benefits from April 16, 2016 through May 17, 2016, a period of 4-4/7 weeks. The parties further stipulated Respondent paid $282,691.02 in TTD benefits and $4,289.37 in maintenance benefits. AX1. Petitioner testified he was paid benefits for the entire time period he was off work. T. 22. The Arbitrator gave Respondent credit of $286,980.39, the total of what was paid. For credit purposes, the Commission notes the above TTD and maintenance periods. The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 18, 2017 decision is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay for medical expenses in the amount of $6,115.00 pursuant to §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $669.64 per week for a period of 41 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the permanent loss of use of the left hand to the extent of 20%.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $669.64 per week for a period of 126.5 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the permanent loss of use of the left arm to the extent of 50%.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury. The Commission notes Respondent paid $282,691.02 in TTD benefits and $4,289.37 in maintenance benefits.

There is no bond for the removal of this cause to the Circuit Court by Respondent pursuant to §19(f)(2) of the Act. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 18 2018
LEC/maw
o03/21/18
43

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

Joshua D. Luskin

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FURCO JR, RICHARD
Employee/Petitioner

Case# **10WC028708**

CITY OF CHICAGO/TRANSPORTATION
Employer/Respondent

18IWCC0241

On 7/18/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0154 KROL BONGIORNO & GIVEN LTD
CRAIG E BUCY
120 N LASALLE ST SUITE 1150
CHICAGO, IL 60602

0010 CITY OF CHICAGO
BARBARA BURKE
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

RICHARD FURCO JR.
Employee/Petitioner

v.

CITY OF CHICAGO/TRANSPORTATION
Employer/Respondent

Case # 10 WC 28708

Consolidated cases: n/a

18IWCC0241

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **MARIA S. BOCANEGRA**, Arbitrator of the Commission, in the city of **CHICAGO, ILLINOIS**, on **4/19/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ 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 _____

18IWCC0241

FINDINGS

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

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

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

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

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

In the year preceding the injury, Petitioner earned **$73,183.76**; the average weekly wage was **$1,407.38**.

On the date of accident, Petitioner was **30** 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 **$282,691.02** for TTD, **$0** for TPD, **$4,289.37** for maintenance, and **$0** for other benefits, for a total credit of **$286,980.39**. Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of **$6,115.00**, to Rush Pain Center as provided in Section 8(a) and Section 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$669.64/week** for **41 weeks** because the injury caused a **20%** loss of use of the Petitioner's **left hand**, as provided under **Section 8(e)** of the Act.

Respondent shall pay Petitioner Permanent Partial Disability benefits of **$669.64/week** for **126-1/2** weeks because the injury caused a **50%** loss of use of the Petitioner's **left arm**, as provided under **Section 8(e)** of the Act.

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

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

Signature of Arbitrator

7-17-2017
Date

JUL 18 2017

18IWCC0241

BACKGROUND

Richard Furco ("Petitioner") alleged injuries to his elbow and wrist on 7/7/10 arising out of and in the course of his employment with the City of Chicago/Transportation ("Respondent"). Ax1-2. Following a previous 19(b) hearing, former Arbitrator Brandon Zanotti found that Petitioner's left wrist was causally related to the 7/7/10 work accident and awarded benefits, including temporary total disability and prospective medical treatment. Px1. Those findings of fact and conclusions of law are fully incorporated by reference herein. On 4/19/17, the parties proceeded to arbitration on the issues of liability for unpaid medical bills and nature and extent of the injury. The following is a recitation of the facts further adduced at trial.

FINDINGS OF FACT

At the time of his accident, Petitioner was a 30 year old asphalt laborer who had worked for the City of Chicago Department of Transportation ("Respondent") since 2000. His job duties included shoveling asphalt from a truck to fill pot holes, swinging a pick and repairing streets in the City of Chicago.

It is undisputed that on 7/7/10, Petitioner was injured shoveling asphalt. He felt an immediate pain in his left forearm and elbow. He timely reported his injuries and was sent by Respondent to Mercy Works. Px1. He was eventually diagnosed with epicondylitis and given a wrist splint. Eventually, Petitioner began treating with Dr. Heller, who administered injections that failed to provide relief. Px1. On 1/18/11, Petitioner saw Dr. John Fernandez of Midwest Orthopedics at Rush for left elbow pain. Px2. Dr. Fernandez diagnosed Petitioner with lateral and medial epicondylitis and related Petitioner's condition to the work accident. Surgery was recommended and on 2/11/1, Dr. Fernandez performed a left elbow lateral partial epicondylectomy with debridement of the common extensor tendon on February 11, 2011. Px1. Petitioner underwent usual post-operative care but began to have pain and discomfort in the left wrist. He was placed back on a wrist splint. Dr. Fernandez eventually diagnosed left wrist scapholunate ligament pain. The doctor opined that Petitioner's swelling and pain complaints were related to his post-op physical therapy and wearing of an arm splint. Petitioner continued to treat for the left wrist and left elbow with Dr. Fernandez.

Dr. Fernandez then prescribed a repeat MRI of the left elbow on 12/15/11, which showed thickening of the radial collateral ligament. Dr. Fernandez diagnosed Petitioner with left elbow lateral epicondylitis and left wrist scapholunate pain. He prescribed surgical intervention. On 2/16/12, Petitioner underwent a Section 12 examination with Dr. Richard Thomas of OAD Orthopedics on 2/16/12. Px1, RxB. Dr. Thomas opined that Petitioner's elbow complaints could be related to his work as an asphalt laborer but did not relate the left wrist condition to Petitioner's work accident of July 7, 2010. On 3/1/12, Dr. Fernandez issued a medical note noting his disagreement with Dr. Thomas' conclusions that the left wrist was not related. Px1-2.

On 7/17/12, the parties proceeded to arbitration before former Arbitrator Brandon Zanotti. Arbitrator Zanotti found Petitioner's left elbow and left wrist conditions to be causally related the work accident and awarded the left elbow and left wrist surgery prescribed by Dr. Fernandez. Px1.

On 1/7/13, Dr. Fernandez performed a left wrist arthroscopy with partial synovectomy and partial debridement of the scapholunate ligament along with a left elbow revision lateral epicondylectomy and left elbow step-cut tenotomy with repair of the common extensor tendon. Px2, 5. Dr. Fernandez found degeneration of the scapholunate ligament with a partial tear involving the dorsal distal portion without

instability and degeneration of the common extensor tendon and the deep capsule. Post operatively, Dr. Fernandez recommended physical therapy and restricted Petitioner from using the left arm. Px2.

On 3/26/13, Petitioner returned to Dr. Fernandez with worsening complaints of left elbow pain and hypersensitivity. Px2. On examination, Dr. Fernandez noted paresthesia along the entire left hand and thickening over the lateral epicondyle. He diagnosed Petitioner with neuritis versus cubital tunnel syndrome and prescribed an EMG to confirm the diagnosis. EMG testing confirmed a left ulnar neuropathy. Dr. Fernandez reviewed the EMG and concluded that it showed significant nerve impingement which would require surgical intervention. Dr. Fernandez found Petitioner's cubital tunnel syndrome related to the post-operative treatment from the lateral epicondyle surgery.

Petitioner continued treating with Dr. Fernandez while waiting for approval of surgery. On 2/17/14, Dr. Fernandez performed a left elbow ulnar nerve release with subcutaneous transposition, partial medial epicondylectomy with debridement of the central tendon and a left elbow central tendon step-cut lengthening for medial epicondylitis. Px2, 5. Dr. Fernandez noted significant instability of the ulnar nerve with swelling and thickening almost double in size.

Petitioner returned to Dr. Fernandez on 3/6/14, for his first post-op visit. Px2. Dr. Fernandez noted that although the paresthesia had improved, Petitioner still exhibited stiffness and swelling in the elbow. He recommended a formal range of motion protocol.

Petitioner underwent therapy and returned to Dr. Fernandez on 5/15/14. Px2. Petitioner stated that his numbness and tingling had greatly improved but he continued to have pain in the left elbow. Dr. Fernandez diagnosed him with left elbow residual lateral epicondylitis and referred Petitioner to Dr. Jeffrey Mjannes for a platelet rich plasma ("PRP") injection.

On 6/10/14, Dr. Mjannes performed the first PRP injection. Px2. Repeat injections were done on 7/15, 9/25 and 10/9/14. Petitioner testified he obtained no lasting relief. On 10/23/14, Petitioner saw Dr. Mjaanes, who diagnosed lateral epicondylitis and chronic medial epicondylitis with ulnar neuritis. The plan was for occupational therapy. Petitioner saw Dr. Mjannes in January 2015, who recommended Petitioner return to Dr. Fernandez for further consultation as he was continuing with pain the lateral epicondyle and numbness in the ring and small finger again.

On 3/12/15, Petitioner saw Dr. Fernandez complaining of left elbow pain radiating down the forearm. Dr. Fernandez noted Petitioner had exhausted all conservative options and prescribed a revision surgery with denervation. Px2.

On 4/11/15, Petitioner underwent a Section 12 evaluation with Dr. Charles Carroll. RxA. Dr. Carroll opined Petitioner's conditions were causally related and that Petitioner's care to date had been appropriate for medial epicondylitis, lateral epicondylitis and ulnar neuritis. Dr. Carroll recommended neurotomy to address lateral elbow pain and light duty work.

On 8/17/15, Petitioner underwent a left elbow revision lateral epicondylectomy with debridement of the common extensor tendon origin, a common extensor tendon step-cut lengthening, and a posterior cutaneous antebrachial nerve resection with proximal neuroma burial. Px2, 5. Petitioner underwent usual post-operative care, including therapy at Athletico on 9/8/15. Px3. He was discharged from therapy on 12/8/15. Px3.

On 12/15/15, Petitioner returned to Dr. Fernandez, complaining of anterior elbow pain along the biceps tendon. An MRI was ordered, which was essentially unremarkable. Dr. Fernandez then prescribed physical therapy and work conditioning before evaluating Petitioner with a functional capacity exam ("FCE"). Px2. On 3/3/16, Dr. Fernandez released Petitioner to light duty with or without the FCE. He further placed Petitioner at maximum medical improvement and instructed him to follow up as needed. Px2. On 4/11/16, Petitioner underwent an FCE, which placed him into the heavy demand level. Px3.

On 5/18/16, Petitioner returned to work in a full duty capacity. He continued to have complaints of pain and was seen by Dr. Asokumar Buvanendran of Rush University Pain Center on 8/2/16. Px4. Petitioner complained of weakness, radiating pain and tingling down the forearm and elbow pain. On examination, Dr. Buvanendran noted weakness of the left upper extremity and diagnosed Petitioner with left elbow pain. He prescribed Tramadol, Gabapentin and instructed Petitioner to follow up in 1 month. Petitioner returned to Dr. Buvanendran on 9/9/16, with continued pain complaints. Petitioner was prescribed Mobic, Lunesta and a series of 3 stellate ganglion blocks. Those blocks were administered on 9/16/16, 9/26/16 and 10/7/16. Px4.

Petitioner last saw Dr. Buvanendran on 11/14/16. He continued to complain of elbow pain and exhibited weakness of the left upper extremity. Medications were refilled and Petitioner was to follow up as needed. Px4.

Prior to the undisputed accident, Petitioner testified he was not having any issues with his left elbow or wrist and he full duty with restrictions. Petitioner confirmed that he returned to work in the same position without restrictions on 5/18/16. He further confirmed he received temporary total disability and maintenance benefits for the entire period he was off work. Petitioner is right hand dominant. Petitioner testified he has a follow up appointment with Dr. Buvanendran in May 2017 for the left elbow. Petitioner stated that there is no expectation of future surgical intervention for his left elbow, merely continued pain management.

Petitioner noted that as a result of his injury, he notices difficulty in the performance of his job. Petitioner's left elbow pain worsens the more he uses it and he noticed that his pain increases around 10 or 11 am every work day. Petitioner uses his left arm as little as possible and ices his arm every night when he gets home from work. Petitioner takes Gabapentin every day, Mobic twice a week and Ibuprofen four times a week to combat pain. Petitioner said his injury constantly causes pain. He rates his pain 5 out of 10 on average, a 3 out of 10 when he wakes up and a 7 out of 10 on his worst day. Petitioner's pain never fully goes away and only improves with rest. Petitioner used to go golfing and to the batting cages with friends and family on a weekly basis before the injury. Since the injury, Petitioner has been unable to participate in these hobbies due to pain and limitations from treatment. He noted that yardwork is much more difficult now, as is carrying groceries, taking the garbage out and other household chores like mopping, dusting and doing the dishes. Petitioner stated he has to limit use of his left arm as much as possible. Petitioner can only play catch with his 2 small children for 5 to 10 minutes before he has to stop. Petitioner was also given a sleeping a by his doctor, as the residual pain makes it difficult to sleep.

Petitioner does not have a valid driver's license and no military experience. He classifies himself as good with computers but has no formal training or certifications. Petitioner has worked for the City of Chicago for 17 years, and worked for Prudential as a clerk prior to his employment with the City. Petitioner has a GED and is a member of Union Local 1001.

18IWCC0241

CONCLUSIONS OF LAW

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 care?***

The Arbitrator adopts the above findings of fact as though fully set forth herein. In addition, the Arbitrator incorporates by reference and adopts the prior findings of fact and conclusions of law set forth by Arbitrator Zanotti as though fully set forth herein. Px1. At the time of the hearing, Petitioner presented an outstanding bill in the amount of $6,115.00 to Rush Pain Center for dates of service 9/9/16, 9/16/16, 9/26/16, 10/7/16 AND 11/14/16. PX6. On the record, the parties agreed that this outstanding bill to Rush Pain Center had been submitted to Coventry with the expectation they would be paid pursuant to the fee schedule. The dates of service represent Petitioner's appointments and stellate ganglion blocks with Dr. Buvanendran. Px4, 6. Respondent does not dispute that Petitioner's left elbow condition is related to the work accident or to subsequent treatment. Therefore, the Arbitrator finds that all treatment regarding the left elbow and wrist has been reasonable and necessary. The Arbitrator awards Petitioner the outstanding medical bill to Rush Pain Center of **$6,115.00**, to be paid by Respondent pursuant to the fee schedule. Respondent shall be entitled to a credit for any amounts paid against this specific award.

ISSUE (L) ***What is the nature and extent of the injury?***

The Arbitrator adopts the above findings of fact and conclusions of law as though fully set forth herein. In addition, the Arbitrator incorporates by reference and adopts the prior findings of fact and conclusions of law set forth by Arbitrator Zanotti as though fully set forth herein. Px1. Petitioner last saw Dr. Buvanendran in November 2016. The doctor released Petitioner from care and advised him to follow up as needed. The Arbitrator finds that Petitioner reached maximum medical improvement for the left wrist and/or elbow in November 2016 and therefore any claim for permanency is ripe for adjudication. Respondent offered the Section 12 report of Dr. Charles Carroll who opined that all Petitioner's treatment had been reasonable and necessary, as was the last surgery prescribed by Dr. Fernandez. RxA.

Petitioner underwent multiple procedures from 2010 to 2017, all related to the work accident: 1) a left elbow lateral partial epicondylectomy with debridement of the common extensor tendon origin; 2) a left wrist arthroscopy with partial synovectomy and partial debridement of the left scapholunate ligament; 3) a left elbow revision lateral epicondylectomy; 4) a left elbow step-cut tenotomy with repair of the common extensor tendon; 5) a left elbow ulnar nerve release with subcutaneous transposition; 6) a left elbow partial medial epicondylectomy with debridement of the central tendon; 7) a left elbow central tendon step-cut lengthening for medial epicondylitis; 8) a left elbow revision lateral epicondylectomy with debridement of the common extensor tendon origin; 9) a left elbow common extensor tendon step-cut lengthening; and 10) a left elbow posterior cutaneous antebrachial nerve resection with proximal neuroma burial. Px2, 5. Petitioner has also undergone numerous cortisone injections, platelet rich plasma injections and a series of 3 stellate ganglion blocks, in an effort to cure his pain complaints. The Arbitrator finds Petitioner's treatment significant and prolonged.

The medical records and Petitioner's testimony reflect that despite his doctors' best efforts, Petitioner reports that he continues to experience significant pain on a daily basis. There is no future surgery recommended by Petitioner's doctors. However, Petitioner is expected see a pain management doctor on a regular basis. The medical records also show that Petitioner was released to the heavy physical demand level per his FCE, which allowed him to return to his pre-injury employment on a full-time basis in May 2016.

Petitioner testified that his pain averages a 5 out of 10, with a 3 out of 10 being the best his elbow feels. As the day goes on, his elbow feels worse. He takes prescription medication daily for pain and ices his elbow daily. The only thing that lessens his pain complaints is resting the left arm.

Petitioner's life is affected daily. He uses his left arm as little as possible, and says he struggles with many household chores such as mowing the yard, taking out the trash, sweeping/mopping the floor and washing dishes. Petitioner is no longer able to play catch with his kids compared to before the injury and no longer goes to the golf course or batting cages with friends, as was his habit prior to the accident. The Arbitrator notes that Petitioner primarily endorsed difficulties and pain as it relates to the left elbow compared to the left wrist.

Petitioner has a GED and has worked for the City of Chicago for 17 years. He returned to the same position he was working in at the time of his injury in a full duty capacity. He was 37 years old at the time of the hearing and his only employment prior to Respondent was as a clerk for Prudential. Petitioner does not have a valid driver's license and has no military experience. He classifies himself as good with computers, but has had no formal training or certifications regarding the same.

Based on the foregoing and the record as a whole, the Arbitrator concludes that Respondent shall pay Petitioner Permanent Partial Disability benefits of **$669.64/week** for **41 weeks** because the injury caused a **20%** loss of use of the Petitioner's **left hand**, as provided under **Section 8(e)** of the Act.

Further, Respondent shall pay Petitioner Permanent Partial Disability benefits of **$669.64/week** for **126-1/2** weeks because the injury caused a **50%** loss of use of the Petitioner's **left arm**, as provided under **Section 8(e)** of the Act.

Signature of Arbitrator

7-17-2017
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF KAKE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JEFFERY STONER,

Petitioner,

vs. NO: 10 WC 43636

MEIJER,

18IWCC0242

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, TTD, notice, and PPD, and being advised of the facts and law, reverses the Decision of the Arbitrator, which is attached hereto and made a part hereof, on the issues of accident and causal connection as stated below and finds Petitioner entitled to benefits under Section 8(a), Section 8(b), and Section 8(d)2 of the Act.

The Decision of the Arbitrator laid out several reasons for finding Petitioner both failed to prove that he sustained accidental injuries that arose out of and in the course of his employment on October 20, 2010, and failed to prove a causal connection between his work activities and any condition of ill-being relatable to his lumbar spine. The Commission, in reviewing the same evidence that led the Arbitrator to find neither an accident nor a causal connection, arrives at the opposite conclusion.

The Arbitrator noted Petitioner did not continually report his low back pain to Leanne Clayton, Respondent's former Pricing Inventory Team Leader and Petitioner's then-supervisor. Petitioner maintains that he informed Ms. Clayton of the pain in his lumbar spine in April, May, June, and July 2010. Ms. Clayton denies this occurred. The Arbitrator conceded that, perhaps "Petitioner did mention back pain on one occasion and she forgot about it because it was of no consequence." The Commission questions why the Arbitrator did not allow for the possibility

18IWCC0242

that Petitioner had mentioned his lumbar back pain as he had testified to and for the possibility that Ms. Clayton repeatedly forgot about it "because it was of no consequence." The Arbitrator found Ms. Clayton credible but made no finding as to the credibility of Petitioner. If the Arbitrator had questions pertaining to Petitioner's credibility, those presumptively would have been addressed in the Decision of the Arbitrator. Nevertheless, whether Petitioner informed Ms. Clayton once or on multiple occasions about his pain, the Commission is unaware of any obligation Petitioner had to regularly apprise Ms. Clayton of his condition under the Act.

The Arbitrator also noted Petitioner associated his back pain with paintball, an activity Petitioner participated in one week prior to presenting to the office of Dr. Robert Reeder where he was seen by Steve Thiel, PA-C, on June 28, 2010. The record created by Mr. Thiel noted Petitioner complained of "aching pain in the lower back." The use of "aching" as an adjective describes the type of pain Petitioner was experiencing after the paintball outing. This, however, does not preclude the possibility that Petitioner had pain of another sort previously. This would be consistent with Petitioner's testimony. Petitioner testified to telling Mr. Thiel, on June 28, 2010, that his low back pain was in a lot of pain at that time and that he attributed it to his participation in paintball. Petitioner's being in "a lot of pain" on June 28, 2010, does not suggest that he was pain-free prior to that day. The Commission does not find Petitioner's complaints of having "aching pain" or being in "a lot of pain" on June 28, 2010, to be inconsistent with his testimony of experiencing lumbar pain in April, May or any day in June 2010 prior to June 28, 2010. The pain Petitioner complained of on June 28, 2010, would appear to be an exacerbation of his as-testified-to lumbar pain that had been present since April 2010.

The Arbitrator found the causation opinion of Dr. Rieger not to be persuasive, given Petitioner's first experiencing pain upon waking in April 2010 and then experiencing pain after participating in a paintball excursion. Dr. Rieger had found Petitioner's work activities to be causally connected to his lumbar complaints. The Commission, contrary to the Arbitrator, finds Dr. Rieger's causation position to be persuasive.

Petitioner's description of his work activities went undisputed. He worked 32 to 36 hours a week over five- to six-hour shifts and, during each shift, he transferred between 2,500 and 3,500 boxes from delivery trucks onto a conveyor belt. The boxes were said to weigh between 10 to 100 pounds each. He testified to waking up one morning in April 2010 after working such a shift with lumbar pain. As noted above, Petitioner testified to reporting this pain to his supervisor, Ms. Clayton.

Petitioner continued with his normal work activities without interruption tfromthe end of April 2010 until October 20, 2010. Within this timeframe, Petitioner sought medical treatment on June 28, 2010, for pain related to his participation in paintball and again on September 29, 2010, for pain that Petitioner said had never gone away. The Commission finds the lumbar pain Petitioner experienced during the second week of April 2010 to have been, at least, the result of the work activities from his work shift from, at least, the day before and further that pain continued until October 20, 2010. The pain Petitioner complained of on June 28, 2010, is not considered to be the result of any intervening accident but simply additional pain that was the result of Petitioner's participation in a seemingly reasonable recreational activity.

Based on Petitioner's testimony, particularly with respect to his unrebutted testimony describing his work activities as well as his treatment records as written by Dr. Rodney Rieger, Petitioner's treating physician, the Commission adopts Dr. Rieger's opinion that Petitioner's work activities resulted in Petitioner experiencing lumbar disc degeneration at the L5-S1 level that eventually caused a disc herniation and displacement of the disc at the same level along with nerve compression also at the same level.

The Commission recognizes that the Arbitrator relied, in part, on the opinion of Dr. Avi Bernstein, Respondent's Section 12 examining physician, in finding that Petitioner did not prove his injuries were the result of an accident that arose out of and in the course of his employment. Dr. Bernstein examined Petitioner twice subject to Section 12 of the Act, once on January 7, 2011, and again on August 31, 2015.

The Arbitrator wrote of Dr. Bernstein's findings that Petitioner had subjective complaints that were inconsistent with his objective findings, particularly the non-dermatomal distribution of numbness with pinwheel testing of Petitioner's right foot. Dr. Rieger had recorded complaints of numbness elicited during examinations of Petitioner both immediately before and after Petitioner's Section 12 examination with Dr. Bernstein. As those three instances appear to be the only time Petitioner complained of numbness in his right foot, the Commission believes that numbness may have been a transient symptom, possibly unrelated to the disc herniation and disc displacement at L5-S1. The Commission cannot find, in Dr. Rieger's treatment records, any evidence that Dr. Rieger relied on Petitioner's complaints of numbness in his right foot to guide his treatment plan.

The Arbitrator also recognized Dr. Bernstein's conclusion that Petitioner's October 27, 2010, MRI of the lumbar spine was not demonstrative of any work-related incident or event. The Commission finds that this omits the possible degeneration of the disc at L5-S1 over time. He did read the MRI as revealing what he described as "minimal" degenerative change and a central to right-sided disc herniation that impinged the right S1 nerve root. In his deposition testimony, he noted that a disc herniation is "not a normal finding." He did not offer an opinion as to how Petitioner, at the age of 21 years old, sustained such a herniation. The Commission finds Dr. Bernstein ignores the obvious to arrive at his conclusion.

The Commission, contrary to the conclusion of the Arbitrator, finds sufficient evidence to conclude both that the injuries Petitioner claimed to be related to his work activities did, in fact, arise out of and in the course of his employment and that the period of time Petitioner was kept off work by his treating physicians as well as the medical treatment he received from those physicians were causally related to his employment.

The Commission finds Petitioner's accidental injury resulted in him experiencing three separate episodes of being temporarily totally disabled. The first episode ran from October 20, 2010, and continued until June 15, 2011. Dr. Rieger removed him from work on October 20, 2010, and Petitioner was continued off work so that he could receive the necessary medical treatment that would allow him to return to work. Petitioner, after abstaining from work and undergoing both physical therapy and epidural steroid injections, was eventually released to return to work in a light duty capacity. Respondent, by that time, had terminated Petitioner's

employment. It wasn't until June 15, 2011, that Petitioner found employment within his light duty restrictions with Wal-Mart. Petitioner then worked for more than two years before being taken off work again. In August 2013, Petitioner experienced a flare-up of low back pain and right leg pain while working and, after seeking medical treatment on September 4, 2013, was released to return to work with a lifting restriction of 25 pounds. Wal-Mart was unable to accommodate this restriction. Petitioner remained off work, all along undergoing additional medical treatment and further physical therapy, until November 4, 2013, when he found employment within his work restrictions with Sedgwick Insurance. On May 2, 2014, Petitioner was again removed from work due to increased lumbar pain and numbness and tingling in his right leg. Petitioner underwent two MRI examinations of his lumbar spine, an orthopedic consultation, SPECT Imaging, and, concluding with a sacroiliac injection on June 7, 2014. That same day, Petitioner was returned to work with light duty restrictions. Petitioner did not argue that he was unable to find employment within the imposed restrictions. The Commission calculates, based on the information provided, Petitioner to have been temporarily totally disabled from October 20, 2010, through June 15, 2011, again from September 4, 2013, through November 4, 2013, and again from May 2, 2014, through June 7, 2014, for a total of 48-2/7 weeks.

Petitioner, in treating the injuries that arose out of and in the course of his employment, sought medical treatment from Fox Valley Orthopedics, CoSport Physical Therapy, Advocate Sherman Hospital, CEP America, and Accelerated Rehabilitation Centers. The medical bills for treatment from these providers totaled $19,431.73. In addition to having theses medical bills, Petitioner paid $195.08 out of his own pocket for the medications prescribed to him by his treating physicians. The Commission awards to Petitioner the sum of $19,431.73, subject to the fee schedule.

Petitioner, through his work activities for Respondent, sustained accidental injuries that were repeatedly described as a mild disc herniation and displacement of the disc at L5-S1. These injuries were treated conservatively through temporarily keeping Petitioner off work, physical therapy, injections, and, finally, permanent work restrictions. To that end, Petitioner was able to resume working albeit with modest restrictions. Dr. Rieger testified that Petitioner should be limited from "very heavy work [that required a] combination of heavy rotation, heavy lifting, and heavy flexion/extension type positioning of the back simultaneously." Dr. Rieger, significantly, was aware that Petitioner sought to become an automobile mechanic but did not see the condition of Petitioner's lumbar spine as being an impediment to that goal. He only hoped that Petitioner would employ a mechanical lift when called upon to lift an engine block.

Petitioner, himself, testified to being currently employed as a parts consultant for an automobile dealership. In that capacity, he testified to selling parts to individual customers and wholesale accounts. His daily activity, as a parts consultant, consists of taking orders, finding parts on the computer, handing paperwork to parts drivers, and bringing parts from the backroom to either a shelf or the front counter. Those parts, at most, weigh about ten pounds, according to Petitioner. This work appears to have little negative effect on Petitioner's lumbar spine as he testified that his back feels pretty good.

The Commission finds Petitioner has suffered a permanent partial disability that appears

to allow him to work in all but the most physically demanding jobs. Petitioner, per Dr. Rieger, is not medically precluded from pursing employment as a mechanic. Dr. Rieger only suggests that Petitioner avoid the heaviest activities associated with being a mechanic. The specific, formal weight restrictions that had been placed upon Petitioner while he was recovering from his injuries seem to have been lifted, replaced with a prohibition against only very heavy lifting. Petitioner, in his current position, seems to be heeding that advice.

Given Petitioner's testimony in which he indicated that his back felt pretty good, his not seeking medical treatment in over two years prior to his arbitration hearing, and Dr. Rieger's very limited restrictions upon Petitioner's ability to work, the Commission finds Petitioner has experienced a 5% loss of the use of the man as a whole as a result of his October 20, 2010, accident.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $220.00 per week for a period of 48-2/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $220.00 per week for a period of 25 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 5% loss of the use of the man as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $19,431.73 for medical expenses under §8(a) of the Act.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $35,700.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 18 2018
KWL/mav
O: 02/20/18
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Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

STONER, JEFFREY
Employee/Petitioner

Case# **10WC043636**

MEIJER
Employer/Respondent

18IWCC0242

On 11/21/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.62% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1836 RAYMOND M SIMARD PC
205 W RANDOLPH ST
SUITE 815
CHICAGO, IL 60606

2461 NYHAN BAMBRICK KINZIE & LOWRY
DAVID A VICTOR
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

J. Stoner v. Meijer , 10 WC 043636

STATE OF ILLINOIS)
)SS.
COUNTY OF Kane)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jeffrey Stoner
Employee/Petitioner

v.

Meijer
Employer/Respondent

Case # 10 WC 043636

18IWCC0242

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 **Geneva, Illinois on July 18, 2016 and Chicago, Illinois on September 1, 2016.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0242

FINDINGS

On **October 20, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$14,313.52**; the average weekly wage was **$275.26**.

On the date of accident, Petitioner was **21** years of age, *single* with **0** dependent children.

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

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

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

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

ORDER

Claim for compensation denied. Petitioner failed to prove that he sustained accidental injuries which arose out of and in the course of his employment by Respondent on October 20, 2010 and failed to prove a causal connection between Petitioner's work activities and any condition of ill-being regarding his low back.

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

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

Signature of Arbitrator

November 21, 2016
Date

ICArbDec p. 2

NOV 21 2016

FINDINGS OF FACT

In October of 2010, Petitioner was employed by Respondent as a shipping and receiving clerk, unloading general merchandise and grocery trucks. He began this job in March of 2009. Petitioner testified that in October of 2010, he was 5'7" tall and weighed around 140 pounds. He was 21 years old at that time. Petitioner's work schedule was 32 to 36 hours per week, 5 to 6 hours per shift. Petitioner's job required him to bend to lift boxes off the floor and turn and put them on a conveyor. Basically, Petitioner stood between a trailer that was being unloaded and the conveyor. He would have to rotate 180 degrees under load to move boxes from the trailer to the conveyor. Boxes weighed from 10 to 100 pounds. Petitioner moved 2500 to 3500 pieces a day. Petitioner's description of the physical activities involved in his job was not rebutted by Respondent.

Petitioner testified that in April of 2010, he was noticing pain and stiffness in his low back: "(w)hen I would wake up in the morning after working the following day." It will be assumed that Petitioner had pain and stiffness in his low back when he would wake up the morning after working. Petitioner testified that he had a conversation with his supervisor, Le Anne Clayton, during the second week of April, 2010. Petitioner told Clayton that his back was sore. Clayton asked Petitioner why he got a job lifting if he had a sore back. Petitioner said that his back didn't hurt until he started working for Respondent. Clayton instructed Petitioner to continue working and unload the trucks. Two co-employees were present for this conversation. Neither Party called the co-employees as a witness.

Petitioner continued to work his regular job duties through April, May and June of 2010.

Petitioner sought medical care with his PCP on June 28, 2010 for low back pain. Petitioner testified that at this time, he was experiencing back pain when he woke up and he had difficulty moving around at times. The difficulty moving around would be only at work. Petitioner was seen by a PA-C, Steve Thiel. Petitioner testified that he told Thiel that his lower back was in a lot of pain. When asked whether he attributed the pain to any activity, Petitioner responded that he told Thiel that the most recent activity that he had was paintball. The paintball activity was about a month before the June 28, 2010 doctor's visit. Thiel charted that Petitioner complained of aching pain in the lower back for the past week. "Symptoms began after playing paintball." Petitioner denied any impact trauma or prior back problems. The nurse's note in the chart states: "Per patient, complains of back injury-lower back, pain times one week." Petitioner testified on cross examination that he did not recall giving this history. He also did not recall saying that his symptoms began after playing paintball. Petitioner was said to be 5'9" and weighed 147 pounds. The diagnosis was lumbar strain and medication, heating pad and stretching exercises was recommended. Petitioner was to follow up if worse or no improvement. (Px 1, Rx 1)

Petitioner testified that he continued to work his regular duties and his back pain increased. He had difficulty performing his job.

Petitioner was again seen by PA-C Thiel on September 29, 2010. The nurse's note says that patient complains of left shoulder pain and lower back pain, same as office visit on 6/28/10. Never went away. Thiel's chart says that the patient complained of aching pain in the low back for past 4 months. The pain was worse with lifting or bending. He had aching pain and weakness in the left shoulder for the past month. He stated that he had intermittent shoulder problems since he dislocated his left shoulder a few years ago. The diagnosis was left shoulder pain and low back pain. Mobic was prescribed and x-rays of the shoulder and low back were ordered.

The patient was instructed to avoid activities that cause pain and seek an orthopedic consult with Fox Valley Orthopedics. (Px1, Rx 1)

Petitioner continued to work his regular job. His back was not getting any better. Petitioner testified that between September 29, 2010 and October 19, 2010, on a Sunday, he had a conversation with Bill Wagner, a management trainee at Respondent, advising Wagner that his back was in severe pain and that he was unable to work. Wagner sent Petitioner home to rest. The same two co-employees who were present for the Clayton conversation were present for this conversation.

Petitioner received a disciplinary write-up from Clayton around October 13, 2010 for using his cell phone. Petitioner testified that he was not talking on the phone. He was taking a picture of what he thought was unsafe stacking of pallets.

Petitioner worked on October 19, 2010. His back was in a lot of pain. He filed a harassment complaint against Clayton on 10/19/2010, regarding an incident that took place on 10/15. (Rx 4)

Petitioner was next seen by Dr. Rieger at Fox Valley Orthopedics on October 20, 2010. Petitioner testified that he described his job to Dr. Rieger at this visit. Petitioner filled out a "Back-Neck Questionnaire" at Dr. Rieger's office on 10/20/10, stating that he "woke up and had pain." The onset was sudden, 5-6 months ago. Dr. Rieger noted that Petitioner's job responsibilities put his back through very heavy flexion/extension cycles that also involved rotation and twisting at the same time. Dr. Rieger ordered a lumbar MRI, a brace and physical therapy. X-rays showed degenerative changes at L5-S1 and there was the possibility of a pars interarticularis injury. Petitioner was advised to take off work for a month or so. (Rx 2, Px 2)

After seeing Dr. Rieger on October 20, 2010, Petitioner reported to Respondent and was given accident report documents to fill out. Petitioner told "Shay" at Respondent that his doctor told him that his back problems were related to repetition of twisting and bending and picking up boxes at work. Petitioner documented this in writing on 10/20/10. "5-6 months ago I woke up and my back was in pain, my boss was informed of my back, nothing was done. I went to the doctor my doctor told me I had a stress fracture and a herniated disc. I was at home when it started to hurt The doctor informed me it was from the lifting snd twisting involved in my job." (Rx 5) Petitioner testified that only Shay was present in the office when he reported his back condition to Respondent on October 20. He did not see Cherie Vasquez in the office. Vasquez testified that she was present and asked Petitioner about the onset of his back pain. His doctor told him to fill out workers' compensation papers. Petitioner advised that he was sleeping about 6 months ago (no specific date) and, when he woke up, he had back pain. He didn't know how it happened, but he thought it was from his job because of all of the lifting that he does. Vasquez documented this event and filled out an Injury Report. (Rx 7) Petitioner was sent for a drug test and tested positive for marijuana. As a result, Petitioner's employment was terminated, effective October 23, 2010. It was Petitioner's testimony that he had smoked marijuana about three weeks before the test. Petitioner's claim was denied. (Px 13) Respondent has a Controlled Substance Policy and Petitioner was not afforded any assistance after testing positive for marijuana. The policy does say that employees who test positive in post-accident testing will be discharged. (Px 14)

Petitioner underwent a lumbar MRI on October 27, 2010. It showed slight facet enlargement at L2-L3, L3-L4, and L4-L5. At L5-S1, there was said to be a right paracentral disc protrusion, contacting the descending right S1 nerve root. Dr. Rieger reviewed the MRI on November 2, 2010 and thought that it showed a disc herniation at L5-S1 with compression and displacement of the exiting nerve root. Petitioner was advised not to return to work doing heavy lifting. He was given a SI brace and was to continue with PT. (Px 2)

Petitioner was seen at Respondent's request by Dr. Avi Bernstein, for a §12 exam, on January 7, 2011. The physical exam was benign. The patient had subjective complaints which were inconsistent with objective findings. There was a nondermatomal distribution of numbness on pinwheel testing of the right foot. Dr. Bernstein thought that the MRI showed a right sided disc herniation at L5-S1 which impinged upon, but did not compress, the right S1 nerve root. Petitioner was capable of full time, full duty, work. He was at MMI and not in need of further treatment or diagnostic work-up. The MRI findings were not related to any particular work incident or event. (Rx 8)

Petitioner was seen by Dr. Rieger on January 19, 2011. PT was not helping enough. Back pain was improving, but the right leg complaints were not improving that much. Petitioner was referred to Dr. Siodlarz for pain management. Dr. Siodlarz performed injections.

Dr. Rieger had released Petitioner to light duty, but he had no job to return to. Eventually, Petitioner got a job at Walmart. At first he was a cashier and then he became a produce department manager. This was an easier physical job than at Respondent, but Petitioner still had pain. At various times, Walmart accommodated work restrictions that were placed on Petitioner, through September 4, 2013.

In November of 2011, Petitioner had a flare-up of pain that he related to work at Walmart and he saw Dr. Rieger. He went back to Dr. Siodlarz and received several injections. He had continued treatment with Dr. Siodlarz through September 26, 2012. He was treated again for flare-ups in 2013 and 2014. IN 2014, Petitioner was referred to Dr. Popp by Dr. Siodlarz. He had a Spect study and a lumbar CT at Sherman Hospital in May of 2014. The Spect study was unremarkable and the CT showed a mild bulging disc at L5-S1. The last treatment that Petitioner had was with Dr. Siodlarz in June of 2014. (Px 2, Px 3)

After working at Walmart, Petitioner obtained employment with Sedgwick, entering claims information regarding Sears and K-Mart work injuries, beginning November 4, 2013. This was a desk job and it did lead to back pain at various times. Petitioner left Sedgwick in April of 2016. He now works at Biggers Mazda as a parts consultant. He lifts about 10 pounds. He takes orders, finds parts on the computer and pulls parts for drivers. He does not do that much lifting and alternates sitting and standing at Biggers.

Petitioner's back feels pretty good at the Biggers job. He currently doesn't have many back complaints.

On cross examination, Petitioner agreed that he was honest and truthful to his doctors and gave them accurate histories. He denied prior and subsequent injuries to his back. There was no specific event or injury at work that caused back pain.

Cherie Vasquez testified at the request of Respondent. She is still employed by Respondent. In October of 2010, she was working as a retail administrative assistant at Respondent's store. She was present when Petitioner reported back problems on October 20, 2010. Petitioner couldn't remember when he was injured. He couldn't remember anything causing his back pain. He just woke up with it.

Le Ann Clayton testified at the request of Respondent. She received a subpoena to testify. She worked for Respondent for 11 years and was fired on May 27, 2016. Her position was P I team leader and she was Petitioner's boss. Petitioner was a truck unloader. Petitioner did not report any back injury or back pain to her. She did not tell Petitioner to get a new job if his back hurt. She prepared a statement for Respondent, in October of 2010, after being advised that Petitioner claimed that he was hurt at work. She said that she had a conversation with Petitioner about a month and a half before October 29, 2010 where Petitioner mentioned that he was injured in a bicycle versus truck accident and hurt his back and shoulder. (Rx 6)

On rebuttal, Petitioner testified that the bike/truck accident was in 2005. He did not have back pain at that time. He had no low back issues from 2005 to 2010. He complained to Clayton regarding back pain 3 or 4 times from April to July of 2010. Petitioner did not agree with Clayton's testimony that she did not tell him to get a new job.

Dr. Rodney Rieger testified at the request of Petitioner. His evidence deposition took place on July 27, 2011. He is a board certified orthopedic surgeon, specializing in orthopedic and spine surgery. He was one of Petitioner's treating physicians. He thought that Petitioner's low back condition was causally related to his job at Respondent. The job activities dramatically increased the stress on Petitioner's discs and would speed, advance and exacerbate disc degeneration and the potential for protrusion and stress along the entire lower spine. The basis for the causation opinion was the cyclic flexion and extension of the spine while twisting experienced in Petitioner's job. (Px 5)

Dr. Avi Bernstein testified at the request of Respondent on September 14, 2011. He is a board certified orthopedic surgeon, specializing in spine surgery. He examined Petitioner on January 7, 2011. He testified in accordance with his report. The physical exam was benign. There were inconsistencies between Petitioner's subjective complaints and the MRI findings. The MRI findings are not the result of a work incident or work event or work activities. Petitioner was at MMI and not in need of further treatment. He could return to work, full duty, unrestricted. (Rx 10)

Dr. Bernstein examined Petitioner again on August 31, 2015. He also reviewed medical records and provided an AMA impairment rating (accident date: 2/10/2010, §8.1(b) applies to accidents occurring on or after 9/1/2011). The physical exam was benign. There were subjective complaints. Petitioner could work at full duty without restrictions. Further treatment or work-up was unnecessary. Treatment after the prior exam in January of 2011 was not indicated or necessary. The AMA impairment rating was 0. (Rx 9)

Petitioner claimed 48-2/7 weeks of TTD for time periods in 2010 and 2011, 2013 and 2014. He also claimed $19,431.73 in medical bills. (Arbx 1)

CONCLUSIONS OF LAW

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

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 failed to prove that he sustained accidental injuries which arose out of and in the course of his employment by Respondent on the claimed accident date of October 20, 2010. The Arbitrator relies on the testimony of the witnesses, the medical records and the persuasive opinions of Dr. Bernstein.

There is no doubt that Petitioner did not suffer a back injury as the result of a specific trauma or accident. He woke up one day with low back pain. This is confirmed by Vasquez's testimony and memo, the Back/Neck Questionnaire and the accident report document that Petitioner wrote on October 20, 2010. (Rx 7, 3, 5)

Petitioner did not continually report low back pain to Clayton. Clayton could have testified that Petitioner continually complained of back pain and related it to his work, but she did not. She obviously is not happy with the circumstances of her discharge by Respondent after working there for 11 years. She could have testified in support of Petitioner, but she did not. The Arbitrator finds Clayton's testimony to be credible. Perhaps Petitioner did mention back pain to Clayton on one occasion and she forgot about it because it was of no consequence.

Petitioner did associate his back pain with paintball (onset about 1 week before the 6/28/2010 visit with Thiel, PA-C, symptoms began after playing paintball) when he first sought treatment for low back pain. Petitioner had the opportunity to call a witness from his PCP to explain the history that was charted, but failed to do so.

The Arbitrator finds that Dr. Rieger's causation opinion in this case is not persuasive, given the history of onset of complaints upon waking, or after playing paintball. Dr. Bernstein's opinion that Petitioner's MRI findings are not the result of a work incident or work event or work activity is persuasive in light of the testimony of all of the witnesses, the medical records (especially the records from Thiel) and the benign physical exam noted by Bernstein and not contradicted by the treating records.

Given the evidence adduced, the Arbitrator cannot support a finding of Accident in this case.

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

The testimony of Petitioner and Vasquez and Respondent's Exhibits 5 and 7 establish that proper Notice, in accordance with §6 of the Act, was given.

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

Regarding causation, the Arbitrator restates his findings above regarding the issue of Accident. Again, Dr. Bernstein's opinions on causation best comport with the evidence adduced. Petitioner has failed to prove that there is a causal connection between Petitioner's current condition of ill-being regarding his low back and his work duties.

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, ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, AND WITH RESPECT TO ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

As the Arbitrator has found that Petitioner failed to prove that he sustained accidental injuries which arose out of and in the course of his employment by Respondent on October 20, 2010, and that there is no causal relationship between Petitioner's work activities and his current condition of ill-being regarding his low back, the Arbitrator needs not decide these issues.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kazimierz Fit,
Petitioner,

vs. No. 12 WC 04286

Continental Window & Glass Corporation;
G & S Paramount Construction Company;
Second City Construction Company, Inc.;
High-Tech Remodeling & Construction Co., Inc.;
Suzette Washington, a/k/a Suzette Bumpas, and
State Treasurer as Ex Officio Custodian of the
Injured Workers' Benefit Fund,
Respondents.

18IWCC0243

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by Respondent High-Tech Remodeling & Construction Co., Inc. ("High-Tech"), and Petitioner herein, and notice given to all parties, the Commission, after considering the issues of jurisdiction, accident, notice, employment, benefit rates, causal connection, medical expenses, temporary disability, permanent disability, penalties and fees, and the application of §1(a)(3) of the Act, 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.

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On December 15, 2011 Petitioner, a construction laborer, was injured when he fell off a scaffolding while installing gutters and downspouts. He sustained an L5-S1 annular tear and an L4-5 herniated disc. He testified he was off work from his date of accident through July 13, 2012. During that time he incurred $53,767.77 in medical bills. The Arbitrator denied Petitioner proved he was entitled to penalties and attorney's fees, but found that Petitioner had proved the following: that on December 15, 2011, he was 57 years of age, single and with no dependent children; the Commission has jurisdiction over his claim under §1(b)2 of the Act because the accident occurred in Chicago; Respondents Continental, Second City and High-Tech are subject to the Act pursuant to §2, §3(1) and §3(3) thereof; Petitioner gave timely notice of his accident to High-Tech; Petitioner's average weekly wage is $500.00; Petitioner has received all reasonable and necessary medical services and High-Tech should be given a credit of $1,000.00 for TTD which it paid Petitioner. The Commission concurs with the Arbitrator's findings on these issues, and affirms and adopts them for the reasons stated in the Arbitrator's decision.

Although the Arbitrator found Petitioner had not proven an employee-employer relationship with High-Tech, the Arbitrator nonetheless found High-Tech liable to Petitioner as a statutory employer, pursuant to §1(a)3 of the Act. The Arbitrator ordered High-Tech to pay Petitioner the following: 25-2/7 weeks of temporary total disability benefits commencing January 11, 2012 through July 11, 2012,[1] at a rate of $333.33/week; $53,767.77 for medical bills, and 25 weeks of permanent partial disability at a rate of $300.00/week, representing 5% loss of person-as-a-whole under §8(d)2. For the reasons stated below, the Commission finds that High-Tech was not Petitioner's statutory employer under §1(a)3 of the Act, and vacates the award entered against High-Tech.

The relationships of the parties involved in this case are complicated. Marek Zbierajewski, who was also known as Mark Spears ("Spears"), testified he was a salesperson and agent of Respondent Second City, but also, that he was a principal of his own company, Respondent, High-Tech. Grzegorz Sztejkowski ("Sztejkowski"), testified he was not only the founder and shareholder of the Respondent corporation, Continental Windows, but was also a principal of another corporation, G & S Paramount Construction Co. A second Marek in this case – Marek Hajdas ("Hajdas") – testified he was an employee of Continental Windows. Several witnesses gave ambiguous testimony, by referring to "Marek," without specifying which Marek; and by giving testimony such as, "he said..." without clearly indicating which of the many involved parties they were referring to.

The Commission adopts the Arbitrator's Statement of Facts which were well laid out in his Arbitration Decision. In essence, Second City entered into a contract with homeowner Suzette Bumpas[2] to install a new roof on her Van Buren residence ("Van Buren job"). Second City then subcontracted its entire obligation to High-Tech. Spears testified that he personally performed all of the roof work on that job, but in so doing, he damaged the homeowner's gutters and downspouts, necessitating their replacement. Spears testified he entered into a verbal agreement with Sztejkowski of Continental Windows to perform the gutter and downspout replacement work on the Van Buren job.

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[1] That period is 26-1/7 weeks, not 25-2/7 weeks.

[2] At the January 21, 2015 arbitration hearing, the Arbitrator granted Petitioner's oral motion to dismiss Suzette Washington, a/k/a Suzette Bumpas from this claim.

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Petitioner testified Hajdas hired him after speaking with Continental's "owner," Sztejkowski, and that Hajdas was his supervisor for the work Petitioner performed for Continental Windows. Petitioner further testified he met with Sztejkowski, "who said that he's hiring me," as an employee of Continental Windows. On December 15, 2011, Petitioner went to Continental's shop to get sheet metal needed for a Continental Windows job on Division Street ("Division St. job"). When Petitioner arrived at the Division St. job, Hajdas told Petitioner they would not be able to work on that job that day. Petitioner testified Hajdas then told him and the other crew members that they could come work on a different job, the Van Buren job, replacing gutters, downspouts, soffits and fascia. Petitioner gave conflicting answers when asked whether "Marek" told him the Van Buren job was a Continental Windows job, first testifying, "He said nothing. When we were at Continental, we took materials from Continental, so I believed it was a Continental job." But when Petitioner was asked if he assumed the Van Buren job was a Continental Windows job because some of the materials came from Continental, Petitioner then testified, "No. Marek told me that it's a Continental job." Petitioner admitted Hajdas paid him in cash for his work replacing the soffits and gutters.

Hajdas testified as a witness for Continental Windows that he was an employee of that company, and that the only work it performed was on windows. He testified that Petitioner was a long-time acquaintance of his; they had previously worked together. In November 2011, Petitioner was unemployed and called Hajdas to ask if he had any work. Hajdas, who sometimes hired other workers to help on Continental Window's jobs, told Petitioner that he did have work for him.

Hajdas further testified that when he, Petitioner and other workers arrived at the Continental Windows Division St. job site on December 15, 2011, they learned that that job would not proceed. Hajdas told Petitioner he had a different job for him to perform: soffit and gutter replacement work at the Van Buren job. Hajdas testified he never told Petitioner that the Van Buren job was a Continental job. Hajdas admitted he performed side jobs. He also admitted that he owned the scaffolding from which Petitioner fell, at the Van Buren job. Hajdas did not consider the Van Buren job to be one of his side jobs. Hajdas believed Petitioner was working for Mark Spears on that job because Spears told him what work needed to be done. Hajdas himself was confused as to whom he (Hajdas) worked for on the Van Buren job: he first testified he was working for Continental Windows, then he testified it was G&S Paramount Construction, and then admitted he wasn't sure who he was working for.

Sztejkowski (Continental Windows) testified that Hajdas, in addition to being a Continental employee, was free to secure other jobs of his own when he was not employed by Continental. For those side jobs, Hajdas could hire whomever he wanted. Sztejkowski testified that the Van Buren job was not a Continental Windows job. Sztejkowski testified he never entered into any contracts with High-Tech or Spears regarding the Van Buren job. Sztejkowski testified that after learning Continental Windows Division St. job could not proceed on December 15, 2011, Hajdas asked him if he had any other jobs for him and his crew to work on. Sztejkowski told Hajdas that he did not, but that his colleague, Mark Spears of High-Tech, did: the Van Buren job. Sztejkowski testified he told Hajdas, "you guys can go." Although Sztejkowski drove by the Van Buren job site on 12/15/11, he had no knowledge of the work being performed there; he observed that Hajdas'

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truck did not have the Continental Windows sign on its side, and he observed nothing at that job site which would indicate Continental Windows was a contractor on that job.

Spears (High-Tech) testified that on the day Petitioner was injured, Sztejkowski asked Spears if he had any other jobs which Spears' guys could work on. Spears then told Sztejkowski about his job on Van Buren. Spears testified that: High-Tech did not perform the gutter work on the Van Buren job; he never exercised control over "Greg's people" when they performed work on the Van Buren job, and he never told those workers what tools to use or how to do work on that job.

The Arbitrator found that Petitioner was uninsured, and that:

> "[A]t the time of the accident... Petitioner was an employee of Marek Hajdas, who was not a named party Respondent (and likely, uninsured). There was a contract of hire between Hajdas and Petitioner to work some jobs while Petitioner was on layoff during the slow construction season. Petitioner testified that his job was to do what Hajdas told him to do. The evidence does not establish that Continental hired Petitioner to do work for it...
>
> "Here, the accident occurred on a job that Continental had no part in... Second City was the principal contractor, and it used High Tech as a subcontractor. High Tech subcontracted with Hajdas to do the facia, soffit, and gutter work on Van Buren.... Hajdas is either Petitioner's employer and uninsured, or Petitioner is a subcontractor of High Tech and is uninsured. In either case, liability attaches to High Tech, in accordance with §1(a)3."

The Commission finds that at the time of his injury on the Van Buren job, Petitioner was an employee of Hajdas, and not an employee or subcontractor of Continental or High-Tech. Whether or not Petitioner was an employee or subcontractor of Continental Windows on the Division St. job is irrelevant to Petitioner's employment status on the Van Buren job, which the Commission finds was not a Continental Windows job.

In finding Petitioner was Hajdas' employee at the time of his accident, the Commission has considered the following: that Hajdas hired Petitioner; he provided Petitioner with work on the Van Buren job, and he instructed and controlled the manner in which Petitioner worked. Further, Hajdas directed Petitioner's work schedule by telling him when to appear on the job, and he paid Petitioner hourly. Hajdas had to authority to discharge Petitioner at will. Finally, Hajdas provided Petitioner with the supplies and the scaffolding which Petitioner used on the Van Buren job.

Petitioner's belief that he was employed by Continental at the time of his fall was mistaken. That belief appears based upon poor communication between Hajdas and Petitioner regarding the origin of the Van Buren job, and upon Petitioner's unsupported assumptions.

In finding Continental Windows had no involvement or control of the Van Buren job, the Commission finds credible the following testimony of Sztejkowski: the Van Buren job was not a Continental Windows job, but rather, it was a side job of Hajdas; Petitioner was working for Hajdas on the Van Buren job; Sztejkowski would go to the job sites and instructs his workers on all Continental Windows jobs, but he did not do so at the Van Buren job, and Continental Windows did not supply the materials used on the Van Buren job. Spears and Hajdas further confirmed that High-Tech paid for all materials used on the Van Buren job. Hajdas further testified that Sztejkowski did not order him to go to the Van Buren job, and that Sztejkowski's only "involvement" at the Van Buren job site was driving by it – something Hajdas admitted Sztejkowski did, not just on Continental Windows jobs, but also on many of Hajdas' side jobs. Finally, Petitioner and Hajdas both confirmed Sztejkowski's testimony that the Van Buren job site had no signs indicating a presence of Continental Windows on that job. In concluding that Continental Windows had no involvement with the Van Buren job, the Commission finds the above testimony of these witnesses on this issue to be persuasive.

The Commission finds Petitioner was not an employee or a subcontractor of High-Tech. Neither Petitioner nor Spears testified that Spears or anyone else at High-Tech hired Petitioner as an employee or subcontractor of High-Tech. Petitioner testified his job was to do what Hajdas told him to do.

Although the Commission agrees with the Arbitrator that Petitioner was an employee of Hajdas, it disagrees that Petitioner proved High-Tech was his statutory employer on the Van Buren job pursuant to §1(a)3 of the Act. Accordingly, the Commission reverses the Arbitration Decision finding High-Tech to be Petitioner's statutory employer.

The pertinent portion of §1(a)3 of the Act states:

> Any one engaging in any business or enterprise referred to in subsections 1 and 2 of Section 3 of this Act who undertakes to do any work enumerated therein, is liable to pay compensation to his own immediate employees in accordance with the provisions of this Act, *and in addition thereto if he directly or indirectly engages any contractor whether principal or sub-contractor to do any such work, he is liable to pay compensation to the employees of any such contractor or sub-contractor unless such contractor or sub-contractor has insured,* in any company or association authorized under the laws of this State *to insure the liability to pay compensation under this Act, or guaranteed his liability to pay such compensation.*
> *(820 ILCS 305/1(a)3, 2011; emphasis added.)*

In this case, High-Tech subcontracted the gutter and downspout work to Hajdas. Because Petitioner was Hajdas' employee, §1(a)3 mandates Petitioner be afforded protection under that section – and therefore, that High-Tech be considered Petitioner's statutory employee – upon proof that Hajdas had no workers' compensation insurance for Petitioner. The Arbitrator believed that to be the case, finding that Hajdas was, "likely, uninsured." However, there is no testimony or evidence in the record showing that Hajdas was uninsured. Without such evidence, it would be speculative for the Commission to so find. Liability cannot be premised upon imagination, speculation or conjecture but must arise from facts established by a preponderance of the evidence.

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Illinois Bell Telephone Co. v. Industrial Comm'n, 265 Ill. App. 3d 681, 638 N.E.2d 307 (1st Dist. 1994). Accordingly, the Commission finds that High-Tech was not Petitioner's statutory employer at the time he was injured, and that §1(a)3 does not apply.

The Commission is aware that Petitioner has not named Hajdas as a Respondent in this claim. Consequently, the Commission does not order Hajdas to pay any benefits to Petitioner.

Based on the Commission's findings hereinabove, the other issues in this claim not otherwise addressed herein are moot.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on July 15, 2016 is modified as noted above and all benefits to Petitioner are denied in accordance with the Commission's finding that Petitioner failed to prove High-Tech to be Petitioner's statutory employer pursuant to §1(a)3 of the Act, at the time and place of his accident.

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

No bond is required for removal of this cause to the Circuit Court. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 18 2018

o-02/28/18
jdl/mcp
68

Joshua D. Luskin

Charles J. DeVriendt

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FIT, KAZIMIERZ
Employee/Petitioner

Case# **12WC004286**

CONTINENTAL WINDOW & GLASS CORP; G&S PARAMOUNT CONSTRUCTION COMPANY INC; SECOND CITY CONSTRUCTION COMPANY INC. HIGH TECH REMODELING & CONSTRUCTION INC; SUZETTE WASHINGTON A/K/A SUZETTE BUMPASS; AND STATE TREASURER AS EX OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

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On 7/15/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.39% 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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K. Fit v. Continental, etc., et al , 12 WC 04286

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

Kazimierz Fit
Employee/Petitioner
v.

Case # 12 WC 04286

Continental Window & Glass Corp; G&S Paramount Construction Company, Inc; Second City Construction Company, Inc. High-Tech Remodeling & Construction, Inc; Suzette Washington, a/k/a Suzette Bumpas; and State Treasurer as Ex Officio Custodian of the Injured Workers' Benefit Fund
Employer/Respondent

18IWCC0243

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 **1/13/14, 11/10/14 & 1/21/15**. 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 **Statutory Employer (§ 1(a)3).**

18IWCC0243

FINDINGS

On 12/15/2011, Respondent, **HIGH-TECH REMODELING & CONSTRUCTION** *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did not*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** 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 **$1,000.00**; the average weekly wage was **$500.00**.

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

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

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

Respondent shall be given a credit of **$1,000.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$1,000.00**.

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

ORDER

Respondent, **HIGH-TECH REMODELING & CONSTRUCTION, Inc.**, shall pay Petitioner **temporary total disability benefits of $333.33/week for 25-2/7 weeks, commencing 1/11/12 through 7/11/12**, as provided in **Section 8(b) of the Act.**

Respondent, **HIGH-TECH REMODELING & CONSTRUCTION, Inc.**, shall pay **reasonable and necessary medical services of $53,767.77, before application of the fee schedule**, as provided in **Sections 8(a) and 8.2 of the Act.**

Respondent, **HIGH-TECH REMODELING & CONSTRUCTION, Inc.**, shall pay Petitioner **permanent partial disability benefits of $300.00/week for 25 weeks**, because the injuries sustained caused the **5% loss of the person as a whole**, as provided in **Section 8(d)2 of the Act.**

The claims against the remaining Respondents are dismissed for the reasons set forth below.

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

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

Signature of Arbitrator

July 11, 2016
Date

JUL 15 2016

INTRODUCTION

This matter was heard and evidence taken over three separate dates. There were a total of six respondents, five of whom were represented by counsel. The only party not participating in the hearings was Suzette Washington a/k/a Suzette Bumpas. Petitioner moved to dismiss Washington a/k/a Bumpas at the end of the first day of testimony. Witnesses Fit, Sztejkowski and Hajdas testified via a Polish/English interpreter. This case involves a claim for injuries sustained by Petitioner on December 15, 2011, when he fell while replacing soffit and fascia and gutters at Bumpas' house at 5334 W. Van Buren in Chicago. Respondent, IWBF disputes all issues. Respondents Continental Windows and Glass Corporation, G&S Paramount Construction Co., Inc., Second City Construction Co., Inc. and High Tech Remodeling and Construction, Inc. disputed Employee/Employer; Accident/Arising Out Of and In The Course Of Employment; Causal Connection; Wages (2nd City agreed to the claimed AWW of $500.00); Liability for Medical Expenses: TTD; and Nature and Extent. Respondents High Tech, G&S, and 2nd City disputed Notice. Petitioner claims that he is entitled to Penalties and Attorneys' Fees.

STATEMENT OF FACTS

Petitioner was 57 years old, divorced, and had no dependant children on the date of accident, December 15, 2011. He lived in the United States since 1990. He works construction.

Petitioner testified that he is familiar with Respondent Continental Window and Glass Corporation ("Continental"). He became familiar with Continental when he worked with Marek Hajdas at Hajdas' business. Petitioner testified that in November 2011, he was unemployed and he met Hajdas. Petitioner had a conversation with Hajdas. Petitioner asked Hajdas if he had a job. Hajdas responded that he was working for Continental and he needed employees, so Hajdas could hire him. Hajdas told Petitioner that he would talk to the owner of Continental and then call him. Hajdas called Petitioner and told him that he had a job.

Petitioner testified that in December 2011, he met with the owner of Continental, Mr. Sztejkowski. Petitioner testified that Sztejkowski explained to him that he was being hired for window installation, but he must know that he would be expected to do everything. This conversation occurred several days after Petitioner started working. Petitioner said that he was told by Hajdas that he would be paid $10.00 per hour because it was the slow season. Petitioner testified that he was paid by Hajdas in cash and by check. Petitioner testified that he would work in Hajdas' group. All of Petitioner's conversations regarding how he was to be paid were with Hajdas. Hajdas told Petitioner what job tasks he should perform.

Petitioner acknowledged he never filled out a job application at Continental. He never filled out any type of tax withholding paperwork for the federal or statement governments. He never provided Continental with any proof of legal residency. He never asked Continental to have any money withheld from his check to pay for taxes. He only received one check, in the amount of $500.00, which represented work he had done over a number of days and weeks at Continental. Apparently, Petitioner worked on a couple of jobs before the accident. One was at Sylwek's place and another was in Skokie. These were not Continental jobs, although Hajdas was involved in the work with Petitioner.

Marek Hajdas testified in this matter. He appeared voluntarily and his attendance at trial was not compelled by subpoena. He drove to the January 21, 2015 hearing with Sztejkowski. He knew Petitioner for at least 15 years. Petitioner is a good colleague of Hajdas. Petitioner and Hajdas worked together at MD Gutters in the past. Hajdas testified that in 2011, he worked for Continental and also performed side jobs. Hajdas was familiar with another person named Marek Spears. Hajdas acknowledged speaking with Petitioner as to whether or not Hajdas had work for him. However, at the time of the initial conversation, Hajdas did not indicate that Petitioner could be hired by Continental. Hajdas testified that he had a subsequent conversation with Petitioner advising he had a job performing siding, soffit and gutter work. When Hajdas was asked

whether Continental performed any work other than window work, he denied same. Hajdas denied being part of a conversation where Mr. Sztejkowski indicated to Petitioner that he was hired.

Grzegorz Sztejkowski testified in this matter. He is the owner of Continental. Sztejkowski testified he knew Petitioner, as Hajdas had brought Petitioner to work with him. Sztejkowski denied that Petitioner ever worked for Continental. Continental only does windows, (production, manufacturing and installation).

Petitioner testified that, on December 15, 2011, he and Hajdas started at the shop at Continental. They took some sheet metal from there and Hajdas told Petitioner they were going to a building where there was a lot of window work. They went to a job site which was a very big building. The anticipated job that they had at this building could not go forward. Petitioner testified that Hajdas told him that the job did not work out, so they were going to another job site. This was the job site on West Van Buren, the Bumpas house. Petitioner testified that he, Hajdas, and two others, Janek and Marian, went to the West Van Buren job site. Petitioner testified that Marian worked for Hajdas. Marian was Hajdas' neighbor. Janek was a Continental employee.

Marek Hajdas testified that on December 15, 2011, he and Petitioner went to a work site on Division Street. When they arrived there, Mark Spears informed him that the job could not go forward that day. Hajdas testified that he then had a conversation with Spears the morning of December 15, 2011 as to whether there was any work available that day. They talked about a job on West Van Buren. Sztejkowski was not involved in the job or conversation about the job on West Van Buren. Sztejkowski did not instruct Hajdas to work on the Van Buren job. When asked if the Van Buren job was a side job for Hajdas, Hajdas replied no, that it was Spears' job.

Marek Spears testified that he is the owner of High Tech Remodeling and Construction, Inc. He also works as an agent on behalf of Second City Construction Company when entering into contracts. He uses the name Mark Spears when he is a salesperson for 2nd City. His real name is Marek Zbierajewski. Spears'

testimony was taken on January 13, 2014. Apparently, per the testimony of Hajdas at the January 21, 2015 hearing, there was a scuffle in the hallway between Marek Hajdas and Marek Zbierajewski on January 13, 2014. Hajdas denied that there was a fistfight, or that the Mareks pushed each other around. "...it was a tough, manly conversation." The Arbitrator did not see a fistfight, pushing or a tough, manly, conversation.

Spears testified that he entered into a contract with Suzette Bumpas, for work on her home on West Van Buren, on behalf of 2nd City. (Px. 20). The contract called for 2nd City to install a roof and replace some drywall. However, on doing the roof, the soffit and gutters fell off. The gutters were added to the job because they got damaged when the roof was being torn off. Spears testified that all of the roofing work called for in Px. 20 was done by him and he did drywall work as well. It was intended that Spears would receive the major part of the proceeds that Bumpas agreed to pay to 2nd City. Apparently, Spears did not have workers available to do the soffit, fascia, woodwork and gutters and he needed to finish the job.

Spears testified that he made a verbal agreement with Greg, the owner of Continental, with respect to soffit and down spouts which Spears had purchased and needed to be put on the Van Buren house. When the job on Division Street could not go forward, Spears testified that Sztejkowski asked if he had anything else for the guys, if there were any other jobs.

Spears acknowledged that he did not purchase the soffit and gutters through Continental. Spears was present at the Van Buren job site in the morning.

Spears testified that a couple of his employees had gone back to Poland by that time, and he was up against it to get the Van Buren job completed. His customer was not happy.

Sztejkowski testified that, on the morning of December 15, 2011, he was at the job site on Division Street. The job could not go ahead on Division Street, for various reasons. Hajdas was a subcontractor for Continental. Sztejkowski also said that Hajdas worked for him. Hajdas also did work on his own. Sztejkowski

knew Hajdas for approximately 18 years. On jobs where Hajdas had the most experience, he would be the leader. It was Sztejkowski's custom to go to the job sites in the morning and tell the workers what to do.

Sztejkowski acknowledged that he and Hajdas had a conversation at the Division Street job. Sztejkowski denied having a conversation that morning with Spears. Sztejkowski testified that he and Hajdas discussed that they could not continue with the job on Division Street. Hajdas asked if Sztejkowski had any other work for them. Sztejkowski did not have any other work. Hajdas told Sztekjowski that a colleague had another job installing gutters. Sztekjowski testified that he told Hajdas that he and the guys could go there.

Sztejkowski testified that the colleague Hajdas was referring to was Spears. Sztejkowski denied entering into a contract with Spears or High-Tech regarding the house on Van Buren. Sztejkowski denied that Continental performed gutter and downspout installation, which the job on Van Buren entailed. Sztejkowski denied that Continental did roofing work.

Spears' business, High-Tech Remodeling and Construction, Inc., wrote a check dated December 15, 2011 payable to Continental Windows in the amount of $900.00 (Px. 21). Spears acknowledged that Sztejkowski told him to write a check to Hajdas for $900.00. Spears testified that the $900.00 was Continentl's share for the Van Buren job. The memo portion of the check says: "5335 W. Van Buren". (Px. 21)

Sztejkowski acknowledged that he wrote a check to Petitioner in the amount of $500.00. The check was paid from the G & S Paramount account, not Continental's account. (Px. 11) Sztejkowski testified that Hajdas told him he needed to pay Petitioner that amount of money. Sztejkowski testified he also provided a check to Hajdas in the amount of $900.00, representing the payment that Spears issued to Continental (Rx. 4).

Petitioner testified that, on December 15, 2011 at the Van Buren job, they had placed ladders and a scaffold. They were replacing wood, and Petitioner felt a thump. He turned toward Janek, and everything just fell. Petitioner testified that he fell from a height of about 12 feet. After the accident, Petitioner learned that a

bottom of a ladder had broken off. Petitioner testified that he landed on concrete. He believes that he landed on his side. After he regained his wits, he had to locate his locate his glasses. He then slowly tried to get up. He had to use the wall on the adjacent building to climb up to a standing position. Petitioner testified that he had pain that felt like he had been cut in half in the area of his spine. Petitioner testified the accident occurred around 2:30 p.m. He was able to make it to the car and he sat and waited while the others finished around 5:00 p.m. He went home and went to bed. Petitioner did not seek medical treatment for several weeks, although he was laid up and could not work.

At the Van Buren site, Petitioner used his own hammer and tool belt. He did not know who supplied the ladders and scaffold. He could not say that the ladders and scaffold came from Continental.

Petitioner saw Dr. Nasilowski for treatment on January 11, 2012. (Px. 7) Dr. Nasilowski referred Petitioner for an MRI (Px. 3). After the MRI, Dr. Nasilowski referred Petitioner to Dr. Sokolowski for treatment. Both Dr. Nasilowski and subsequently Dr. Sokolowski kept Petitioner off work and placed him in physical therapy. A CT scan was performed as well, in order to rule out spinal fracture. Dr. Sokolowski released Petitioner to return to work without restriction as of July 12, 2012. Sokolowski thought that the MRI showed a L5-S1 annular tear and a L4-L5 herniated disc. (Px. 1)

Petitioner sent Continental a letter, advising of his injury and requesting workers' compensation insurance information via fax on January 27, 2012. Sztejkowski acknowledged seeing the letter around that date. No response was made to the letter. (Px. 9)

At Respondent Continental's request, Petitioner was examined by Dr. Mark Levin. (Rx. 6) Dr. Levin examined Petitioner and reviewed the medical records made available to him. He rendered an opinion that Petitioner sustained an impairment to the extent of 1% of the whole person pursuant to the AMA Guides, Sixth Edition. The MRI and CT showed degenerative findings, not consistent with a trauma. (Rx. 6)

Respondent, Continental also obtained Utilization Review for PT (Partially certified, 16 visits), Work Conditioning (Non certified, 20 visits), and Work Hardening (Non certified, 12 sessions). Dr. Sloane Blair testified in support of the UR findings. (Rx. 7)

Petitioner testified that at the present time, it is difficult for him to bend over, and he has pain in his spine and his low back. He was not in pain at the time of trail. He usually experiences pain when working. He does not participate in recreational activities, as he does not want to aggravate his back. Petitioner continues to work in the construction trade. At the time he testified, he had been employed by Illinois Energy and had done so ever since returning to work. He now makes $15.00 per hour.

Marek Hajdas testified that he paid Petitioner $1,000.00 while he was off work. Petitioner agreed that this amount should be a credit against TTD awarded. There were some conversations between Petitioner and Hajdas that Petitioner's lost time and bills would be paid for by Continental.

Edward Baker testified that he was the president of Second City Construction Company, Inc. 2nd City is a general contractor and has been in business for 35 years. He identified Px. 20 as the contract between Bumpas and 2nd City for the job at 5334 W. Van Buren. Spears had authority to enter into the contract on behalf of 2nd City. 2nd City gets its jobs done via subcontractor, such as High Tech. None of the work at 5334 W. Van Buren was done by 2nd City. High Tech was hired for the Van Buren job. Baker had no knowledge of any involvement on the job by Continental. Spears drives a 2nd City sales van. During his testimony, Baker identified Spears/Zbierajewski as the Mark that owns High Tech and signed the contract for the work at 5334 W. Van Buren. Baker did not identify Marek Hajdas.

Sztejkowski testified that he is the owner of G & S Paramount Construction Company, Inc. G & S does not have workers' compensation insurance. It has no employees. It is located at the same address as Continental. Basically, G & S appears to be a materials purchasing company. The check that was issued to

Petitioner was from the G & S account because Sztejkowski could not get a Continental check because they were locked up.

There may have been a language barrier with some of the witnesses and the Arbitrator will comment on apparent misunderstandings. Further, the Arbitrator finds that the testimony of several witnesses lacked credibility and the same will be commented on below.

First, Sztejkowski answered some questions without the question being interpreted. Sztejkowski's testimony regarding how many times he went to the Van Buren site (and when, and what the reason for the visit was) was inconsistent. He claimed that he never had a work accident at his company—very hard to believe in a construction related business. No evidence of any prior filings against Continental at the IWCC was submitted. He also referred to Marek Hajdas as a subcontractor, but Marek Hajdas was likely an employee. This was likely done to save on taxes and insurance premiums. Sztejkowski did not observe corporate formalities (issuing the check to Petitioner from the G & S account) and appears to have been laundering funds from Hajdas' side jobs through the Continental account. Hajdas was considered to be a trusted colleague, as was Sztejkowski to Hajdas. The Arbitrator believes that Hajdas was not authorized to hire Continental employees.

Petitioner answered questions sometimes before the questions were interpreted. There was no testimony regarding what language the conversation with Sztejkowski that Petitioner alleges established that he worked for Continental was in. Petitioner actually had his own company when he worked for another contractor (Studio 41?). The Arbitrator does not believe that Sztejkowski hired Petitioner as a Continental employee. Petitioner was an employee of Hajdas.

Hajdas started a conversation with Sztejkowski while Hajdas was on the witness stand. The Arbitrator believes that Hajdas thought that a side job was a project that he would have initiated and would have responsibility for and receive the profits for. Thus, the Division Street job and the Van Buren job were Marek

Spears' jobs. Hajdas did not think that work he did as a subcontractor was a side job. Hajdas also spoke in English to the Arbitrator at one point, after the Arbitrator reminded him that he (Hajdas) does not get to asks questions as a witness.

CONCLUSIONS OF LAW

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

A. Act.

The Commission has jurisdiction over this claim under §1(b)2 of the Act because the accident occurred in Chicago. Respondents Continental, 2nd City and High Tech are subject to the Act under §§2, 3(1) and 3(3) of the Act.

B. Was there an employee-employer relationship?

At the time of the accident on Van Buren street, Petitioner was an employee of Marek Hajdas, who was not a named party Respondent (and, likely, uninsured). There was a contract of hire between Hajdas and Petitioner to work some jobs while Petitioner was on layoff during the slow construction season. Petitioner testified that his job was to do what Hajdas told him to do. The evidence does not establish that Continental hired Petitioner to do work for it. If the accident occurred at the Division street job, the Arbitrator would likely have found an employee/employer relationship between Petitioner and Continental, or at least liability pursuant to §1(a)3. In any event, on the Division Street job, liability would have attached to Continental in accordance with §1(a)3 of the Act.

Here, the accident occurred on a job that Continental had no part in. Continental's business involves the manufacture, production and installation of windows. The job on Van Buren involved soffit, fascia and gutters. 2nd City was the principal contractor, and it used High Tech as a subcontractor. High Tech subcontracted with

Hajdas to do the fascia, soffit and gutter work on Van Buren. Hajdas had some materials that were taken from Continental to be used on the Division Street job. Hajdas also bought more materials using High Tech's account. Hajdas is either Petitioner's employer and uninsured, or Petitioner is a subcontractor of High Tech and is uninsured. In either case, liability attaches to High Tech, in accordance with §1(a)3.

The record is clear that Spears controlled the work at the Van Buren job. He paid for the materials; he held the contract; he described what needed to be done. Spears needed help fulfilling the contract he had with 2nd City for the Van Buren job. The Division Street job did not go forward on December 15, 2011. Continental had no work for Marek Hajdas' crew (Hajdas, Marian [Marek Hajdas' neighbor and not a Continental employee], Petitioner and Janek [a Continental employee]). Hajdas' crew would make no money that day unless they worked at the Van Buren job. The members of the Hajdas crew chose to work on that site on the accident date. Respondent High-Tech Remodeling, Inc. is the statutory employer and is liable for compensation benefits to Petitioner.

Regarding the remaining respondents, as to Washington/Bumpas, she clearly is not an employer of Petitioner and she has no liability under any other section of the Act. There was no employee/employer relationship between Petitioner and G & S. G & S has no liability to Petitioner under any other section of the Act. As G & S has no liability, no liability attaches to the IWBF. There is no employee/employer relationship between Petitioner and 2nd City. 2nd City would be liable to Petitioner for compensation under §1(a)3 of the Act, if High Tech did not have workers' compensation insurance.

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

The unrebutted testimony of Petitioner, as corroborated by Marek Hajdas confirms that Petitioner sustained accidental injuries arising out of and in the course of his employment on December 15, 2011.

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

Petitioner denied any prior or subsequent accidents or injuries to his low back. The Arbitrator finds that Petitioner's current condition of ill-being regarding his low back is causally related to the accident herein.

G. What were petitioner's earnings?

Petitioner acknowledged the $500.00 he received was for work he did over a number of days or weeks; it did not represent payment for one week of work. Hajdas and Petitioner testified that Petitioner was to be paid in cash and by check. He was to make $10.00 per hour, working 50 hours a week, to start. The Arbitrator believes this testimony and finds the AWW to be $500.00.

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

The Arbitrator finds that Petitioner incurred medical expenses totaling $53,767.77, prior to application of the fee schedule, as provided in Section 8(a) and 8.2 of the Act, and the same are awarded, as follows: Dr. Nasilowski/Capital Health, Inc., $653.00 (Pxs. 7&8); MRI Lincoln Imaging Center, $650.00 (Pxs. 3&4); Dr. Sokolowski, $1,471.00 (Pxs. 1&2); Clinic of Chicago Professionals, $50,993.77. The said expenses are found to reasonable and necessary to cure or relieve the effects of the injury. The said expenses are causally related to the injury.

The Arbitrator considered the UR opinion of Dr. Blair and finds it not persuasive in this case. First, the basis of the non-cert appears to be based upon the lack of a job description (which, of course can't be given if there is no employment relationship--because there is no job to describe). Petitioner worked in construction and likely performed heavy lifting as a part of his job. Second, the reasonableness and necessity of the work

hardening and work conditioning is established by the fact that Petitioner was able to return to work in construction after the therapy, work conditioning and work hardening.

K. What temporary benefits are in dispute?

Petitioner did not see a doctor until January 11, 2012, this is the first date there was any authorization to be off work. Petitioner was allowed to return to work by Dr. Sokolowski July 13, 2012. The period of time that Petitioner is entitled to TTD is 26-4/7 weeks and the same is awarded at the rate of $360.00/week.

L. What is the nature and extent of the injury?

Since this accident took place after September 1, 2011, the Arbitrator is obligated to consider the factors in Section 8.1(b) of the Act.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that the record contains an impairment rating of 1% of the whole person as determined by Dr. Mark Levin, pursuant to the most current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. (Respondent Continental Ex 6, Ex 2) The Arbitrator notes that this level of impairment does not necessarily equate to permanent partial disability under the Workers' Compensation Act but, instead, is a factor to be considered in making such a disability evaluation. The doctor noted Petitioner has chronic preexisting spondylosis. Because of Petitioner's return to full duty work activities, the Arbitrator therefore gives greater weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a laborer at the time of the accident and that he is able to return to work in his prior capacity as a result of said injury. The Arbitrator notes that Petitioner has returned to work as a laborer doing the same job as he was performing on the accident date. Because of Petitioner's return to full duty work activities, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 57 years old at the time of the accident. Because Petitioner is older, the Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes Petitioner is earning more now than before his accident. Because of the increase in earnings, the Arbitrator therefore gives no weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes on his last visit to Dr. Sokolowski on July 11, 2012, Petitioner had tenderness to palpation and pain with hyperextension; otherwise he had a normal exam. He could lift up to 90 pounds. Petitioner testified only to subjective complaints of pain at trial and has not seen a doctor in two years for his back. Because of Petitioner's ability to work as a laborer and lack of medical care for two years for his back, the Arbitrator therefore gives lesser weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 5% loss of use of use of the personn as a whole pursuant to §8(d)(2) of the Act.

M. Should penalties or fees be imposed upon Respondent.

There is no evidence that petitioner ever made demands upon Respondent High-Tech to pay TTD or medical expenses. There is ample evidence of record to call into question exactly who was Petitioner's employer at the Van Buren job. The disputes by the respondents in this case do not appear unreasonable. Therefore, Petitioner's Petition for Penalties and Attorney's Fees is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF ADAMS)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

John M. Carpenter,
Petitioner,

vs. NO: 04 WC 31927

Snelling Personnel Services &
RPG Manufacturing,
Respondent.

18IWCC0244

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, permanent partial disability, medical expenses, prospective medical expenses, penalties, attorney's fees, evidentiary rulings, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 7, 2016 is hereby affirmed and adopted.

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

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

18IWCC0244

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

DATED: APR 18 2018

Joshua D. Luskin

o-04/11/18
jdl/wj
068

Charles J. DeVriendt

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CARPENTER, JOHN M
Employee/Petitioner

Case# **04WC031927**

06WC047049

SNELLING PERSONNELSERVICES AND RPG MANUFACTURING
Employer/Respondent

18IWCC0244

On 9/7/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.47% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0393 THOMAS R LICHTEN LTD
53 W JACKSON BLVD
SUITE 224
CHICAGO, IL 60604

2795 HENNESSY & ROACH PC
JENNIFER YATES WELLER
415 N 10TH ST SUITE 200
ST LOUIS, MO 63101

STATE OF ILLINOIS)
)SS.
COUNTY OF ADAMS)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

John M. Carpenter
Employee/Petitioner
v.

Case # 04 WC 31927

18IWCC0244

Snelling Personnel Services and RPG Manufacturing
Employer/Respondent

Consolidated cases: 06 WC 47049

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Quincy**, on **July 6, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☒ Is Respondent due any credit?
O. ☒ Other **Hold Harmless; Admissibility of PX5 and PX 17**

18IWCC0244

FINDINGS

On, **12/17/2001** 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 **$19,500.00**; the average weekly wage was **$375.00**.

On the date of accident, Petitioner was **36** years of age, ***single*** with **1** dependent child.

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

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

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

Respondent is entitled to a credit of **$-0-** for any medical bills paid by a group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of **$225.00/week** for **41.12 weeks** because the injuries sustained caused the additional **17.5% loss of use of Petitioner's left arm** and permanent partial disability benefits of **$225.00/week** for **33.25 weeks** because the injuries sustained caused the additional **17.5% loss of Petitioner's left of use hand**, as provided in Section 8 (e) of the Act. The total number of weeks of PPD being awarded is **74.37**. This permanency award is in addition to the statutory amputations of 100% loss of use of Petitioner's left index finger and left long finger previously paid by Respondent.

Respondent shall pay reasonable and necessary medical services of **$171.00** as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner compensation that has accrued between **December 17, 2001** and **July 6, 2016** and shall pay the remainder of the award, if any, in weekly installments.

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

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

Nancy Lindsay
Signature of Arbitrator

September 3, 2016
Date

SEP - 7 2016

John M. Carpenter v. Snelling Personnel Services and RPG Manufacturing, 04 WC 31927

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner is alleging injuries to his left upper extremity, elbow, hand, and wrist, as a result of an undisputed accident occurring on December 17, 2001 while he was employed by Respondent herein. Petitioner also has a case pending against Adecco Employment Services and J.M. Huber (#06 WC 47049) in which he alleges injuries to his left upper extremity, elbow, hand, and wrist and low back and neck as a result of an accident occurring on January 6, 2005. A 19(b) hearing was held in case #04 WC 31927 on October 4, 2006.

The Arbitrator finds:

The Arbitrator acknowledges the prior 19(b) hearing held in this matter and that findings of fact and conclusions of law were rendered on the issues in dispute at the time of that hearing, including causal connection through October 4, 2006 and prospective medical care. She has reviewed the transcript of the earlier proceeding, including all admitted medical records considered by the Commission, solely in light of the issues presented to her in this proceeding.

Summary of the October 4, 2006 19(b) Hearing

On December 17, 2001 Petitioner was working for Snelling Temporary Services at a company called RPG Manufacturing. At that time a stamping machine came down on his left hand and he lost his left index finger and a half or more of his left long finger. He was immediately taken to Blessing Hospital where he was treated. Petitioner underwent surgery with Dr. Craig Olson consisting of an amputation of the left index finger down to the metacarpophalangeal joint and an amputation of the left long finger down to the proximal part of the middle phalanx. (PX 1 – pet. ex. 1, pet. ex. 3, res. ex. 4)

Petitioner continued to follow up with Dr. Olson. Dr. Olson's records reflect an ongoing desire to get Petitioner back to work as it would constitute "valuable therapy." (PX 1 – pet. ex. 1 1/23/02 o/n) Petitioner underwent physical therapy from January 16, 2002 through February 27, 2002 and, at discharge, was noted to have had 100% resolution of his therapy problems. He was instructed to continue with his home exercise program which was designed to help with strengthening and desensitization. (PX 1 – pet. ex. 1, pet. ex. 2, res. ex. 4)

According to Dr. Olson's March 5, 2002 office note, Petitioner was working as a cook and doing okay. Petitioner reported that he would occasionally experience some abnormal sensations and that vibratory machinery "seemed to set him off." Dr. Olson felt cooking would be okay but that he should refrain from any vibratory machinery for about two months. (PX 1 – pet. ex. 1, res. ex. 4) As of April 30, 2002 Petitioner was doing much better and it was felt he was at maximum medical improvement. Petitioner reported he was working full-time as a cook and doing well with that. Dr. Olson suspected Petitioner might need a finger compression glove at some point but didn't need to see him again for a year. (PX 1 – pet. ex. 1, res. ex. 4)

Petitioner returned to see Dr. Olson one year later on April 29, 2003 reporting no current desensitization problems and almost symmetric grip strength with the right side. Petitioner was reportedly doing "regular work" and noticing less and less occasional cramping in his hand. Dr. Olson felt Petitioner would have excellent function with it and very little limitation. Petitioner was released with no restrictions and told to return as needed. (PX 1 – pet. ex. 1; res. ex. 4)

On February 24, 2004 Petitioner underwent a pre-employment examination lumbar spine x-ray per Dr. Philip Wilson. The x-ray revealed significant degenerative changes in the lower lumbar spine with bilateral spondylolysis at L5 with 20% anterior spondylolisthesis of L5 on sacrum. (PX 1 – pet. ex. 1, res. ex. 4)

Petitioner filed his Application for Adjustment of Claim in this case on June 16, 2004, alleging "left hand and body injuries as a result of an accident on December 17, 2001. (AX 2 to TA from 10/4/06; AX 2)

Petitioner returned to see Dr. Olson on January 6, 2005 reporting numbness and tingling of his left upper extremity and pain at night. Dr. Olson noted that Petitioner had had multiple jobs since his injury. He noted, "With heavy lifting and things of that nature he has started to get numbness and tingling at night, pain that wakes him up from his sleep and his remaining long finger and the ulnar side of his ring finger and thumb are numb. Dr. Olson wrote, "[Petitioner] said this injury happened on 12/17/01 when he lost the fingers with a 60 ton press. Nothing seemed to help." (PX 1 – pet. ex. 1, res. ex. 4) On examination Petitioner had a positive Tinel's on the left side at the carpal tunnel. Dr. Olson suspected carpal tunnel syndrome "until proven otherwise." He noted it had been ongoing for several months without resolution and added, "He feels this is work related. In my opinion, I think it is related to the function of his hand with the amputated digits." An EMG was recommended along with a cock-up wrist splint which Petitioner had already been wearing for some time He was taken off work until the EMG results were received. (PX 1 – pet. ex. 1, res. ex. 4)

On February 8, 2005 Petitioner filed his Notice of Motion and Order in this case regarding a hearing on a 19(b) Petition and Petition for Attorney's Fees and Penalties which was scheduled for March 2, 2005. (PX 1 – pet. ex. 7)

On March 21, 2005 Petitioner filed his Notice of Motion and Order in this case regarding a hearing on a 19(b) Petition and Petition for Attorney's Fees and Penalties which was scheduled for April 6, 2005. (PX 1 – pet. ex. 8, pet. ex. 9)

On/about March 31, 2005 Petitioner failed to appear for his shift at County market Express and the manager for County Market Express had to hire someone else to work his shift. (PX 1 – pet. ex. 5)

Petitioner's case against Respondent herein proceeded to arbitration on a 19(b) Petition on October 4, 2006. The issues in dispute were causal connection, medical, prospective medical care, TTD, and penalties and attorney's fees. (10/4/06 T.A. pp. 4-5) Petitioner testified that he is right handed. Petitioner further testified that on December 17, 2001 he was working for

Respondent at a company called RPG Manufacturing. At that time a stamping machine came down on his left hand and he lost his left index finger and a half or more of his left long finger. He was immediately taken to Blessing Hospital where he was treated. Petitioner subsequently underwent physical and occupational therapy and he began receiving TTD benefits. Those benefits were terminated as of February 4, 2002. (10/4/06 T.A. pp. 21 – 24)

Petitioner further testified that he was released by Dr. Olson on January 23, 2002 with instructions to avoid vibratory machines and "things like that." Petitioner testified that he contacted Respondent about going back to work but he never received any follow-up. Petitioner testified to trying to find other jobs thereafter, eventually finding full-time employment at Santino's Mexican Restaurant around March 5, 2002. Petitioner worked there for about six months. He would cook tortilla chips in a deep fryer which required him to "grab tortilla chips, throw them out and dip with a pair of tongs." He would use his right hand. Petitioner further testified that he would also help with prep in the morning and be "on the pans" mainly used for fajitas. According to Petitioner, he did not have to use his left hand for cooking with the cast iron skillets because they were heavy, awkward, and he couldn't grip them correctly. Petitioner did not have to clean the dishes or the grill. He further testified that he could pretty much perform all of his necessary job duties although when he cut steak he couldn't do so the way he normally would. There was a machine that automatically diced the onions, tomatoes, and peppers. To make salsa, he would open up a can of diced tomatoes, put it in a can, and use a whip to stir it up. Petitioner testified that the cramping and tingling showed up in his hand after working at Santino's.

Petitioner was unemployed from approximately July through October of 2002.

Petitioner then began working for Industrial Support Services "taking up plastic" and putting it in a box and running it through a tape machine. He would hold a small plastic piece with his thumb, ring finger and pinky and a glue gun with his right hand. He did that job for about a year. On cross-examination Petitioner testified that it was seasonal forty hour work for six months "off and on." He did the "glue gun" job for about three days. The remaining time he worked as a packer folding box lids in and putting the lid down for the tape machine.

Petitioner also testified that, through Adecco, he found a job at JM Huber where he would use a tow motor to put two ton sacks into a machine, let it drain, and then separate the product. He also bagged fifty pound bags every day. He would use both hands to pull the product off because he couldn't grab with just one. He described the job as a lot different from his other jobs but paying better. It was a forty hour work week. He could not recall when he went to work for Huber. He thought it was around the end of 2003. On cross-examination he agreed that he worked there from March of 2003 through March of 2004. Petitioner testified that while working for Huber he noticed that his left hand would go numb. He would get home from work and notice numbness and tingling. Petitioner testified that when he would get home from work he couldn't even grab a glass of water to drink. The longer he worked there the worse his symptoms became and he eventually went back to Dr. Olson on January 6, 2005. Petitioner testified that Dr. Olson wanted him to undergo a test and stop working but

workman's compensation denied both. At the time of the 19(b) hearing Petitioner had an appointment scheduled for December 14th with Dr. Lockhart and had insurance to cover it.

On cross-examination Petitioner agreed that he was unemployed from March of 2004 through March of 2005.

Petitioner testified that he began working for County Market Express on March 7, 2005 as a part-time cashier. He also stocked soda and beer. He mainly used his right hand. Petitioner worked at County Market for about three months before he was terminated.

Petitioner testified, on cross-examination, that he didn't immediately go to work after his employment with County Market Express ended. He moved to St. Louis for personal family reasons and he worked at O'Reilly's Auto Parts as a cashier.

Petitioner attended an IME with Dr. Ollinger on March 31, 2005.

At the time of his 19(b) hearing Petitioner was working for Manchester Tank as a welder, having begun in May of 2006. He described his job as that of a "Mig welder" and that it required the use of his right hand. Petitioner testified he was working full duty and full-time.

Petitioner testified to difficulties he had with everyday activities and how he uses his hands. Petitioner testified that in order to cut steak he has to put the fork in his left hand to cut with his right hand and if the fork gets on what's left of his middle finger, it "gets on that nerve in there" and he ends up dropping the fork. Petitioner testified that it is difficult to work with his hand all day and he can't pick things up anymore. Sometimes it is difficult for him to tie his shoes or button his pants. It often depends upon how much he has worked his hand on a particular day. His hand still goes numb and tingles. Petitioner also testified that if he tries to use his middle finger it cramps and shakes. Petitioner testified that his ring finger goes numb. He takes more time to do things such as washing dishes or grabbing plates and glasses. He further explained that since his hand goes numb he tries not to use "this finger" as much because of the nerve so he uses his thumb to grip. Petitioner testified that he has pain on the top half of his hand and the thumb. He knows when cold weather is coming because his hand will have a dull ache and cramp. Petitioner testified that he wished to undergo the EMG test if the doctor still thought it was necessary. He also wished to undergo carpal tunnel surgery if it was deemed appropriate. (T.A. 10/4/06)

Post -19(b) Hearing Developments

On October 23, 2006 Petitioner signed his Application for Adjustment of Claim in case # 06 WC 47049 against Adecco Employment Services and J.M. Huber. Petitioner alleged an accident date of January 6, 2005 and alleged injuries to his left hand and body. (AX 4)

On November 21, 2006 the Arbitrator entered his Decision in case #04 WC 31927. The Arbitrator found that Petitioner's left carpal tunnel syndrome was not caused or aggravated by

the amputation injury he sustained on December 17, 2001 and denied Petitioner's claim for treatment of his left carpal tunnel syndrome. [1] Petitioner appealed the Arbitrator's Decision.

Petitioner presented to Dr. Jim Daniels on December 17, 2007 for a re-evaluation having last been seen approximately one year earlier albeit by Dr. Hambrick. Dr. Daniels noted that when previously seen the examining doctor did not think Petitioner had the correct symptoms for carpal tunnel syndrome but, rather, might have had entrapment of the median nerve in his forearm secondary to hypertrophy of the other flexor muscles that had hypertrophied since his amputation injury. Dr. Daniels noted Petitioner's case was very complex in that his workers' compensation claim was initially denied and then allowed. Petitioner was no longer working at Manchester Tank. He had injured his back although it was reportedly "not bothering him too much" at the time of the visit and he was currently unemployed. Petitioner's main symptoms were pain, achiness, and numbness in his left upper extremity. He also complained of some left upper shoulder pain. Dr. Daniels noted a change in Petitioner's physical examination as his forearm was not as large as it had been when previously seen. Median nerve compression testing at the wrist didn't really reproduce his symptoms until just the last couple of seconds. His primary positive finding was a positive Phalen's sign at the elbow. The ulnar nerve did not appear subluxed. He was non-tender over Guyon's Canal. He could abduct his thumb without difficulty. Two-point discrimination testing wasn't that good over what was left of the amputated finger but he had a 3 or 4 point discrimination pattern on the ring and small finger. Dr. Daniels felt Petitioner's case was indeed a complex one with some social issues as it had been going on for so long. His exam that day was less suggestive of pronator teres syndrome (as previously suspected) and more that of ulnar nerve entrapment. Petitioner wished to see Dr. Mackinnon as they had spoken about that before and a referral was to be made. Petitioner was also advised that some of his shoulder problems might be stemming from his cervical issues. (PX 16, pet. ex. 3)

In conjunction with his appointment with Dr. Mackinnon, Petitioner underwent an EMG on February 14, 2008. The study was read as within normal limits and with no electrodiagnostic evidence for left median or ulnar neuropathy. (PX 15, dep. ex. 2; PX 16, pet. dep. ex. 3)

In a letter dated February 16, 2008 Dr. Susan Mackinnon reported on her evaluation of Petitioner performed two days earlier. (PX 15, dep. ex. 2; PX 16, pet. dep. ex. 3) Dr. Mackinnon noted that Petitioner presented with his sister and case manager and complained of significant numbness and tingling and pain in the left ulnar nerve distribution in his left proximal forearm. Petitioner gave a history of sustaining a crush injury to his left hand in December of 2011 that had resulted in an amputation of his index finger and middle finger at the PIP joint. Petitioner further stated that in 2005 he began developing numbness and tingling in the ulnar nerve distribution of his left hand and aching in the medical aspect of his left forearm. Petitioner also reported sensitivity at the amputation stump especially in the long finger and he was starting to drop things. Additional complaints included an aching in the medial aspect of his elbow. Electrodiagnostic studies reportedly showed mild left cubital tunnel syndrome. Petitioner

[1] While not an exhibit in either Petitioner's or Respondent's exhibits, the Arbitrator takes judicial notice of the Commission's Decision.

denied any median nerve symptoms. Petitioner rated his pain at "9/10" and believed it had a 90% impact on his quality of life. Petitioner had thought about suicide in the past but had not thought out any details. Petitioner also reported back pain but having no health insurance to cover any treatment. Petitioner was reportedly depressed. (PX 15, dep. ex. 2)

Dr. Mackinnon noted that Petitioner was divorced with a 17 year old child. He smoked two packs of cigarettes a day and had done so for thirty years. He was an occasional beer and whiskey drinker. Petitioner's medications included occasional aspirin, Vicodin, Advair, and Proventil. He had gained more than ten lbs. in the preceding year. Petitioner's other medical problems included sleep apnea, chronic bronchitis, a fracture in his left arm[2], low back pain and occasional headaches. (PX 15, dep. ex. 2)

Dr. Mackinnon performed a physical examination which she detailed in her report. She recommended that Petitioner undergo a left ulnar nerve transposition and a release, to a significant degree, of the median nerve in the proximal forearm. She further recommended a release of the left ulnar nerve through Guyon's Canal specifically releasing the deep motor branch. Dr. Mackinnon also addressed with Petitioner a possible tenotomy of the profundus tendons of the index and long finger as she felt his forearm pain was more related to a quadriga effect rather than a pronator teres syndrome. Dr. Mackinnon indicated she could perform surgery the next day if possible. She also believed that at some point in time Petitioner might need a more definitive pronator teres release but she was optimistic she could relieve Petitioner's pain without an anterior forearm incision. (PX 15, dep. ex. 2)

Surgery as recommended by Dr. Mackinnon was cancelled due to insurance issues. (PX 15, dep. ex. 2)

On February 26, 2008 Petitioner filed a Petition for Penalties and Attorney's Fees in this case. He set the Petition, as well as a 19(b) Petition for hearing on March 5, 2008. (PX 3)

On March 10, 2008 Petitioner filed a Notice of Motion and Order in this case regarding his intent to proceed to hearing on April 2, 2008 regarding his 19(b) Petition and Petition for Attorney's Fees. (PX 4)

Dr. Henry Ollinger evaluated Petitioner on March 19, 2008. (RX A, dep. ex. 2)[3] As part of the examination Dr. Ollinger was provided with copies of Petitioner's testimony from the transcript of the October 4, 2006 19(b) hearing (pp. 21 – 62). He was also provided with a copy of Dr. Daniels' 12/17/07 report and Dr. Mackinnon's 2/16/08 report. Dr. Ollinger's report discussed the work history provided to him by Petitioner. Petitioner reported that he worked as a temporary worker at Manchester Tank from February through May of 2006. He was then hired full-time as a head press operator and worked there through January 3, 2007. As a head press operator Petitioner rolled and pulled cylinders onto an angle iron which stabilized it from

[2] Records found in PX 1 indicate Petitioner fractured his left arm as a child.

[3] While Petitioner's attorney and Respondent Adecco's attorney argued the doctor's reports were inadmissible hearsay at the time of the deposition, the Arbitrator overruled those objections as the doctor was being deposed and was, therefore, available for adequate cross-examination and inquiry regarding those reports.

rolling and he would put end caps on the right end with his right hand and on the left side with his left hand. He held a MIG welder in his right hand to put a couple of tacks into each cap to hold them in place and then rolled the cylinder to the head press that completed the process of sealing the caps. He would then add a few more tacks with the MIG and roll the cylinder to the next station. Petitioner described the work as rapid because there was a quota but it wasn't heavy or hard work. Petitioner described the hardest part of the job as requiring a one-time weekly lift of 10-15 lb. tanks. Most of the other tanks were rolled. Petitioner also described some prior employment at a gas station and before that he had been unemployed for six months. Prior to that (May of 2004 to May of 2005) he worked through Adecco at JM Huber and while working there he had seen Dr. Olson for left upper extremity symptoms. He also recalled being a cook in early 2002. Dr. Ollinger noted in his report that Petitioner's summary of his job history in 2008 was somewhat different than what he had provided to the doctor at a previous examination held in 2005.

Petitioner gave Dr. Ollinger a history of left-sided symptoms beginning when he was working at J.M. Huber through Adecco. Again, the doctor noted some inconsistencies regarding the time frame of this employment but he noted that Petitioner consistently attributed the onset of the complaints to his work at JM Huber. Petitioner told Dr. Ollinger that Dr. Daniels had referred him to Dr. Mackinnon and that prior to being examined by her he had undergone new nerve conduction studies but "Work Comp did not approve a carpal tunnel release because the NCV's were reported as revealing another condition and not carpal tunnel and that Dr. Mackinnon recommended operations which were not carpal tunnel and therefore not approved." (RX A, dep. ex. 2, p. 3 of 2008 report) Petitioner's current complaints included waking up with the little and ring fingers and, occasionally, the long finger feeling numb. On physical examination Dr. Ollinger noted Petitioner's prior amputations. Petitioner was tender at the ulnar nerve of the left elbow and had a positive Tinel's and positive elbow flexion test at the elbow. Petitioner also had a positive Tinel's at the carpal tunnel and a positive Phalen's primarily producing pain in the long and ring fingers but not the little finger. Provocative maneuvers of the median nerve of the forearm and radial nerve of the forearm were negative as was Spurling's maneuver. On the topic of "Impression," Dr. Ollinger wrote, "His history and examination change in the record through time. See below." (RX A, dep. ex. 2, p. 4 of 2008 report)

Under "Discussion" Dr. Ollinger wrote that Petitioner's changing histories, examinations, and employers over time made for difficulty rendering opinions within a reasonable degree of medical certainty. He had no doubt that each doctor, in turn, reported the history as Petitioner provided it at that time. He felt Dr. Phillips should perform an electrical study on Petitioner's left upper extremity as he was not currently impressed that Petitioner's symptoms were being generated by any tendon situation in his hand or fingers. Until he could see the results of such testing he had no other comments or opinions. However, Dr. Ollinger added, "That being so, at this time I am giving energy that his symptoms actually did change through time and consequently his diagnosis changed and that there may well be another employer involved. What we all need to do is agree exactly when his symptoms changed from median carpal tunnel to ulnar nerve cubital tunnel and for whom he was working at that time.

If his diagnosis changed from the carpal tunnel diagnosis that I made when he was working for Huber to a cubital tunnel diagnosis when he was working for another company that changes this whole case." (RX A, dep. ex. 2, p. 4 of 2008 report)

Dr. Ollinger issued another report on July 8, 2008 having reviewed the NCV and EMG of Dr. Al-Lozi performed on February 14, 2008 and read as normal. Based upon it and the report of Dr. Mackinnon dated 2/16/08, Dr. Ollinger was unable to diagnose the etiology of Petitioner's current complaints within a reasonable degree of medical certainty. He recognized, however, the amputation of the left index finger and partial amputation of the left long finger from the December 17, 2001 injury. "No other diagnosis that may be considered in his left upper extremity would related to the work accident of 12/17/01." Dr. Ollinger offered no surgery. He noted Dr. Mackinnon's recommendations and felt he would let her explain the basis for her opinions on treatment. The doctor wrote, "the histories and exams that I have available to me whether they be through record or through direct interview with [Petitioner] do not allow me to determine within a reasonable degree of medical certainty that his current condition or considered treatment, whatever that may or may not be, related to the work accident of 12/17/01 – I see no basis that there is a relationship by cause or aggravation." (RX A, dep. ex. 2, p. 1)

Evidence Deposition of Dr. Henry Ollinger taken 10/14/10

The deposition of Dr. Henry Ollinger was taken on October 14, 2010. Dr. Ollinger, a board certified plastic surgeon specializing in hand and upper extremity work, evaluated Petitioner on March 19, 2008. He had seen him previously in 2005. As part of the 2008 examination Dr. Ollinger reviewed various medical records provided to him prior to his 2005 exam along with pages 21 through 62 of the transcript of Petitioner's testimony at the 19(b) hearing on October 4, 2006, a two page report of Dr. Jim Daniels dated December 17, 2007 and a report of Dr. Mackinnon dated February 16, 2008. Dr. Ollinger further testified that he took a history from Petitioner with Petitioner telling him he had last worked on January 3, 2007 at Manchester Tank, having begun there in February of 2006 through a temporary service and then being hired in May of 2006. Prior to working for Manchester Tank, Petitioner had worked at O'Reilly's Auto Parts and then he was unemployed for six months. Dr. Ollinger testified that Petitioner failed to tell him he had worked at a supermarket for six months and that before that he had worked at JM Huber, ISS, and Snelling.

Dr. Ollinger testified that Petitioner told him he was experiencing left upper extremity symptoms that began while he was working for JM Huber. He also recalled his visits with Dr. Daniels and Dr. Mackinnon and undergoing nerve conduction studies. Dr. Ollinger performed a physical examination noting Petitioner's complete amputation of his left index finger and partial amputation of his left long finger. Petitioner reported some numbness and tingling in the left little and ring fingers. He had a positive Tinel's at the left elbow and positive elbow flexion test. Petitioner also had a positive Tinel's and Phalen's at the carpal tunnel. Spurling's was negative. Provocative maneuvers to the median nerve in the forearm and radial nerve of the forearm were negative. Dr. Ollinger testified that he was unable to arrive at a specific diagnosis at that time as he wished to be cautious by recommending nerve conduction studies and EMG

to have additional objective evidence to consider. Thereafter, Dr. Ollinger was provided with the February 14, 2008 EMG/NCV study which was normal. Based upon his review of that study he was unable to establish a diagnosis within a reasonable degree of medical certainty that would explain Petitioner's symptoms (other than the amputations).

Dr. Ollinger testified that he was unable to make a diagnosis of carpal tunnel syndrome. He explained that Petitioner's 2008 symptoms in his ring and little fingers are usually related to the ulnar nerve as opposed to the median nerve. Further, Petitioner's history had changed through time and his nerve conduction study was normal but his symptoms had been ongoing for a long time. Dr. Ollinger explained that, in his experience, if someone has symptoms for that long a period of time, the nerve conduction studies should be abnormal. He further noted that Petitioner's median nerve symptoms dated back some time and had waned and, more currently, the ulnar nerve distribution symptoms were becoming prominent. The doctor acknowledged Petitioner's symptoms but didn't believe they were attributable to carpal tunnel syndrome.

Dr. Ollinger testified that he recommended Petitioner undergo another EMG/NCS for the left upper extremity.

On cross-examination Dr. Ollinger testified regarding his charges for examinations and depositions and the number of exams he performs for employer. He acknowledged that his deposition is frequently taken in cases where he does not find causation between one's carpal tunnel syndrome and one's employment; however, he testified that there are any number of times he does find causation thereby obviating the need for his deposition.

Dr. Ollinger also acknowledged that there were some missing bits of information provided by Petitioner regarding his history but he wouldn't characterize Petitioner as a poor historian. Rather, he felt Petitioner lacked, "quite normally," some uncertainties about dates given the passage of time. Dr. Ollinger estimated that he spent about thirty minutes with Petitioner on March 19th and that he, himself, took the history and conducted the discussion.

Dr. Ollinger testified that he has seen situations where an individual had normal nerve conduction studies, proceeded with surgery, and subsequently improved. He has also seen situation where they didn't get better and that even with positive nerve conduction studies the results after surgery are not predictable. He agreed that someone experiencing carpal tunnel syndrome could have portions of one's ring finger affected by symptoms. Classically it's the radial side (thumb side) of the ring finger but it can affect all five fingers. Dr. Ollinger further testified that pronator teres syndrome is an entrapment of the anterior interosseous branch of the median nerve of the forearm and produces hand weakness without paresthesias and the muscles are inundated by that. He testified that he wanted Dr. Daniels to perform the nerve conduction studies because he is a neurologist and does nothing but NCVs and EMGs. He likes the quality of his work and reports. Dr. Ollinger testified that when he issued his March of 2008 report he knew that electrical studies had been done as Dr. Mackinnon noted as much but he had not seen them. He acknowledged that Dr. Al-Lozi performed the tests he wanted done and he reviewed them. Dr. Ollinger had less experience with Dr. Al-Lozi than Dr. Phillips.

Dr. Ollinger was asked some questions about Dr. Mackinnon's opinions and reports. He testified that he would defer to her to explain her reasoning regarding her opinions. He found her report somewhat confusing as it appeared she wished to operate on the nerve in Petitioner's forearm but was stating "it" was probably more related to the tendon. He explained that "quadriga effect" is adhesions of flexor tendons that can occur after tendon injuries and primarily involve the little, ring and long fingers because the injuries there produce enough scar that it affects the range of motion of the other. It can occur with amputations and is a type of "tethering." Dr. Ollinger explained that the tethering, in his experience, is almost always limited to motion consequences in the finger joints themselves where an amputation is because of the way the tendons scar down after the injury and affect the flexion of the joints of adjacent fingers. Dr. Ollinger believed that Dr. Mackinnon was suggesting operating on the tendons in Petitioner's fingers to relieve the forearm pain because she believed that might be where the forearm pain was coming from but she was also talking about decompressing the forearm nerve. However, in Dr. Ollinger's opinion, the nerve conduction studies didn't support a pronator syndrome, objectively. Dr. Ollinger noted that Dr. Mackinnon was also discussing/recommending a left ulnar nerve transposition at the same time.

Dr. Ollinger agreed that Petitioner's case was a difficult and complex one. The doctor agreed that Petitioner has irritated nerves at the wrist and at his elbow. Some doctors would operate and others would re-study. He did not believe any of Petitioner's symptoms were related to the Arcade of Frohse because that would be the radial nerve and only Petitioner's ulnar and median nerves are currently "in play." He also explained that Guyon's Canal is a neighbor of the carpal tunnel but on the little finger side of the wrist. (RX A , pp. – 100)

On cross-examination by Adecco's attorney Dr. Ollinger agreed that Petitioner provided different histories at different times. Those differing opinions don't make it impossible to render a causation opinion but it made it more difficult. He explained that there is a point, however, when it becomes very difficult and such was the case when the doctor saw Petition in 2008. Dr. Ollinger agreed that Petitioner is right hand dominant and that Petitioner never had any right-sided symptoms. He acknowledged that Petitioner never presented to him with any history of using his left hand/upper extremity in a way that would cause the doctor to think he had left cubital tunnel syndrome but not right cubital tunnel syndrome.

Dr. Ollinger believed Petitioner worked at JM Huber from March of 2003 to March of 2004 and used both hands. He agreed that he had no opinion as to the current medical condition in Petitioner's left upper extremity. He also acknowledged that he had no current opinion as to whether any condition in Petitioner's left wrist or left upper extremity was causally related to any work he might have performed as an employee at Adecco. The doctor confirmed that that would apply to his exam in 2008 as well as at the time of his deposition. (RX A, pp. 100 – 114)

Evidence Deposition of Dr. Craig Olson taken 8/30/11

Dr. Olson is a board certified orthopedic surgeon previously licensed to practice medicine in Illinois from 1997 through May of 2005. Dr. Olson treated Petitioner for his

December 17, 2001 traumatic amputations to his entire left index finger and left middle finger amputation at the pip joint. (PX 14, pp. 1 -6)

Dr. Olson testified that he last saw Petitioner on January 6, 2005. At that time Petitioner was having some left-sided symptoms consistent with carpal tunnel syndrome or median nerve changes as well as some ulnar ring finger symptoms. He recommended an EMG. He didn't know if that ever occurred. Dr. Olson believed that Petitioner's symptoms as of January 6, 2005 were related to his traumatic amputation either directly or indirectly. (PX 14, pp. 6-8)

Dr. Olson acknowledged that he was provided with records from Dr. Mackinnon to review. While he didn't know her, he was familiar with her expertise to a certain degree. Dr. Olson testified that Dr. Mackinnon recommended performing ulnar releases at the cubital and Guyon Canal for Petitioner's ulnar nerve as she felt his forearm had some area of entrapment on the medial nerve that needed to be released. Dr. Olson felt Dr. Mackinnon's surgical recommendation was appropriate. He also believed that Dr. Mackinnon's findings on February 14, 2008 were related to the trauma of December of 2011 because the accident caused some effect to the nerves that were crushed with Petitioner's hands or due to the change in function of the hand after the fingers were amputated. He also believed that the tethering effect of the profundus tendon was due to the trauma. Dr. Olson agreed that Dr. Mackinnon didn't note any diagnosis of carpal tunnel syndrome; however, she had the benefit of an EMG which he didn't have when he examined Petitioner in January of 2005. (PX 14, pp. 8 – 14)

On cross-examination Dr. Olson acknowledged that he initially released Petitioner back to work at maximum medical improvement as of April 29, 2003. At that time Petitioner's grip strength was almost symmetric and he had been working with occasional cramping but even that was becoming less common. He also agreed that at that point in time he thought Petitioner was going to have excellent function with very little limitation and he had no reason to be concerned with any type of nerve compression. (PX 14, pp. 14-16)

Dr. Olson acknowledged that after April 29, 2003 he did not see Petitioner again until January 6, 2005 at which point Petitioner was complaining of symptoms with heavy lifting. He agreed that he had never prohibited Petitioner from heavy lifting when he examined him in April of 2003. When asked if the nature of the work Petitioner described to him in January of 2005 could have placed some kind of a contributing cause to his condition at that time, Dr. Olson noted it would "be difficult to be able to divide them out, but it's certainly possible." (PX 14, p. 17)

Dr. Olson further testified that Petitioner does not have a normal hand and he has less fingers to work with. As a result, Dr. Olson felt Petitioner was more likely to have these neuropathies because of the changes of his hand when working with it. (PX 14, p. 31) He further testified that had Petitioner had a normal hand, he might not have developed any neuropathies. He also acknowledged that his work activities (such as with Adecco) could have caused him to develop the neuropathies as well. Dr. Olson also testified that as of April in 2003 he could not say he had no concerns whatsoever that Petitioner might develop ulnar or median compression neuropathies. (PX 14, pp. 31-33) Dr. Olson also acknowledged that he had a very limited

understanding of Petitioner's work activity and he was unaware that Petitioner wasn't working from April of 2004 through January 6, 2005. If he wasn't working the doctor would have expected some improvement in Petitioner's symptoms. (PX 14, p. 56) Finally, Dr. Olson testified that despite the fact there might be other activities which might have accelerated or brought on some of Petitioner's symptoms, he was still of the opinion that Petitioner's December 17, 2001 injury was the primary cause of those symptoms and he could not sever the relationship between the accident in December of 2001 as being the cause for his current symptoms. (PX 14, p. 60)

Evidence Deposition of Dr. Susan Mackinnon taken on 10/12/12

Dr. Mackinnon testified she is board certified in plastic surgery and restricts her practice to nerve injuries, most notably in the upper extremities. Dr. Mackinnon testified that she evaluated Petitioner on February 14, 2008 at the referral of Dr. Daniels. She has only seen him on that one occasion. (PX 15, pp. 1 – 10)

Dr. Mackinnon testified consistent with her earlier written report furnished to Dr. Daniels. In addition Dr. Mackinnon testified that the EMG she ordered as part of the exam was normal but she attributed no significance to that finding as she had recommended the EMG simply to have a baseline of Petitioner's nerve function. He appeared to have normal electrical function in his left hand and after she operated on him she hoped he would continue to have normal function. According to Dr. Mackinnon probably ten to twenty percent of electrical studies are normal in patients with carpal tunnel and cubital tunnel syndromes. The doctor explained that pain is transmitted through very tiny nerve fibers and aren't always picked up on electrical studies. (PX 15, pp. 10-11)

Dr. Mackinnon further testified that Petitioner's primary problem was pain and he had evidence of a quadrigia effect. Dr. Mackinnon compared the quadrigia effect to four horses being asked to pull a chariot. The horses are like tendons in one's hand and there are four that go to the small, index, ring and long finger. The tendons meet in a common muscle belly so that when one grips, the nerve fibers go to the muscle belly in the forearm and pull the tendons in. If a patient asks one tendon to go in one direction and another tendon to go in yet a different direction it's as chaotic as asking the four horses to go in different directions. Dr. Mackinnon further explained that once a finger is amputated, the flexor tendons can get stuck in the scar tissue and when one goes to grip something, the common muscle (or chariot) pulls on all the tendons but, in Petitioner's case, his ring and small fingers will flex into his hand but his other two tendons would be stuck in the scar tissue from the amputation. If the doctor grabbed onto a person's index and long finger and held them so they couldn't move and then had one flex hard, one would get pain running right up one's forearm as Petitioner had. The solution, according to Dr. Mackinnon, was to go in and separate the tendons from the scar and let them slide back a little bit so they could move and float around. Petitioner should then notice less pain and increased strength. (PX 15, pp. 11 – 14)

Dr. Mackinnon testified that in her opinion Petitioner's amputation injury was the cause of the different conditions she was describing for Petitioner. She based her opinion on the fact

that she had no other history or information to suggest otherwise and his physical examination findings could be easily explained by his injury and the amputation. She added that Petitioner has a weak and painful hand and doesn't use it as much which tends to mean he keeps it in a flexed position more than an extended position. Due to the positioning of his left arm due to the amputation and pain, it would be perfectly in keeping that he could develop ulnar nerve symptoms over time. Dr. Mackinnon didn't think Petitioner's median nerve issue was from the carpal tunnel; rather, she felt it was from the pronator which is the same area of origin as Petitioner's flexors and if it gets a little "sticky" and the pull isn't normal one can experience some pressure on the median nerve in the arm. Dr. Mackinnon believed she could go through her ulnar incision and "move over and loosen" the median nerve enough to avoid another incision site. (PX 15, pp. 14-18)

On cross-examination by Snelling's attorney, Dr. Mackinnon identified the records that she had reviewed as part of her evaluation of Petitioner. She did not review any records of Dr. Olson or Dr. Ollinger. She had some records from Dr. Daniels. She also testified that she didn't review any part of the transcript from the October 4, 2006 arbitration hearing but she did get a copy of the Commission's Decision. Dr. Mackinnon was asked if she had any knowledge of Petitioner's work activities and she testified that she really had no recollection. She agreed that the electrical studies performed on Feb. 14, 2008 were normal. When asked about her notation in her written report wherein she noted Petitioner had had electrodiagnostic studies which showed left cubital tunnel syndrome, she explained that she believed Petitioner probably had earlier studies which showed a mild condition. She further believed it might have been the case manager who related the earlier study results to her. If Petitioner had not undergone any earlier studies that revealed a mild cubital tunnel syndrome, her opinions, nonetheless, would remain unchanged. (PX 15, pp. 18 - 28)

Dr. Mackinnon testified that she will operate on individuals with normal nerve conduction studies. According to the doctor it is not common to do so in her practice because most of her cases deal with horrific traumatic nerve injuries but she does perform some "simple stuff like carpal tunnel and cubital tunnel" and a small percentage of those will involve normal studies. (PX 15, p. 28)

Dr. Mackinnon further testified that a normal nerve conduction study doesn't mean that there is no compression in the nerves. As the doctor explained, nerve compression derives from a blood-nerve barrier breakdown. She explained that there is a brain barrier and a nerve barrier and it keeps molecules in the nervous system and keeps the nervous system happy and safe. If one breaks the nerve barrier then one gets a diffusion of proteins in and out of the nerve barrier and it is unhappy. According to Dr. Mackinnon, "That's the first think that happens with nerve compression, and of course, nerve studies are normal." Patients at that point may not even be symptomatic. However, as fibrosis begins outside the nerve, along with some swelling on the outside of the nerve, the "little tiny choke vessels" that come in and out through that connective tissue into the inside of the nerve have trouble getting in there which results in lack of blood flow and "then when you get in these funky positions that actually would take some of the blood flow away," the patient becomes symptomatic. In time the myelin or the lining around

the nerve fiber gets stripped resulting in demyelination. As one loses the lining the electrical conduction begins to change. (PX 15, pp. 28 – 35)

Dr. Mackinnon was asked if she would be surprised to know that after his amputation injury Petitioner had been able to work as a cook at a Mexican restaurant, at a company on a packing line, as a cashier, as a welder, and at a company where he used a tow motor and bagged all day. She responded, "That's great" and added that he might perhaps be able to do it more comfortably if he had an operation. (PX 15, p. 50) She also believed that performing some of those activities would cause him to hurt more. (PX 15, p. 51)

Dr. Mackinnon was asked about her notation of depression in Petitioner. She explained that she asked him if he was depressed and he said "yes." She acknowledged, however, that she is not a psychiatrist. She also acknowledged that he was obese and that obesity can contribute to cubital tunnel syndrome in about 14 percent of cases. Thereafter the deposition was ended due to time constraints and the doctor's schedule. The doctor's cross-examination had not been completed. (PX 15, pp. 55-56)

Additional Medical Treatment

Petitioner returned to see Dr. Mackinnon on January 8, 2013, having last seen her on February 14, 2008. In a letter to Dr. Daniels, Dr. Mackinnon noted her earlier exam in 2008. At the time of the January 8th visit she noted no real change in his symptoms or his physical examination although the sensitivity over the third digit was not as significant as when she saw him earlier. Petitioner had undergone back surgery in 2009 followed by a cervical spine fusion in 2010. He was taking Vicodin and Xanax, was married, and disabled. She still recommended surgery but that the sensitivity around the stump of the third digit not be addressed at that time. (PX 16, pet. dep. ex. 3, 4)

Surgery with Dr. Mackinnon was scheduled and performed on February 19, 2013. The post-operative diagnosis was left ulnar nerve compression, cubital tunnel, left ulnar nerve compression, Guyon's Canal, median nerve compression of the forearm and carpal tunnel. (PX 16, pet. dep. ex. 2; pet. dep. ex. 3,4)

Post-operatively Dr. Mackinnon re-examined Petitioner on February 26, 2013. She noted that Petitioner had "as much fascial compression over the median nerve in his arm and forearm as she had ever seen and that would very much explain the pain that he had been experiencing in his arm and elbow region." Pre-operatively there was no evidence of any issues with the profundus tendons to the amputated finger so she did not need to perform a tenotomy of the profundus tendons. She expressed optimism regarding Petitioner's significant pain. (PX 16, pet. ex. 3, 4)

Dr. Mackinnon re-examined Petitioner on March 13, 2013 at which time he was doing well and he was instructed in early physical therapy. (PX 16, pet. dep. ex. 3, 4)

Petitioner attended physical therapy on March 19, 2013 reporting moderate complaints of pain and difficulty with therapy. Overall rehabilitation potential was felt to be excellent. (PX 16, pet. dep. ex. 3, 4)

Petitioner attended physical therapy on April 15, 2013 with the therapist noting great progress with active range of motion and strength. Petitioner's pain levels were reducing; however, he continued to note sensitivity and weakness as well as hand cramps and occasional dropping of things. Petitioner asked about wearing his night-time wrist cock-up splint while playing pool as he was on a league. (PX 16, pet. dep. ex. 3)

Petitioner was discharged from physical therapy on May 29, 2013. It was noted that Petitioner had not been working since January of 2007 due to back disability. Petitioner reported that his numbness was nearly gone since his surgery and the MF tremors had resolved. Petitioner was discharged from therapy due to non-compliance/attendance issues as he had not appeared for therapy since April 29, 2013. (PX 16, dep. ex. 13)

In anticipation of his visit with Dr. Mackinnon on July 18, 2013 Petitioner completed a DASH questionnaire regarding his left upper extremity on July 15, 2013. Petitioner noted severe difficulty opening a tight or new jar, carrying a heavy object weighing over ten lbs., engaging in recreational activities requiring some force or impact through his arm, shoulder or hand, and managing transportation needs. Petitioner described his arm and hand pain as moderate, tingling in his hand as mild to moderate, weakness as mild, and hand stiffness as mild to moderate. (PX 16, pet. dep. ex. 3)

Dr. Mackinnon last saw Petitioner on July 18, 2013 and felt he was "doing beautifully." She noted that she wished she could bring him back every week just to enjoy his "superb recovery." Pinch and grip on the right was 38 and 120 lb. It was 18 and 45 on the left. She noted a "little bit" of a snapping extensor tendon in his long finger for which he was given a button hole splint that day. She discharged him from care, "delighted" with the result and felt he would continue to improve over time. He was welcome to return if needed. (PX 16, pet. dep. ex. 3, 4)

At the request of Respondent Petitioner was examined by Dr. Robert Hagan on March 23, 2015 and a written report issued. (RX B) According to Dr. Hagan's written report Petitioner provided a history of his traumatic injury in December of 2001, treatment thereafter, and his eventual return to work. Dr. Hagan noted that during the foregoing period of time Dr. Olson noted that Petitioner had some residual stump tenderness and pain but was able to perform different jobs, including cooking and lifting up to 50 lbs. with both hands. During that same time Petitioner experienced some numbness and tingling in the ulnar and median distributions. Petitioner advised Dr. Hagan that within one year of discharge from Dr. Olson's care he noticed an increase and worsening of his symptoms. He also reported that "secondary to some delays" he ended up seeing someone finally in 2003 or 2004 for pain in his stumps, numbness in the amputated fingers, and numbness in the working portion of his hand, including the ulnar digits. Dr. Hagan reviewed Petitioner's treatment with Drs. Daniels, Ollinger, and Mackinnon including the 2013 surgery. Petitioner reported significant improvements with surgery

including a decrease in pain in both the median and ulnar distributions and an increase in sensation, especially in the ulnar nerve distribution as well as an overall increase in motion in the residual hand and fingers. Petitioner reported intermittent discomfort or pain that he would rate as high as a "7" and some mild residual numbness in his small finger. Dr. Hagan noted, "He has the capacity to do full duty work regarding his hand but is disabled secondary to a lower lumbar spine injury which was a separate work-related injury." (RX B, dep. ex. 2) On examination the doctor noted the surgical scars and described them as "well healed". Two-point discrimination was within normal limits in the ulnar nerve distribution but he had poor range of motion in the ring and small fingers. There was good capillary refill and good strength in the digits. Petitioner's thumb showed no significant arthritis and normal 2-point discrimination. Petitioner denied, and the doctor observed, no clicking of Petitioner's dorsal long finger. There was no residual positive compression test at the wrist or the proximal forearm nor were there Tinel's signs. Dr. Hagan was of the opinion that Petitioner's carpal tunnel syndrome and Guyon's Canal compression were related to his 2001 injury as they were within the "zone of trauma." He did not feel Petitioner's other surgical conditions were related to the 2001 injury as they were remote enough from the original injury "based upon current information." The doctor noted that it was important that all of the procedures were done as if they had not been, it would have been difficult to discriminate the residual symptoms. The surgeries also resolved a significant component of Petitioner's overall pain and he was functionally improved. Dr. Hagan felt Petitioner needed no restrictions or additional treatment. (RX B, dep. ex. 2)

On June 29, 2015 Petitioner presented to Dr. Daniels regarding some questions about hand surgery. Petitioner wasn't seeking any treatment, just "an opinion from the examiner." Petitioner reported undergoing multiple nerve entrapment in his right forearm both at Guyon's Canal and also at the cubital tunnel. He stated he was lucky enough to get in to see Dr. Mackinnon who performed the surgery. Dr. Daniels' notes indicate uncertainty as to exactly what procedures Petitioner underwent and noted "[Petitioner] actually stated that he got Dr. Mackinnon irritated at him because it was a Worker's Comp Issue. He followed up with her and she said there really was not a whole lot to be done. He is wanting the examiner's opinion." (PX 8) Dr. Daniels noted that Petitioner could flex and extend his elbow, had a well-healed surgical scar on the medial side of his left elbow, lacked any evidence of tenderness, had a negative Tinel's, and, despite the loss of two fingers, his ulnar nerve strength was fine. Dr. Daniels further noted a 4 cm. well-healed surgical scar on the ulnar aspect of Petitioner's wrist with some slight tenderness in that area. Dr. Daniels was of the opinion that Petitioner "really had a pretty excellent outcome." He noted that Petitioner also agreed that his outcome had been good and wanted to make sure things were finished. Petitioner reported that he might have a little bit of occasional numbness on the inside of his elbow. Both he and the doctor believed that probably wouldn't go away. Dr. Daniels noted no evidence of any other neurological issues or any type of neck problems. He felt Petitioner was at maximum medical improvement and released him from care with instructions to follow-up if necessary. (PX 8)

Evidence Deposition of Dr. Robert Hagan taken 11/6/15

Dr. Hagan is a board certified plastic surgeon predominantly specializing in peripheral nerve, hand and wrist surgery. Dr. Hagan testified that he examined Petitioner on March 23, 2015, a single visit. As part of the examination he reviewed records from Dr. Olson, Dr. Daniels, Dr. Emanuel[4], Dr. Mackinnon, Dr. Ollinger and Dr. Al-Lozi. Dr. Hagan understood that Petitioner sustained a crush-type injury to his left non-dominant hand on December 17, 2011. At the time of the accident he was treated for acute injuries, including an amputation of the middle phalanx of the index finger and the long finger altogether. Dr. Hagan testified that Petitioner recovered from his injury and was able to return to employment; however, he had persistent pain in the amputated digits and the palmar region of his left hand all of which the doctor found consistent with the nature of Petitioner's injury. Ultimately he was examined by Dr. Mackinnon and she performed surgery on February 19, 2013. Dr. Hagan believed she performed a median nerve decompression of the wrist, a release of the ulnar nerve at the wrist (Guyon's Canal), a left ulnar nerve release at the cubital tunnel, and a proximal median nerve release. Dr. Hagan acknowledged that his review of the records indicated that surgery had been initially recommended back in February of 2008 but he was unsure why it was delayed. He did understand that Petitioner had undergone a lumbar fusion and cervical fusion as well as a hernia procedure and a colon resection.

According to Dr. Hagan, his review of Dr. Mackinnon's records indicated that Petitioner improved with surgery, did well, and ultimately recovered and returned to some level of working with his upper extremity. When he examined Petitioner, Petitioner was reporting some level of intermittent symptoms but he was significantly improved. He would expect some level of residual discomfort given the nature of the injury and surgery. On examination he noted a large but well-healed incision proximally at the level of the cubital tunnel and proximal forearm at the level of the transposition. Petitioner also had a well-healed incision overlying the proximal hand extending into the distal forearm from the release of his Guyon's Canal and carpal tunnel. His 2-point discrimination was within normal limits in the ulnar nerve distribution but he had poor range of motion of his ring and small finger. He had good strength in those digits and good capillary refill with no significant arthritis and no sign of triggering. He noted no sign of recurrent or persistent neuroma and there was no clicking of the dorsal long finger. He appeared to have no residual positive compression tests at the wrist or proximal forearm. Dr. Hagan believed Petitioner had a positive result from his surgery. Dr. Hagan was asked what diagnoses he arrived at regarding Petitioner's left wrist and he replied, "the decompression of the ulnar nerve and the median nerve at the level of the wrist and hand." (RXB, p. 17) He felt the hand and wrist problems were certainly within the zone of trauma and related to his finger and crush injury. He found it difficult to relate the elbow symptoms (his cubital tunnel and proximal median nerve pronator releases) to Petitioner's injury as they were out of the zone of trauma.

Dr. Hagan was asked if he could discern which of Petitioner's residual symptoms were coming from the wrist condition as opposed to the elbow condition and he testified that it was really difficult to determine because they overlap in the distal segment and both give symptoms

[4] The Arbitrator notes no reports/records from Dr. Emanuel are contained within the record.

to the hand. However, he felt the elbow pathology was unrelated to the injury. Dr. Hagan was of the opinion Petitioner needed no permanent restrictions for his left upper extremity and he had reached maximum medical improvement. (RX B, pp. 1 – 22)

On cross-examination Dr. Hagan explained that about eighty percent of his practice is focused on peripheral nerves of the upper extremity. Only about ten percent of his practice focuses on medical-legal work with just slightly more of the work being done for employers rather than employees. Dr. Hagan testified that he knows of Dr. Mackinnon and described her medical reputation as very good. Having reviewed her operative report he agreed that she performed four separate procedures during the one operation and he had no criticism of what she did.

Dr. Hagan testified that quadriga is a condition where one of a person's tendons is tethered and it affects the excursion of the others. He added that it can occur at the level of the hand and within the zone of trauma.

Dr. Hagan was asked about his review of Dr. Olson's records and, in particular, a record of January 6, 2005. He agreed that the doctor's note includes a discussion of problems Petitioner was having with heavy lifting and things of that nature and that his remaining long finger and the ulnar side of his ring finger and thumb were numb, consistent with an ulnar nerve problem. However, the doctor's notes don't indicate when the problems began and how it was bothering his elbow in terms of flexion or extension activities. It also involved his median nerve at that time. Dr. Hagan acknowledged that Dr. Olson's impression in January of 2005 was carpal tunnel syndrome and there was no mention of ulnar nerve compression or anything like that. He also noted that Dr. Olson mentioned in his note that it was related to the function of his hand with the amputated digits.

Dr. Hagan was asked about Dr. Mackinnon's intra-operative findings at surgery and he explained that the fact she noted seeing as much fascial compression over the median nerve in Petitioner's arm and forearm as she had ever seen supported that Petitioner was having a very chronic problem in his left arm and that, perhaps, it had even been there before his amputation injury. Dr. Hagan testified that if Petitioner's fascia had a congenital component any form of repetitive use would have caused it to become symptomatic. Dr. Hagan further testified that heavy lifting, such as fifty pound sacks, repetitively over a period of months could have initiated symptoms at both levels of Petitioner's left upper extremity.

Dr. Hagan testified that Petitioner himself told him he was disabled from a lumbar injury which was a separate work-related injury. (RX B, pp. 22 – 60)

On cross-examination Dr. Hagan acknowledged that Petitioner could have had a pre-existing asymptomatic congenital condition in his left upper extremity. He also agreed that a type of injury as Petitioner sustained could result in a change as to how one's hand is used. He would consider the Guyon's Canal within the zone of trauma. He felt it would be difficult to determine whether Petitioner's complaints were coming from his elbow or his wrist but it was

probably both. He was of the opinion that a minor change in the mechanics with which Petitioner used his hand would not have caused the proximal compressions. (RX B)

Deposition of Dr. Susan Mackinnon dated 12/11/15

Dr. Mackinnon testified that she is a board certified plastic surgeon specializing in nerve injuries of the upper extremities. Dr. Mackinnon testified that she performed surgery on Petitioner on February 19, 2013. She further identified her records pertaining to her care and treatment of Petitioner (pet. dep. ex. 2, 3) Dr. Mackinnon further testified that her surgery was aimed at removing tension and pressure on the median and ulnar nerves of Petitioner's left upper extremity in the forearm, elbow and wrist area. There were four separate spots under compression – two ulnar and two median. Dr. Mackinnon testified that Petitioner's hand injury would have potentially caused pain because his nerves in the long and index finger were cut. In addition, the tendons to those fingers were cut. Those injuries, in turn, would impact all the way up the arm as the nerves connect up to the spinal cord and the tendons go up to the elbow. Dr. Mackinnon further testified that patients with the amputation injuries like Petitioner had frequently hold their extremity with the elbow bent as though cradling the hand because it feels temporarily more comfortable; however, the cradling can causes cubital tunnel syndrome and it can work downstream and irritate the Guyon's Canal at the wrist. Similarly, the flexor tendons all go back to one muscle belly in the forearm and can cause stickiness, compression, and irritation along the entire process from where the flexor tendons were cut to where they attach to the muscle. The median nerve goes right between the two heads of the pronator flexor muscles and can become compressed and irritated in the forearm. Thus, Dr. Mackinnon was of the opinion that Petitioner's conditions for which she performed surgery were causally related to Petitioner's amputation injury on December 17, 2001. (PX 16, pp. 10-13, 35-42) She testified that if Petitioner had not sustained amputations to the two fingers she would not have had to perform surgery adding "that the proof is that he got remarkably better after I did those operations." (PX 16, p. 13)

Dr. Mackinnon was asked about her last office visit with Petitioner and acknowledged she would have to rely solely on her office notes as she had no recollection of him. He appeared to be doing beautifully although he had a little bit of snapping of the extensor tendon of the long finger. He was given a small splint for that and she noted his recovery was superb. (PX 16, p. 14)

Petitioner's attorney asked Dr. Mackinnon about Petitioner's ability to work. She testified that it is her practice to not comment on work restrictions for patients she hasn't operated on. When she saw Petitioner in 2008 she didn't operate on him and would not have thought about his ability to work. (PX 16, pp. 14-15) As of July 15, 2013 she did not give him any restrictions explaining that if he went back to work and couldn't perform his work she would have recommended a functional capacity evaluation and deferred to it. (PX 16, p. 16)

On cross-examination by Respondent Snelling, Dr. Mackinnon acknowledged that she did not see any treatment records prior to November of 2006 except for a note of Dr. Daniels. She also acknowledged that she took no detailed history from Petitioner regarding his work

history and different jobs since his work accident. She also agreed that there are certain work activities that can impact or affect a person's nerve function in their arm. (PX 16, pp. 16-20) Dr. Mackinnon also acknowledged that she has operated on individuals with compression in the ulnar nerve and the median nerve in the forearm based upon repetitive-type positions but they also lacked amputated digits. She then testified that she doesn't get involved in very many workers' compensation cases as she only sees patients with really bad problems, not easy ones. (PX 16, pp. 20-21) She went on to explain that in cases of cubital tunnel syndrome the only activity that has a strong association with the condition is vibratory exposure (ex. dental hygenists). She concluded noting, "There is no answer to prove any job is causing cubital tunnel." (PX 16, pp. 21-23, 24)

Dr. Mackinnon acknowledged that there was nothing in the medical records she had seen or the history provided by Petitioner to indicate that he held his arm in a flexed position all the time. (PX 16, pp. 24, 27) When asked if she was hypothesizing about that, she responded that she was basing it on three decades of treating patients with painful hand and nerve injuries and seeing their tendency to move into a fetal position when something hurts. (PX 16, p. 25) She further explained that the more we have our elbows bent, the more likely we are to develop chronic ulnar nerve compression at the elbow. (PX 16, p. 26)

Dr. Mackinnon further testified that Petitioner was born with fascial bands and they didn't come on as a result of his amputated fingers. However, over time, with the amputations, it was "almost like a perfect storm." His obesity and smoking would have been irrelevant. (PX 16, pp. 29-30)

Post-Deposition Developments

Petitioner's case herein appeared above the red line for the January 2016 Quincy Call. Petitioner was reportedly unable to be present due to illness[5]. This was the Arbitrator's first time appearing in Quincy after zone re-assignments. The case had been scheduled for a trial certain; however, it was continued, for a trial date certain, to April 6, 2016, in light of Petitioner's represented illness.

On/about March 21, 2016 Petitioner's attorney received a records review report from Dr. Samuel Chmell. Thereafter, on March 22, 2016 Petitioner's attorney and the attorney for Snelling Personnel Service agreed to the deposition of Dr. Chmell on March 31, 2016. The next day (April 1, 2016) Snelling's attorney e-mailed Petitioner's attorney withdrawing her agreement to proceed with the deposition of Dr. Chmell scheduled for March 31, 2016. Petitioner's attorney sent out a Notice of Deposition regarding Dr. Chmell's March 31, 2016 deposition. Thereafter, on March 29, 2016 a conference call was held between the Arbitrator, Petitioner's attorney and the attorneys for Respondent herein and Snelling. During that conference call the Arbitrator advised the attorneys that in light of the fact the attorneys for both parties had withdrawn their prior agreement well in advance of the deposition, there was no agreement to proceed with the

[5] Petitioner so testified at arbitration.

deposition and Petitioner's attorney needed to file an appropriate motion since there was no agreement.[6]

It appears from PX 17 that Petitioner's attorney proceeded with the evidence deposition of Dr. Chmell on March 31, 2016 with neither attorney for Respondent or Adecco being in attendance. (PX 17)

Petitioner's case was above the red-line for the April 6, 2016 Quincy Call. At that time the case was to go to trial pursuant to a Trial Date Certain Order entered in January by the Arbitrator. On the afternoon of April 5, 2016 the Arbitrator received an email from Petitioner's attorney, with a doctor's note attached, stating counsel was unable to travel to Quincy on April 6, 2016 due to illness. The case was continued for a trial date certain until July 6, 2016.

On June 27, 2016 Petitioner filed a Notice of Motion and Order regarding a Dedimus Potestatum. The hearing on the motion was set for July 6, 2016. (PX 18)

On July 5, 2016 at 3:38 p.m. Petitioner filed a Supplemental Motion for Penalties, Attorney's Fees and Costs in case #04 WC 31927. (PX 5)

The July 6, 2016 Arbitration Hearing

On the morning of July 6, 2016, Petitioner's attorney presented PX 18, the Motion for Dedimus Potestatum, for hearing. Petitioner's attorney indicated he wished to take Dr. Chmell's deposition on September 8, 2016. The Arbitrator denied the Motion as it did not comport with the Rules and because the case had been set for a trial date certain, at least, since January of 2016. The admissibility of PX 17, Dr. Chmell's deposition taken on March 31, 2016, was reserved as an issue for the case.

Petitioner's cases against Respondents, Snelling Personnel Services, and Respondent, Adecco Employment Services, proceeded to arbitration on July 6, 2016. Petitioner was the sole witness testifying at the hearing. Both of Petitioner's claims were consolidated for purposes of hearing with the understanding that separate decisions would be issued.

The parties further stipulated that the previous 19(b) award was paid by Respondent and that Respondent had also made statutory payments of 75 weeks at a rate of $225.00 for Petitioner's amputated fingers.

With regard to the instant case, the disputed issues were causal connection, medical bills, temporary total disability, nature and extent, a hold harmless for Medicaid payments, Penalties and Attorney's Fees, a credit to Respondent in the amount of $1,000.00 and the admissibility of Petitioner's Exhibits 5 and 17.

Petitioner testified to remembering the earlier 19(b) hearing and that, at that time, he had been denied any further treatment, including an EMG. Petitioner also recalled having gone to

[6] This summary is based upon representations made to the Court on 7/6/16 and a review of PX 17 and its exhibits which had to be done in addressing the admissibility of the exhibit.

Dr. Olson, his orthopedic surgeon, for treatment as a result of his amputation injury on December 17, 2001. Petitioner testified that he would see Dr. Olson and tell him about his left arm and hand problems. Petitioner testified that he last saw Dr. Olson on January 6, 2005. Petitioner also recalled receiving a phone call and a letter from his attorney in late November/early December of 2007 telling him it was okay to get the EMG so he went back to Dr. Daniels on September 17, 2007 and he referred her to Dr. Susan Mackinnon in St. Louis.

Petitioner testified that he saw Dr. Mackinnon on February 14, 2008 and he was there with his sister and a nurse case manager on behalf of Respondent Snelling. Petitioner recalled undergoing an EMG that day. Petitioner further testified that Dr. Mackinnon scheduled him for surgery the next day but it was cancelled. Petitioner subsequently underwent surgery on February 19, 2015 as Medicare paid for some of it. Petitioner testified that Dr. Mackinnon released some nerves and tendons in his fingers and there was carpal tunnel and an ulnar nerve that needed to be replaced. As a result of the surgeries, Petitioner has some scars in the palm of his hand on his wrist and around his left elbow. Petitioner further testified that he underwent some physical therapy. Petitioner believed the surgery was helpful. He couldn't make a fist before the surgery because his hand would shake and he felt lots of cramping in his left arm. After the surgery his hand, forearm, and thumb stopped cramping and he could close it without experiencing any shaking. All in all, Petitioner thought things were much better after surgery. Petitioner testified that when he last saw Dr. Mackinnon he told her he was doing fine and much better than before the surgery.

Petitioner also testified that he has gone to Dr. Daniels since moving back to Quincy from St. Louis as he is closer in location and it's hard to get in to see Dr. Mackinnon. According to Petitioner, Dr. Daniels eased his mind and told him everything was fine. That was on June 29, 2015.

Petitioner testified that he isn't working and hasn't worked since January 3, 2007. Petitioner testified that on January 3, 2007 he went to Dr. Hambrick complaining about his back and neck. He couldn't recall if he ordered x-rays or an MRI but he took him off work and told him he shouldn't work with his back the way it was. Petitioner testified he applied for Social Security but was initially denied but then he received an award. He received his disability on July 1, 2009.

Petitioner testified that when he worked at J.M. Huber he was employed there through Adecco. He had to lift 50 pound sacks, fill them up on a machine, turn, put them on a pallet behind himself and when the pallet was full he got a forklift and moved it and started another pallet. He thought he did at least 400 bags a day but that was a guess. Petitioner worked for Huber about one year. Petitioner was asked if he told or reported to the man in charge of his area (Laren Farr) that his work was causing back problems and Petitioner testified that he told him he had problems with his arm and his back and the supervisor referred him to a chiropractor who he went to for a few times. Petitioner testified that he ended up undergoing three low back surgeries and two neck surgeries all with Dr. Terrence Piper. Petitioner testified he was referred to Dr. Piper through his sister. He couldn't recall if Dr. Poetz, a family doctor,

referred him. Petitioner underwent surgery at Barnes-Jewish, St. Peters, and one other St. Louis hospital.

Petitioner testified that, with regard to his left arm, he is beginning to get problems "down towards his elbow" and his hand cramps us a little bit every now and then depending upon how much he uses it. He still has some pain inside his elbow and a little numbness around his elbow. He also doesn't have the grip he used to have.

With regard to his back and neck, Petitioner is on a ten pound weight lifting restriction and isn't supposed to engage in impact exercises. Petitioner has two brackets and six screws in his neck and one bracket and three screws in his lower back. Petitioner testified to daily pain and limited ability to turn his neck before it "messes" with his vision and he gets a headache. Petitioner also testified that he is getting ready to go back and see what, if anything, can be done for his neck and back as the pain is starting to go down his legs again and he can't turn his neck very much. Petitioner testified that he spent the last year getting off pain pills and could end it sometimes. Petitioner also testified that he discussed his mental health with Dr. Mackinnon in February of 2008 as he was frustrated because he couldn't get any help and when he asked for it, Snelling or the workers' compensation board denied it.

Petitioner testified that he has a GED but no special skills or training.

On cross-examination by the attorney for Snelling Petitioner acknowledged that he was aware his case was set for a trial date certain on January 6, 2016 but he believed he was under the weather/sick at the time. He believed he let his attorney know he was sick the morning of the scheduled trial.

Petitioner agreed that he worked for Snelling one week in December of 2001. He was then injured and treated with Dr. Olson. Petitioner did not return to work for Snelling. From about March of 2002 through July of 2002 Petitioner worked at Santino Mexican Restaurant. He thought he worked about 40 hours per week. Petitioner also recalled working for Adecco three or four different times one of which was in October of 2002. He recalled working on a line supplying products for Bed Bath and Beyond. He worked 40 hours a week at that job. He agreed that he used both of his upper extremities to perform that job. He also agreed that he worked for J.M. Huber through Adecco from about March 2003 through March of 2004 and he worked 40+ hours a week. Petitioner agreed that he drove a forklift and picked up 50 pound bags all day long using both of his arms.

Petitioner agreed that Dr. Olson found him at maximum medical improvement in April of 2002 and that he returned in April of 2003 for a one year check-up with no changes being noted at that time although Petitioner thought he was maybe told to stay away from vibratory machinery because it was bothering him.

Petitioner testified that after his job with Huber ended he worked at County Market Express on a part-time basis performing cashier and stock work. In February of 2006 he began working for a temporary serve at Manchester Tank. Petitioner then worked for Manchester

Tank from February of 2006 through January 3, 2007. Petitioner worked as a welder. Petitioner was asked if he stopped working at Manchester Tank on account of his back complaints and Petitioner added that he left because of his hand also. He agreed, however, that he had testified that he was taken off work because of his back.

Petitioner agreed that he hasn't sought any additional employment since that time or performed any kind of job search since then. When asked if he had undergone any kind of vocational evaluation or assessment, he said "no." He agreed that he worked for over five years after his December 17, 2001 injury to his hand. He also agreed that he is receiving social security because of his amputation injury, his degenerative disc disease, chronic bronchitis, sleep apnea, obesity, major depressive disorder, and antisocial personality traits.

Petitioner also agreed that when he saw Dr. Mackinnon she did not address any work restrictions or status and that when he saw her it had been over a year since he had last worked. When asked if he hadn't worked since January of 2007 because of his back, Petitioner replied yes but added that it was also because of his hand as he couldn't lift anything with it.

Petitioner recalled undergoing colon surgery in September of 2009 and he had his first back surgery in December or January thereafter. He then had cervical surgery in February of 2010. Petitioner had another neck surgery in 2012 and saw Dr. Mackinnon again in 2013. He agreed that he returned to Dr. Mackinnon in 2013 on his own and she sent him back to Dr. Daniels. Petitioner also had two other surgeries and a hernia surgery between 2009 and 2012.

Petitioner acknowledged that Dr. Mackinnon did not restrict his activities in any way and released him from care on July 18, 2013. He also agreed that Dr. Daniels has not placed any permanent restrictions on him.

Petitioner was also asked questions by Adecco's attorney. Petitioner agreed he last worked for Adecco through J.M. Huber on March 20, 2004. He also agreed that he was unemployed from March of 2004 through March of 2005 and then he began working for County Market Express. Petitioner was shown the Application for Adjustment of Claim in the case against Adecco. He did not recall seeing it but knew he must have signed it. According to the Application for Adjustment of Claim he was being shown, he was claiming an accident to his left hand and body that occurred on January 6, 2005. When asked what happened at that time, Petitioner did not know nor could he recall. He then added that "if anything it would be from lifting the sacks and having to turn with every sack." He also thought his hand was probably hurting like "all get up and his back also." During this line of questioning, Petitioner's attorney stated to the Arbitrator that the claim against Adecco was based upon a repetitive trauma theory.

Petitioner was asked why he didn't testify in the 19(b) hearing about his back hurting while working for Huber and he responded that he didn't really know except that maybe he wasn't asked about it.

Petitioner also testified that he worked for County Market Express a short period of time and then he moved back to St. Louis due to a custody battle with his ex-wife and while there he worked as a cashier for O'Reilly Auto Parts a short while followed by work at Manchester Tank in 2006. Petitioner agreed that he worked steady up until he was taken off work by Dr. Hambrick in 2007. Petitioner testified that he went to Dr. Daniels in November of 2006 due to issues with sleep apnea and he thought he told the doctor about his issues with his neck or back. If nothing was said about it in his records then the records would probably be correct. He thought his first mention of any back pain might have been in December of 2006. Petitioner didn't recall falling on the ice two times but he could have. He acknowledged being seen at the Springfield Clinic on March 20, 2007 and relating back pain off and on throughout his left and that his most recent episode began in August of 2006. He agreed that he denied any injury and reported being employed as a welder and being on his feet a lot lifting tanks to and from carts at Manchester Tank. He did not dispute that he very well may have gone to Blessing Hospital on April 11, 2007 complaining of increased back pain since 2006 that had markedly increased since January of 2007. He did not recall seeing Dr. Daniels in December of 2007 and telling him he was no longer working for Manchester Tank and had injured his back but if the records stated that he would agree with it.

Petitioner also testified that because of his amputations and problems with his left hand he did use his right hand to help out with lifting and carrying responsibilities on those jobs.

Petitioner acknowledged being right hand dominant and a smoker. He smokes a pack a day and has done so for 35 years.

Petitioner's medical bills are set forth in PX 8 (Blessing Hospital) and PX 20 (Washington University/Dr. Mackinnon).

<u>The Arbitrator concludes:</u>

<u>Issue (O) Admissibility of PX 17 (Deposition of Dr. Chmell)</u>

This case was set for Trial Date Certain on January 6, 2016 and continued for another Trial Date Certain on April 6, 2016. On January 6, 2016 the case was continued due to Petitioner's illness and inability to appear.

On March 11, 2016 Petitioner's attorney sent a cover letter and records to Dr. Samuel Chmell requesting a records review. Petitioner's attorney obtained a report from Dr. Samuel Chmell dated March 21, 2016.

On or about March 21, 2016, Petitioner's attorney provided a copy of Dr. Chmell's report to Respondent's attorney. On March 23, 2016, Respondent's attorney emailed Petitioner's counsel a letter withdrawing her tentative consent which had been provided on March 22, 2016 for the deposition of Dr. Chmell. After consent was withdrawn, Respondent's attorney received a Notice of Deposition for Dr. Chmell's deposition to be taken on March 31, 2016. On March 29, 2016 a conference call was held with Petitioner's attorney, the attorney for Respondent herein and Respondent's attorney in Petitioner's companion case against Adecco. The Arbitrator

advised the parties that the deposition should not go forward on March 31, 2016 as there appeared to be no agreement between the attorneys to proceed.

Despite the foregoing, Petitioner's attorney proceeded to take the deposition of Dr. Chmell on March 31, 2016 without Respondent's attorney being in attendance. Therefore, Petitioner's attorney filed a Dedimus for Dr. Chmell's deposition to be taken on April 29, 2016 at 10:30 a.m. and filed a Notice of Motion and Order setting the Dedimus for hearing on the April 6, 2016 docket. Counsel for Petitioner did not attend the April 6, 2016 docket due to illness and the matter was continued to July 6, 2016. On July 6, 2016 Petitioner's Dedimus for Dr. Chmell's deposition to be taken on September 8, 2016 was denied. The case proceeded to trial and Petitioner offered the deposition of Dr. Chmell as PX 17.

In Spilker v. IPC Intern, Inc., 04 IL.W.C. 10738 (2006), petitioner's counsel, on a last minute basis as the deposition was about to begin, withdrew his consent to the deposition. There was an issue about a request for production of documents and petitioner's counsel then refused to participate in the deposition and hung up the phone. The Commission found that the Arbitrator erred and should have admitted Dr. Orth's deposition and reports noting petitioner's counsel had agreed to the deposition and only withdrew his consent just as the deposition was about to begin. The Commission found it was reasonable for respondent to rely on this agreement.

In the Arbitrator's view Spilker is distinguishable from the present matter in that Respondent herein was first provided notice of Dr. Chmell's report and possible deposition date on March 21, 2016. Respondent's attorney provided tentative agreement to the March 31, 2016 date on March 22, 2016 but withdrew that consent less than 24 hours later on March 23, 2016 via email to counsel for Petitioner. The withdrawal of consent was provided before Petitioner's attorney had sent out a formal Notice of Deposition and was still eight days before the scheduled deposition. In addition, the parties conferred with the Arbitrator to discuss the issue two days prior to the proposed deposition date at which time the Arbitrator advised everyone that there appeared to be no agreement to proceed with the deposition. The Arbitrator views Respondent's actions herein as reasonable and Petitioner's actions in proceeding with the deposition knowing the attorneys had objected and would not be there, as unreasonable.

Based upon the foregoing, the Arbitrator concludes that Respondent's attorney did not provide consent to the deposition and Petitioner's Exhibit 17 is rejected as being inadmissible. The exhibit will be marked rejected and travel with the file.

Issue (F) Causal Connection.

Petitioner's current condition of ill-being in his left upper extremity (amputated fingers, hand, wrist, and elbow) is causally connected to his undisputed accident of December 7, 2001. This conclusion is based upon a chain of events, the Commission's prior 19(b) Decision, the records of Dr. Daniels, as well as the opinions of Dr. Craig Olson, Dr. Susan Mackinnon and, in part, the opinion of Respondent's examiner, Dr. Robert Hagan.

As a result of Petitioner's December 17, 2001 accident, Petitioner sustained amputation injuries to two of his fingers on his left hand. As most, if not all, of the doctors agreed, Petitioner was not left with a "normal" hand. Testimony elicited from Petitioner at the 2006 hearing illustrated how he used his hand post-injury and he described issues with the amputated digits, including irritated nerves. As of January 2005 when Petitioner returned to see Dr. Olson, Petitioner's original treating orthopedic surgeon, he described (and the doctor noted) both ulnar and median type symptoms. Dr. Olson focused on the median nerve and suspected carpal tunnel syndrome "until proven otherwise." In any event, he found Petitioner's condition at that time causally related to the accident. The Commission agreed.

Since the initial 19(b) proceeding Petitioner has been seen by Dr. Daniels, Dr. Mackinnon, Dr. Ollinger and Dr. Hagan. The former two physicians have treated Petitioner and have seen him more frequently than the latter two, both of whom were examining physicians. All of these doctors appear to be in agreement, via their records and/or testimony, that the amputation of Petitioner's two fingers has altered the function in Petitioner's left hand. All appear to agree that Petitioner has had irritated nerves, including both the median and ulnar nerves. The doctors also agree that Petitioner's nerve issues within his wrist are causally related to his amputation and accident in 2001. The only real disagreement appears to be over the elbow/forearm surgery and symptoms.

Both Dr. Olson and Dr. Mackinnon testified that the alteration in function of the Petitioner's left upper extremity caused by the amputation injury of December 17, 2001, resulted in the various nerve entrapments that Dr. Mackinnon released surgically on February 19, 2013. (PX 14, PX 15, PX 16, RX B) The Arbitrator was especially persuaded by the detailed explanation provided by Dr. Mackinnon as to how the alteration in comfort and function caused by the amputation injuries, along with Petitioner's congenitally thick fascia and the normal activities of daily living and sleeping, caused the four marked nerve compressions, of the median nerve in the carpal tunnel and forearm, and of the ulnar nerve in Guyon's Canal and in the cubital tunnel, from which Petitioner would not have suffered but for Petitioner's amputation injury of December 17, 2001. As she testified to during her 2015 deposition, her surgery was aimed at removing tension and pressure on the median and ulnar nerves of Petitioner's left upper extremity in the areas of the elbow, forearm, and wrist. Her surgery on Petitioner successfully did so.

The Arbitrator notes that Respondent's examiner, Dr. Robert Hagan, admitted that the carpal tunnel and Guyon's Canal nerve compressions were related to the amputation injuries. He also acknowledged that it was "really difficult" to determine which of Petitioner's residual symptoms were from the wrist or from the elbow because the nerves overlap and both produce hand symptoms. Dr. Hagan's doubt that the compressions close to the elbow were related was effectively refuted by Dr. Mackinnon, a nationally recognized expert in nerve injuries and their mechanisms. The Arbitrator also notes that Dr. Hagan was not entirely correct in interpreting Dr. Olson's January 2005 office note as showing "no mention of ulnar nerve compression or anything like that." While there may not have been a diagnosis related to the ulnar nerve, the

doctor clearly indicated in his notes that Petitioner was experiencing ulnar-related symptoms and complaints in his fingers/hand. (PX 1 – pet. ex. 1, res. ex. 4; PX 14, pp. 6-8)

Respondent's other examiner, Dr. Ollinger, was essentially unable to diagnose Petitioner's condition. Dr. Ollinger examined Petitioner one time in March of 2008. He noted positive findings on examination and took no issue with the veracity of Petitioner's complaints. He was, however, unable to determine the etiology of Petitioner's complaints within a reasonable degree of medication certainty. He testified that he could not diagnose Petitioner with carpal tunnel syndrome in 2008 because his symptoms and complaints were related to the ulnar nerve. He agreed that Petitioner had irritated nerves at his wrist and elbow. He did not necessarily disagree with Dr. Mackinnon; rather, he did not completely understand where she was coming from in terms of her surgical recommendations. He further acknowledged that he had no opinion regarding Petitioner's condition as of his deposition in 2010.

The Arbitrator is fully aware that Petitioner was released with no restrictions in 2003 and has had a number of different jobs since his December 17, 2001 accident. Petitioner's return to work was within the treatment parameters originally set forth by Dr. Olson as the doctor thought work activities would help Petitioner with his amputated fingers. Even Dr. Mackinnon acknowledged that the fact Petitioner was able to work in so many different jobs despite his amputated fingers was "great" but she added he might be able to perform them more comfortably after undergoing the surgery she was recommending. (PX 15, pp. 50-51) Petitioner testified, without rebuttal, as to how he used or didn't use his left hand in his various jobs. In the end, Dr. Mackinnon succinctly summed up the situation testifying, "Well, I'd say that if he hadn't had that amputation – those amputations, I don't think I would have operated on him." (PX 16, p. 42) While Respondent may reasonably contend that Petitioner's elbow and forearm symptoms and surgeries were due to Petitioner's employment with Adecco, it appears that Petitioner has never truly been symptom free in his left upper extremity since his accident in 2001. He has lived with it and worked with it but has continued to have issues until his surgery with Dr. Mackinnon. As such, the Arbitrator finds that Petitioner's December 17, 2001 accident has remained a cause of Petitioner's ongoing left elbow, hand, and wrist symptoms and complaints. Under current Illinois law, the accident need not be the sole cause of a claimant's condition. It only needs to be "a" cause. Petitioner has met that burden of proof herein.

Issue (J) Medical Bills; Issue (O) Hold Harmless.

Consistent with her liability determination set forth above, Petitioner is awarded the following medical bill: (1) Dr. Daniels - $171.00 (PX 8). While PX 20 from Washington University shows charges for Dr. Mackinnon, Petitioner's attorney represented at the time of trial that he was only seeking payment of PX 8, the bill from Dr. Daniels, from Respondent. He so indicated that position on the Request for Hearing form (AX 1) and he stated so on the record. Accordingly, Petitioner is bound by his stipulation.

The Arbitrator further concludes that Respondent is not liable to hold Petitioner harmless for the payment of any medical bills paid by Medicare and Medicaid as Petitioner failed to submit any evidence at trial identifying what, if any bills or amounts, were paid by

Medicare and Medicaid. While PX 20 reflects payments by Medicare/Medicaid to Dr. Mackinnon for services rendered in 2013, Petitioner did not seek an award of that bill as noted above.

Issue (K) Temporary Total Disability Benefits (TTD)

Petitioner has failed to meet his burden of proof that he is entitled to TTD benefits for the period from December 17, 2007 through July 15, 2013. Prior to the hearing it appears that the only demand for TTD made by Petitioner occurred in his Motion for Penalties, Attorney's Fees and Costs filed on February 26, 2008 and again on March 10, 2008. This Motion was not accompanied by any off work slips documenting that Petitioner was to be off of work or on light duty status during that time. Petitioner failed to present any such documentation at trial. The medical records are also void of any mention of work status in the treatment records for the period of time being claimed. The only evidence proffered by Petitioner on the issue of work status was given by Dr. Mackinnon in her deposition testimony on December 11, 2015. At that time, she initially testified that it is her practice not to comment on work status for patients she does not operate on and that when she saw Petitioner in 2008 she would not have gone through the thought process to answer a question about his work status at that time. (See PX 16 pp.14-5). Furthermore, her later testimony "hypothetically" stated she would have restricted him from the date of her evaluation on February 14, 2008 and not from December 17, 2007 as claimed by Petitioner. Such testimony is not sufficient to support an award of TTD benefits.

Furthermore, Petitioner testified that he last worked on January 3, 2007. On that date, he saw Dr. Hambrick complaining of his back and neck and that Dr. Hambrick told him "he was taking me off work, that I shouldn't work with the way my back was." Petitioner testified that he applied for and was awarded Social Security Disability benefits after a finding that he was disabled since January 3, 2007. (PX 21) Within this same period of alleged TTD, Petitioner had seven surgeries in three years, with his first one in 2009. The last surgery would have been in 2012. These surgeries included but were not limited to surgery to remove 10 inches of his colon, two-level fusion at L4-5 and L5-S1, two cervical surgeries and two additional back surgeries. Petitioner testified that after each surgery there was a period of time that he was incapacitated and unable to work. Medical records show Petitioner told his therapist in May of 2013 and Dr. Hagan in 2015 that he was not working due to a back disability.

Therefore, the Arbitrator concludes that Petitioner is not entitled to any TTD benefits as he did not present documentation of work status for the period alleged and, additionally, heremoved himself from the work force for a considerable amount of time for several, un-related neck and back surgeries.

Issue (L) Nature and Extent of Petitioner's Injury.

Petitioner is claiming permanent and total disability as of December 17, 2007. The evidence presented at trial documents that after Petitioner's injury on December 17, 2001, he had multiple jobs for another 5 years until he last worked on January 3, 2007. Those jobs included working at a restaurant as a cook, for another temporary staffing agency, Adecco, with

multiple placements, a market working as a cashier/stocker, and as a welder at Manchester Tank. Petitioner testified that he is right hand dominant and that his subsequent jobs involved heavy lifting with both upper extremities. Petitioner stopped working on January 3, 2007 due to a back disability unrelated to this claim.

Petitioner testified that he has not sought any additional employment since he last worked on January 3, 2007, has not performed any job search (nor was any evidence presented of a job search at trial), has not sought any vocational assistance or training, and is not allowed to work while collecting Social Security Disability.

Furthermore, no treating or evaluating physician has indicated Petitioner requires any restrictions on his activities as a result of the December 17, 2001 injury. As noted above, these doctors include Dr. Mackinnon, Dr. Ollinger, Dr. Hagan and Dr. Daniels.

While Petitioner may contend his Social Security Disability Decision supports a finding of permanent total disability, such reliance is misplaced. Not only is the standard for disability under Social Security different than what is required by the Illinois Workers' Compensation Commission, the Social Security Decision included not only the amputation injury to Petitioner's left second finger and left third finger but also degenerative disc disease, chronic bronchitis, sleep apnea, obesity, major depressive disorder and antisocial personality traits – all of which are un-related to the December 17, 2001 injury.

Petitioner has failed to present any evidence that he is permanently and totally disabled as a result of the December 17, 2001 injury. Therefore, the Arbitrator concludes that Petitioner has failed to establish entitlement to benefits under Section 8(f).

With respect to the nature and extent of Petitioner's injury, Petitioner has sustained two amputated fingers as a result of his accident of December 17, 2001. The parties acknowledged that Petitioner has been paid for those injuries. Petitioner has subsequently undergone one operation in which four different procedures were performed on his left upper extremity. Two procedures involved the median nerve and two procedures involved the ulnar nerve. Petitioner's medical records show he has had a very good result from the surgery. He was released with no restrictions. Indeed, he has never been given any permanent restrictions on account of his accident at any time. Petitioner's injuries have been to his non-dominant hand. Drs. Mackinnon, Hagan, and Daniels have all noted an excellent recovery on Petitioner's part. Petitioner testified that, with regard to his left arm, he is beginning to get problems "down towards his elbow" and his hand cramps up "a little bit every now and then" depending upon how much he uses it. He still has some pain inside his elbow and a little numbness around his elbow. He also doesn't have the grip he used to have. He did not present any testimony at this hearing showing he must rely more on his right hand than his left hand to perform any activities. Petitioner has had no further treatment to his hand or arm since being released by Dr. Mackinnon.

Based upon the foregoing, the Arbitrator concludes that Petitioner has sustained, in addition to the 100% loss of his long finger and 100% loss of his index finger (both of which he

has previously been paid for) the 17.5% loss of use of his left arm and the 17.5% loss of use of his left hand as a result of his December 17, 2001 accident.

Issue (M) Penalties and Attorney's Fees; Issue (O) Admissibility of PX 5.

Respondent objected to the admissibility of PX 5, Petitioner's Supplemental Motion for Penaltics, Attorney's Fees and Costs, on the basis of lack of notice. The Arbitrator notes that the Supplemental Motion was filed with the Commission on July 5, 2016. Even if PX 5 were not a part of the record, the Arbitrator could take judicial notice of it as it is a pleading that has been filed with the Commission as part of this case. Therefore, PX 5 is admitted with the understanding that Respondent is objecting to the timeliness of the Motion.

Petitioner makes a claim for penalties under Section 19(k) and 19(l) and attorney's fees under Section 16 alleging that Respondent's failure to authorize medical treatment and pay TTD was unreasonable and vexatious. Petitioner filed Motions for Penalties, Attorneys Fees and Costs in February and March 2008. Counsel for Petitioner filed a Supplemental Motion for Penalties, Attorneys Fees and Costs to Respondent via facsimile late in the afternoon on the eve of trial on July 6th. Under 50 Ill. Adm. Code 7020.70 (b)(1)(A) notice of motions shall be served upon the Arbitrator or Commissioner and the attorney of record 3 days preceding the day of the status call set forth in the notice. Petitioner did not file a Notice of Motion and Order setting the Motion for hearing on July 6, 2016 and, furthermore, notice was not provided to Respondent three days before the status call, or in this case, trial.

Therefore, the Arbitrator finds Petitioner's Supplemental Motion for Penalties, Attorneys Fees and Costs was not timely filed. Nonetheless, and assuming, arguendo, that the Supplemental Motion is perceived as timely filed, Petitioner's claim for costs as set forth therein should be denied as no documentation was provided supporting the costs alleged. Petitioner has the burden to prove his case on medical causation, and, as such, may incur costs. Those costs are Petitioner's responsibility. Furthermore, as discussed below, the Arbitrator does not find the actions of Respondent herein to be unreasonable or vexatious.

The Commission Decision issued on November 21, 2007 ordered Respondent to pay for "all necessary and reasonable prospective medical care for the treatment of Petitioner's left carpal tunnel syndrome." It is important to also note that Petitioner testified at the 2006 hearing that he wished to undergo an EMG and carpal tunnel surgery "if it was still deemed appropriate." After the Commission's Decision was issued, Petitioner went to Dr. Daniels on December 17, 2007. This was approximately fourteen months after the 19(b) hearing. At that time Dr. Daniels felt Petitioner had evidence of nerve entrapment in the upper extremity and also noted Petitioner's exam had changed somewhat. He felt there was some question about diagnosis and referred Petitioner to Dr. Susan Mackinnon. Dr. Daniels also noted that part of his problem, at least in his shoulder may be more from his neck than his back. He did not diagnosis Petitioner with carpal tunnel syndrome nor did he suggest Petitioner undergo a carpal tunnel release at that time.

Dr. Mackinnon evaluated Petitioner on February 14, 2008 and she recommended a left ulnar nerve transposition with a release of the left ulnar nerve through Guyon's Canal specifically releasing the deep motor branch. She also discussed performing a tenotomy of the profundus tendons to the index and long finger. Again, there was no diagnosis of left carpal tunnel syndrome and no recommendation for a left carpal tunnel release. Furthermore, Dr. Mackinnon did not comment on medical causation and did not indicate the recommended treatment was the result of the December 17, 2001 injury. In fact, Dr. Mackinnon noted that in 2005, Petitioner started to develop numbness and tingling in the ulnar nerve distribution on his left hand. Petitioner had been released from treatment for his amputation injury since April 2003 and had been working multiple, subsequent jobs using his upper extremities since March 2002.

Following Dr. Mackinnon's evaluation on February 14, 2008, Respondent obtained an evaluation with Dr. Ollinger on March 19, 2008 to address Dr. Mackinnon's surgical recommendation and the causation issue. Dr. Ollinger recommended an EMG/NCV and noted he was not impressed that Petitioner's symptoms were generated by any tendon situation in his hand or fingers. Dr. Ollinger questioned the timing of when Petitioner's complaints changed from carpal tunnel to cubital tunnel, especially in light of Petitioner's subsequent employment. Dr. Ollinger reviewed an EMG/NCV from February 14, 2008 and issued a supplemental report on July 8, 2008 opining that Petitioner's current condition or considered treatment did not relate to the work accident of December 17, 2001 by cause or aggravation.

Despite Petitioner's evaluation by Dr. Mackinnon on February 14, 2008, Petitioner did not take the deposition of Dr. Mackinnon to address medical causation until October 2012, some 4 ½ years later. That deposition was not completed due to time constraints and was not rescheduled for completion until December of 2015. In the interim, Petitioner had surgery with Dr. Mackinnon on February 19, 2013.

Prior to surgery, Dr. Mackinnon evaluated Petitioner on January 8, 2013. It was during this visit that Dr. Mackinnon first diagnosed left carpal tunnel syndrome and recommended release of the left carpal tunnel in addition to the previously recommended left ulnar nerve transposition and release of the median nerve in the forearm and release of the left ulnar nerve through Guyon's Canal. She also recommended a tenotomy of the profundus tendons to the second and third digits. However, her post-operative diagnosis was left ulnar nerve compression, cubital tunnel, left ulnar nerve compression, Guyon's Canal, median nerve compression at the forearm and carpal tunnel.

Dr. Mackinnon last saw Petitioner on July 18, 2013, felt he was "doing beautifully", and discharged him from care. She made no indication of any restrictions and did not recommended additional treatment.

Thereafter, Respondent arranged for an updated evaluation with Dr. Robert Hagan. Dr. Hagan evaluated Petitioner on March 23, 2015. He opined that the carpal tunnel syndrome and Guyon's Canal compression should be regarded as part of the December 2001 injury. However, he did not feel the cubital tunnel syndrome in the elbow and proximal median nerve

compression were part of that injury. Dr. Hagan did not recommend any restrictions for Petitioner's left upper extremity and did not recommend any future treatment. By this point, Petitioner had undergone surgery two years prior.

Petitioner then saw Dr. Daniels on June 29, 2015, having last seen Dr. Mackinnon on July 18, 2013. Dr. Daniels noted that Petitioner had "a pretty excellent outcome." Despite some minimal complaints of occasional numbness on the inside of his elbow, he had no evidence of any type of other neurological issues. Dr. Daniels opined that Petitioner was at maximum medical improvement and released him from care. Dr. Daniels did not provide any restrictions on his activity or recommend any future medical treatment. (PX 8)

It is unreasonable to award penalties and fees for failing to authorize a procedure that, in reality, was no longer being recommended when Petitioner resumed treatment after the first 19(b) hearing. The conditions originally diagnosed by Dr. Mackinnon in 2008 were not those encompassed in the Commission's Decision ordering Respondent to provide treatment for left carpal tunnel syndrome. Once these additional medical conditions were presented, Respondent was entitled to further evaluate and address medical causation – especially in the absence of any medical causation opinion provided by Petitioner. Respondent promptly obtained an evaluation and supplemental report from Dr. Ollinger in March and July 2008, respectively. These reports provided a basis for Respondent to deny the recommended treatment with Dr. Mackinnon.

The deposition of Dr. Ollinger was not completed until October 2010. That this was through fault or lack of effort by Respondent was not shown. Furthermore, throughout this time it appears Petitioner took no attempts to move the matter to trial.

As shown by the Commission records for this case, as of September of 2010, Respondent began filing a series of Motions for Trial Date Certain in an effort to move the matter to hearing and resolve the disputed issues. It appears that each Motion was met with objection as trials were not held. Throughout this time Petitioner had still not provided Respondent with a medical causation opinion or a work status/off work slip. Petitioner took Dr. Olson's deposition in August 20 of 2011 and Dr. Mackinnon's deposition was begun on October 12, 2012, but it was not completed until December of 2015. It was at the first deposition of Dr. Mackinnon begun in 2012 that any evidence of medical causation was elicited on behalf of Petitioner. While the direct examination was completed on that date, the cross-examination was not. That would not be completed for another 3 years.

By the time Respondent secured the report from Dr. Hagan in March 2015 confirming a left carpal tunnel condition (as diagnosed by Dr. Mackinnon in January 2013 and subsequently operated on in February 2013) as related to the December 17, 2001 injury, Petitioner had already undergone treatment for the condition (as well as several others) and had been released from care.

Given the series of events noted above, Respondent's refusal to authorize treatment with Dr. Mackinnon in February 2008 was not contrary to the Commission's Decision as issued nor

was Respondent's refusal unreasonable and vexatious. Furthermore, Petitioner failed to present Respondent with documentation entitling Petitioner to TTD from December 17, 2007 through July 2013. As such, Respondent's failure to pay TTD was also not unreasonable and vexatious.

Since Respondent's failure to authorize the surgery with Dr. Mackinnon in 2008 was based on the lack of medical causation opinion by Dr. Mackinnon and the reports of Dr. Ollinger, Petitioner has failed to meet his burden of proof showing he is entitled to penalties under Sec. 19(k). While Petitioner also claims penalties under Sec. 19(l) for Respondent's failure to authorize medical treatment with Dr. Mackinnon, under Hollywood Casino-Aurora, Inc. v. Illinois Workers' Compensation Commission, 967 N.E.2d 848, 359 Ill.Dec. 818, the Court found that Section 19(k) does not include giving of authorization for service and as such, penalties for delay in providing authorization could not be awarded.

The Arbitrator also finds that Petitioner failed to present evidence of entitlement to TTD and as such, Petitioner has failed to meet his burden of proof on the issue of Sec. 19(k) and Sec. 19(l) penalties for Respondent's alleged failure to pay TTD.

Therefore, the Arbitrator concludes that neither penalties nor fees nor costs should be imposed upon Respondent.

Issue (N) Credit.

Respondent asserted a credit in the amount of $1,000.00. Petitioner objected and the issue was placed in dispute. No evidence was presented at the time of arbitration regarding this issue. As such, the Arbitrator concludes that Respondent has failed to prove its entitlement to a credit against the PPD award.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF ADAMS)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

John M. Carpenter,
Petitioner,

vs.

NO: 06 WC 47049

18IWCC0245

Adecco Employment Services &
J. M. Huber,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, permanent partial disability, medical expenses, prospective medical expenses, employer-employee relationship, notice, evidentiary rulings, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 7, 2016 is hereby affirmed and adopted.

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

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

18IWCC0245

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: APR 18 2018

Joshua D. Luskin

o-04/11/18
jdl/wj
068

Charles J. DeVriendt

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CARPENTER, JOHN M
Employee/Petitioner

Case# **06WC047049**

04WC031927

ADECCO EMPLOYMENT SERVICES AND J M HUBER
Employer/Respondent

18IWCC0245

On 9/7/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.47% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0393 THOMAS R LICHTEN LTD
53 W JACKSON BLVD
SUITE 224
CHICAGO, IL 60604

0507 RUSIN & MACIOROWSKI LTD
TERRY E SCHRIEDER
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF ADAMS)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

John M. Carpenter
Employee/Petitioner
v.

18IWCC0245

Case # 06 WC 47049

Adecco Employment Services and J.M. Huber
Employer/Respondent

Consolidated cases: 04 WC 31927

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Quincy**, on **July 6, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☒ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☒ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Hold Harmless; Admissibility of PX 17; Respondent's Motion to Dismiss**

FINDINGS

On, **01/06/2005** Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did not* exist between Petitioner and Respondent.

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

Timely notice of this accident *was not* given to Respondent.

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

In the year preceding the injury, Petitioner earned **$3,456.25**; the average weekly wage was **$384.03**.

On the date of accident, Petitioner was **40** years of age, ***single*** with **1** dependent child.

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

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

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

Respondent is entitled to a credit of **$-0-** for any medical bills paid by a group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Petitioner failed to prove an employee/employer relationship existed on the alleged date of accident, failed to prove he sustained an accident on January 6, 2005 that arose out of and in the course of his employment with Respondent, failed to prove that timely notice of an alleged accident was provided and failed to prove that his current condition of ill-being in his left upper extremity, lumbar spine, and cervical spine are causally related to the alleged injury or his employment duties for Respondent. Petitioner's claim for compensation is denied and no benefits are awarded.

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

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

Nancy Lindsay
Signature of Arbitrator

September 3, 2016
Date

SEP - 7 2016

John M. Carpenter v. Adecco Employment Services and J.M. Huber, 06 WC 47049

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner is alleging injuries to his left upper extremity, elbow, hand, and wrist, neck, and low back as a result of an accident occurring on January 6, 2005 while he was employed by Respondent herein. Petitioner also has a case pending against Snelling Personnel Services (#04 WC 31927) in which he alleges injuries to his left upper extremity, elbow, hand, and wrist as a result of an undisputed accident occurring on December 17, 2001. A 19(b) hearing was held in that case on October 4, 2006.

The Arbitrator finds:

Summary of the 19(b) Hearing held on October 4, 2006 and Evidence

The following summary is based upon evidence and testimony presented at the October 4, 2006 hearing in case #04-WC -31927 which was admitted as PX 1 at the time of trial.

On December 17, 2001 Petitioner was working for Snelling Temporary Services at a company called RPG Manufacturing. At that time a stamping machine came down on his left hand and he lost his left index finger and a half or more of his left long finger. He was immediately taken to Blessing Hospital where he was treated. Petitioner underwent surgery with Dr. Craig Olson consisting of an amputation of the left index finger down to the metacarpophalangeal joint and an amputation of the left long finger down to the proximal part of the middle phalanx. (PX 1 – pet. ex. 1, pet. ex. 3, res. ex. 4)

Petitioner continued to follow up with Dr. Olson. Dr. Olson's records reflect an ongoing desire to get Petitioner back to work as it would constitute "valuable therapy." (PX 1 – pet. ex. 1 1/23/02 o/n) Petitioner underwent physical therapy from January 16, 2002 through February 27, 2002 and, at discharge, was noted to have had 100% resolution of his therapy problems. He was instructed to continue with his home exercise program which was designed to help with strengthening and desensitization. (PX 1 – pet. ex. 1, pet. ex. 2, res. ex. 4)

According to Dr. Olson's March 5, 2002 office note, Petitioner was working as a cook and doing okay. Petitioner reported that he would occasionally experience some abnormal sensations and that vibratory machinery "seemed to set him off." Dr. Olson felt cooking would be okay but that he should refrain from any vibratory machinery for about two months. (PX 1 – pet. ex. 1, res. ex. 4) As of April 30, 2002 Petitioner was doing much better and it was felt he was at maximum medical improvement. Petitioner reported he was working full-time as a cook and doing well with that. Dr. Olson suspected Petitioner might need a finger compression glove at some point but didn't need to see him again for a year. (PX 1 – pet. ex. 1, res. ex. 4)

Petitioner returned to see Dr. Olson one year later on April 29, 2003 reporting no current desensitization problems and almost symmetric grip strength with the right side. Petitioner was reportedly doing "regular work" and noticing less and less occasional cramping in his hand. Dr.

Olson felt Petitioner would have excellent function with it and very little limitation. Petitioner was released with no restrictions and told to return as needed. (PX 1 – pet. ex. 1; res. ex. 4)

On February 24, 2004 Petitioner underwent a pre-employment examination lumbar spine x-ray per Dr. Philip Wilson. The x-ray revealed significant degenerative changes in the lower lumbar spine with bilateral spondylolysis at L5 with 20% anterior spondylolisthesis of L5 on sacrum. (PX 1 – pet. ex. 1, res. ex. 4)

Petitioner filed his Application for Adjustment of Claim in case # 04 SC 31927 against Snelling Personnel Services on June 16, 2004, alleging "left hand and body injuries as a result of an accident on December 17, 2001. (AX 2 to TA from 10/4/06; AX 2)

Petitioner returned to see Dr. Olson on January 6, 2005 reporting numbness and tingling of his left upper extremity and pain at night. Dr. Olson noted that Petitioner had had multiple jobs since his injury. He noted, "With heavy lifting and things of that nature he has started to get numbness and tingling at night, pain that wakes him up from his sleep and his remaining long finger and the ulnar side of his ring finger and thumb are numb. Dr. Olson wrote, "[Petitioner] said this injury happened on 12/17/01 when he lost the fingers with a 60 ton press. Nothing seemed to help." (PX 1 – pet. ex. 1, res. ex. 4) On examination Petitioner had a positive Tinel's on the left side at the carpal tunnel. Dr. Olson suspected carpal tunnel syndrome "until proven otherwise." He noted it had been ongoing for several months without resolution and added, "He feels this is work related. In my opinion, I think it is related to the function of his hand with the amputated digits." An EMG was recommended along with a cock-up wrist splint which Petitioner had already been wearing for some time He was taken off work until the EMG results were received. (PX 1 – pet. ex. 1, res. ex. 4)

On February 8, 2005 Petitioner filed his Notice of Motion and Order in case #04 WC 31927 regarding a hearing on a 19(b) Petition and Petition for Attorney's Fees and Penalties which was scheduled for March 2, 2005. (PX 1 – pet. ex. 7)

On March 21, 2005 Petitioner filed his Notice of Motion and Order in case #04 WC 31927 regarding a hearing on a 19(b) Petition and Petition for Attorney's Fees and Penalties which was scheduled for April 6, 2005. (PX 1 – pet. ex. 8, pet. ex. 9)

On/about March 31, 2005 Petitioner failed to appear for his shift at County Market Express and the manager for County Market Express had to hire someone else to work his shift. (PX 1 – pet. ex. 5)

Petitioner's case against Snelling Personnel Services (case # "04 WC 31927") proceeded to arbitration on a 19(b) Petition on October 4, 2006. The issues in dispute were causal connection, medical, prospective medical care, TTD, and penalties and attorney's fees. (10/4/06 T.A. pp. 4-5) Petitioner testified that he is right handed. Petitioner further testified that on December 17, 2001 Petitioner was working for Snelling at a company called RPG Manufacturing. At that time a stamping machine came down on his left hand and he lost his left index finger and a half or more of his left long finger. He was immediately taken to Blessing

Hospital where he was treated. Petitioner subsequently underwent physical and occupational therapy and he began receiving TTD benefits. Those benefits were terminated as of February 4, 2002. (10/4/06 T.A. pp. 21 – 24)

Petitioner further testified that he was released by Dr. Olson on January 23, 2002 with instructions to avoid vibratory machines and "things like that." Petitioner testified that he contacted Snelling about going back to work but he never received any follow-up. Petitioner testified to trying to find other jobs thereafter, eventually finding full-time employment at Santino's Mexican Restaurant around March 5, 2002. Petitioner worked there for about six months. He would cook tortilla chips in a deep fryer which required him to "grab tortilla chips, throw them out and dip with a pair of tongs." He would use his right hand. Petitioner further testified that he would also help with prep in the morning and be "on the pans" mainly used for fajitas. According to Petitioner, he did not have to use his left hand for cooking with the cast iron skillets because they were heavy, awkward, and he couldn't grip them correctly. Petitioner did not have to clean the dishes or the grill. He further testified that he could pretty much perform all of his necessary job duties although when he cut steak he couldn't do so the way he normally would. There was a machine that automatically diced the onions, tomatoes, and peppers. To make salsa, he would open up a can of diced tomatoes, put it in a can, and use a whip to stir it up. Petitioner testified that the cramping and tingling showed up in his hand after working at Santino's.

Petitioner was unemployed from approximately July through October of 2002.

Petitioner then began working for Industrial Support Services "taking up plastic" and putting it in a box and running it through a tape machine. He would hold a small plastic piece with his thumb, ring finger and pinky and a glue gun with his right hand. He did that job for about a year. On cross-examination Petitioner testified that it was seasonal forty hour work for six months "off and on." He did the "glue gun" job for about three days. The remaining time he worked as a packer folding box lids in and putting the lid down for the tape machine.

Petitioner also testified that, through Respondent herein, he found a job at JM Huber where he would use a tow motor to put two ton sacks into a machine, let it drain, and then separate the product. He also bagged fifty pound bags every day. He would use both hands to pull the product off because he couldn't grab with just one. He described the job as a lot different from his other jobs but paying better. It was a forty hour work week. He could not recall when he went to work for Huber. He thought it was around the end of 2003. On cross-examination he agreed that he worked there from March of 2003 through March of 2004. Petitioner testified that while working for Huber he noticed that his left hand would go numb. He would get home from work and notice numbness and tingling. Petitioner testified that when he would get home from work he couldn't even grab a glass of water to drink. The longer he worked there the worse his symptoms became and he eventually went back to Dr. Olson on January 6, 2005. Petitioner testified that Dr. Olson wanted him to undergo a test and stop working but workman's compensation denied both. At the time of the 19(b) hearing Petitioner

had an appointment scheduled for December 14th with Dr. Lockhart and had insurance to cover it.

On cross-examination Petitioner agreed that he was unemployed from March of 2004 through March of 2005.

Petitioner testified that he began working for County Market Express on March 7, 2005 as a part-time cashier. He also stocked soda and beer. He mainly used his right hand. Petitioner worked at County Market for about three months before he was terminated.

Petitioner testified, on cross-examination, that he didn't immediately go to work after his employment with County Market Express ended. He moved to St. Louis for personal family reasons and he worked at O'Reilly's Auto Parts as a cashier.

Petitioner attended an IME with Dr. Ollinger (in regard to case #04 WC 31927) on March 31, 2005.

At the time of his 19(b) hearing Petitioner was working for Manchester Tank as a welder, having begun in May of 2006. He described his job as that of a "Mig welder" and that it required the use of his right hand. Petitioner testified he was working full duty and full-time.

Petitioner testified to difficulties he had with everyday activities and how he uses his hands. Petitioner testified that in order to cut steak he has to put the fork in his left hand to cut with his right hand and if the fork gets on what's left of his middle finger, it "gets on that nerve in there" and he ends up dropping the fork. Petitioner testified that it is difficult to work with his hand all day and he can't pick things up anymore. Sometimes it is difficult for him to tie his shoes or button his pants. It often depends upon how much he has worked his hand on a particular day. His hand still goes numb and tingles. Petitioner also testified that if he tries to use his middle finger it cramps and shakes. Petitioner testified that his ring finger goes numb. He takes more time to do things such as washing dishes or grabbing plates and glasses. He further explained that since his hand goes numb he tries not to use "this finger" as much because of the nerve so he uses his thumb to grip. Petitioner testified that he has pain on the top half of his hand and the thumb. He knows when cold weather is coming because his hand will have a dull ache and cramp. Petitioner testified that he wished to undergo the EMG test if the doctor still thought it was necessary. He also wished to undergo carpal tunnel surgery if it was deemed appropriate. (T.A. 10/4/06)

Post-19(b) Developments

On October 23, 2006 Petitioner signed his Application for Adjustment of Claim in case # 06 WC 47049 against Adecco Employment Services and J. M. Huber, Respondent herein. Petitioner alleged an accident date of January 6, 2005 and alleged injuries to his "left hand and body." As for how the accident occurred, Petitioner listed "The injury arose from and is related to the employment." (AX 4)

On November 16, 2006 Petitioner presented to Dr. Michael Hambrick in follow-up after initially establishing care with the doctor on the "8th." Petitioner was reporting feeling very tired throughout the day. He had no other complaints and was mainly concerned about his obstructive sleep apnea. Dr. Hambrick noted Petitioner had a GED and "earned his living with his back." He reported no other medical problems although he was on Provagil. A sleep study was pending. (RX 4, p. 25)

On November 21, 2006 the Arbitrator entered his Decision in case #04 WC 31927. The Arbitrator found that Petitioner's left carpal tunnel syndrome was not caused or aggravated by the amputation injury he sustained on December 17, 2001 and denied Petitioner's claim for treatment of his left carpal tunnel syndrome. (RX 2) Petitioner appealed the Arbitrator's Decision.

While Petitioner's case in 04-WC 31927 was pending on review before the Commission, Petitioner returned to Dr. Hambrick on December 4, 2006 in follow-up for his sleep apnea. He also reported continued lumbar back pain that wasn't being helped by tramadol. Back x-rays were ordered. No other problems were noted other than a family history of coronary artery disease, leukocytosis, and probable chronic obstructive pulmonary disease. (RX 4, p. 23; RX 7, pp. 47-48)

Dr. Hambrick re-examined Petitioner on December 18, 2006 regarding his multiple problems as identified earlier in December. No hand or left upper extremity complaints were noted. (RX 4, pp. 21-22)

Petitioner underwent an MRI of his lumbar spine on December 27, 2006 in Quincy. The report indicates multilevel degenerative disc changes most pronounced at L4-5 and L5-S1. The changes at L4-5 showed moderate to severe central canal stenosis. He also had evidence of spondylolysis and anterolisthesis of L5 as well as loss of L5-S1 disc space resulting in bilateral nerve root impingement. (RX 7, p. 44)

Petitioner returned to Dr. Hambrick on January 3, 2007 regarding his very severe low back pain for which he had missed work that day. Given his physical examination findings, they discussed a referral to a neurosurgeon (Dr. Russell in Springfield). No left hand or left upper extremity complaints were noted. (RX 4, p. 19; RX 7, pp. 45-46)

Petitioner saw Dr. Hambrick in follow-up for his back pain on January 31, 2007. Petitioner was scheduled to see the surgeon on the 15th and was going to lose his job if he didn't return to work by Friday. Petitioner requested a release to go back to work but was told if he did so he would probably have a re-injury and cause a new and worse problem. Petitioner had fallen on ice two times. He was given Vicodin for his back pain. No left hand or left upper extremity complaints were noted. (RX 4, pp. 17-18)

Petitioner was examined by Dr. Brian Russell, a neurosurgeon, at Springfield Clinic on March 20, 2007. Prior to the examination Petitioner completed a Patient Information form. He noted that he was working for Manchester Tank. Petitioner denied being injured on the job or in

an auto accident. He gave an injury date of "9-06." (RX 7, p. 58) Petitioner reported a history of back pain off and on all of his life. His most recent episode began in August. He denied any original injury. Petitioner reported pain down above his waist, radiating to both of his hips, and down his legs associated with some numbness and tingling in his feet. Petitioner reported being employed as a welder, oftentimes standing for an extended period of time. He was also busy lifting tanks to and from carts and noticing more and more back pain. Petitioner had undergone physical therapy for three weeks but it failed to help. He had not tried surgery. Petitioner's December MRI from Quincy was reviewed. Dr. Russell suspected Petitioner, clinically, was having a lot of back and leg symptoms secondary to his spondylolisthesis and degenerative disc disease. He wrote, "He has certainly had this for many years." Dr. Russell thought a course of epidural steroids might be of benefit but, if not, the other option was a fusion. Dr. Russell also wanted Petitioner examined by one of the Clinic's orthopedic surgeons. (RX 7, pp. 16-17, 59-61)

Petitioner completed a "Patient History" form for Springfield Clinic on April 3, 2007. In it Petitioner indicated he was being seen for back problems and the possibility of surgery. Petitioner reported constant symptoms that had been ongoing for a "long time." Asked if there had been an injury, Petitioner replied "No." (RX 7, p. 92) He denied being involved in any legal action for the problem and that he couldn't do his job so Dr. Hambrick took him off work. Petitioner did not answer the question, "Is this a work related problem/injury?" (RX 7, p. 92)

Dr. Stephen Pineda, an orthopedic surgeon, examined Petitioner on April 3, 2007. Dr. Pineda's office notes refer to a history of low back pain, present for a number of years which had been treated with observation and medication. Dr. Russell recommended the possibility of surgical fusion or an epidural. Dr. Pineda was seeing Petitioner for an additional evaluation. Dr. Pineda reviewed an MRI taken in Quincy on December 27, 2006. It revealed a listhesis with degeneration at L5-S1. There was also some evidence of some stenosis at that level. Petitioner was able to stand and walk and could fire his upper and lower extremity musculature strongly. Dr. Pineda recommended an x-ray and an epidural, the latter of which could be done in Quincy. Petitioner was given the name of Dr. Rodriguez in Quincy. (RX 7, pp. 13-15, 54-55, 91, 83)

Petitioner underwent lumbar spine x-rays on April 3, 2007 due to a history of worsening back pain. The impression was that of degenerative changes most pronounced at the L5-S1 level, coupled with Grade 1 anterolisthesis and spondylolsis. (RX 7, pp. 82, 94)

Petitioner underwent an epidural lumbar injection on April 11, 2007. Petitioner gave a long history of low back pain with bilateral radiculopathy. Petitioner told Dr. Bharwani that his pain had increased in intensity since August of 2006 and it had "markedly increased" since January of this year. The pain was so bad that he had to get off work. Petitioner reported a constant, dull, aching, pain that shifted from one leg to another and only relieved with medication. Valsalva maneuvers like coughing and sneezing increased his pain intensity. Petitioner reported that he used to do heavy work but he had been laid off due to the pain. A history of depression was noted. Petitioner tolerated the procedure well. (RX 7, p. 56)

Petitioner phoned Dr. Pineda's office on April 27, 2007 reporting the injection helped for about 8-9 days. Petitioner wanted to know what the doctor's next step would be. (RX 7, p. 90)

Dr. Pineda left a chart note regarding Petitioner on May 3, 2007 noting that he had called Petitioner that day and spoke with him about his back, including a repeat injection and the pros and cons of fusion surgery. Petitioner also asked about activity and the doctor told him he could do any activity as tolerated by his symptoms. (RX 7, pp. 11, 88)

Petitioner was sent a letter dated July 10, 2007 advising him that he had been terminated from further use of Springfield Clinic's services due to the fact he knowingly presented inaccurate insurance information when establishing care with Dr. Brian Russell's office. Petitioner was advised to follow up with his primary care doctor, Dr. Hambrick, to obtain another referral to another provider. (RX 7, pp.51, 81, 93)

Petitioner then presented to Dr. Stacey Pogue on November 14, 2007 to establish care. Petitioner reported being out of his medications for his chronic back pain for about two weeks. He was unable to undergo back surgery due to loss of his insurance, job, "etc." Petitioner wished to continue on his pain medication and get released to return to work until he was able to have surgery. Petitioner reported being discharged from Dr. Russell's care due to giving the doctor's office an expired insurance card. Petitioner's MRI had shown multi-level degenerative disc disease and central canal stenosis as well as spondylothesis and bilateral nerve root impingement. Petitioner had tried epidural injections without help. Petitioner was interested in working again and had a driving job he thought he could do. Petitioner reported no left upper extremity complaints or concerns. (RX 4, pp. 15-16)

On November 21, 2007 the Commission entered its Decision reversing the Arbitrator's Decision and finding that Petitioner's current condition of ill-being in his left hand, including his left carpal tunnel syndrome, was casually related to the December 17, 2001 accident. Petitioner was awarded TTD benefits from December 18, 2001 through March 4, 2002 and from January 6, 2005 through March 6, 2005 along with prospective medical care for the treatment of his left carpal tunnel syndrome, medical bills of $80.00 and $45.50 for lost wages incurred by Petitioner in conjunction with a Section 12 examination. (RX 2) No further appeal was taken.

On December 17, 2007 Petitioner presented to Dr. Jim Daniels for a re-evaluation of his left wrist. Dr. Daniels had not seen Petitioner for almost a year. By history, Dr. Daniels noted that Petitioner had an amputation-type injury to his left hand while working at Titan Wheel. He suffered a complete amputation to the middle finger and partial amputation to the index finger but he "doesn't really have any ability to use it at all." Petitioner reported the inability to flex or extend and was complaining of a lot of problem with tingling in his hand but Dr. Daniels, at that time, didn't think Petitioner had the "right symptoms for carpal tunnel syndrome." He did seem to have some sort of nerve entrapment and it was thought he might have entrapment of the median nerve in the forearm secondary to hypertrophy of the other flexor muscles that had hypertrophied after the injury. Petitioner reported that his case had become very complex as it had been denied but subsequently it was determined that it was work-related and Petitioner wished to get something done. Petitioner was no longer working at Manchester Tank. He had injured his back but stated his back was not bothering him too much at this point. Petitioner was currently unemployed. On examination Petitioner was noted to have decreased range of

motion of his neck. Spurling's maneuver reproduced a lot of his symptoms in his "shoulder" but he pointed to an area just medial and inferior to the scapula. Petitioner could abduct without any difficulty. The rotator cuff muscles were normal. Regarding Petitioner's hand, his examination was "somewhat changed" from the last time he had been seen. His forearm was not as large as it was when he was seen earlier. A median nerve compression test at the carpal tunnel didn't really reproduce his symptoms until the last couple of seconds when he had some tingling in his hand and that wasn't exactly the same. He also had a positive Phalen's sign at the elbow and that seemed to bother him more than anything on the day of the visit. The ulnar nerve didn't appear subluxed and Petitioner was not tender over Guyon's Canal. He could abduct his thumb without any difficulty. There was no evidence of any type of atrophy of the thenar eminence. Petitioner did not have very good feeling of what was left of his finger on the radial aspect of his hand but he had about a 3 or 4 point discrimination pattern on 2-point discrimination on the ring and small finger. Dr. Daniels felt Petitioner had some evidence of nerve entrapment in his left upper extremity but it was a complex case probably "with some social issues". The last time he had seen Petitioner the doctor was concerned about pronator teres syndrome but on today's examination it appeared his symptoms were more related to the ulnar nerve. Petitioner wished to be referred to Dr. Mackinnon in St. Louis and they had discussed that before and the doctor thought it would be fine. Petitioner was further advised that some of his shoulder problems may be related to his neck and some of his back problems could be affecting his neck. Petitioner was to return as needed. (RX 4, pp. 10-11; PX 16, pet. dep. ex. 3)

In conjunction with his appointment with Dr. Mackinnon, Petitioner underwent an EMG on February 14, 2008. The study was read as within normal limits and with no electrodiagnostic evidence for left median or ulnar neuropathy. (PX 15, dep. ex. 2; PX 16, pet. dep. ex. 3)

Petitioner then presented to Dr. Mackinnon on February 14, 2008. In a letter dated February 16, 2008, and addressed to Dr. Daniels, Dr. Mackinnon reported on her evaluation of Petitioner performed two days earlier. (PX 15, dep. ex. 2; PX 16, pet. dep. ex. 3) Dr. Mackinnon noted that Petitioner presented with his sister and case manager and complained of significant numbness and tingling and pain in the left ulnar nerve distribution of his left proximal forearm. Petitioner gave a history of sustaining a crush injury to his left hand in December of 2011 that had resulted in an amputation of his index finger and middle finger at the PIP joint. Petitioner further stated that in 2005 he began to develop numbness and tingling in the ulnar nerve distribution of his left hand and aching in the medical aspect of his left forearm. Petitioner also reported sensitivity at the amputation stump especially in the long finger and he was starting to drop things. Additional complaints included an aching in the medial aspect of his elbow. Electrodiagnostic studies reportedly showed mild left cubital tunnel syndrome. Petitioner denied any median nerve symptoms. Petitioner rated his pain at "9/10" and believed it had a 90% impact on his quality of life. Petitioner had thought about suicide in the past but had not thought out any details. Petitioner also reported back pain but no health insurance to cover it. Petitioner was depressed. (PX 15, dep. ex. 2)

Dr. Mackinnon further noted that Petitioner was divorced with a 17 year old child. He smoked two packs of cigarettes a day and had done so for thirty years. He was an occasional beer and whiskey drinker. Petitioner's medications included occasional aspirin, Vicodin, Advair, and Proventil. He had gained more than ten lbs. in the preceding year. Petitioner's other medical problems included sleep apnea, chronic bronchitis, a fracture in his left arm, low back pain and occasional headaches. (PX 15, dep. ex. 2)

Dr. Mackinnon performed a physical examination which she detailed in her report. She recommended that Petitioner undergo a left ulnar nerve transposition and a release, to a significant degree, of the median nerve in the proximal forearm. She further recommended a release of the left ulnar nerve through Guyon's Canal, specifically releasing the deep motor branch. Dr. Mackinnon also addressed with Petitioner a possible tenotomy of the profundus tendons of the index and long finger as she felt his forearm pain was more related to a quadriga effect rather than a pronator teres syndrome. Dr. Mackinnon indicated she could perform surgery the next day if possible. She also believed that at some point in time Petitioner might need a more definitive pronator teres release but she was optimistic she could relieve Petitioner's pain without an anterior forearm incision. (PX 15, dep. ex. 2)

Surgery as recommended by Dr. Mackinnon was cancelled due to insurance issues. (PX 15, dep. ex. 2)

On February 26, 2008 Petitioner filed a Notice of Motion and Order in case # 04 WC 31927 regarding his intent to proceed to hearing on March 5, 2008 regarding his 19(b) Petition and Petition for Penalties and Attorney's Fees. (PX 3)

On March 10, 2008 Petitioner filed a Notice of Motion and Order in case #04 WC 31927 regarding his intent to proceed to hearing on April 2, 2008 regarding his 19(b) Petition and Petition for Attorney's Fees. (PX 4)

Petitioner presented to Dr. Poetz, D.O., on June 3, 2008 regarding lower back pain. Petitioner gave an onset of 2006 with no known injury. Petitioner was assessed with chronic low back pain. (RX 6, p. 16)

Petitioner returned to Dr. Poetz on July 10, 2008 regarding a rash. No back, neck, or left upper extremity complaints (except for the rash on his elbow and neck) were mentioned. (RX 6, p. 15)

Dr. Poetz re-examined Petitioner on July 15 and 21, 2008 regarding COPD. No back, neck, or left upper extremity complaints were noted. (RX 6, pp.13-14)

Petitioner presented to Dr. Poetz on August 15, 2008 with complaints of depression, lack of sleep and mid to low back pain of two years duration. He was diagnosed with insomnia. (RX 6, p. 12) Petitioner again returned to Dr. Poetz on September 8, 2008 with similar complaints. He was diagnosed with bronchitis/pneumonia, depression and tinea corpis. (RX 6, p. 11) At his September 23, 2008 with Dr. Poetz Petitioner again voiced similar complaints and the doctor discussed getting a colonscopy. (RX 6, p. 10)

Petitioner underwent an open MRI of his lumbar spine on December 3, 2008 due to radiating pain to his hips and calves. The report suggests degenerative changes of central disc and osteophyte superimposed on borderline developmental spinal stenosis at L4-5.Petitioner also had evidence of Grade I listhesis with pseudobulging, marked degenerative facet disease and tilting of the foramen at L5-S1. (RX 6, p. 25)

Petitioner returned to see Dr. Poetz on December 5, 2008 regarding his bronchitis and COPD. (RX 6, p. 9)

Petitioner again presented to Dr. Poetz on February 3, 2009 with symptoms and complaints related to depression, lack of energy, and COPD. There was no mention of left upper extremity, neck, or back issues. (RX 6, p. 7)

Petitioner was seen by Dr. Poetz on May 18, 2009 regarding high lipids, high blood pressure and his COPD. No left upper extremity complaints, neck complaints, or back complaints were recorded. (RX 6, p. 7)

On August 21, 2009 Petitioner and Dr. Poetz discussed his COPD and the use of inhalers. (RX 6, p. 5)

Petitioner initiated care with Dr. Terrence Piper on October 6, 2009 in regard to chronic low back pain and bilateral leg pain, numbness, and tingling. Petitioner reported ongoing symptoms for the previous three years with progressive worsening. He had been seeing a pain management doctor but it no longer helped. Petitioner's back x-ray revealed two level disc disease at L4-5 and L5-S1 with associated lytic spondylolisthesis at L5-S1. Petitioner reported the inability to stand or walk for any length of time. Sitting and lying down were okay. Petitioner reported being on disability since 2007 for chronic back complaints. Petitioner had previously lived in Quincy, Illinois but had moved to his mother's in St. Louis and recently wed. Dr. Piper recommended surgery for Petitioner's back. (RX 3)

Petitioner underwent lumbar spine surgery for degenerative disc disease at L4-5, Lytic grade 1 spondylolisthesis at L5-S1, chronic debilitating back pain and chronic left leg pain on December 2, 2009. (RX 3, pp. 54-56)

Petitioner followed up with Dr. Piper or N.P. Hemmer post-operatively. As of January 21, 2010 Dr. Piper reported Petitioner was doing better and getting around; however, he noted some bilateral hip pain. Overall he was doing well. His Neurontin was "bumped up" a little. (RX 3)

On February 16, 2010 Petitioner presented to N.P. Hemmer for left arm pain. Mr. Hemmer noted Petitioner was "battling back from a two level TLIF quite well." Petitioner was now reporting significant left arm pain with numbness and tingling from which he described himself as 'miserable." A recent MRI showed severe two level degenerative disc disease at 5-6 and 6-7. Mr. Hemmer recommended a two level ACDF. (RX 3) In an Addendum of the same date, Dr. Piper noted that Petitioner's pre-surgical low back complaints had abated after surgery. Dr. Piper agreed with the surgical recommendation regarding Petitioner's neck. (RX 3)

Petitioner underwent cervical spine surgery for advanced degenerative disc disease at C5-6 and C6-7, neck pain, and chronic left cervical radiculopathy over the C7 nerve root on February 22, 2010. (RX 3, pp. 52-53)

Petitioner followed up with his doctor post-operatively. At the April 12, 2010 visit Petitioner reported having fall about two weeks earlier. (RX 3)

In August of 2010 Petitioner presented to Dr. Piper's office for low back pain and bilateral radiating hip pain and leg pain. Petitioner was given Lyrica and told to try aquatic rehab. NP Hemmer noted that Petitioner "continues to have difficulties to the extent that he is not ready for gainful employment between his back and his neck. He needs further rehabilitation as well as a strengthening program." (RX 3) He subsequently went through some injections also. As of January 26, 2011 Mr. Hemmer was recommending a CT myelogram. Petitioner was also reporting a lot of left posterior scapular pain. They reviewed a recent MRI which demonstrated a disc protrusion at C3-4 to the left commensurate with his symptoms. A therapeutic and diagnostic nerve block at C4 was recommended. (RX 3)

Petitioner remained symptomatic in his low back and Dr. Piper subsequently recommended hardware removal on the left side of the lower back. Petitioner underwent surgery on April 16, 2011. After that he "fell and busted his wound open." (RX 3) Petitioner continued to treat with Dr. Piper for leg and neck complaints. As of October of 2011 Dr. Piper was concerned about pseudoarthrosis at C5-6 and C6-7. A nerve root injection at C4 provided excellent relief for a week or two and the doctor recommended additional neck surgery. (RX 3)

Deposition of Dr. Craig Olson taken on 8/30/11

Dr. Olson is a board certified orthopedic surgeon previously licensed to practice medicine in Illinois from 1997 through May of 2005. Dr. Olson treated Petitioner for his December 17, 2001 traumatic amputations to his entire left index finger and left middle finger amputation at the pip joint. (PX 14, pp. 1 -6)

Dr. Olson testified that he last saw Petitioner on January 6, 2005. At that time Petitioner was having some left-sided symptoms consistent with carpal tunnel syndrome or median nerve changes as well as some ulnar ring finger symptoms. He recommended an EMG. He didn't know if that ever occurred. Dr. Olson believed that Petitioner's symptoms as of January 6, 2005 were related to his traumatic amputation either directly or indirectly. (PX 14, pp. 6-8)

Dr. Olson acknowledged that he was provided with records from Dr. Mackinnon to review. While he didn't know her, he was familiar with her expertise to a certain degree. Dr. Olson testified that Dr. Mackinnon recommended performing ulnar releases at the cubital and Guyon Canal for Petitioner's ulnar nerve as she felt his forearm had some area of entrapment on the medial nerve that needed to be released. Dr. Olson felt Dr. Mackinnon's surgical recommendation was appropriate. He also believed that Dr. Mackinnon's findings on February 14, 2008 were related to the trauma of December of 2011 because the accident caused some effect to the nerves that were crushed with Petitioner's hands or due to the change in function of

the hand after the fingers were amputated. He also believed that the tethering effect of the profundus tendon was due to the trauma. Dr. Olson agreed that Dr. Mackinnon didn't note any diagnosis of carpal tunnel syndrome; however, she had the benefit of an EMG which he didn't have when he examined Petitioner in January of 2005. (PX 14, pp. 8 – 14)

On cross-examination Dr. Olson acknowledged that he initially released Petitioner back to work at maximum medical improvement as of April 29, 2003. At that time Petitioner's grip strength was almost symmetric and he had been working with occasional cramping but even that was becoming less common. He also agreed that at that point in time he thought Petitioner was going to have excellent function with very little limitation and he had no reason to be concerned with any type of nerve compression. (PX 14, pp. 14-16)

Dr. Olson acknowledged that after April 29, 2003 he did not see Petitioner again until January 6, 2005 at which point Petitioner was complaining of symptoms with heavy lifting. He agreed that he never prohibited Petitioner form heavy lifting when he examined him in April of 2003. When asked if the nature of the work Petitioner described to him in January of 2005 could have placed some kind of a contributing cause to his condition at that time, Dr. Olson noted it would "be difficult to be able to divide them out, but it's certainly possible." (PX 14, p. 17)

Additional Medical Treatment

There are no records showing medical treatment between October of 2011 and February 13, 2012.

On February 13, 2012 Petitioner underwent cervical spine surgery for a chronic left C4 radiculopathy and bony stenosis of the left 3-4 foramen with compression of the C4 nerve root. (RX 3) As of April 17, 2012 Petitioner was doing alright after his previous fusion at L4-S1 and had ended up with almost a calcified disc after surgery on the left at L5-S1 requiring a "Wiltse approach" decompression with screw removal. Overall he had improvement but he was starting to have symptoms again. He denied any weakness but was very specific about L5 and continuing with difficulties. A CT myelogram was ordered. (RX 3, pp. 5-8)

Deposition of Dr. Mackinnon taken on 10/12/12

Dr. Mackinnon testified she is board certified in plastic surgery and restricts her practice to nerve injuries, most notably in the upper extremities. Dr. Mackinnon testified that she evaluated Petitioner on February 14, 2008 at the referral of Dr. Daniels. She has only seen him on that one occasion. (PX 15, pp. 1 – 10)

Dr. Mackinnon testified consistent with her earlier written report furnished to Dr. Daniels. In addition Dr. Mackinnon testified that the EMG she ordered as part of the exam was normal but she attributed no significance to that finding as she had recommended the EMG simply to have a baseline of Petitioner's nerve function. He appeared to have normal electrical function in his left hand and after she operated on him she hoped he would continue to have normal function. According to Dr. Mackinnon probably ten to twenty percent of electrical studies are normal in patients with carpal tunnel and cubital tunnel syndromes. The doctor

explained that pain is transmitted through very tiny nerve fibers and aren't always picked up on electrical studies. (PX 15, pp. 10-11)

Dr. Mackinnon further testified that Petitioner's primary problem was pain and he had evidence of a quadrigia effect. Dr. Mackinnon compared the quadrigia effect to four horses being asked to pull a chariot. The horses are like tendons in one's hand and there are four that go to the small, index, ring and long finger. The tendons meet in a common muscle belly so when one grips, the nerve fibers go to the muscle belly in the forearm and pull the tendons in. If a patient asks one tendon to go in one direction and another tendon to go in yet a different direction it's as chaotic as asking the four horses to go in different directions. Dr. Mackinnon further explained that once a finger is amputated, the flexor tendons can get stuck in the scar tissue and when one goes to grip something, the common muscle (or chariot) pulls on all the tendons but, in Petitioner's case, his ring and small fingers will flex into his hand but his other two tendons would be stuck in the scar tissue from the amputation. If the doctor grabbed onto a person's index and long finger and held them so they couldn't move and then had one flex hard, one would get pain running right up one's forearm as Petitioner had. The solution, according to Dr. Mackinnon, was to go in and separate the tendons from the scar and let them slide back a little bit so they could move and float around. Petitioner should then notice less pain and increased strength. (PX 15, pp. 11 – 14)

Dr. Mackinnon testified that in her opinion Petitioner's amputation injury was the cause of the different conditions she was describing for Petitioner. She based her opinion on the fact that she had no other history or information to suggest otherwise and his physical examination findings could be easily explained by his injury and the amputation. She added that Petitioner has a weak and painful hand and doesn't use it as much which tends to mean he keeps it in a flexed position more than an extended position. Due to the positioning of his left arm due to the amputation and pain, it would be perfectly in keeping that he could develop ulnar nerve symptoms over time. Dr. Mackinnon didn't think Petitioner's median nerve issue was from the carpal tunnel; rather, she felt it was from the pronator which is the same area of origin as Petitioner's flexors and if it gets a little "sticky" and the pull isn't normal one can experience some pressure on the median nerve in the arm. Dr. Mackinnon believed she could go through her ulnar incision and "move over and loosen" the median nerve enough to avoid another incision site. (PX 15, pp. 14-18)

On cross-examination by Snelling's attorney, Dr. Mackinnon identified the records that she had reviewed as part of her evaluation of Petitioner. She did not review any records of Dr. Olson or Dr. Ollinger. She had some records from Dr. Daniels. She also testified that she didn't review any part of the transcript from the October 4, 2006 arbitration hearing but she did get a copy of the Commission's Decision. Dr. Mackinnon was asked if she had any knowledge of Petitioner's work activities and she testified that she really had no recollection. She agreed that the electrical studies performed on Feb. 14, 2008 were normal. When asked about her notation in her written report wherein she noted Petitioner had had electrodiagnostic studies which showed left cubital tunnel syndrome, she explained that she believed Petitioner probably had earlier studies which showed a mild condition. She further believed it might have been the case

manager who related the earlier study results to her. If Petitioner had not undergone any earlier studies that revealed a mild cubital tunnel syndrome, her opinions would, nonetheless, remain unchanged. (PX 15, pp. 18 - 28)

Dr. Mackinnon testified that she will operate on individuals with normal nerve conduction studies. According to the doctor it is not common to do so in her practice because most of her cases deal with horrific traumatic nerve injuries but she does perform some "simple stuff like carpal tunnel and cubital tunnel" and a small percentage of those will involve normal studies. (PX 15, p. 28)

Dr. Mackinnon further testified that a normal nerve conduction study doesn't mean that there is no compression in the nerves. As the doctor explained, nerve compression derives from a blood-nerve barrier breakdown. She explained that there is a brain barrier and a nerve barrier and it keeps molecules in the nervous system and keeps the nervous system happy and safe. If one breaks the nerve barrier then one gets a diffusion of proteins in and out of the nerve barrier and it is unhappy. According to Dr. Mackinnon, "That's the first think that happens with nerve compression, and of course, nerve studies are normal." Patients at that point may not even be symptomatic. However, as fibrosis begins outside the nerve, along with some swelling on the outside of the nerve, the "little tiny choke vessels" that come in and out through that connective tissue into the inside of the nerve have trouble getting in there. That results in lack of blood flow and "then when you get in these funky positions that actually would take some of the blood flow away," the patient becomes symptomatic. In time the myelin or the lining around the nerve fiber gets stripped resulting in demyelination. As one loses the lining the electrical conduction begins to change. (PX 15, pp. 28 – 35)

Dr. Mackinnon was asked if she would be surprised to know that after his amputation injury Petitioner had been able to work as a cook at a Mexican restaurant, at a company on a packing line, as a cashier, as a welder, and at a company where he used a tow motor and bagged all day. She responded, "That's great" and added that he might perhaps be able to do it more comfortably if he had an operation. (PX 15, p. 50) She also believed that performing some of those activities would cause him to hurt more. (PX 15, p. 51)

Dr. Mackinnon was asked about her notation of depression in Petitioner. She explained that she asked him if he was depressed and he said "yes." She acknowledged, however, that she is not a psychiatrist. She also acknowledged that he was obese and that obesity can contribute to cubital tunnel syndrome in about 14 percent of cases. Thereafter the deposition was ended due to time constraints and the doctor's schedule. Cross-examination had not been completed. c(PX 15, pp. 55-56)

Additional Medical Treatment

Petitioner returned to see Dr. Mackinnon on January 8, 2013, having last seen her on February 14, 2008. In a letter to Dr. Daniels, Dr. Mackinnon noted her earlier exam in 2008. At the time of the January 8th visit she noted no real change in his symptoms or his physical examination although the sensitivity over the stump of the third digit was not as significant as

when she saw him earlier. Petitioner had undergone back surgery in 2009 followed by a cervical spine fusion in 2010. He was taking Vicodin and Xanax, was married, and disabled. She still recommended surgery but not to the stump of the third digit. (PX 16, pet. dep. ex. 3, 4)

N.P.[1] Hemmer re-evaluated Petitioner on January 21, 2013 at which time Petitioner reported a lot of L5 type distribution and discomfort but no weakness. A CT myelogram was to be ordered along with a diagnostic L5 block to be considered after the myelogram. (RX 3, pp. 2 - 4)

Surgery with Dr. Mackinnon was scheduled and performed on February 19, 2013. The post-operative diagnosis was left ulnar nerve compression, cubital tunnel, left ulnar nerve compression, Guyon's Canal, median nerve compression of the forearm and carpal tunnel. (PX 16, pet. dep. ex. 2; pet. dep. ex. 3,4)

Post-operatively Dr. Mackinnon re-examined Petitioner on February 26, 2013. She noted that Petitioner had "as much fascial compression over the median nerve in his arm and forearm as she had ever seen and that would very much explain the pain that he had been experiencing in his arm and elbow region." Pre-operatively there was no evidence of any issues with the profundus tendons to the amputated finger so she did not need to perform a tenotomy of the profundus tendons. She expressed optimism regarding Petitioner's significant pain. (PX 16, pet. ex. 3,4)

Dr. Mackinnon re-examined Petitioner on March 13, 2013 at which time he was doing well and he was instructed in early physical therapy. (PX 16, pet. dep. ex. 3,4)

Petitioner attended physical therapy on March 19, 2013 reporting moderate complaints of pain and difficulty with therapy. Overall rehabilitation potential was felt to be excellent. (PX 16, pet. dep. ex. 3, 4)

Petitioner attended physical therapy on April 15, 2013 with the therapist noting great progress with active range of motion and strength. Petitioner's pain levels were reducing; however, he continued to note sensitivity and weakness as well as hand cramps and occasional dropping of things. Petitioner asked about wearing his night-time wrist cock-up splint while playing pool as he was on a league. (PX 16, pet. dep. ex. 3)

Petitioner was discharged from physical therapy on May 29, 2013. It was noted that Petitioner had not been working since January of 2007 due to back disability. Petitioner reported that his numbness was nearly gone since his surgery and the MF tremors had resolved. Petitioner was discharged from therapy due to non-compliance/attendance issues as he had not appeared for therapy since April 29, 2013. (PX 16, dep. ex. 13)

Dr. Mackinnon last saw Petitioner on July 18, 2013 and felt he was "doing beautifully." She noted that she wished she could bring him back every week just to enjoy his "superb recovery." Pinch and grip on the right was 38 and 120 lb. It was 18 and 45 on the left. She noted

[1] Dr. Piper's office

a "little bit" of a snapping extensor tendon in his long finger for which he was given a button hole splint that day. She discharged him from care, "delighted" with the result and felt he would continue to improve over time. He was welcome to return if needed. (PX 16, pet. dep. ex. 3, 4)

On May 20, 2015 Respondent filed its Motion to Dismiss in this matter alleging that this case should be dismissed as it was barred by the Commission's Decision in case # 04 WC 31927/07 IWCC 153. (RX 1)

On June 29, 2015 Petitioner presented to Dr. Daniels regarding some questions about hand surgery. Petitioner wasn't seeking any treatment, just "an opinion from the examiner." Petitioner reported undergoing multiple nerve entrapment in his right forearm both at Guyon's Canal and also at the cubital tunnel. He stated he was lucky enough to get in to see Dr. Mackinnon who performed the surgery. Dr. Daniels' notes indicate uncertainty as to exactly what procedures Petitioner underwent and noted "[Petitioner] actually stated that he got Dr. Mackinnon irritated at him because it was a Worker's Comp Issue. He followed up with her and she said there really was not a whole lot to be done. He is wanting the examiner's opinion." (PX 8) Dr. Daniels noted that Petitioner could flex and extend his elbow, had a well-healed surgical scar on the medial side of his left elbow, lacked any evidence of tenderness, had a negative Tinel's, and, despite the loss of two fingers, his ulnar nerve strength was fine. Dr. Daniels further noted a 4 cm. well-healed surgical scar on the ulnar aspect of Petitioner's wrist with some slight tenderness in that area. Dr. Daniels was of the opinion that Petitioner "really had a pretty excellent outcome." He noted that Petitioner also agreed that his outcome had been good and wanted to make sure things were finished. Petitioner reported that he might have a little bit of occasional numbness on the inside of his elbow. Both he and the doctor believed that probably wouldn't go away. Dr. Daniels noted no evidence of any other neurological issues or any type of neck problems. He felt Petitioner was at maximum medical improvement and released him from care with instructions to follow-up if necessary. (PX 8)

Deposition of Dr. Susan Mackinnon dated 12/11/15

Dr. Mackinnon testified that she is a board certified plastic surgeon specializing in nerve injuries of the upper extremities. Dr. Mackinnon testified that she performed surgery on Petitioner on February 19, 2013. She further identified her records pertaining to her care and treatment of Petitioner (pet. dep. ex. 2, 3) Dr. Mackinnon further testified that her surgery was aimed at removing tension and pressure on the median and ulnar nerves of Petitioner's left upper extremity in the forearm, elbow and wrist area. There were four separate spots under compression – two ulnar and two median. Dr. Mackinnon testified that Petitioner's hand injury would have potentially caused pain because his nerves in the long and index finger were cut. In addition, the tendons to those fingers were cut. Those injuries, in turn, would impact all the way up the arm as the nerves connect up to the spinal cord and the tendons go up to the elbow. Dr. Mackinnon further testified that patients with the amputation injuries like Petitioner had frequently hold their extremity with the elbow bent as though cradling the hand because it feels temporarily more comfortable; however, the cradling can causes cubital tunnel syndrome and it

can work downstream and irritate the Guyon's Canal at the wrist. Similarly, the flexor tendons all go back to one muscle belly in the forearm and can cause stickiness, compression, and irritation along the entire process from where the flexor tendons were cut to where they attach to the muscle. The median nerve goes right between the two heads of the pronator flexor muscles and can become compressed and irritated in the forearm. Thus, Dr. Mackinnon was of the opinion that Petitioner's conditions for which she performed surgery were causally related to Petitioner's amputation injury on December 17, 2001. (PX 16, pp. 10-13, 35-42) She testified that if Petitioner had not sustained amputations to the two fingers she would not have had to perform surgery adding "that the proof is that he got remarkably better after I did those operations." (PX 16, p. 13)

Dr. Mackinnon was asked about her last office visit with Petitioner and acknowledged she would have to rely solely on her office notes as she had no recollection of him. He appeared to be doing beautifully although he had a little bit of snapping of the extensor tendon of the long finger. He was given a small splint for that and she noted his recovery was superb. (PX 16, p. 14)

Petitioner's attorney asked Dr. Mackinnon about Petitioner's ability to work. She testified that it is her practice to not comment on work restrictions for patients she hasn't operated on. When she saw Petitioner in 2008 she didn't operate on him and would not have thought about his ability to work. (PX 16, pp. 14-15) As of July 15, 2013 she did not give him any restrictions explaining that if he went back to work and couldn't perform his work she would have recommended a functional capacity evaluation and deferred to it. (PX 16, p. 16)

On cross-examination by Respondent Snelling, Dr. Mackinnon acknowledged that she did not see any treatment records prior to November of 2006 except for a note of Dr. Daniels. She also acknowledged that she took no detailed history from Petitioner regarding his work history and different jobs since his work accident. She also agreed that there are certain work activities that can impact or affect a person's nerve function in their arm. (PX 16, pp. 16-20) Dr. Mackinnon also acknowledged that she has operated on individuals with compression in the ulnar nerve and the median nerve in the forearm based upon repetitive-type positions but they also lacked amputated digits. She then testified that she doesn't get involved in very many workers' compensation cases as she only sees patients with really bad problems, not easy ones. (PX 16, pp. 20-21) She went on to explain that in cases of cubital tunnel syndrome the only activity that has a strong association with the condition is vibratory exposure (ex. dental hygenists). She concluded noting, "There is no answer to prove any job is causing cubital tunnel." (PX 16, pp. 21-23, 24)

Dr. Mackinnon acknowledged that there was nothing in the medical records she had seen or the history provided by Petitioner to indicate that he held his arm in a flexed position all the time. (PX 16, pp. 24, 27) When asked if she was hypothesizing about that, she responded that she was basing it on three decades of treating patients with painful hand and nerve injuries and seeing their tendency to move into a fetal position when something hurts. (PX 16, p. 25) She

further explained that the more we have our elbows bent, the more likely we are to develop chronic ulnar nerve compression at the elbow. (PX 16, p. 26)

Dr. Mackinnon further testified that Petitioner was born with fascial bands and they didn't come on as a result of his amputated fingers. However, over time, with the amputations, it was "almost like a perfect storm." His obesity and smoking would have been irrelevant. (PX 16, pp. 29-30)

Post-Deposition Developments

Petitioner's case herein appeared above the red line for the January 2016 Quincy Call. Petitioner was reportedly unable to be present due to illness[2]. This was the Arbitrator's first time appearing in Quincy after zone re-assignments and the case was continued, for a trial date certain, to April 6, 2016.

On/about March 21, 2016 Petitioner's attorney received a records review report from Dr. Samuel Chmell. Thereafter, on March 22, 2016 Petitioner's attorney and the attorney for Snelling Personnel Service agreed to the deposition of Dr. Chmell on March 31, 2016. The next day (April 1, 2016) Snelling's attorney e-mailed Petitioner's attorney withdrawing her agreement to proceed with the deposition of Dr. Chmell scheduled for March 31, 2016. Petitioner's attorney sent out a Notice of Deposition regarding Dr. Chmell's March 31, 2016 deposition. Thereafter, on March 29, 2016 a conference call was held between the Arbitrator, Petitioner's attorney and the attorneys for Respondent herein and Snelling. During that conference call the Arbitrator advised the attorneys that in light of the fact the attorneys for both parties had withdrawn their prior agreement in advance of the deposition, there was no agreement to proceed with the deposition and Petitioner's attorney needed to file an appropriate motion since there was no agreement. [3]

It appears from PX 17 that Petitioner's attorney proceeded with the evidence deposition of Dr. Chmell on March 31, 2016 with neither attorney for Snelling or Respondent being in attendance. (PX 17)

Petitioner's case was above the red-line for the April 6, 2016 Quincy Call. At that time the case was to go to trial pursuant to a Trial Date Certain Order entered in January by the Arbitrator. On the afternoon of April 5, 2016 the Arbitrator received an email from Petitioner's attorney, with a doctor's note attached, stating counsel was unable to travel to Quincy on April 6, 2016 due to illness. The case was continued for a trial date certain until July 6, 2016.

On June 27, 2016 Petitioner filed a Notice of Motion and Order regarding a Dedimus Potestatum. The hearing on the motion was set for July 6, 2016. (PX 18)

[2] Petitioner so testified at arbitration.

[3] As stated on the record at the July 6th hearing, Respondent's attorney concurred with the time line as set forth herein and his withdrawal of any agreement to proceed with the deposition.

On July 2, 2016 Petitioner filed a supplemental Motion for Penalties, Attorney's Fees and Costs in case #04 WC 31927. (PX 5)

The July 6, 2016 Arbitration Hearing

On the morning of July 6, 2016, during the general call, Petitioner's attorney presented PX 18, the Motion for Dedimus Potestatum, for hearing. Petitioner's attorney indicated he wished to take Dr. Chmell's deposition on September 8, 2016. The Arbitrator denied the Motion as it did not comport with the Rules and because the case had been set for a trial date certain, at least, since January of 2016. The admissibility of PX 17, Dr. Chmell's deposition taken on March 31, 2016, was reserved as an issue for the case.

Petitioner's cases against Respondents, Snelling Personnel Services, and Respondent herein proceeded to arbitration on July 6, 2016. Petitioner was the sole witness testifying at the hearing. Both of Petitioner's claims were consolidated for purposes of hearing with the understanding that separate decisions would be issued.

With regard to the instant case, the disputed issues were employer/employee relationship, accident, notice, causal connection, medical bills, nature and extent, a hold harmless for Medicaid payments, Respondent's Motion to Dismiss (collateral estoppel) and the admissibility of Petitioner's Exhibit 17.

Petitioner testified to remembering the earlier 19(b) hearing and that, at that time, he had been denied any further treatment, including an EMG. Petitioner also recalled having gone to Dr. Olson, his orthopedic surgeon, for treatment as a result of his amputation injury on December 17, 2001. Petitioner testified that he would see Dr. Olson and tell him about his left arm and hand problems. Petitioner testified that he last saw Dr. Olson on January 6, 2005. Petitioner also recalled receiving a phone call and a letter from his attorney in late November/early December of 2007 telling him it was okay to get the EMG so he went back to Dr. Daniels on September 17, 2007 and he referred her to Dr. Susan Mackinnon in St. Louis.

Petitioner testified that he saw Dr. Mackinnon on February 14, 2008 and he was there with his sister and a nurse case manager on behalf of Respondent Snelling. Petitioner recalled undergoing an EMG that day. Petitioner further testified that Dr. Mackinnon scheduled him for surgery the next day but it was cancelled. Petitioner subsequently underwent surgery on February 19, 2015 as Medicare paid for some of it. Petitioner testified that Dr. Mackinnon released some nerves and tendons in his fingers and there was carpal tunnel and an ulnar nerve that needed to be replaced. As a result of the surgeries, Petitioner has some scars in the palm of his hand on his wrist and around his left elbow. Petitioner further testified that he underwent some physical therapy. Petitioner believed the surgery was helpful. He couldn't make a fist before the surgery because his hand would shake and he felt lots of cramping in his left arm. After the surgery his hand, forearm, and thumb stopped cramping and he could close it without experiencing any shaking. All in all, Petitioner thought things were much better after surgery. Petitioner testified that when he last saw Dr. Mackinnon he told her he was doing fine and much better than before the surgery.

Petitioner also testified that he has gone to Dr. Daniels since moving back to Quincy from St. Louis as he is closer in location and it's hard to get in to see Dr. Mackinnon. According to Petitioner, Dr. Daniels eased his mind and told him everything was fine. That was on June 29, 2015.

Petitioner testified that he isn't working and hasn't worked since January 3, 2007. Petitioner testified that on January 3, 2007 he went to Dr. Hambrick complaining about his back and neck. He couldn't recall if he ordered x-rays or an MRI but he took him off work and told him he shouldn't work with his back the way it was. Petitioner testified he applied for Social Security but was initially denied but then he received an award. He received his disability on July 1, 2009.

Petitioner testified that when he worked at J.M. Huber he was employed there through Adecco. He had to lift 50 pound sacks, fill them up on a machine, turn, put them on a pallet behind himself and when the pallet was full he got a forklift and moved it and started another pallet. He thought he did at least 400 bags a day but that was a guess. Petitioner worked for Huber about one year. Petitioner was asked if he told or reported to the man in charge of his area (Laren Farr) that his work was causing back problems and Petitioner testified that he told him he had problems with his arm and his back and the supervisor referred him to a chiropractor who he went to for a few times. Petitioner testified that he ended up undergoing three low back surgeries and two neck surgeries all with Dr. Terrence Piper. Petitioner testified he was referred to Dr. Piper through his sister. He couldn't recall if Dr. Poetz, a family doctor, referred him. Petitioner underwent surgery at Barnes-Jewish, St. Peters, and one other St. Louis hospital.

Petitioner testified that, with regard to his left arm, he is beginning to get problems down towards his elbow and his hand cramps us a little bit every now and then depending upon how much he uses it. He still has some pain inside his elbow and a little numbness around his elbow. He also doesn't have the grip he used to have.

With regard to his back and neck, Petitioner is on a ten pound weight lifting restriction and isn't supposed to engage in impact exercises. Petitioner has two brackets and six screws in his neck and one bracket and three screws in his lower back. Petitioner testified to daily pain and limited ability to turn his neck before it "messes" with his vision and he gets a headache. Petitioner also testified that he is getting ready to go back and see what, if anything, can be done for his neck and back as the pain is starting to go down his legs again and he can't turn his neck very much. Petitioner testified that he spent the last year getting off pain pills and could end it sometimes. Petitioner also testified that he discussed his mental health with Dr. Mackinnon in February of 2008 as he was frustrated because he couldn't get any help and when he asked for it, Snelling or the workers' compensation board denied it.

Petitioner testified that he has a GED but no special skills or training.

On cross-examination by the attorney for Snelling Petitioner acknowledged that he was aware his case was set for a trial date certain on January 6, 2016 but he believed he was under

the weather/sick at the time. He believed he let his attorney know he was sick the morning of the scheduled trial.

Petitioner agreed that he worked for Snelling one week in December of 2001. He was then injured and treated with Dr. Olson. Petitioner did not return to work for Snelling. From about March of 2002 through July of 2002 Petitioner worked at Santino Mexican Restaurant. He thought he worked about 40 hours per week. Petitioner also recalled working for Adecco three or four different times one of which was in October of 2002. He recalled working on a line supplying products for Bed Bath and Beyond. He worked 40 hours a week at that job. He agreed that he used both of his upper extremities to perform that job. He also agreed that he worked for J.M. Huber through Adecco from about March 2003 through March of 2004 and he worked 40+ hours a week. Petitioner agreed that he drove a forklift and picked up 50 pound bags all day long using both of his arms.

Petitioner agreed that Dr. Olson found him at maximum medical improvement in April of 2002 and that he returned in April of 2003 for a one year check-up with no changes being noted at that time although Petitioner thought he was maybe told to stay away from vibratory machinery because it was bothering him.

Petitioner testified that after his job with Huber ended he worked at County Market Express part-time performing cashier and stock work. In February of 2006 he began working for a temporary serve at Manchester Tank. Petitioner then worked for Manchester Tank from February of 2006 through January 3, 2007. Petitioner worked as a welder. Petitioner was asked if he stopped working at Manchester Tank on account of his back complaints and Petitioner added that he left because of his hand also. He agreed, however, that he had testified that he was taken off work because of his back.

Petitioner agreed that he hasn't sought any additional employment since that time or performed any kind of job search since then. When asked if he had undergone any kind of vocational evaluation or assessment, he said "no." He agreed that he worked for over five years after his December 17, 2001 injury to his hand. He also agreed that he is receiving social security because of his amputation injury, his degenerative disc disease, chronic bronchitis, sleep apnea, obesity, major depressive disorder, and antisocial personality traits.

Petitioner also agreed that when he saw Dr. Mackinnon she did not address any work restrictions or status and that when he saw her it had been over a year since he had last worked. When asked if he hadn't worked since January of 2007 because of his back, Petitioner replied yes but added that it was also because of his hand as he couldn't lift anything with it.

Petitioner recalled undergoing colon surgery in September of 2009 and he had his first back surgery in December or January thereafter. He then had cervical surgery in February of 2010. Petitioner had another neck surgery in 2012 and saw Dr. Mackinnon again in 2013. He agreed that he returned to Dr. Mackinnon in 2013 on his own and she sent him back to Dr. Daniels. Petitioner also had two other surgeries and a hernia surgery between 2009 and 2012.

Petitioner acknowledged that Dr. Mackinnon did not restrict his activities in any way and released him from care on July 18, 2013. He also agreed that Dr. Daniels has not placed any permanent restrictions on him.

Petitioner was also asked questions by Adecco's attorney. Petitioner agreed he last worked for Adecco through J.M. Huber on March 20, 2004. He also agreed that he was unemployed from March of 2004 through March of 2005 and then he began working for County Market Express. Petitioner was shown the Application for Adjustment of Claim in the case against Adecco. He did not recall seeing it but knew he must have signed it. According to the Application for Adjustment of Claim he was being shown, he was claiming an accident to his left hand and body that occurred on January 6, 2005. When asked what happened at that time, Petitioner did not know nor could he recall. He then added that "if anything it would be from lifting the sacks and having to turn with every sack." He also thought his hand was probably hurting like "all get up and his back also." During this line of questioning, Petitioner's attorney stated to the Arbitrator that the claim against Respondent herein was based upon a repetitive trauma theory.

Petitioner was asked why he didn't testify in the 19(b) hearing about his back hurting while working for Huber and he responded that he didn't really know except that maybe he wasn't asked about it.

Petitioner also testified that he worked for County Market Express a short period of time and then he moved back to St. Louis due to a custody battle with his ex-wife and while there he worked as a cashier for O'Reilly Auto Parts a short while followed by work at Manchester Tank in 2006. Petitioner agreed that he worked steady up until he was taken off work by Dr. Hambrick in 2007. Petitioner testified that he went to Dr. Daniels in November of 2006 due to issues with sleep apnea and he thought he told the doctor about his issues with his neck or back. If nothing was said about it in his records then the records would probably be correct. He thought his first mention of any back pain might have been in December of 2006. Petitioner didn't recall falling on the ice two times but he could have. He acknowledged being seen at the Springfield Clinic on March 20, 2007 and relating back pain off and on throughout his left and that his most recent episode began in August of 2006. He agreed that he denied any injury and reported being employed as a welder and being on his feet a lot lifting tanks to and from carts at Manchester Tank. He did not dispute that he very well may have gone to Blessing Hospital on April 11, 2007 complaining of increased back pain since 2006 that had markedly increased since January of 2007. He did not recall seeing Dr. Daniels in December of 2007 and telling him he was no longer working for Manchester Tank and had injured his back but if the records stated that he would agree with it.

Petitioner also testified that because of his amputations and problems with his left hand he did use his right hand to help out with lifting and carrying responsibilities on those jobs.

Petitioner acknowledged being right hand dominant and a smoker. He smokes a pack a day and has done so for 35 years.

Petitioner's medical bills are set forth in PX 8 (Dr. Daniels) and PX 20 (Washington University).

The Arbitrator concludes:

Issue (O) The Admissibility of PX 17 (Deposition of Dr. Chmell).

Petitioner's Exhibit 17 is the evidence deposition of Dr. Samuel J. Chmell taken on March 31, 2016 in Petitioner's cases against Respondent herein and Snelling Personnel Services. Respondent's attorney objected to the admissibility of the deposition on the basis of hearsay citing his timely withdrawal of his prior agreement to take the deposition of the doctor.

As to Respondent herein, Exhibit 5 to the deposition submitted by Petitioner's attorney (ie., PX 17) is a letter from Respondent's attorney dated March 22, 2016 advising Petitioner's attorney that Respondent, Adecco, would be objecting to the report obtained by Petitioner's attorney based on the timing of his request for that report and advising that he would require the doctor's deposition. The letter stated "please provide formal notice along with the doctor's business address so that I can find him for the deposition."

It has been represented to the Arbitrator, and confirmed by a second piece of correspondence also contained in deposition exhibit 5 to Petitioner's Exhibit 17, that Respondent's attorney subsequently withdrew his prior agreement to any deposition (Petitioner's attorney acknowledges that letter, "I am aware of your subsequent letter, dated March 23, 2016 in which you state you withdraw your previously expressed consent to take Dr. Chmell's deposition on March 31, 2016 at 1:30 p.m. at his office.").

The Arbitrator notes that Petitioner's attorney filed a Motion for Dedimus Potestatem for Dr. Chmell's deposition which was denied by the Arbitrator on the date of the hearing (July 6th). The Arbitrator further notes that this was the second time Petitioner's attorney had presented a Motion for Dedimus. Petitioner had previously set a Motion for Dedimus for hearing on April 6, 2016 but it was continued due to Petitioner's attorney's inability to be in Quincy due to illness. The first time was presented improperly, and was objected to by both Respondents, and denied by this Arbitrator.

The Arbitrator finds the Commission's Decision in Spilker v. IPC International Inc. 06 I.W.C.C.0757, 2006 WL 3020243 instructive on this issue.

In Spilker the parties agreed to take the deposition of Dr. Oarth. During the morning hours of the day of the deposition the petitioner's attorney telephoned the respondent's attorney and asked that Dr. Oarth's deposition be performed by telephone because petitioner's attorney wanted to avoid traveling to Chicago.

Approximately thirty minutes prior to the deposition start time petitioner's attorney called and provided a telephone number where he could be reached for the deposition. When the two attorneys were on the phone immediately prior to when the deposition was set to begin, the

petitioner's attorney demanded that the respondent's attorney procure certain documents that had been generated by the insurance company and supplied to Dr. Oarth. Respondent's attorney contended the documents for which petitioner's attorney asked were work product and, therefore, privileged. Respondent's attorney also informed petitioner's attorney that he would be willing to ask his client if they would be willing to tender the work product at a later time, but he would not be willing to cancel the deposition. Petitioner's attorney then refused to agree to the deposition and hung up the phone prior to swearing in the doctor.

The Commission, in that case, found that the Arbitrator had erred in not admitting the deposition and reports. The Commission indicated that petitioner's attorney had agreed to the deposition and cannot be allowed to argue there was no agreement at the last minute. The Commission found that petitioner's attorney acted unreasonably in demanding that documents be produced and then retracting his agreement immediately before the witness being sworn in, because respondent's attorney refused to tender the documents for which he had asked.

The Commission stated "we note that while Respondent could have then sought a formal Dedimus Potestatem, we find that it is reasonable and practical for [respondent's attorney] to rely on opposing counsel's statement of agreement to take the deposition. We believe it would be inequitable to require [respondent's attorney] to seek formal Dedimus Potestatem after he reasonably relied on [the petitioner's attorney's] statements, which were not withdrawn until the deposition was about to begin."

In the instant case, records indicate that Respondent's attorney initially agreed to the deposition by letter on March 22, 2016, and that was e-mailed to Petitioner's attorney. This letter is contained in the exhibit tendered by Petitioner's attorney as Exhibit 5 to the deposition. However, as indicated above, the letter from Petitioner's attorney to Respondent's attorney, Mr. Schroeder, confirms receipt of a subsequent letter dated March 23, 2016, the day after the initial agreement. Petitioner's attorney's letter confirms that attorney Schroeder withdrew any consent to the deposition less than 24 hours after providing the original consent. This was eight days before the scheduled deposition. A conference was then held via telephone between the attorneys for all parties and the Arbitrator at which time the Arbitrator advised all parties that, in her opinion, there appeared to be no agreement to take the deposition and that Petitioner's attorney would need to file an appropriate motion. Despite, the foregoing, Petitioner's attorney proceeded with the deposition on March 31, 2106.

The Arbitrator further finds that with regard to the withdrawal of Respondent's consent to the deposition, unlike the Spilker case discussed above, Respondent's attorney acted reasonably, and in good faith. The consent to take the deposition of Dr. Chmell was withdrawn in writing, and in a timely manner within 24 hours of the agreement and in more than adequate time for Petitioner to cancel the deposition of Dr. Chmell, file a Dedimus Potestatem, and obtain a hearing on that motion prior to moving forward with the deposition. Indeed, Petitioner's attorneys actions in proceeding with the deposition, knowing the attorneys would not be present, and then continuing to pursue a Dedimus Motion thereafter, is very troubling, especially when all of this is taken within the context that Petitioner's case against

Respondent has been pending for over ten years and it was not until March of 2016, when the case had already been set for a trial certain, that Petitioner's attorney pursued a report from Dr. Chmell. (see PX 17)

Accordingly, the Arbitrator finds that Petitioner's Exhibit 17 is inadmissible and is, therefore, rejected. The exhibit will be marked as such and included in the record.

Issue (B) Was there an employee-employer relationship?

Petitioner failed to prove that he and Respondent had an employee-employer relationship on January 6, 2005. Petitioner's Application for Adjustment of Claim is very vague in describing how Petitioner's alleged accident of January 6, 2005 occurred. On its face, one could not determine if Petitioner was alleging a specific accident/trauma or a repetitive trauma injury. It was not until cross-examination of Petitioner that Petitioner's attorney clarified his theory of the case. Despite this representation, the Arbitrator has considered both theories in concluding that no employee-employer relationship occurred on that date.

With regard to viewing January 6, 2005 as a specific date of accident, the Arbitrator notes that Petitioner failed to prove he was employed by Respondent on that date. Petitioner testified, without rebuttal, that he stopped working for Adecco/J.M. Huber Company on March 30, 2004. Furthermore, Petitioner testified that he was unemployed in January of 2005.

With regard to viewing January 6, 2005 as a manifestation date for a repetitive trauma claim, the Arbitrator is aware that for purposes of a manifestation date in a repetitive trauma case, the date of accident and, in turn, the relationship of employee-employer, could conceivably post-date the actual dates of employment. Given the conclusions the Arbitrator has reached on the issues of accident, causal connection, and notice, she finds there was no employer-employee relationship on January 6, 2005 for purposes of a repetitive trauma claim.

Issue (C) Did an accident occur on January 6, 2005 that arose out of and in the course of Petitioner's employment with Respondent?

Issue (D) What was the date of the accident?

Issue (F) Is Petitioner's current condition of ill-being causally related to the injury?

Petitioner failed to prove that he sustained an accident on January 6, 2005 that arose out of and in the course of his employment with Respondent or that his current condition of ill-being in his left upper extremity, low back, or neck is causally related to that accident or his employment duties for Adecco/J.M. Huber.

While not a part of the record, the Arbitrator notes that Petitioner's proposed decision only addressed Petitioner's alleged back injury. It was silent concerning issues relevant to an alleged left upper extremity injury. It was also quite vague regarding discussion of Petitioner's lumbar spine and cervical spine (two distinct injuries and parts of the body) referring simply to Petitioner's "back" and/or "spine."

It is well settled law that a claimant must prove all elements of his claim, including accident and causal connection. *Illinois Bell Telephone v. Industrial Commission*, 265 Ill.App.3d 681, 685, 638 N.E.2d 307, 310 (1st Dist. 1994) Additionally, a claimant seeking benefits for an injury due to repetitive trauma, must meet the same standard of proof as a claimant alleging a single, definable accident. *Three "D" Discount Store v. Industrial Commission*, 198 Ill.App.3d 43, 47, 556 N.E.2d 261,264 (4th Dist. 1990)

With regard to the significance of January 6, 2005 under either theory of accident (specific or repetitive) the Arbitrator finds Petitioner's inability to describe what, if anything, happened on January 6, 2005 very important. Petitioner testified that he didn't know, and couldn't really recall, what happened on January 6, 2005. The only significance the Arbitrator can associate with the date of January 6, 2005 is that it was on that date that Petitioner returned to see Dr. Olson, the orthopedic surgeon who treated him for his amputations. On that date, Petitioner reported numbness and tingling of his left upper extremity and pain at night. Dr. Olson noted that Petitioner had had multiple jobs since his injury. He noted, "With heavy lifting and things of that nature he has started to get numbness and tingling at night, pain that wakes him up from his sleep and his remaining long finger and the ulnar side of his ring finger and thumb are numb. Dr. Olson wrote, "[Petitioner] said this injury happened on 12/17/01 when he lost the fingers with a 60 ton press. Nothing seemed to help." (PX 1 – pet. ex. 1, res. ex. 4) On examination Petitioner had a positive Tinel's on the left side at the carpal tunnel. Dr. Olson suspected carpal tunnel syndrome "until proven otherwise." He noted it had been ongoing for several months without resolution and added, "He feels this is work related. In my opinion, I think [it] is related to the function of his hand with the amputated digits." An EMG was recommended along with a cock-up wrist splint which Petitioner had already been wearing for some time He was taken off work until the EMG results were received. (PX 1 – pet. ex. 1, res. ex. 4) Petitioner made no specific mention of his work for Respondent/Huber as a cause or aggravating factor to his complaints. Petitioner made no reference to any low back or neck complaints. He continued to associate his symptoms with his December 17, 2001 accident. At that time Dr. Olson never rendered a causation opinion regarding any association between Petitioner's employment duties for Respondent/Huber and Petitioner's left upper extremity complaints, low back, and neck. At most, Dr. Olson associated Petitioner's left upper extremity complaints with Petitioner's traumatic injury of December 17, 2001 (which is the subject of Petitioner's claim in 04-WC -31927). The Arbitrator further notes that the Commission had previously determined in Petitioner's case against Snelling Personnel Services (case #04-WC-31927) that Petitioner's complaints as of January 6, 2005 were causally connected to his December 17, 2001 accident. The Arbitrator is unable to conclude that January 6, 2015 is a viable manifestation date.

That Petitioner was not complaining to Dr. Olson about his back or neck during the time he treated with him is further evidenced by Petitioner's testimony at arbitration. His attorney specifically asked him on direct examination if he was seeing Dr. Olson and telling him about various problems that he was continuing to have or that he was additionally having and Petitioner replied "Yes." His attorney then asked him if "those" pertained to his left upper extremity and to his back and Petitioner replied, "Left arm, yes, and my hand." Petitioner did

not affirm that the visits pertained to his back. Furthermore, nothing was asked Petitioner about his neck.

The Arbitrator also notes the absence of any reference to an accident of January 6, 2005, or neck, back, or left upper extremity complaints associated with work for Adecco/J.M. Huber within any of the medical records. Petitioner was seen by Dr. Hambrick on November 16, 2006 (RX 4, p. 23). At that time Dr. Hambrick indicated Petitioner was there for a follow-up visit. He stated that Petitioner had been there on the 8th and was feeling tired throughout the day. Petitioner indicated that he had no other complaints and that he was being seen for obstructive sleep apnea. A follow-up note with Dr. Hambrick indicated that Petitioner was complaining of continued lumbar back pain that was not being helped by the use of Tramadol. He was diagnosed with lumbago and treated for his sleep apnea. There was absolutely no mention of Petitioner's left hand, upper extremity, back or neck in relation to an alleged work injury stemming from his employment with Respondent/Huber or a specific accident date of January 6, 2005.

On December 18, 2006 Petitioner returned to Dr. Hambrick. At that time Petitioner was diagnosed with lumbar disc disease. The doctor indicated Petitioner was having lower back pain and was placed on pain killers and seen for a review of x-rays which revealed L4-L5 and L5-S1 degenerative disc disease and possible L3-L4 disc disease and other lumbar issue. (RX4, pp. 21-22) Again, there was no mention of Petitioner's work for Respondent/Huber or a specific accident of January 6, 2005.

Petitioner again returned to Dr. Hambrick on January 3, 2007 (RX 4, p. 19) at which time he was referred to Dr. Russell in Springfield for further evaluation with regard to his lumbar disc disease and spinal stenosis. Again, there was no mention of Petitioner's work for Respondent/Huber or a specific accident of January 6, 2005.

Petitioner followed up once again with Dr. Hambrick on January 31, 2007. In the history section of the notes Petitioner stated he was having continued back pain and had an appointment with a surgeon scheduled for the 15th. Petitioner was concerned about losing his job (a different job than the one he previously had with Respondent/Huber) and wished to be released to return to work so he wouldn't lose his job. The doctor indicated that he would write the release but if Petitioner returned to work he would probably re-injure himself or make himself much worse. (RX4, pp 17-18) Again, there was no mention of Petitioner's work for Respondent/Huber or a specific accident of January 6, 2005.

The Arbitrator also notes a treatment note of March 20, 2007 with Dr. Russell wherein the doctor noted, "John has had a long history of having low back pain off and on all of his life. His most recent episode began in August. No original injury." That same record goes on to state that Petitioner "has been employed as a welder, often times he stands for an extended period. He is busy lifting tanks too [sic] and from the carts, he gets more and more back pain. (RX7, p. 60) According to the nursing note from the same visit date, Petitioner reported "LBP pain off and on, this episode started August 6, zero injury, pain above waist, radiates to hips and down legs. Numbness legs and feet." (RX7, p 59)

A Springfield Clinic office note dated April 11, 2007 indicates that Petitioner is a 42 year old white male with a long history of low back pain and bilateral radiculopathy. Petitioner reported that "the pain has increased in intensity since August of 2006 and the pain has markedly increased since January of this year. The pain was so bad that he had to get off work." (RX7, p.56)

No corroborating history is found in Dr. Pineda's records. (RX 7)

Petitioner also presented to Dr. Daniels in December of 2007 regarding an ongoing problem with tingling in his left hand. Petitioner did not mention any association between his former employment with Adecco/Huber and his hand complaints/symptoms. Furthermore, he didn't associate any neck or back problems with his work for Respondent/Huber. Indeed, he told the doctor, "he was no longer working at Manchester Tank. He injured his back. He states his back is not bothering him too much at this point. He is currently unemployed." (RX4, p.10)

The Arbitrator notes that Petitioner, at arbitration, acknowledged a long list of treatment, including multiple low back surgeries and cervical surgeries, all of which occurred after 2006. The record before the Arbitrator shows that Petitioner, after leaving his employment with Respondent, worked multiple jobs over the subsequent 2-3 years and the medical records (Drs. Olson, Hambrick, Russell, Pineda, Banarwani, Pogue, Daniels, Poetz, and Piper) show no evidence of ongoing back issues dating back to Petitioner's employment with Respondent, Adecco.

Based on statements made by Petitioner's attorney at trial, Petitioner appears to allege a repetitive trauma injury to the lumbar and cervical spine. However, he presented no evidence of any such injury. Medical records entered into evidence at trial, as well as Petitioner's own testimony with regard to those records, clearly indicate that there is no correlation between Petitioner's employment with Respondent herein and any of the subsequent back and neck surgeries. Petitioner also failed to provide an expert opinion on causation between his back and neck complaints and his work for Respondent/J.M. Huber. If anything, the timeline of the Petitioner's back and neck treatment as documented in the contents of the associated medical treatment notes, seem to suggest his problems developed subsequent to his employment at Manchester Tank.

Petitioner has failed to meet his burden of proving a repetitive trauma injury related to his left upper extremity, back or neck, and its relationship to his employment with Respondent. Accordingly, the Arbitrator concludes that Petitioner has failed to prove he sustained an accident related to his left upper extremity, lumbar or cervical spine areas while an employee of Respondent or that his condition of ill-being in his left upper extremity, back, and neck was caused by his accident or his employment duties for Respondent. Alternatively, Petitioner has failed to prove he sustained a specific traumatic accident on January 6, 2005 that arose out of and in the course of his employment with Respondent. Petitioner's claim for compensation is denied and no benefits are awarded.

Issue (E) Was timely notice of the accident given to Respondent?

Petitioner failed to prove he provided timely notice of his alleged January 6, 2015 work injury to Respondent. Petitioner has the burden of proving proper notice of an alleged injury was given within 45 days thereof.

Petitioner testified that he spoke with Lauren Farr and told him he was having "problems with his arm and his back" and he was referred to a chiropractor. This testimony does not meet the requirements for proper notice under the Act. Petitioner did not testify to telling Mr. Farr about a work accident involving his arm and/or back. He didn't mention his neck. He didn't testify that he related any "problems" to his work duties for Huber or a specific accident. Furthermore, it is unclear when this alleged conversation even occurred. Petitioner was employed by Respondent and working at Huber from March of 2003 through March of 2004. Petitioner did not state with specificity when during this time of employment, if ever, he spoke to Mr. Farr. Petitioner's alleged accident date post-dates his employment with Respondent/Huber. Petitioner did not provide any testimony or explanation as to how he might have provided notice of an alleged accident before it occurred or whether he provided any notice to Respondent/Huber within forty-five days of January 6, 2005. The Arbitrator notes the Application for Adjustment of Claim in this case was filed on October 30, 2006 which is well beyond the 45 day time period.

Petitioner further testified that after speaking with Mr. Farr he was seen by Dr. Irving, a chiropractor. Dr. Irving's records might have corroborated Petitioner's testimony and helped establish when notice was given. Those records were not included in the record nor were they tendered as exhibits.

Petitioner failed to prove he provided notice of his alleged accident within 45 days thereof. Petitioner's claim for compensation is denied and no benefits are awarded.

Issue (J) Medical Bills; Issue (L) Nature and Extent; and Issue (O) Hold Harmless and Respondent's Motion to Dismiss (Collateral Estoppel).

Given the Arbitrator's determinations on employer/employee relationship, accident, notice, and causal connection, Issues (J), (L), and (O – Hold Harmless; Motion to Dismiss) are rendered moot.

Petitioner's claim for compensation is denied and no benefits are awarded.

****

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MICHELLE ODOM,

Petitioner,

vs.

NO: 09 WC 17016

CHICAGO MERCANTILE EXCHANGE,

Respondent.

ORDER

This matter comes before Commissioner Michael J. Brennan pursuant to the parties' "Joint Motion to Approve Amended Settlement Contract Rider Regarding Medicare Set-Aside." (See Attached Commission Exhibit 1).

Pursuant to Section 9070.40(e) of the Rules Governing Practice Before the Illinois Workers' Compensation Commission, the parties may reserve the right to amend an approved Settlement Contract by stipulation and Order of a Commissioner to conform with regulatory requirements including, but not limited to, those of Social Security and Medicare. In no event may those amendments abridge the substantive rights of the parties as listed in the previously approved Settlement Contract.

That by the terms of the Settlement Contract Lump Sum Petition and Order ("Settlement Contract"), approved by Arbitrator Carolyn Doherty, on February 23, 2012, the Respondent agreed that Petitioner's rights under Section 8(a) of the Act would remain open. (See Attached Commission Exhibit 2);

That since the approval of the referenced contract, the Respondent has obtained a Workers' Compensation Medicare Set Aside (WCMSA) agreement from NuShield Certified Medicare Set Aside. (See Attached Exhibit A);

That the parties have advised the Commissioner that on March 27, 2018, Petitioner agreed to the NuShield Certified Medicare Set Aside of $342,732.32 funded by annuity, with seed money

of $20,772.00, and subsequent equal payments of $10,061.26 per year, commencing March 27, 2019 and continuing for 32 years. The total expected funding of the NuShield Certified Medicare Set Aside is $342,732.32. The parties have determined that this amount adequately considers Medicare's interests with respect to Medicare-covered future medical items and services, including prescription drugs;

The parties have agreed that the NuShield Certified Medicare Set Aside will be professionally administered, with the understanding that said monies are to be placed in an interest-bearing account and the funds used to satisfy Medicare Allowable Expenses and in accordance with Medicare guidelines;

In addition, Petitioner has accepted an additional annuity, for a Non-MSA issue, Attendant Care, with a total payout of $754,776.00. The annuity will be funded on a monthly basis in the amount of $1,906.00, commencing June 1, 2018, and guaranteed for 33 years, with the last guaranteed payment on May 1, 2051. (See Attached Exhibit B); and,

That by the parties' stipulation, Petitioner's medical benefits under Section 8(a) of the Act will terminate as of April 19, 2018.

Therefore, the Commission having jurisdiction over said claim, it is hereby ordered:

1. That the Settlement Contract Lump Sum Petition and Order, as was approved by Arbitrator Carolyn Doherty, on February 23, 2012, is hereby modified by the terms of the stipulation of the parties, a copy of which is attached hereto and made a part hereof as Commission Exhibit 3, so as to conform to the requirements of CMS pursuant to Section 9070.40(e) of the Rules Governing Practice Before the Illinois Workers' Compensation Commission;

2. That it is the further Order of the Commission that pursuant to the referenced Settlement Contract and the parties' subsequent stipulation, Petitioner's continuing rights under Section 8(a) of the Act are hereby closed as of April 19, 2018; and,

3. That the heretofore approved Settlement Contract, as was approved by Arbitrator Carolyn Doherty, on February 23, 2012, remains in full force and effect, and shall be read in concert with this Order and Stipulation.

APR 20 2018

DATED:
MJB/pm
04-19-18
052

Commissioner Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF MOTION AND ORDER

ATTENTION. You must attach the motion to this notice. If the motion is not attached, this form may not be processed.
Upon filing of a motion before a Commissioner on review, the moving party is responsible for payment for preparation of the transcript.

Michelle Odom,
Employee/Petitioner

v.

Chicago Mercantile Exchange,
Employer/Respondent

Case # **09** WC **17016**

2018 APR -5 PM 1:32

TO: **Eric H. Check**
Law Offices of Eric H. Check
161 N. Clark St., Ste. 2575
Chicago, IL 60601

Commissioner Kevin Lamborn
IWCC
100 W. Randolph St., 8th Floor
Chicago, IL 60601

On **April 19, 2018**, at **9:00** AM, or as soon thereafter as possible, I shall appear before the Honorable **Commissioner Lamborn**, or any arbitrator or commissioner appearing in his or her place at **100 W. Randolph St., 8th Floor, Chicago**, Illinois, and present the attached motion for:

- ☐ Change of venue (#3072)
- ☐ Consolidation of cases (#3071) (list case#)
- ☐ Dismissal of attorney (#3052)
- ☐ Dismissal of review (#3085)
- ☐ Fees under Section 16 (#1600)
- ☐ Fees under Section 16a (#1645)
- ☐ Hearing under Sect.19(b) (#1902)
- ☐ Penalties under Sect. 19(k) (#1911)
- ☐ Penalties under Sect. 19(l) (#1912)
- ☐ Reinstatement of case (#3074)
- ☐ Request for hearing (#R33)
- ☐ Withdrawal of attorney (#3073
- ☒ Other (explain) **Joint Motion to Approve Amended Settlement Contract Rider Regarding Medicar Set-Aside**

Daniel K. Swanson
Signature Petitioner ☐ Respondent ☒

Daniel K. Swanson #2097
Attorney's name and IC code # (please print)

Fanning & Olsen
Name of law firm, if applicable

300 S Riverside Plaza, Ste. 2050
Street address

Chicago, IL 60606
City, State, Zip code

312/775-9749 **daniel.swanson@zurichna.con**
Telephone number E-mail address

ORDER

The motion is set for hearing on _____

_____ _____
Signature of arbitrator or commissioner Date

ORDER

The motion is ___ Granted ___ Withdrawn ___ Continued to _____
___ Denied ___ Dismissed ___ Set for trial (date certain) on _____

_____ _____
Signature of arbitrator or commissioner Date

COMMISSION EXHIBIT 1

STATE OF ILLINOIS)
) SS.
COOK COUNTY)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MICHELE ODOM,	)	
	)	
Petitioner,	)	
	)	
vs.	)	IWCC No.: 09 WC 17016
	)	
CHICAGO MERCANTILE EXCHANGE,	)	
	)	
Respondent.	)	

2010 APR -5 PM 1:32

JOINT MOTION TO APPROVE AMENDED SETTLEMENT CONTRACT RIDER REGARDING MEDICARE SET-ASIDE

NOW comes the Respondent, CHICAGO MERCANTILE EXCHANGE, by its attorneys, FANNING & OLSEN, and in support of its Joint Motion to Approve Amended Settlement Contract Rider regarding Medicare Set-Aside, states as follows:

1. On February 23, 2012, Arbitrator Doherty approved the Settlement Contract Lump Sum and Order for $415,000.00 (paid previously on February 24, 2012) with open future medical rights pursuant to Section 8(a) of the Act.

   (Exhibit No. 1)

2. On March 27, 2018, Petitioner accepted a NuShield Certified Medicare Set-Aside (MSA) arrangement totaling $342,732.00, funded by annuity, with seed money of $20,772.00 and subsequent annual payments of $10,061.26 beginning on March 27, 2019 with the last guaranteed payment on March 27, 2050.

3. Both Petitioner and Respondent have agreed to jointly revise the Settlement Contract Lump Sum and Order to include the MSA, and therefore, terminating medical rights under Section 8(a) of the Act. (Exhibit No. 2)

WHEREFORE, the Respondent, CHICAGO MERCANTILE EXCHANGE, respectfully requests that this Honorable Illinois Workers' Compensation Commission approve the Amended Settlement Contract Lump Sum and Order closing out future medical rights under Section 8(a) of the Act and replacing it with a NuShield Certified MSA arrangement funded by annuity.

Respectfully submitted,
FANNING & OLSEN

By: _____
Daniel K. Swanson,
Attorney for the Respondent

_____
Eric H. Check,
Attorney for Petitioner

ILLINOIS WORKERS' COMPENSATION COMMISSION
SETTLEMENT CONTRACT LUMP SUM PETITION AND ORDER

ATTENTION. Please type or print. Answer all questions. File four copies of this form. Attach a recent medical report.

Workers' Compensation Act ☒ Occupational Diseases Act ☐ Fatal case? No ☒ Yes ☐ Date of death _____

Michelle Odom,
Employee/Petitioner

Case # 09 WC 17016

v.

Chicago Mercantile Exchange
Employer/Respondent

Setting Chicago/Doherty

To resolve this dispute regarding the benefits due the petitioner under the Illinois Workers' Compensation or Occupational Diseases Act, we offer the following statements. We understand these statements are not binding if this contract is not approved.

Michelle Odom Employee's name	1667 Plum Tree Lane Street address	Aurora, IL 60504 City, State, Zip code
Chicago Mercantile Exchange Employer's name	20 S. Wacker Dr., 6N Street address	Chicago, IL 60606 City, State, Zip code

Male ☐ Female ☒ Married ☐ Single ☒

Dependents under age 18 1 Birthdate 10/2/77 Average weekly wage $ 1,307.70

Date of accident 4/2/09

How did the accident occur? File cabinet fell on Petitioner

What part of the body was affected? Right arm and person as a whole

What is the nature of the injury? Permanent & severe

The employer was notified of the accident orally ☒ in writing ☐. Return-to-work date N/A

Location of accident Chicago, IL Did the employee return to his or her regular job? Yes ☐ No ☒
If not, explain below and describe the type of work the employee is doing, the wage earned, and the current employer's name and address.

Petitioner is voluntarily seeking other employment respectful of her physical restrictions.

TEMPORARY TOTAL DISABILITY BENEFITS: Compensation was paid for 150-4/7 weeks at the rate of $ 871.80/week.

The employee was temporarily totally disabled from 4/3/09 through present.

MEDICAL EXPENSES: The employer has ☐ has not ☒ paid all medical bills. List unpaid bills in the space below.

SEE TERMS OF SETTLEMENT

PREVIOUS AGREEMENTS: Before the petitioner signed an *Attorney Representation Agreement*, the respondent or its agent offered in writing to pay the petitioner $ 0 as compensation for the permanent disability caused by this injury.

An arbitrator or commissioner of the Commission previously made an award on this case on N/A regarding

TTD $ 0 Permanent disability $ 0 Medical expenses $ 0 Other $ 0

COMMISSION EXHIBIT 2

TERMS OF SETTLEMENT: Attach a recent medical report signed by the physician who examined or treated the employee.

SEE ATTACHED TERMS OF SETTLEMENT

Total amount of settlement	$ 415,000.00
Deduction: Attorney's fees	$ 63,467.04
Deduction: Medical reports, X-rays	$ 125.00
Deduction: Other (explain)	$
Amount employee will receive	$ 351,532.96

PETITIONER'S SIGNATURE. *Attention, petitioner. Do not sign this contract unless you understand all of the following statements.* I have read this document, understand its terms, and sign this contract voluntarily. I believe it is in my best interests for the Commission to approve this contract. I understand that I can present this settlement contract to the Commission in person. I understand that by signing this contract, I am giving up the following rights:

1. My right to a trial before an arbitrator;
2. My right to appeal the arbitrator's decision to the Commission;
3. ~~My right to any further medical treatment, at the employer's expense, for the results of this injury;~~
4. My right to any additional benefits if my condition worsens as a result of this injury.

Michelle Odom — Signature of petitioner

Michelle Odom — Name of petitioner (please print)

630/898-4626 — Telephone number

2/21/12 — Date

PETITIONER'S ATTORNEY. ~~I attest that any fee petitions on file with the IWCC have been resolved.~~ Based on the information reasonably available to me, I recommend this settlement contract be approved.

E. Check — Signature of attorney

2/20/12 — Date

Eric H. Check # 2962
Attorney's name and IC code # (please print)

The Law Offices of Eric H. Check
Firm name

161 N. Clark Street, Ste. 2575
Street address

Chicago, IL 60601
City, State, Zip code

312/704-8600
Telephone number

E-mail address

RESPONDENT'S ATTORNEY. ~~I attest that any fee petitions on file with the IWCC have been resolved.~~ The respondent agrees to this settlement and will pay the benefits to the petitioner or the petitioner's attorney, according to the terms of this contract, promptly after receiving a copy of the approved contract.

Daniel K. Swanson — Signature of attorney or agent

2/20/12 — Date

Daniel K. Swanson #2097
Attorney's name and IC code # or agent (please print)

Grant & Fanning
Firm name

10 S. Riverside Plaza, Ste. 1770
Street address

Chicago, IL 60606
City, State, Zip code

312/775-9749
Telephone number

E-mail address

Zurich North America
Name of respondent's insurance or service company (please print)

ORDER OF ARBITRATOR OR COMMISSIONER: Having carefully reviewed the terms of this contract, in accordance with Section 9 of the Act, by my stamp I hereby approve this contract, order the respondent to promptly pay in a lump sum the total amount of settlement stated above, and dismiss this case.

APPROVED BY AUTHORITY OF THE ILLINOIS WORKERS' COMPENSATION COMMISSION pursuant to the provisions of the Workers' Compensation and Workers' Occupational Diseases Acts

FEB 23 2012

By: Carolyn M. Doherty, Arbitrator

MICHELLE ODOM, Petitioner,	)	
vs	)	IWCC No.: 09 WC 17016
CHICAGO MERCANTILE EXCHANGE, Respondent.	)	

TERMS OF SETTLEMENT

In lieu of litigation, the parties hereby compromise and adjust any and all claims for benefits under the Illinois Workers' Compensation Act (Act) on account of accidental injuries suffered by the Petitioner on April 2, 2009 including claims for the cost of future first aid, medical, surgical and hospital services incurred and claims for compensation and other further benefits on account of any and all disablements, disfigurements, diseases and death, whether known or unknown, present or future sequelae or developments, fatal or non-fatal, allegedly resulting from such accidental injuries. Further, the Petitioner waives any and all rights she may have under Section 19(h) of the Act. There are disputed questions of law and fact and in order to avoid further litigation, the Respondent has agreed to pay and the Petitioner has agreed to accept the sum of $415,000.00 as full, final and complete settlement of any and all claims, of any kind, nature and description pursuant to the Illinois Workers' Compensation Act which resulted from the alleged injuries of April 2, 2009. This settlement represents a lump sum compromise of the present cash value of a permanent total disability. Respondent shall leave Petitioner's medical rights open for all reasonable, necessary and related medical care that is causally connected to the April 2, 2009 accident.

It is further agreed by and between the parties that this settlement was entered into with the understanding that the lump sum payment of $415,000.00 represents the final and only award the Petitioner will ever receive from his the Respondent with respect to the contested claims alleged herein. From this amount will be deducted litigation expenses of $125.00 and payment of attorneys' fees of $63,467.04, leaving the Petitioner with a lump sum settlement of $351,532.96, which should be allocated to that period of time extending from the date this agreement is approved by the Illinois Workers'

MICHELLE ODOM, Petitioner, vs CHICAGO MERCANTILE EXCHANGE, Respondent.	)))))))	IWCC No.: 09 WC 17016

AMENDED TERMS OF SETTLEMENT

In lieu of litigation, the parties hereby compromise and adjust any and all claims for benefits under the Illinois Workers' Compensation Act (Act) on account of accidental injuries suffered by the Petitioner on April 2, 2009 including claims for the cost of future first aid, medical, surgical and hospital services incurred and claims for compensation and other further benefits on account of any and all disablements, disfigurements, diseases and death, whether known or unknown, present or future sequelae or developments, fatal or non-fatal, allegedly resulting from such accidental injuries. Further, the parties waive any and all rights they may have under Sections 8(a) and 19(h) of the Act. There are disputed questions of law and fact and in order to avoid further litigation, the Respondent has agreed to pay and the Petitioner has agreed to accept the sum of $415,000.00, a NuShield Certified MSA of $342,732.00, via annuity plus a Waterville Annuity guaranteed by Pacific Life for a Non-MSA for Attendant Care, which pays out $754.776.00 (Exhibit A and B, MSA and Attendant Care Non-MSA for annuity funding quotes, which are incorporated herein) as full, final and complete settlement of any and all claims, of any kind, nature and description pursuant to the Illinois Workers' Compensation Act which resulted from the alleged injuries of April 2, 2009. This settlement represents a lump sum compromise of the present cash value of a permanent total disability.

It is further agreed by and between the parties that this settlement was entered into with the understanding that the lump sum payment of $415,000.00, which was paid previously on February 24, 2012, represents the final and only award the Petitioner will ever receive from his the Respondent with respect to the contested claims alleged herein. From this amount will be deducted litigation expenses of $125.00 and payment of attorneys' fees of

COMMISSION EXHIBIT 3

$63,467.04, leaving the Petitioner with a lump sum settlement of $351,532.96, which should be allocated to that period of time extending from the date this agreement is approved by the Illinois Workers' Compensation Commission through the period of the Petitioner's life expectancy. According to the table set out in U.S. Bureau of the Census, National Center for Health Statistics and United States Life Tables, 2004, Petitioner, who has a birth date of October 2, 1977 and is presently 34 years of age, has a remaining life expectancy of 2340 weeks or 45 years. Dividing this number of weeks into the net recovery amount the Petitioner will receive of $351,532.96 produces the weekly settlement rate of $150.37, a weekly settlement rate envisioned by and stipulated to by the parties.

This payment shall not be considered as a substitute for periodic payments and is made solely to terminate the within litigation. Petitioner shall repay $795,000.00 to Zurich to satisfy its 5(b) lien rights.

This settlement also includes an amount of Medicare Set-Aside funds (MSA). (Exhibit No. 1, Settlement Rider Terms and Conditions of Professionally Administered MSA Annuity Payments and No. 1(a), NuShield Certified MSA Support Services Agreement, which is incorporated herein) Respondent also agrees to reimburse Medicare should it have made any conditional payments on behalf of the Petitioner relative to medical care related to this case.

It is not the intention of the carrier to shift the burden of medical costs for this injury to Medicare. In conjunction with Federal Regulations 42 CFR §411.46 et. seq., the parties agree that they have made a careful review of the medical evidence, the medical history, the petitioner's life expectancy, and have inquired regarding the future medical needs of the petitioner, finding that there is expected future Medicare exposure for this injury.

The Respondent will provide said Medicare Set-Aside funds with an annuity, which will be professionally administered and at which time, Petitioner's medical rights under Section 8(a) of the Act shall terminate. Said annuity will be funded via a seed money

deposit of $20,772.00 and subsequent annual payments of $10,061.26 beginning on March 27, 2019 with the last guaranteed payment on March 27, 2050. The parties agree to cooperate in executing and submitting all documents necessary for the establishment of any MSA and annuity.

The Respondent will fund a Non-Medicare Set-Aside fund for Attendant Home Health Care with an annuity. Said Non-MSA for Attendant Care will be funded by monthly payments of a $1906.00 beginning June 1, 2018, guaranteed payment of 33 years with the last payment on May 1, 2051. (Exhibit No. 2,Attendant Care Non-MSA Agreement). The parties agree to cooperate in executing and submitting all documents necessary for the establishment the Non- MSA and annuity.

The Petitioner will be solely responsible for any future lien reimbursements including, but not limited to, Illinois Dept. of Healthcare & Family Services and Blue Cross Medicare RX Plan.

SETTLEMENT ADDENDUM

1. To prevent a cost shift of future injury alleged medical care to Medicare, the Respondent agrees to fund a NuShield Certified MSA and its administration in connection with this settlement. (42 C.F.R. Section 411.46,42 U.S.C. Section 1395y (b)(2)).
2. The NuShield Certified MSA amounts to $342,732.00 and the NuShield administration amounts to $10,000.00.
3. The NuShield Certified MSA will be professionally administered by Bridge Pointe in accordance with the Bridge Pointe Professional Custodial Account Agreement that is incorporated as a part of this settlement agreement.
4. NuQuest certifies that this NuShield Certified MSA reasonably considers Medicare's interests in accordance with the Medicare Secondary Payer Act and regulations. As part of this certification:
    a. NuQuest will assist the Medicare beneficiary in pursuing appeals of any denied injury related Medicare covered bills after the NuShield Certified MSA account is properly exhausted as defined by the Bridge Pointe Self Administration Support Services Agreement.
    b. Should CMS deny the injury related bills after the appeals are exhausted, NuQuest will pay for injury related Medicare covered

treatment up to the amount of the total settlement less the original MSA amount.

c. The certification extends to conditions noted in the NuShield Certified MSA and does not apply to any other additional conditions that may be released in the settlement.

d. Claimant agrees to waive any right to a private cause of action under 42 U.S.C. Section 1395y(b)(3)A of the Medicare Secondary Payer Act.

5. By virtue of the certification provided in the NuShield Certified MSA, this MSA will not be submitted to CMS for review.
6. CMS will be given notice of the establishment of the NuShield Certified MSA by Bridge Pointe.
7. Claimant agrees to cooperate with NuQuest during any negotiations, appeals or litigation concerning the NuShield Certified MSA or conditional payments.
8. Conditional payments involving treatment incurred prior to the funding of the NuShield Certified MSA will be resolved in the following manner: Respondent satisfy the repayment to Medicare of any conditional payment for reasonable and necessary medical treatment related to the April 2, 2009 incident.
9. The terms of this Addendum will govern in the event of any conflicting provisions in the settlement terms.

Michelle Odom

Michelle Odom/
Petitioner

Date: 4/18/18

Eric H. Check/
Attorney for Petitioner

Date: 4-19-18

Daniel K. Swanson/
Attorney for Respondent

Date: April 16, 2018

treatment up to the amount of the total settlement less the original MSA amount.

c. The certification extends to conditions noted in the NuShield Certified MSA and does not apply to any other additional conditions that may be released in the settlement.

d. Claimant agrees to waive any right to a private cause of action under 42 U.S.C. Section 1395y(b)(3)A of the Medicare Secondary Payer Act.

5. By virtue of the certification provided in the NuShield Certified MSA, this MSA will not be submitted to CMS for review.

6. CMS will be given notice of the establishment of the NuShield Certified MSA by Bridge Pointe.

7. Claimant agrees to cooperate with NuQuest during any negotiations, appeals or litigation concerning the NuShield Certified MSA or conditional payments.

8. Conditional payments involving treatment incurred prior to the funding of the NuShield Certified MSA will be resolved in the following manner: Respondent satisfy the repayment to Medicare of any conditional payment for reasonable and necessary medical treatment related to the April 2, 2009 incident.

9. The terms of this Addendum will govern in the event of any conflicting provisions in the settlement terms.

Michelle Odom/
Petitioner

Date: 4/18/18

Eric H. Check/
Attorney for Petitioner

Date: 4-19-18

Daniel K. Swanson/
Attorney for Respondent

Date: April 16, 2018

OBJECTIVE SETTLEMENT ADVISORS

RINGLER
Everybody Wins

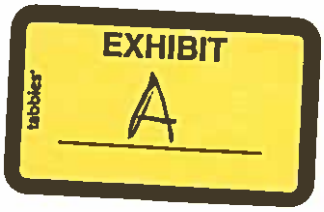
(309) 662-0569
Fax (309) 410-5000

MEDICARE SET-ASIDE ARRANGEMENT (PERIOD CERTAIN) WITH REVERSIONARY INTEREST TO CLAIMANT'S ESTATE

Claimant: MICHELLE ODOM
Date of Birth: 10/02/77
Gender: Female

BENEFIT	COST	EXPECTED YIELD
MSA Seed		
MSA Seed	$20,772.00	$20,772.00
MSA Allocation		
Annual Income $10,061.26 per year guaranteed 32 years starting on 3/27/2019.	$207,734.47	$321,960.32
TOTALS	$228,506.47	$342,732.32

Rate Series = RB180321 (3/21/2018)
Proposal Preparation Date: 3/27/2018
Proposal Purchase Date: 5/4/2018
This proposal is valid for 7 days from the proposal preparation date.
This proposal design is for illustration and planning purposes only, and is not valid or binding until verified with the appropriate life company quoting software.



WATERVILLE
ADVISORS

161 North Clark Street • Suite 2925 • Chicago, IL • 60601
Phone (312) 781-9340 • *Fax* (312) 781-9345

STRUCTURED SETTLEMENT PROPOSAL

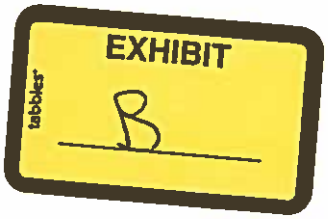
MICHELLE ODOM
DATE OF BIRTH: OCTOBER 2, 1977
PACIFIC LIFE INSURANCE COMPANY
RATING: A+ (SUPERIOR)

MARCH 26, 2018
BASED ON A PURCHASE DATE OF MAY 1, 2018

*** ALL PAYMENTS ARE TAX FREE. RATES EXPIRE APRIL 2, 2018 (3PM CST). ***

BENEFITS	GUARANTEED PAYOUT	COST
Monthly Payments		
$1,906.00 payable monthly, guaranteed for 33 years, beginning on 06/01/2018, with the last guaranteed payment on 05/01/2051	$754,776.00	
TOTAL	**$754,776.00**	**$485,266.00**

Internal Rate-of-Return: 2.94%
Taxable Equivalent Yield: 4.08%
(based on a marginal tax rate of 28.00%)



SETTLEMENT RIDER
TERMS AND CONDITIONS OF PROFESSIONALLY ADMINISTERED
MSA ANNUITY PAYMENTS

Payments

In consideration of the Agreement, American Zurich Insurance Company ("Insurer") agrees to make the following payments due at the time of settlement:

MSA Seed Money: $20,772.00 : Payable to BRIDGE POINTE F/B/O MICHELLE ODOM

Periodic Payments

In consideration of the Agreement, Insurer agrees to make future Periodic Payments as follows (the "Periodic Payments"):

Payable to BRIDGE POINTE F/B/O MICHELLE ODOM:
$10,061.26 payable annually, guaranteed for 32 years, beginning on 03/27/2019, with the last guaranteed payment on 03/27/2050.

All sums set forth herein constitute damages on account of personal injuries and sickness in a case involving physical injury or physical sickness within the meaning of Section 104(a)(1) of the Internal Revenue Code of 1986, as amended.

Right to Payments

Payee acknowledges that the Periodic Payments cannot be accelerated, deferred, increased or decreased by any payee; nor shall any payee have the power to sell, mortgage, encumber, or anticipate the Periodic Payments, or any part thereof, by assignment or otherwise.

Payee's Beneficiary

Any payments to be made after the death of the Payee shall be made to such person or entity as shall be designated in writing by Payee to the Assignee or the Annuity Issuer. If no person or entity is so designated by Payee, or if the person designated is not living at the time of the Payee's death, such payments shall be made to the estate of the Payee. No such designation, nor any revocation thereof, shall be effective unless it is in writing and delivered to the Assignee or the Annuity Issuer. The designation must be in a form acceptable to the Assignee or the Annuity Issuer before such payments are made.

Consent to Qualified Assignment

Payee acknowledges and agrees that the Insurer may make a "qualified assignment", within the meaning of Section 130(c) of the Internal Revenue Code of 1986, as amended, of the Insurer's liability to make the Periodic Payments set forth above to MetLife Assignment Company, Inc. (the "Assignee"). The Assignee's obligation for payment of the Periodic Payments shall be no greater than that of Insurer (whether by judgment or agreement) immediately preceding the assignment of the Periodic Payments obligation.

Any such assignment, if made, shall be accepted by the Payee without right of rejection and shall completely release and discharge the Insurer from the Periodic Payments obligation assigned to the Assignee. The Payee recognizes that, in the event of such an assignment, the Assignee shall

EXHIBIT #1

Medicare Set-Aside Custodial Agreement

This Certified Medicare Set-Aside Custodial Agreement (the "Agreement"), dated this 28th day of March, 2018, is made by and between Michelle Odom ("Beneficiary"), and **ALLOCATION SERVICES, INC., D/B/A BRIDGE POINTE ("Bridge Pointe") and NUQUEST ("NuQuest")**, ("Custodian"). Beneficiary, American Zurich Insurance Company ("Payer"), and Custodian are sometimes referred to herein each as a "party" and together as the "parties".

WHEREAS, Beneficiary and Payer have entered into a settlement of a claim (the "Settlement") relating to the Injury alleged by Beneficiary;

WHEREAS, pursuant to the Medicare Secondary Payer Act, Medicare's interests must be considered in any settlement where a claimant, currently or at some point in the future, may rely on Medicare for coverage for the Injury;

WHEREAS, the Settlement established a certified Medicare set-aside allocation amount ("MSA") for the payment of Allowable Expenses arising from the Injury;

NOW THEREFORE, in consideration of the mutual promises set forth below, the parties to this Agreement agree as follows:

1. DEFINITIONS: For purposes of this Agreement, the following terms shall have the meanings set forth below:

1.1 Account Activation Date: shall mean that date on which Custodian receives the Documents and complete payment from Payer (as further described in **Section 3** below).

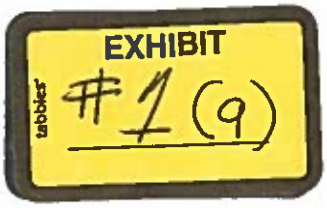
1.2 Account Effective Date: shall mean that date on or before the Account Activation Date, which is the later of, (a) the Final Settlement Date, or (b) the date determined by the Payer.

1.3 Allowable Expenses: shall include: (i) Medical/RX Expenses, (ii) administrative expenses allowable by CMS, including, bank fees, mailing fees/postage and document copying fees directly related to the certified MSA Account, (iii) reimbursement to CMS, and/or (iv) reimbursement of income tax paid on interest income earned on the certified MSA Account. *For clarification*, Allowable Expenses shall not include co-payments, medical or prescription insurance premiums, reimbursement or payment for Services incurred during periods of temporary depletion of the certified MSA Account, or any medical services or prescription drug expenses not covered by Medicare.

1.4 CMS Release: shall mean the release authorizing CMS to disclose Injury related information with those specified individuals or entities.

1.5 Documents: shall mean, at a minimum, (i) this Agreement fully executed, (ii) General Release, (iii) Beneficiary's Form W-9, (iv) a copy of the executed settlement documents between the Beneficiary and Payer, (v) a final court order, commission order or settlement order, as applicable, (vi) certified MSA report; and (vii) any documentation reasonably requested by Custodian or Payer necessary for the Custodian to perform the Services under this Agreement.

1.6 General Release: shall mean the release authorizing the Custodian to, among other things; communicate with medical providers about Beneficiary's past and future medical needs in order to effectively administer custodial services pursuant to this Agreement.



1.7 Injury: shall mean any medical condition related to or arising from the actual or alleged injury described on Exhibit A, attached hereto and incorporated herein.

1.8 Medical/RX Expense: shall mean only those expenses for Services which would otherwise be reimbursable or payable by Medicare or prescription drug expenses prescribed either for the FDA labeled use or for a recognized off-label use in the compendia citations accepted by CMS.

1.9 Certified MSA Account: shall mean the separate, interest bearing certified Medicare Set-Aside Account established by Custodian and funded by the Payer.

1.10 Provider: shall mean the physician, medical provider, supplier or pharmacy providing Injury- related medical services, supplies or prescription drugs to Beneficiary.

1.11 Services: shall mean any Injury related services, procedures, prescription or other items provided to the Beneficiary by Providers. "Services" exclude case management services such as locating Providers, setting appointments and other similar services.

1.12 Supporting Documents: shall mean, at a minimum, (i) name of the Provider, (ii) amount charged by the Provider, (iii) the date of the Service, and (iv) a description of Service received by Beneficiary. Custodian may require additional information, including but not limited to medical diagnosis and Provider notes, and/or Provider's W-9.

2. COMPLIANCE WITH APPLICABLE LAWS: The parties will comply with all applicable statutes, regulations and orders of, and all applicable restrictions imposed by, all governmental bodies.

3. DUTIES OF PAYER:

3.1 Fund certified MSA Account. Payer shall fund the certified MSA Account by way of a lump sum payment ("Lump Sum Account"), or through installment payments ("Structured Account"), as provided on Exhibit B attached hereto and incorporated by reference (individually and collectively, the "Payment"). Payer shall be solely and exclusively responsible for the Payment to Custodian for deposit in the certified MSA Account. If Payer fails to make the Payment, each Beneficiary and Payer acknowledges and understands that Custodian shall have no obligation to deposit any amount in the certified MSA Account for Allowable Expenses or for any other purpose.

3.2 Custodial Fee. In accordance with the Fee Schedule attached hereto and incorporated by reference as Exhibit C, Payer shall pay Custodian a fee for the establishment and administration of the certified MSA Account (the "Custodial Fee").

3.3 Assignment of Obligation. If Payer assigns its duties and obligations to make any applicable future Periodic Payments for either the certified MSA Account or the Custodial Fee to an Assignee via a qualified assignment, Assignee shall make said Periodic Payments directly to the Custodian and Payer shall be released from all obligations to make such periodic payments; provided, however, Payer provides a copy of the fully executed qualified assignment and copy of the annuity policy to the Custodian. Assignee shall assume the duties and responsibilities of Payer with respect to such periodic payments to Custodian. All other duties and obligations of the Payer shall continue to be subject to this Agreement.

4. DUTIES OF CUSTODIAN:

4.1 Certified MSA Account. Custodian shall promptly establish the certified MSA Account for Beneficiary following its receipt of each of the following: (a) the Documentation from Beneficiary or his/her representative, (b) the Payment from the Payer, and (c) the Custodial Fee from Payer.

4.2 Medical/RX ID Card. Within five (5) calendar days following the Account Activation Date, Custodian will provide Beneficiary with a Medical/RX I.D. Card, designating Custodian as the primary payer for Allowable Medical/RX Expenses.

4.3 Disbursements.

a. During the Term of this Agreement, and only to the extent the certified MSA Account has sufficient funds, Custodian agrees to make the following disbursements from the certified MSA Account (each a "Disbursement" and collectively, "Disbursements"):

(i) Allowable Expenses to the Beneficiary, following Custodian's receipt of Supporting Documents;

(ii) Medical/RX Expenses to Provider, following Custodian's receipt of Supporting Documents;

(iii) Reimbursement to Beneficiary of income tax paid on interest income earned on the MSA Account, if any, pursuant to **Section 5.7**;

(iv) Reimbursement to CMS of any conditional or excess Services provided on or after the Account Effective Date;

(v) Reimbursement or disbursement to Payer, if applicable, pursuant to **Section 3**;

(vi) Distribution of the balance, if any, of the certified MSA Account upon the termination of this Agreement pursuant to **Section 8.4**.

b. BENEFICIARY HAS SOLE AND EXCLUSIVE RESPONSIBILITY FOR ANY AND ALL SERVICES AND RELATED EXPENSES THAT ARE NOT DEFINED AS AN ALLOWABLE EXPENSE.

4.4 Reimbursement Rate. Custodian shall pay medical expenses at a rate up to the amount as stated in the Settlement (as part of the certified MSA) and RX expenses at the contract rate amount for Custodian's then current in-network vendor. However, if said medical or out of network RX provider refuses to accept an amount at or lower than the applicable fee schedule rate, the Custodian will either (a) use reasonable efforts to negotiate a reduced charge on behalf of the Beneficiary, or (b) pay up to the full amount of the expenses charged.

4.5 Reliance upon Supporting Documents. Custodian may assume the authenticity of the Supporting Documents provided to it by a Provider and/or Beneficiary. Custodian shall pay the Allowable Expenses evidenced by the Supporting Documents without any obligation of obtaining further support for or verification of the information provided. In the event Custodian pays for an Allowable Expense in reliance upon any deceptive, misleading or erroneous Supporting Documents, then Beneficiary has the option to either (a) reimburse the certified MSA Account in the amount equal to such erroneous Disbursement, or (b) accept the depleted certified MSA Account consistent with **Section 4.8** below.

4.6 No Investment Supervision. Each Beneficiary and Payer acknowledges and agrees that Custodian is not providing and will not provide any investment management or investment management type services.

4.7 Record Keeping; Reporting.

a. Custodian will provide Beneficiary or its designated representative, an annual report detailing Disbursement and Payments. If Beneficiary does not dispute any Disbursements or Payments in such report within 30-days of receipt, then such report shall be deemed to be accurate and complete.

b. Within five (5) business days following the Account Activation Date, Custodian will provide certain reference materials and instructions to Beneficiary or its designated representative, including but not limited to, the following:

(i) Medical/RX ID card
(ii) Certified MSA Account Information Booklet
(iii) Pharmacy Referral Introductory Letter
(iv) Introductory Letter to be delivered to each Provider

4.8 Depletion of Certified MSA Account. If the certified MSA Account lacks sufficient funds for Custodian to make any or all of the Disbursements, Custodian shall first attempt to make the Disbursements consistent with **Section 8.4**, up to the certified MSA Account balance. Once the certified MSA Account balance is insufficient to make any Disbursement (as determined in Custodian's reasonable discretion), or if the certified MSA Account balance has reached zero, then:

a. If a Lump Sum Account, the certified MSA Account will terminate pursuant to **Section 8.2(b)(i)**.

b. If a Structured Account and no additional Payments are due, then the certified MSA Account will terminate pursuant to **Section 8.2(b)(ii)**.

c. If a Structured Account and additional Payments are due, then Custodian will notify Beneficiary or its designated representative(s) in writing that the certified MSA Account is temporarily depleted and the date Payment is due to Custodian (the "Due Date"). If Payment is received on or before the Due Date, then Custodian will resume its obligations pursuant to this Agreement on the Due Date. If Payment is not received on or before the Due Date, then Custodian may terminate its obligations pursuant to **Section 8.2(c)**.

5. DUTIES OF BENEFICIARY:

5.1 Accurate Documentation. Beneficiary represents and warrants to Custodian that all Documentation, Supporting Documentation and any other information, documents or reports provided by Beneficiary are accurate and contain no material misrepresentation or omissions.

5.2 Contact Information: Beneficiary shall promptly notify Custodian in writing upon a change of name, address or phone number. Beneficiary agrees to promptly provide Custodian an updated W-9 upon Custodian's request.

5.3 Guardianship. In the event Beneficiary is currently appointed or becomes appointed a guardian, Beneficiary or the guardian, as applicable, will provide Custodian documentation of guardianship in the form of a durable power of attorney or other relevant and appropriate form as mutually agreed upon by the parties that comply with applicable law. Upon receipt of such proof of guardianship, the guardian shall assume all obligations of Beneficiary pursuant to this Agreement to the extent granted pursuant to such documentation.

5.4 Medicare Entitlement Status. Beneficiary shall promptly notify Custodian, in writing, upon any change in his/her Medicare entitlement status.

5.5 Provider Notice: Beneficiary shall present the Medical/RX I.D. card (see **Section 4.2**) to Provider prior to the receipt of any Service and if Beneficiary chooses to use mail order services, Beneficiary agrees to utilize an in network vendor. Beneficiary agrees not to submit any claimed injury related medical and prescription expenses to Medicare unless and until notification has been given that the certified Medicare Set-Aside Account is exhausted. This includes Medicare Part C replacement plans and Part D prescription plans.

5.6 Misdirected Corpus Funds or Fees: In the event Beneficiary receives a Payment or Custodial Fee in error, then Custodian shall have the option to (a) cease making any Disbursements until such time the Payment or Custodial Fee is properly received, or (b) terminate this Agreement pursuant to **Section 8.2(d)**. If the Custodian elects to terminate this Agreement pursuant to Section 8.2(d), the certification and indemnification provisions that apply to the Beneficiary are null and void as of the date of the termination of this Agreement.

5.7 Taxes. Beneficiary shall be solely responsible for any and all local, state, or federal taxes incurred as a result of interest income earned by the certified MSA Account. Custodian shall, however, reimburse Beneficiary using funds from the certified MSA Account for any taxes paid as a result of interest income earned on the certified MSA Account, but only to the extent that adequate funds exist in the certified MSA Account. Prior to any such Distribution, Beneficiary shall provide Custodian with sufficient evidence supporting the amount of tax liability attributed to the certified MSA Account interest; such as (a) a copy of the Form 1099-INT or the equivalent, and (b) a copy of Beneficiary's filed Federal Income Tax Return.

6. Certified MSA ACCOUNT INTEREST: Any interest earned on the funds in the certified MSA Account will accrue and be applied to the Distributions.

7. COMPENSATION.

7.1 Custodian shall receive compensation from Payer in accordance with the Fee Schedule. In the event the Custodial Fee is not received by Custodian, Custodian will be unable to activate the certified MSA Account and/or may terminate this Agreement pursuant to **Section 8.2(c)**.

7.2 Custodian may receive volume discounts and/or placement fees from certain vendors that may provide services to the Beneficiary; such discounts and/or fees are not passed on to the Beneficiary and are not subject to this Agreement.

8. TERM; TERMINATION:

8.1 This Agreement shall become effective upon the Account Activation Date and shall continue in full force and effect until completed or terminated.

8.2 This Agreement shall terminate upon the occurrence of the following events:

a. Death of Beneficiary. This Agreement shall be terminated 180 days following the death of Beneficiary.

b. Permanent Depletion of the Certified MSA Account. This Agreement shall terminate immediately upon Custodian's written notice and accounting to CMS (if applicable) and Beneficiary that: (i) the balance of the Lump Sum Account has reached zero; or (ii) the balance of the Structured Account has reached zero, and no further Payment is due from Payer.

c. Payer's Failure to Pay Custodian: This Agreement shall terminate if Payer fails to pay any Payment or Custodial Fee more than ten (10) days following written notice from Custodian. On the eleventh (11th) day, Custodian will initiate release of all funds in the MSA Account to Beneficiary or Beneficiary's designated successor custodian. If the Payer fails to pay the Custodial Fee in a timely manner, the certification and indemnification provisions that apply to the Payer are null and void as of the date of the termination of this Agreement.

d. Termination for Cause: This Agreement may be terminated immediately by Custodian upon Beneficiary's material failure to properly perform its duties and responsibilities hereunder or because of Beneficiary's gross negligence or dishonesty. Termination shall become effective upon the delivery of written notice of termination to Beneficiary or at such later time as may be specified in the written notice. If the Custodian elects to terminate this Agreement, the certification and indemnification provisions that apply to the Beneficiary are null and void as of the date of the termination of this Agreement.

8.3 In the event Beneficiary fails to provide Custodian with the Documents, Custodian shall have the option, in its sole discretion, to stop remitting payment for Medical/RX Expenses from the MSA Account, or terminate this Agreement. If the Custodian elects to terminate this Agreement, the certification and indemnification provisions that apply to the Beneficiary are null and void as of the date of the termination of this Agreement.

8.4 Distribution of MSA Account Balance Following Termination: Pursuant to **Section 8.2 (a)** above, if there is a balance remaining in the certified MSA Account following the death of the Beneficiary, Custodian shall distribute the funds as follows:

a. First, reimbursement to CMS pursuant to **Section 4.3(a)(iv)**;

b. Second, all other Medical/RX Disbursements in order of receipt by Custodian;

c. If a balance remains in the certified MSA Account after any reimbursement to CMS, if applicable, and payment of all Allowable Expenses, then Custodian shall withdraw the sum of $300.00 from the MSA Account as a closure fee. Custodian shall distribute the entire remaining balance to Beneficiary, or if Agreement terminates due to the death of Beneficiary then to Beneficiary's designee (pursuant to the Death Beneficiary Designation Form, attached hereto as Exhibit D and incorporated by reference), or as otherwise may be required by state law.

8.5 Designation of Death Beneficiary. Beneficiary shall complete the Death Beneficiary Designation Form attached hereto as Exhibit D on or prior to execution of this Agreement. This Form may be revoked or replaced at any time during the term of this Agreement by Beneficiary, so long as in writing, signed by the Beneficiary and delivered to Custodian. If Beneficiary fails to complete the

attached Death Beneficiary Designation Form or if the person(s) designated is/are not living or cannot be located at the time of the Beneficiary's death, then Custodian shall pay the certified MSA account balance to Beneficiary's estate or as otherwise may be required by state law.

Primary beneficiary: Each surviving primary beneficiary will be paid his or her share of the death proceeds. If the primary beneficiary predeceases Beneficiary, that beneficiary's share will be split among the surviving primary beneficiaries. That split will be based on the ratio of the specified percentages for those surviving primary beneficiaries to the total percentage of those survivors. If no percentages are specified, the death proceeds will be split equally among the surviving primary beneficiaries.

Contingent beneficiary: If no primary beneficiary survives Beneficiary, each contingent beneficiary, if designated, surviving Beneficiary will be paid their share of the death proceeds in the same manner as described above for the primary beneficiary.

Upon Custodian's final disbursement of the MSA Account balance, this Agreement shall terminate and Custodian shall have no further obligations under this Agreement.

9. NOTICES:

9.1 Each Party giving or making any notice or other communication (each, a "Notice") pursuant to this Agreement shall (i) give the Notice in writing, and (ii) use one of the following methods of delivery: (A) personal delivery; (B) registered or certified mail, in each case, return receipt requested and postage prepaid; (C) nationally recognized overnight courier, with all fees prepaid; (D) facsimile, or (E) email. A Notice is effective only if the Party giving the Notice has complied with Section 9 and if the addressee has received the Notice.

9.2 Notices shall be addressed as indicated below, or to such other addressee or to such other address as may be designated by a Party in a Notice pursuant to this Section 9:

If to Custodian:	Allocation Services, Inc., d/b/a Bridge Pointe PO Box 915619 Longwood, FL 32791-5619 Attention: Jul Mullen Facsimile No.: (321) 460-5121 Email: jmullen@mybridgepointe.com
With a copy to:	Brown & Brown, Inc. 655 N. Franklin Street, Suite 1900 Tampa, FL 33602 Attention: Carrie R. Brown, Corporate Counsel Facsimile No.: (813) 222-5374 Email: cbrown@bbinslegal.com
If to Payer:	American Zurich Insurance Company Maureen McNett P.O. Box 66946 Chicago, IL 60666-0946
If to Beneficiary:	Michelle Odom 1667 Plum Tree Lane Aurora, IL 60504

10. MISCELLANEOUS:

10.1 Entire Agreement. Except as otherwise provided in Section 10.7, this Agreement, including the attached Exhibits, constitutes the sole and complete agreement between the parties and replaces all other written and oral agreements relating to the matters referred to herein. The parties agree that each party and its counsel has reviewed and approved this entire Agreement inclusive of the Exhibits.

10.2 Waiver. Failure to enforce any term of this Agreement shall not constitute a waiver of such term. If any part of this Agreement is found to be unenforceable by a court, administrative body or agency of competent authority and jurisdiction, the rest of the Agreement shall remain in full force and effect.

10.3 Successors and Assigns. This Agreement shall be binding upon and inure to the benefit of the successors and permitted assigns of the parties hereto.

10.4 Assignment. Custodian may assign this Agreement without the prior written consent of the other parties hereto.

10.5 Headings. All headings in this Agreement are inserted for convenience of reference only and shall not affect the meaning or interpretation of the Agreement.

10.6 Governing Law. This Agreement shall in no way be deemed to amend or supersede the settlement agreement and release entered into by Beneficiary pertaining to the Beneficiary's claim, which settlement and release shall be governed by the laws of the State of Jurisdiction. Any dispute regarding Medicare or Medicare coverage shall be governed under Federal law.

10.7 Modifications. This Agreement may only be modified by a written agreement signed by the parties hereto.

10.8 Counterparts; Signatures. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original but all of which taken together shall constitute one and the same instrument binding on all of the parties hereto. Each of the parties agrees that a photocopy of the signatures to this Agreement shall be considered as effective and valid as the original.

10.9 Authority. Each of the parties represents that it has the full and complete power and authority to execute this Agreement and that, assuming the due execution of this Agreement by all other parties hereto, this Medicare Set-Aside Custodial Agreement constitutes a valid and binding obligation of such party and is enforceable in accordance with its terms.

CERTIFICATION AND INDEMNIFICATION

1. NuQuest certifies that the MSA reasonably considers Medicare's interests in accordance with the Medicare Secondary Payer Act and regulations, and that after proper exhaustion of the certified MSA funds, Medicare will become the primary payer for the Beneficiary's injury related Medicare-covered medical expenses; provided, however, that the Beneficiary is then enrolled as a Medicare beneficiary.

2. The Beneficiary agrees that the medical and prescription treatment that is summarized and included in the NuShield Cost Projection, which is incorporated in this Professional Administration Agreement, accurately represents the Beneficiary's treatment regimen for the past two years and up through the date of the execution of this Agreement.

3. NuQuest shall indemnify, defend and hold the Beneficiary, free and harmless from and against any and all liabilities, damages, losses, claims, costs or expenses, including reasonable attorney's fees (collectively "Claims), that are hereafter made or brought against the Beneficiary by CMS arising from a negligent or intentional act or omission relating to NuQuest's completion of the certified MSA, provided however that NuQuest's indemnification obligations shall not extend to Claims that are found to be attributable to the acts, omissions or negligence of the Beneficiary or his agents that do not adhere to the Beneficiary's obligations under this Agreement.

4. NuQuest's obligations hereunder are only for the benefit of the Beneficiary and are limited to the Beneficiary.

5. The Beneficiary agrees to promptly notify NuQuest in writing of any such claim by CMS or suit within ten (10) business days that the pleading, demand letter, or any other written notice is served upon the Beneficiary; and agrees to cooperate in a reasonable manner with NuQuest, and at NuQuest's expense, with respect to the defense and disposition of such claim.

NuQuest shall have control of the defense or settlement; provided, however, that NuQuest shall not enter into any settlement that obligates the Beneficiary to take any action or incur any expense, without such Beneficiary's prior written consent.

****

[SIGNATURE PAGE FOLLOWS]

IN WITNESS WHEREOF, the Parties have signed this Agreement as of the day and year first above written.

CUSTODIAN:

Allocation Services, Inc. d/b/a Bridge Pointe

By: _____
Name: _____.
Title: _____.

BENEFICIARY:

By: Michelle Odom
Name: Michelle Odom

Exhibit A
Information about Beneficiary and Payer

1. Payer Information

Name: American Zurich Insurance Company
Contact Person: Maureen McNett
Address: P.O. Box 66946
Chicago, IL 60666-0946
Telephone Number: (847)240-8132

2. Beneficiary Information

Name: Michelle Odom
1667 Plum Tree Lane
Aurora, IL 60504
Telephone Number: (630)898-4626

Email: _____
Date of Birth: 10/02/1977
Life Expectancy: 33 years

3. Guardian for Beneficiary (applies only if Beneficiary has a court appointed legal guardian) or Legal Conservator for Beneficiary:

Name: N/A

4. Date of Injury: 04/02/2009

5. Description of Injury: Neck pain, Contusion of right knee, Right shoulder pain, Right upper arm/elbow, pain Right forearm / wrist / hand pain, Right thigh pain, Right lower leg pain Complex regional pain syndrome right upper limb & Complex regional pain syndrome right lower limb

6. State of Jurisdiction: Illinois

7. Settlement Consultant: Ringler Associates Phone: (309)662-0569

8. Plaintiff Attorney's Name: Eric Check, Esq. Phone: (312) 704-8600

9. Defense Attorney's Name: Daniel Swanson, Esq. Phone: (312) 775-9750

Exhibit B

MSA Account Payment

The following Payment shall be paid by, or caused to be paid by, Payer to Custodian in the amounts and on the dates (if applicable) set forth below:

Structured Account:

The initial Payment shall be in the amount of $20,772.00. THIS PAYMENT MUST BE RECEIVED BY CUSTODIAN IN ORDER TO ESTABLISH THE MSA ACCOUNT, AS PROVIDED IN **SECTION 4.1** OF THE AGREEMENT.

The annual Payment shall be in the amount of $10,061.26 per year guaranteed for 32 years beginning March 27, 2019 and shall be received by Custodian on or before the due date each year.

All Payments shall be mailed to:

Bridge Pointe
PO Box 915619
Longwood, FL 32791-5619

Exhibit C

Fee Schedule

The following Custodial Fee shall be paid, or caused to be paid, by Payer to Custodian in the amounts and on the dates (if applicable) set forth below:

A lump sum Custodial Fee in the amount of $10,000.00. THIS AMOUNT MUST BE RECEIVED BY CUSTODIAN IN ORDER TO ESTABLISH THE MSA ACCOUNT, AS PROVIDED IN **SECTION 3.2** OF THE AGREEMENT.

All Custodial Fees shall be mailed to:

Bridge Pointe
PO Box 915619
Longwood, FL 32791-5619

Exhibit D:

Death Beneficiary Designation Form.

www.mybridgepointe.com | Phone: 1-877-551-3900 | Fax: 407-389-0299

_____ Initial Beneficiary Designation(s). I hereby revoke any previous beneficiary designation(s), if any, for my Medical Fund and direct that the proceeds payable under the Medical Fund be paid as indicated below

Account Information Please supply the following information.

Name (First)	(Middle)	(Last)	Social Security Number
Michelle		Odom	340-66-1021
Fund ID#		**Phone Number**	
CMSA2892	~~(630)308-4026~~	3122875827	

It is important that your beneficiary designation be clear so that there will be no question as to your intent. It is also important that you name a primary (first in line to receive named benefits) and contingent beneficiary (alternate choice if the Primary Beneficiary(ies) is not alive to accept benefits at the time benefits are to be paid). When naming your beneficiary(ies) please indicate their full name, address, social security number, relationship and, if a minor, the age of that minor. If the beneficiary is not related either by blood or marriage, insert the words, "Not Related." If you need assistance, contact your own legal counsel.

I would like the primary beneficiary (beneficiaries) of any remaining funds in my Bridge Pointe Medicare Set-Aside Custodial Account to be:

2. Primary Beneficiary Name:

Primary Beneficiaries

Name				Designated %
Kimani Mobley				50%
Home Street Address (no P.O. boxes, please)	City	State	Zip Code	
1667 Plum Tree LN	Aurora	IL	60504	
Relationship	Social Security/Tax ID Number	Date of Birth (mm/dd/yyyy)	Telephone Number	
Son	321940428	04/15/1997	3122875827	

Name				Designated %
Joshua Benford				50%
Home Street Address (no P.O. boxes, please)	City	State	Zip Code	
719 N. Drake Avenue	Chicago	IL	60624	
Relationship	Social Security/Tax ID Number	Date of Birth (mm/dd/yyyy)	Telephone Number	
Nephew		06/23/2007	7736363714	

Name				Designated %
Home Street Address (no P.O. boxes, please)		City	State	Zip Code
Relationship	Social Security/Tax ID Number	Date of Birth (mm/dd/yyyy)	Telephone Number	

Contingent Beneficiaries

I would like the contingent beneficiary (beneficiaries) of any remaining funds in my Bridge Pointe Medicare Set-Aside Custodial Account to be:

Contingent Beneficiaries

Contingent beneficiaries will inherit assets only if there are no surviving primary beneficiaries at the time of death of the account holder.

Name					Designated %
Home Street Address (no P.O. boxes, please)		City	State	Zip Code	
Relationship	Social Security/Tax ID Number	Date of Birth (mm/dd/yyyy)	Telephone Number		

Name					Designated %
Home Street Address (no P.O. boxes, please)		City	State	Zip Code	
Relationship	Social Security/Tax ID Number	Date of Birth (mm/dd/yyyy)	Telephone Number		

Name					Designated %
Home Street Address (no P.O. boxes, please)		City	State	Zip Code	
Relationship	Social Security/Tax ID Number	Date of Birth (mm/dd/yyyy)	Telephone Number		

* If you would like to list additional beneficiaries, make a photocopy of this page and attach it to this form.

Total must equal 100%

3. Designate an Authorized Party

Please name an Authorized Party below. An "Authorized Party" is a person you identify as being able to assist Bridge Pointe in locating and/or identifying your beneficiary(ies).

Name of Authorized Party (First Name)	(Middle Initial)	(Last Name)	Relationship to You		
Karen	E.B.	Odom	Sister		
Home Street Address (no P.O. boxes, please)		City	State	Zip Code	
718 N. Drake Avenue		Chicago	IL	60624	
Email Address(es)		Telephone Number			
mskaren23e@yahoo.com		7735263714			

4. Signature

I, the undersigned, reserve the right to change the beneficiary(ies) without the consent of said beneficiary(ies).

Signature and Date Required

X Michelle Odom 4/18/18

Account Holder Signature — Print Name — Date

1.0 Payments

In consideration of the release set forth above, CME GROUP, INC. and ZURICH NORTH AMERICA, agrees to pay to the individual(s) (the "Payee(s)") named below the sums outlined in this Section 2.0 below:

1.1 Periodic payments made according to the schedule as follows (the "Periodic Payments"):

Payee: Michelle Odom

Annuity with a present cost of $485,266.00 to be paid as follows:

$1,906.00 payable monthly, guaranteed for 33 years, beginning on 06/01/2018, with the last guaranteed payment on 05/01/2051

All sums set forth herein constitute damages on account of personal physical injuries or physical sickness, within the meaning of Section 104(a)(2) of the Internal Revenue Code of 1986, as amended.

2.0 Payee's Rights to Payments

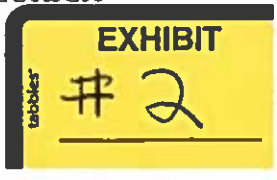
PLAINTIFF acknowledges that the Periodic Payments cannot be accelerated, deferred, increased or decreased by the PLAINTIFF or any Payee; nor shall the PLAINTIFF or any Payee have the power to sell, mortgage, encumber, or anticipate the Periodic Payments, or any part thereof, by assignment or otherwise.

3.0 Payee's Beneficiary

Any payments to be made after the death of any Payee pursuant to the terms of this Settlement Agreement shall be made to such person or entity as shall be designated in writing by PLAINTIFF to CME GROUP, INC. and ZURICH NORTH AMERICA or the CME GROUP, INC. and ZURICH NORTH AMERICA'S Assignee. If no person or entity is so designated by PLAINTIFF, or if the person designated is not living at the time of the Payee's death, such payments shall be made to the estate of the Payee. No such designation, nor any revocation thereof, shall be effective unless it is in writing and delivered to CME GROUP, INC. and/or ZURICH NORTH AMERICA's Assignee. The designation must be in a form acceptable to CME GROUP, INC. and/or ZURICH NORTH AMERICA's Assignee before such payments are made, but in no event shall the request of the payee be unreasonably withheld or denied.

4.0 Consent to Qualified Assignment

4.1 PLAINTIFF acknowledges and agrees that CME GROUP, INC. and/or ZURICH



NORTH AMERICA will make a "qualified assignment", within the meaning of Section 130(c) of the Internal Revenue Code of 1986, as amended, of CME GROUP, INC. and/or ZURICH NORTH AMERICA's liability to make the Periodic Payments set forth in Section 2.1 to Pacific Life & Annuity Services, Inc. ("the Assignee"). The Assignee's obligation for payment of the Periodic Payments shall be no greater than that of CME GROUP, INC. and ZURICH NORTH AMERICA (whether by judgment or agreement) immediately preceding the assignment of the Periodic Payment obligation.

4.2 Any such assignment, if made, shall be accepted by the PLAINTIFF without right of rejection and shall completely release and discharge CME GROUP, INC. and ZURICH NORTH AMERICA from the Periodic Payments obligation assigned to the Assignee. The PLAINTIFF recognizes that, in the event of such an assignment, the Assignee shall be the sole obligor with respect to the Periodic Payments obligation, and that all other releases with respect to the Periodic Payments obligation that pertain to the liability of CME GROUP, INC. and ZURICH NORTH AMERICA shall thereupon become final, irrevocable and absolute.

5.0 Right to Purchase an Annuity

CME GROUP, INC. and/or ZURICH NORTH AMERICA, itself or through its Assignee reserves the right to fund the liability to make the Periodic Payments outlined in Section 1.1 through the purchase of an annuity policy from Pacific Life Insurance Company ("the Annuity Issuer"). The Assignee shall be the sole owner of the annuity policy and shall have all rights of ownership. The Assignee may have Pacific Life Insurance Company mail payments directly to the Payee(s). The Payee shall be responsible for maintaining a current mailing address for Payee(s) with Pacific Life Insurance Company.

6.0 Discharge of Obligation

The obligation of the Assignee to make each Periodic Payment shall be discharged upon the mailing of a valid check or electronic funds transfer in the amount of such payment on or before the due date to the last address on record for the Payee(s) or Beneficiary with the Annuity Issuer named in Section 5.0 of this Settlement Agreement. If the Payee or Beneficiary notifies the Assignee that any check or electronic funds transfer was not received, the Assignee shall direct the Annuity Issuer to initiate stop payment action and, upon confirmation that the check was not previously negotiated or electronic funds transfer deposited, the Annuity Issuer shall process a replacement payment in the amount of such payment to the designated address of the Payee or Beneficiary.

Plaintiff: Michelle Odom

Michelle Odom

Date: 4/19/18

16 INC 306

STATE OF ILLINOIS)
) SS
COUNTY OF MADISON)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

IWCC,	)	18IWCC0246
	)	
Petitioner,	)	
	)	NO. 16 INC 306
	)	
	)	
Precision Crushing, et al.,	)	
	)	
Respondent.	)	

DECISION AND ORDER

This matter came before Commissioner Deborah L. Simpson in Collinsville on January 10, 2018 and a record was taken. Petitioner alleged that Respondent Precision Crushing was uninsured for a period of 60 days from July 12, 2014 through September 12, 2014. Notice was provided to Respondent Precision Crushing and Respondent did not appear. IWCC insurance compliance investigator Michael Cummins testified for Petitioner. Mr. Cummins testified that his investigation confirmed that Respondent was doing business in Illinois during this period and employed workers, but failed to carry workers' compensation insurance as required by the Workers' Compensation Act. Petitioner offered exhibits supporting its allegation that Respondent was in violation of Act from July 12, 2014 through September 12, 2014.

Under the Rules Governing Practice Before the Illinois Workers' Compensation Commission, a certification from an employee of the National Council on Compensation Insurance (NCII) stating that no policy information page has been filed shall be deemed prima facie evidence of that fact. Certified records from NCII show that Respondent cancelled its workers' compensation insurance policy effective July 13, 2014. Mr. Cummins testified to having first-hand knowledge that after September 12, 2014 Respondent ceased all operations in Illinois. Section 4(d) of the Act states that a noncompliant employer may be assessed a penalty of up to $500 per day, with a minimum fine of $10,000.

After considering all the evidence, we find that the Respondent Precision Crushing operated as an uninsured employer in the State of Illinois from July 14, 2014 to September 12, 2014, a period of 60 days. Petitioner presented evidence supporting the imposition of a fine against Precision Crushing in the amount of $30,000 in statutory maximum daily fines.

18IWCC0246

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $30,000 pursuant to §4(d) of the Act. Payment of the penalty shall be made by certified check or money order made payable to the State of Illinois. Payment shall be mailed or presented within thirty (30) days of the final order of the Commission or the order of the court on review after final adjudication.

DATED:
DLS/plv
r-1/10/18
46

APR 20 2018

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

STATE OF ILLINOIS)
) SS.
COUNTY OF LASALLE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Richard C. Pozzi, Sr.,
Petitioner,

18IWCC0247

vs.

NO: 09 WC 51193

Mair Petroleum,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 6, 2017, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the petitioner the sum of $466.13/week for life, commencing December 3, 2012, as provided in Section 8(f) of the Act, because the injury caused the permanent and total disability of the petitioner. Commencing on the second July 15th after the entry of this award, the petitioner may become eligible for cost-of-living adjustments, paid by the ***Rate Adjustment Fund***, as provided in Section 8(g) of the Act.

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

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

18IWCC0247

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

DATED: APR 20 2018
o4/5/18
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0247

POZZI SR, RICHARD C
Employee/Petitioner

Case# **09WC051193**

MAIR PETROLEUM
Employer/Respondent

On 1/6/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.63% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0400 LOUIS E OLIVERO & ASSOC
DAVID W OLIVERO
1615 FOURTH ST
PERU, IL 61354

0522 THOMAS MAMER & HAUGHEY LLP
JOHN M STURMANIS
PO BOX 560
CHAMPAIGN, IL 61824

18IWCC0247

18IWCC0247

STATE OF ILLINOIS)
)SS.
COUNTY OF LASALLE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

RICHARD C. POZZI, SR.,
Employee/Petitioner

v.

MAIR PETROLEUM,
Employer/Respondent

Case # **09** WC **51193**

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 **Robert Falcioni**, Arbitrator of the Commission, in the city of **Ottawa**, on **11/28/16**. 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 **Mileage**

FINDINGS

On **07/24/09**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$30,768.40**; the average weekly wage was **$591.74**.

On the date of accident, Petitioner was **61** years of age, ***married*** with **no** dependent children.

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

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

Respondent shall be given a credit of **$29,924.19** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$29,924.19**.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

Respondent shall pay petitioner temporary total disability benefits and maintenance of $394.49/week for 159-3/7 weeks, commencing 11/10/09 through 12/3/12 as provided in Section 8(b) of the Act, Respondent to receive credit for all sums previously paid hereunder.

Respondent shall pay petitioner the temporary total disability benefits that have accrued from 11/20/09 through 12/3/12 and shall pay the remainder of the award, if any, in weekly benefits.

Respondent shall pay reasonable and necessary medical service of $383.85 as provided in Section 8(a) of the Act and pursuant to the medical fee schedule, respondent to receive credit for all sums previously paid.

Respondent shall pay petitioner permanent and total disability benefits of $466.13/week for life, commencing 12/3/12, as provided in Section 8(f) of the Act.

Commencing on the second July 15th after the entry of this award, petitioner may become eligible for cost-of-living adjustments, paid by the Rate Adjustment Fund, as provided in Section 8(g) of the Act.

Respondent shall pay petitioner $5,611.20 for mileage as set forth herein.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Robert E Lahmann

Signature of Arbitrator

January 3, 2017
Date

JAN 6 - 2017

18IWCC0247

MEMORANDUM OF DECISION OF ARBITRATOR

STATEMENT OF FACTS

Petitioner Richard Pozzi testified at Arbitration as follows. H stated that that he is 69 years old and his highest level of education is the eighth grade. His past work history has consisted of truck driving. He was 18 years old when he obtained a CDL and a couple years ago, he did not renew it due to his left arm condition.

Petitioner further testified that he began working for Respondentin either 2005 or 2006. His job consisted of driving a truck to deliver petroleum products as well as moving 55 gallon drums weighing 400 pounds. Petitioner testified that he never had any problems with his left shoulder until July 24, 2009.

On July 24, 2009, Petitioner testified that he returned to the company's warehouse in Princeton, Illinois, where he was going to pump left over oil from his truck into a large storage tank. He climbed up a step ladder with an industrial hose strung across him and as he was attempting to put the hose down into the bottom of the storage tank, his ladder started to slide and he fell face first onto the concrete floor. When he was able to stand, he noticed that he had a bump on his forehead, had a bump on his knee, his left arm felt like it was cut and he couldn't lift his left arm. He testified that he then drove his truck from the warehouse to the office but had no memory of doing so. Petitioner testified that he immediately notified people at work, including his boss, that he hurt himself when the ladder slid out from under him. He stated that the secretary in the office helped clean him up and that he was offered medical care by a supervisor named "Gene" but refused due to fear of losing his job and income and benefits, explaining that prior to working for Respondent he had sustained a long period of unemployment and did not want to return to that status.

After injuring his left shoulder, Petitioner kept working by keeping his left arm close to his body. He stated that during this period he could not lift his left arm and had increasing levels of pain. He performed his job duties by lifting with his body rather his left arm, and demonstrated the motion in court. It appeared to the Arbitrator that Petitioner was demonstrating a frozen or stiff shoulder. He further stated that he was taking Ibuprofen and other over-the-counter pain medication on a daily basis for the pain in his left arm.

Petitioner testified that eventually the pain worsened to the point where he sought medical treatment. Petitioner testified that the superintendent at Mair Petroleum, Gene Menard, recommended that he see Dr. Gregg Davis for his left shoulder pain. On November 10, 2009, Petitioner saw Dr. Davis, who believed he had a torn rotator cuff in his left shoulder. Dr. Davis then referred Petitioner to Dr. Paul Beck, a local orthopedic surgeon.

On November 13, 2009, Petitioner saw Dr. Paul Beck, who also believed Petitioner tore his left rotator cuff. Dr. Beck ordered a MRI of the left shoulder which showed a massive rotator cuff tear. Dr. Beck prescribed physical therapy, but Petitioner was unable to get it approved.

Petitioner testified that he last worked for Respondentin November 2009 and that he has never returned back to work for anyone. At that time he was taken off work by Dr Beck, per his records.

Petitioner eventually saw Dr. Komanduri for a medical examination recommended by his attorney, and Dr. Komanduri thereafter began treating Petitoiner. Dr. Komanduri diagnosed Petitioner with a massive rotator cuff tear of the left shoulder involving all four tendons with 5cm retraction of the muscle, a labral tear and a proximal biceps tendon repair. Dr. Komanduri recommended surgery but was very cautious about the possible outcome due to both the length of time that had passed without treatment and the severity and complexity of the tear itself. Dr.

Komanduri eventually performed surgery on his left shoulder by. After surgery, Dr. Komanduri recommended that Petitioner have physical therapy at the hospital in Ottawa, Illinois. Petitioner testified that he lives in Tiskilwa and it is approximately 40 miles one way to Ottawa, Illinois.

Petitioner testified that Dr. Komanduri released him from his care in December 2012 and restricted him from using his left arm. Petitioner testified that if he extends his left arm straight out in front of his body, he can only hold it for 30 seconds. He further testified that he cannot hold a newspaper out in front of him. He also testified that he cannot even lift his left arm above his shoulder. He further stated that his left shoulder is sore all the time and that even sleeping is difficult. He described the pain in his shoulder as being like a muscle spasm.

Petitioner testified that his left shoulder is 4 inches lower in height than the right shoulder. He also stated that his left biceps muscle is falling down off of his arm because it doesn't seem like it is attached.

After Petitioner had his left shoulder surgery and was released to return to work on restrictions, he requested that Respondenttake him back to work with light duty restrictions. He testified that Mair Petroleum refused.

Petitioner testified that in July 2013, he met with vocational specialist, Ron Malik, to determine his employability.

In August 2014, Petitioner saw Dr. Robert Eilers, who performed an independent medical examination.

Petitioner testified that he returned to see Dr. Komanduri in 2016 because of his ongoing left shoulder pain, increased neck pain and not being able to use his arm. Dr. Komanduri prescribed more physical therapy. After receiving physical therapy, Petitioner testified that there was no improvement in his condition.

Petitioner also testified that his daily activities consist of doing just little things around his house in the country, like carrying small buckets of corn and water for his wildlife. He further testified that he does not use his left arm for any kind of weight. Just the weight of his left arm causes him pain when he goes for a walk. The only thing he can do to help with the pain is to hold his left arm close to his body.

Dr. Gregg Davis - Records (PX. 2)

On November 10, 2009, Petitioner saw Dr. Gregg Davis and gave him this history of injury:

> "unloading oil when he was up on a ladder, ladder slid away, had a hose over shoulder L. Felt a tear in L shoulder. Getting worse. This happened July 24, 2009."

Dr. Davis examined Petitioner's left shoulder and elicited pain in the posterior aspect of his shoulder. Petitioner's range of motion was limited in all planes. Dr. Davis diagnosed the condition as shoulder pain and to rule out rotator cuff tear, Dr. Davis referred Petitioner to Dr. Beck, an orthopedic surgeon. Dr. Davis placed Petitioner's left arm in a sling and took him off-work.

Dr. Paul Beck - Records (PX. 3)

On November 16, 2009, Petitioner saw Dr. Paul Beck, an orthopedic surgeon, for his left shoulder pain. Petitioner gave a history that on July 24, 2009, while working as a truck driver, he was pulling a hose from a delivery truck when his ladder slipped and he fell injuring his left shoulder.

Dr. Beck performed a physical examination and found limited range of motion, weakness and pain in Petitioner's left arm. Dr. Beck ordered a MRI of the left shoulder and took Petitioner off-work.

On December 2, 2009, Petitioner followed up with Dr. Beck for his left shoulder condition and Dr. Beck reviewed the MRI which showed a complete tear of the rotator cuff and 5cm of medial retraction.

Dr. Beck recommended that Petitioner see a shoulder specialist and Dr. Beck continued to restrict Petitioner from work.

Dr. Mukund Komanduri - Report (PX. 4)

On March 17, 2010, Dr. Mukund Komanduri performed an Independent Medical Evaluation on Petitioner. Petitioner gave a history of falling ten feet and landing on his left shoulder and immediately experiencing left shoulder pain. Petitioner complained that he could not elevate his arm and that his shoulder pain became more severe as time went on. Dr. Komanduri noted that there was a delay in medical treatment between July 2009 and November 2009.

Dr. Komanduri reviewed the MRI film of Petitioner's left shoulder taken on November 25, 2009, which showed a massive rotator cuff tear involving all four tendons. Dr. Komanduri concluded that Petitioner had an injury at work and whether the rotator cuff tear was pre-existing or substantially worsened by the fall, there was no question that he was aggravated to the point that his shoulder is no longer bearable or comfortable. Dr. Komanduri concluded that further treatment was necessary, such as surgical repair most likely with the use of a patch.

Dr. Mukund Komanduri - Deposition (PX. 5)

On July 22, 2011, Dr. Mukund Komanduri testified at his deposition that he is board certified in orthopedic surgery and has treated patients with torn rotator cuffs. He further testified that he performs Independent Medical Evaluations which comprise less than three (3) percent of his practice. Dr. Komanduri also stated that eighty-five (85) percent of the IME's he performs are for defense and approximately ten (10) to fifteen (15) percent are for the plaintiff.

On March 17, 2010, Petitioner gave a history of falling ten feet and landing on his left shoulder. He immediately experienced left shoulder pain and had difficulty elevating his arm. As time went on, the shoulder pain became more severe. Dr. Komanduri noted that there was a delay in medical treatment between July 2009 and November 2009.

Dr. Komanduri reviewed a MRI of the Petitioner's left shoulder taken on November 25, 2009, which showed a fairly massive rotator cuff tear involving all four tendons. He also noted a fairly substantial inflammatory process which would indicate that it was more likely recent trauma rather than an old trauma. Dr. Komanduri noted that petitioner passed D.O.T. to be a truck driver and that he delivered bulk oil, climbed ladders, pulled hoses up to trucks, so it would not make sense that he had any prior left shoulder problems.

On examination of Petitioner's left shoulder, Dr. Komanduri found the deltoid mass was preserved, which would not have been the case if this was a chronic rotator cuff tear. According to Dr. Komanduri, a chronic rotator cuff tear such as Petitioner sustained would lead to deltoid atrophy as well as significant shoulder arthritis and proximal migration of the humeral head, none of which was present when he examined Petitioner. Dr. Komanduri also noted that

petitioner had weakness of his supraspinatus and infraspinatus and clearly had no functional overhead strength.

Dr. Komanduri testified that his findings undermined the Responddent's IME doctor's position that this was a chronic injury. Dr. Komanduri expressed the opinion that there was a direct causal connection between Petitioner's left shoulder rotator cuff tear and his falling ten feet and landing on his left shoulder.

Dr. Komanduri recommended that surgery be performed on the left shoulder with some sort of graft. Dr. Komanduri also opined that Petitioner could end up needing a shoulder replacement in the future.

Dr. Komanduri believed that Petitioner essentially had no use of the affected arm and was one-handed. 25 pound weight limit and no overhead work.

On cross-examination, Dr. Komanduri testified that you cannot date a rotator cuff tear with a MRI. He did indicate that if you look at the soft tissue mass and don't see a process called fatty infiltration, which is an indication of an old rotator cuff tear, it is another indication that the tear is of fairly recent origin.

Dr. Komanduri - Records (PX. 6)

On November 9, 2011, Petitioner saw Dr. Komanduri for evaluation of his left shoulder. Dr. Komanduri recommended rotator cuff repair with the use of an artelon patch and restricted him from work.

On November 21, 2011, Dr. Komanduri rechecked Petitioner's left shoulder and cautioned him that the surgery would not give him overhead motion.

On December 22, 2011, Dr. Komanduri performed left shoulder arthroscopy with mini-open rotator cuff repair with application of artelon patch as well as a labral repair.

On January 6, 2012, Petitioner presented to Dr. Komanduri for recheck of the left shoulder. Dr. Komanduri's notes indicate that the massive rotator cuff was repaired and that a labral tear required repair as well. Dr. Komanduri ordered Petitioner to start therapy three times a week for four weeks. Dr. Komanduri also restricted him from work.

On March 9, 2012, Petitioner returned to Dr. Komanduri for a recheck of his left shoulder. Dr. Komanduri was pleased with the range of motion Petitioner had in almost every plane, however, it was noted that he had endurance and strength deficits.

On April 9, 2012, Dr. Komanduri re-evaluated Petitioner's left shoulder. Petitioner had an aggravation during physical therapy when he used a band. Dr. Komanduri noted that this was a four tendon massive rupture that had to be handled with care. Dr. Komanduri ordered physical therapy consisting of high repetitions with no weights or bands.

On May 9, 2012, Petitioner returned to see Dr. Komanduri, who indicated that he had a minor setback about six weeks ago when he was a little bit overactive and had some tendinitis and inflammation that had gotten better. Dr. Komanduri indicated that this was a full tendon rupture and was a very complex surgical reconstruction.

On June 11, 2012, Petitioner complained to Dr. Komanduri that he was having deep pain in the shoulder and was having difficulty sleeping at night. Dr. Komanduri noted that he has some strength deficits.

On August 10, 2012, Petitioner saw Dr. Komanduri for re-evaluation. Dr. Komanduri found him to be at maximum medical improvement and put him on a 10 pound weight limit with no use of the left arm above shoulder height. The 10 pound weight limit was with both hands.

On October 19, 2012, Petitioner saw Dr. Komanduri because of decreased range of motion and left shoulder pain. On examination, Dr. Komanduri found his shoulder to be quite swollen and tender with an area of spasm. Dr. Komanduri ordered one more month of physical therapy.

On December 3, 2012, Petitioner saw Dr. Komanduri because he continued to have muscle spasms and soreness. Dr. Komanduri concluded that his left arm was completely disabled.

On April 6, 2016, employee returned to Dr. Komanduri and reported that his neck hurt and that he has tenderness from his shoulder and into his neck. Dr. Komanduri indicated that the reconstruction of his rotator cuff was a failure and concluded that Petitioner has no function in the left arm. He cannot elevate it. He cannot abduct it. He cannot externally rotate it. It is a useless limb and he has been permanently disabled as a result of inadequate care and treatment. Dr. Komanduri recommended a reverse shoulder replacement surgery. On the work status report for April 6, 2016, Dr. Komanduri indicated "**permanently disabled. Off work.**"

AmSurg Surgery Center - Records (PX. 7)

On December 22, 2011, petitioner was admitted to the AmSurg Surgery Center with the preoperative diagnosis:

"PREOPERATIVE DIAGNOSIS
1. Complex chronic tear of rotator cuff.
2. Extensive tearing of the superior and anterior labrum.
3. Extensive bursitis and subacromial impingement."

During surgery, Dr. Komanduri noted that "**The patient's rotator cuff tear was massive and was amongst the most complete circumferential tears I have ever seen.**" The operative procedure was mini-open rotator cuff repair of all four tendons with artelon patch.

Malik & Associates - Vocational Consultants - Report (PX. 8)

On July 29, 2013, Ron Malik, a vocational consultant, performed a vocational analysis of Petitioner's employability.

Ron Malik reported that Petitioner was functioning at a limited sedentary/light physical demand level and cannot return to the position of truck driver.

In regards to employability, Ron Malik determined that Petitioner was capable of performing one arm work. However, one arm work, such as an usher or attendant requires the ability to stand on their feet for long periods of time. Due to a foot condition, Petitioner is unable to stand on his feet for any length of time. Ron Malik concluded that Petitioner was unemployable.

Dr. Mukund Komanduri - Report (PX. 9)

On August 25, 2014, Dr. Komanduri prepared an Independent Medical Evaluation report and found that Petitioner had permanent disability for any use in his left arm. Dr. Komanduri noted that he has no strength and no function in his left arm and is unable to lift over the head safely or stabilize his left arm.

Dr. Robert Eilers - Deposition (PX. 10)

On March 21, 2014, Dr. Robert Eilers testified at his deposition that he is board certified in physical medicine and rehabilitation and that in addition to treating patients, he performs independent medical evaluations.

On November 18, 2013, Petitioner gave Dr. Eilers a history of climbing up a step ladder to put oil back in a storage tank when the ladder started to fall, which caused him to hit the cement floor. Petitioner sustained a contusion over his right eye, contusions to his right knee and his left shoulder felt like it had been cut.

Dr. Eilers performed a physical examination of Petitioner's left upper extremity and it showed that his left biceps reflex was diminished and his grip strength on the left side was diminished. He also had atrophy in his biceps muscle, the deltoid muscle and the triceps muscle. Petitioner also had significant pain in the left shoulder as well as limited internal range of motion.

Dr. Eilers expressed his medical opinion that as a result of Petitioner's fall, he sustained significant injury to his left rotator cuff and lost function for the upper extremity and also had a mild traumatic brain injury.

Dr. Eilers testified that Petitioner has permanent disabilities and cannot return to work as a truck driver since he has lost the use of his left upper extremity.

Dr. Eilers further testified that due to Petitioner's age, lack of employment skills and his physical limitations, petitioner was basically totally disabled from competitive employment.

Perry Memorial Hospital - Records (PX. 11)

On November 25, 2009, Petitioner presented to Perry Memorial Hospital for a left shoulder MRI. The radiologist's impression was:

"Complete tear of the rotator cuff with 5 cm medial retraction.
Joint effusion with fluid in the subcoracoid bursa. There is also fluid within the biceps tendon sheath.
Degenerative changes acromioclavicular joint."

OSF St. Elizabeth Medical Center - Records (PX. 12)

On January 17, 2012, Petitioner, who lives in Tiskilwa, Illinois, was ordered by Dr. Komanduri to receive physical therapy for his left shoulder at OSF St. Elizabeth Medical Center in Ottawa, Illinois.

Petitioner began his physical therapy on January 19, 2012 and received therapy three times a week. He was discharged from physical therapy on August 9, 2012, when his progress seemed to have reached a plateau.

On November 6, 2012, Dr. Komanduri restarted physical therapy because of Petitioner's increased pain and lack of motion in the left shoulder. He ordered physical therapy three times a week for four weeks. On December 3, 2012, Petitioner was discharged from physical therapy.

Employer Surveillance CD (RX. 4)

On May 10, 2016, Respondentconducted surveillance of Petitioner, which showed him carrying a small bale of straw on his right shoulder. He also was seen using his right arm to move a sheet of building material in order to open a door with his right hand.

The video also showed Petitioner walking and carrying another small bale of hay with his right arm, which he threw with his right arm.

Petitioner was also seen reaching to the ground with his right arm to pick up objects. He was also seen briefly carrying a broom with his right arm.

The video demonstrates that Petitioner used his left arm very minimally.

18IWCC0247

CONCLUSIONS OF LAW

The Arbitrator adopts the above findings of material fact in support of the following conclusions of law:

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?

On July 24, 2009, Petitioner was working as a delivery driver for Respondentand was returning back to the warehouse where he was going to pump oil out of his truck and into a storage tank. Petitioner testified that he climbed up a step ladder with an industrial size hose strung across him so he could pump the oil back into the storage tank. As Petitioner was attempting to put the hose down into the bottom of the tank, his ladder started to slide and he landed face first on the concrete floor. When Petitioner was able to stand up, he immediately noticed that he had a bump on his forehead, had a bump on his knee and he couldn't lift up his left arm. He then reported his accident to the company secretary, who helped clean him up and then he reported his accident to his boss, Gene Menard.

With regard to the issue of accident, the Arbitrator finds Petitioner has met his burden of proof. Petitioner's testimony that he injured himself when he attempted to pump oil into a storage tank is credible and uncontested and supported by every history he gave to numerous medical treaters in this case and is consistent with the history contained in the medical records. The Arbitrator also finds significant, the fact that Petitioner immediately notified his supervisor of his accident. Again, no evidence was adduced rebutting this testimony or the medical histories. Wherefore, the Arbitrator finds Petitioner has proved that he sustained an accident arising out of and in the course of his employment on July 24, 2009.

F. IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

On July 24, 2009, Petitioner climbed up a step ladder to pump oil into a storage tank when his ladder started to slide, causing him to fall and strike the concrete floor. He immediately experienced pain in his left shoulder and noticed that he could not lift his left arm.

Petitioner testified that he did not seek medical treatment immediately because he was concerned about possibly losing his job if he did seek medical care. Petitioner testified that he continued to work by keeping his left arm close to his body and by taking over-the-counter pain medication on a daily basis.

On November 10, 2009, Petitioner saw Dr. Gregg Davis and gave him a history of being injured on July 24 2009, when the ladder he was on slid away. Dr. Davis diagnosed Petitioner's with shoulder pain and to rule out a rotator cuff tear, Dr. Davis referred Petitioner to Dr. Paul Beck, an orthopedic surgeon.

On November 16, 2009, Petitioner saw Dr. Beck who ordered a MRI of his left shoulder. The MRI showed a complete tear of the rotator cuff and 5cm of medial retraction. Dr. Beck recommended that Petitioner see a sports medicine orthopedic surgeon.

On March 17, 2010, Dr. Mukund Komanduri, an orthopedic surgeon, performed an Independent Medical Evaluation on Petitioner. Dr. Komanduri examined Petitioner's medical records as well as the left shoulder MRI and concluded that Petitioner had a work accident and whether the rotator cuff tear was pre-existing or substantially worsened by the fall, there was no question that Petitioner was aggravated to the point that his shoulder was no longer bearable or comfortable.

On November 18, 2013, Dr. Robert Eilers performed an independent medical examination at the request of Respondent on Petitioner and he concluded that Petitioner's fall caused a significant injury to his left rotator cuff, found causal connection and stated that the medical care Petitioner received was appropriate.

On December 10, 2009, Respondent had Petitioner examined by Dr. Michael Nogalski, an orthopedic surgeon whose CV indicates that his practice is primarily centered on knee issues. Dr. Nogalski found that Petitioner's shoulder injury was likely of long standing nature and that Petitioner could not have functioned from July of 2009 to November of 2009 with such an injury, and therefore found no causal connection to the accident claimed herein.

The Arbitrator, after carefully considering all of the evidence in this case, finds that Petitioner has proven by a preponderance of the evidence that his present condition of ill-being is causally related to this injury. The Arbitrator notes in particular the well reasoned opinions of the treating physician Dr. Komanduri and notes the opinion of Respondent's own examining physician, Dr. Eilers as well.

J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?

The Arbitrator adopts his previous findings for disputed issues (C) and (F). Petitioner submitted into evidence, various medical expenses and reimbursement claim. The Arbitrator, after carefully considering the testimony of the various witnesses as well as the medical records and depositions, finds the following medical expenses are reasonable and necessary:

	Awarded
PX. 13 Dr. Gregg Davis	$93.00
PX. 14 Prescriptions	

(Reimbursement to petitioner)	$290.85
TOTAL	$383.85

The Arbitrator, therefore, orders Respondentto pay $383.85 in accordance with Section 8(a) of the Act, subject to Section 8.2 Medical Fee Schedule and as set forth in the medical records attached hereto. Respondentis entitled to credit for any payments made under Section 8(j) of the Act.

K. WHAT TEMPORARY BENEFITS ARE IN DISPUTE? TTD? MAINTENANCE?

Petitioner claims that from November 10, 2009 through July 29, 2013, a period representing 192-6/7 weeks, he was entitled to receive weekly TTD benefits in the amount of $394.49.

Additionally, Petitioner claims that from July 30, 2013 through November 28, 2016, a period representing 173-3/7 weeks, he was entitled to receive weekly maintenance benefits in the amount of $394.49.

On July 24, 2009, Petitioner was claiming a step ladder with an industrial size hose strung across him when his ladder started to slide, causing him to fall face first on the concrete floor. Petitioner testified that he not receive any medical treatment right away because of his concern over losing his job.

On November 10, 2009, Petitioner saw Dr. Gregg Davis for his left shoulder pain and Dr. Davis immediately took him off-work since he believed Petitioner had a torn rotator cuff on his left shoulder.

On November 13, 2009, Petitioner saw Dr. Paul Beck, an orthopedic surgeon, who ordered a MRI of the left shoulder and also took him off-work.

On December 2, 2009, Dr. Beck reviewed the MRI which showed a complete tear of the rotator cuff. He referred Petitioner to a shoulder specialist and continued to restrict him from work.

On March 17, 2010, Petitioner saw Dr. Mukund Komanduri, who opined that Petitioner had a massive left rotator cuff tear from his work accident was in need of surgical repair.

On July 22, 2011, Dr. Komanduri testified at his deposition that Petitioner was in need of a left shoulder surgery with the use of a graft. Dr. Komanduri believed that Petitioner essentially had no use of his left arm.

On December 22, 2011, Dr. Komanduri performed left shoulder arthroscopy with mini-open rotator cuff repair with application of artelon patch.

On January 6, 2012, Dr. Komanduri ordered Petitioner to begin physical therapy three times a week.

On August 10, 2012, Petitioner saw Dr. Komanduri for re-evaluation. Dr. Komanduri found him to be at maximum medical improvement and put him on a 10 pound weight limit with no use of the left arm above shoulder height.

Petitioner testified that Respondent did not return him to back to work.

On October 19, 2012, Petitioner saw Dr. Komanduri because of decreased range of motion and left shoulder pain. On examination, Dr. Komanduri found his shoulder to be quite swollen and tender with an area of spasm. Dr. Komanduri ordered one more month of physical therapy.

On December 3, 2012, Petitioner saw Dr. Komanduri because he continued to have muscle spasms and soreness. Dr. Komanduri concluded that his left arm was completely disabled.

On February 4, 2013, Petitioner, through his counsel, sent a letter to employer, Mair Petroleum's counsel, requesting that Petitioner be returned back to modified work:

> "Finally, your IME physician, Dr. Dru Hauter, stated that my client can safely return to work with restrictions of light duty, no lifting greater than 25lbs. and no work above the shoulders. Since my client was a delivery driver, I need to know if Mair Petroleum will modify his position so he can return to work or provide him with a position which pays a similar amount. My client is currently on Social Security Disability because of his work injury and willing to return to modified work."

Petitioner testified that his Respondent never returned him back to work.

On July 29, 2013, Ron Malik, a vocational consultant, performed a vocational analysis of Petitioner's employability and he concluded that he was unemployable.

On November 18, 2013, Dr. Robert Eilers performed an IME on Petitioner and opined that he had permanent disability and could not return to work as a truck driver.

Dr. Eilers also opined that due to Petitioner's lack of employment skills and his physical limitations, he was basically totally disabled from competitive employment.

On August 25, 2014, Dr. Komanduri prepared an IME report and found that Petitioner had permanent disability for any use of his left arm.

On April 6, 2016, Petitioner returned to Dr. Komanduri complaining that he had tenderness from his shoulder and into his neck. Dr. Komanduri indicated that the reconstruction of his rotator cuff was a failure and that Petitioner had no function in the left arm. Dr. Komanduri indicated that Petitioner was permanently disabled and off work.

Based on the above the the Arbitrator finds that Petitioner is entitled to TTD from September 9, 2009 through December 3, 2012, the date on which Dr. Komanduri found Petitioner to be at MMI, a total of 159-3/7 weeks. Respondent to receive credit for all sums previously paid for said periods.

With regards to maintenance, no job search or vocational rehabilitation was undertaken following Dr. Komanduri's finding of MMI, nor was vocational rehabilitation requested by Petitioner, and therefore the Arbitrator declines to award maintenance for the period requested by Petitioner.

/

L. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

The Arbitrator incorporates herein by reference thereto the findings set forth above. Petitioner testified that he has had a CDL since he was 18 years old and has worked primarily as a truck driver since that age. Until his work accident on July 24, 2009, he was able to perform his job of driving a truck without any difficulty. As a result of his injury at work, Petitioner testified that he has been unable to work since November 10, 2009. He was diagnosed with a massive rotator cuff tear that went untreated for 2 ½ years. Petitioner now has a total disability to his left arm as stated by his treating physician, and supported by the medical records and reports.

Respondent has work within any of the restrictions of any of the medical providers,k including it's own IME doctors and Petitioner has not worked since November 10, 2009.

Petitioner hired vocational specialist, Ron Malik, to determine his employability and Mr. Malik opined that Petitioner is unemployable. Respondent's vocational rehabilitation expert found that Petitioner was employable, but every job that was described in the report would have required the use of Petitioner's left arm. As such, the Arbitrator finds that the opinion of Mr. Malik is more credible and gives more weight to said opinion.

Dr. Robert Eilers, who performed an IME, testified that Petitioner has permanent disabilities and cannot return to work as a truck driver since he has lost the use of his left upper extremity. Dr. Eilers further testified that due to Petitioner's age, lack of employment skills and his physical limitations, Petitioner was basically totally disabled from competitive employment.

Dr. Komanduri, the treating orthopedic surgeon, last saw Petitioner on April 6, 2016, and he indicated that the reconstruction of his rotator cuff was a failure and that Petitioner had a useless limb. Dr. Komanduri declared him to be permanently disabled and off-work.

Petitioner testified that his daily activities consist of doing just little things around his house in the country. He further testified that just the weight of his left arm causes him pain.

Wherefore , based on the record as a whole, the Arbitrator finds Petitioner to be permanently and totally disabled as of the date that Dr. Komanduri found him to be at MMI, that is December 3, 2012.

O. OTHER - MILEAGE

Petitioner, who lives in Tiskilwa, Illinois, submitted at hearing, a claim for mileage expenses since he had to travel out of town to attend physical therapy sessions at St. Elizabeth Medical Center in Ottawa, Illinois, as well as attending appointments with Dr. Komanduri in Joliet, Illinois. Petitioner testified that Dr. Komanduri recommended physical therapy at the hospital in Ottawa, Illinois. Petitioner traveled a total of 10,020 miles to attend these appointments. Using 56 cents per mile, which is the reimbursement rate for the State of Illinois, Petitioner's mileage reimbursement claim is $5,611.20.

The Arbitrator finds that Petitioner is entitled to reimbursement of $5,611.20 for his mileage expenses since Section 8(a) of the Illinois Workers' Compensation Act states that the

employer shall pay "physical, mental and vocation rehabilitation of the employee, including all maintenance costs and expenses incidental thereto."

STATE OF ILLINOIS	)	☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
	) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF MADISON	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

John DeAngelo,
Petitioner,

18IWCC0248

vs.

NO: 11 WC 47678

Dynegy Midwest Generation,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, statute of limitations and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 6, 2017, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 20 2018
o4/5/18
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0248

DeANGELO, JOHN
Employee/Petitioner

Case# **11WC047678**

DYNEGY MIDWEST GENERATION
Employer/Respondent

On 1/6/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.63% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

4463 GALANTI LAW OFFICES PC
GIAMBATTISTA PATTI
PO BOX 99
EAST ALTON, IL 62024

0299 KEEFE & DePAULI PC
NEIL A GIFFHORN
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

18IWCC0248

18IWCC0248

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

JOHN DEANGELO
Employee/Petitioner

v.

DYNEGY MIDWEST GENERATION
Employer/Respondent

Case # **11** WC **47678**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Collinsville**, on **April 21, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☒ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Exposure; Statue of Limitations; Date of Disablement**

18IWCC0248

FINDINGS

On **August 26, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment within the applicable statute of limitations period.

Timely notice of this accident ***was not*** given to Respondent.

Petitioner's current condition of ill-being ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$85,484.36**; the average weekly wage was **$1,643.93**.

On the date of accident, Petitioner was **66** years of age, ***married*** with **0** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**.

ORDER

The Arbitrator finds that the Petitioner has failed to prove that he filed his claim for benefits within the requisite statute of limitations period, and therefore that his claim is barred.

As such, no benefits are awarded.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

December 2, 2016
Date

JAN 6 - 2017

18IWCC0248

STATEMENT OF FACTS

This case involves a claim for hearing loss based on alleged noise exposure at work. The Petitioner testified: "I suffered hearing loss due to exposure to high frequency, high volume noise over the period of my employment. *I claim that it happened before OSHA came into being and hearing protection became available* (emphasis added)." He initially testified that this protection became available sometime around 1982, then indicated he wasn't sure when it became mandatory, but that it was either the late 1980's or early 1990's. He didn't wear hearing protection prior to that, but indicated he wore the hearing protection regularly thereafter.

The Petitioner was asked about his understanding of his hearing loss after hearing protection became mandatory, and testified: "I think it seemed to stabilize." He indicated that there was a lot more noise exposure before the hearing protection became available, and a lot less afterwards: "In the first, what, 10, 12 years, maybe more it was a lot more noisy. The jobs that I got were because of the design of the instrumentation, how it was installed and just my seniority in the job qualified me for more quiet location type jobs so the newer people got the dirty work." He indicated that he began to get the easier and less noisy jobs at some point, and he would have to go out and test running machines "once in a while but not as often as I was in the early days."

A few months prior to his retirement in 2011, the Petitioner indicated to plant safety director, James Reynolds, that he wished his health insurance covered hearing aids. He testified that Reynolds suggested he file a workers' compensation claim, so he completed the paperwork to do so, and obtained the most recent plant audiometric survey results. He also requested a copy of his yearly audiograms going back to 1982, but testified that the Respondent initially would not provide the audiograms because they were company property.

Petitioner began working for Respondent on 5/3/71 as a maintainer of all of the instrumentation and automation controls in the plant, and did this job for 40 years. The job required him to read schematics and blueprints and physically go to various pieces of equipment while they were running to diagnose/troubleshoot and make any needed repairs. He would address on average two or three machines per day, and the majority of his workday was spent in various places within the plant. He testified that "the plant" included the coal room, the water treatment facilities at the lake, and once in a while at the river pump house where water was pumped out of the river into the lake. A workshop was located behind the control room, and sometimes pieces of equipment would be brought to the workshop to be fixed. The Petitioner generally worked 8 hour shifts with a half hour lunch, but there was a three year period where he worked rotating 12 hour shifts. During that time, he said he worked "every job that was worked" because he was a group leader, and so he had to be where the mechanics and electricians were. He would get a ½ hour break for lunch, but any other breaks were dependent on the job requirements. He agreed that his job originally required him to move all over the plant to perform his work, but he was able to take the quieter jobs as he gained more seniority until his retirement in September, 2011.

In order to troubleshoot the machines, the Petitioner could remain at any given job site from 15 minutes to 8 hours. This included the fan room, which he described as being so loud he could feel the sound vibrate in his chest. It was too loud to communicate with co-workers unless you yelled, and this was the case with or without hearing protection. He indicated that conversations in the fan room were very short because it was just too hard to communicate. The Petitioner testified that you could carry on a conversation in the plant without removing the hearing protection, but in a place like the fan room there was simply too much mass of sound to deal with.

The Petitioner would be at the main turbine generators a minimum of a half day per week in the early years of his employment, and he always did it without hearing protection. By the time the protection was provided, that particular job was no longer necessary.

Petitioner testified that the noisiest area he worked in after he started wearing hearing protection was next to the boiler feed pump turbines, where he would replace the controls for the bottom ash removal system. He testified that this area had a higher pitched noise, while the fan room had a lower pitched noise. The Petitioner testified that in this area while using ear plugs his ears didn't ring, but it was still loud.

He testified that in the last three years of his employment he spent extensive time replacing the control systems for the ash disposal systems on site without shutting the system down. He noted these units were located three feet away from the boiler feed pumps. He testified: ". . . I was spending eight hours a day five days a week for several weeks at those locations while I was doing that programming for that control system." He did not testify regarding any exposure to noise occurring at that time while he was not wearing hearing protection.

With regard to hearing protection, the Petitioner testified that he regularly utilized two forms of hearing protection. These earplugs had noise reduction ratings from 33 (MAX) to 29 (3M E.A.R. Classic). Petitioner indicated he mainly used the 33 NRR style because they were the ones the Respondent had available in containers at the plant entrances. (see Rx1-4b). He testified that he only wore extra protection in the form of earmuffs on top of the plugs a few times. The MAX version was more comfortable than the other style that had squared ends, the E.A.R., but Petitioner also felt that they did not offer as much protection from high frequency noise.

On cross examination, the Petitioner testified that nothing unusual had specifically occurred on 8/26/11 in terms of noise exposure that led to him claiming that date as his date of disablement in this case, but rather that the date was about a week prior to his retirement, and that his hearing loss was cumulative.

Mark Bradley, the plant operation manager, testified on behalf of the Respondent. Prior to moving into this position, he had worked as a welder starting in 1992, then was a shift tech, then a group leader, a shift supervisor and then a training supervisor. While he had not worked in the Petitioner's control instrumentation field, he testified that he was familiar with the Petitioner's position and job duties, and the parts of the plant the Petitioner worked in. He agreed that the Petitioner's job required him to move throughout the plant to work on a variety of machines in different locations, and that some jobs would require him to be at a location for extended periods of time. Some areas of the plant are quieter than others, and Bradley testified that machines were not always running while being worked on, and sometimes machines would be moved to locations off the plant floor to be worked on.

Bradley testified that he was familiar with the average time the Petitioner and other workers spent in the fan room, and that while it may have been different prior to his time with the Respondent, during his time there he was not aware of any workers spending an entire shift in the fan room. The Respondent had provided hearing protection throughout Mr. Bradley's tenure with the Respondent, and he and most of the employees would utilize the protection on a daily basis. The MAX style foam devices were available in dispensers throughout the plant at entries to noisy areas. In certain jobs, Bradley testified that a manager would require dual hearing protection, which meant foam plus muffs, specifically in the fan room while two of the three fans were operational while the third was being worked on.

When cross examined, Mr. Bradley testified that he also experienced a sensation in his chest in the fan room due to the noise level. In general, Bradley would only wear foam hearing protection, unless he was in the fan room. The dual protection requirement was enforced during specific maintenance activities, but not so much during normal operations. Bradley testified that he listened to the Petitioner's testimony, and "nothing was inconsistent that I was aware of." He testified that the Petitioner was a very good employee. He agreed that there were times

that the Petitioner was under his supervision when Bradley worked as a shift supervisor and Petitioner was a group leader, and he was compliant with hearing protection to his knowledge. The control and repair rooms were significantly quieter than the rest of the plant.

A 7/19/11 report of Dr. McGrady at the Ear, Nose & Throat Institute of Southern Illinois (Px4) indicates Petitioner reported complaints of hearing loss, noting he did not wear hearing protection for the first 10 to 15 years of his forty career with Respondent. He also complained of some tinnitus. Audiogram testing indicated bilateral mixed hearing loss. Dr. McGrady stated: "His hearing was tested before I cleaned his ears. He has a minimal conductive hearing loss in the low frequencies. His biggest problem is mid to high frequency bilateral sensorineural loss. This is suspicious for noise-induced hearing loss. There also may be some aging effects, and he understands this." Following updated audiogram testing on 12/20/12, Dr. McGrady stated that audiogram testing showed a relatively unchanged, bilateral, high-frequency, sensorineural hearing loss with very minimal conductive component. He felt that this was most likely due to noise exposure and that the Petitioner would benefit from hearing aids. (Px4).

Petitioner presented the Respondent's June-July, 2006 Industrial Hygeine Survey as Px1. The Arbitrator notes that the decibel level ranges in the vast majority of the plant areas tested had a high level which exceeded 90 decibels. The fan rooms tested between 100 and 116 decibels.

Dr. Hullar, a board certified ear, nose and throat physician specializing in neurotology, was asked by the Petitioner to perform a records review and to determine if the Petitioner had suffered noise-related hearing loss. (Px7). He issued reports on 5/9/14 and 10/13/14. (Px6 & 7). Dr. Hullar also testified regarding this case on 11/24/15. (Px7). Dr. Hullar testified that, because OSHA only provides general standards for age related hearing loss through age 60, he was unable to opine specifically with regard to Petitioner's hearing loss after 2004 in terms of percentage of loss attributable to age versus noise. He was provided with the noted Industrial Hygeine Survey and Petitioner's audiometric testing results through 2012, and he also reviewed the Section 12 examination of Dr. Mikulec. He did not review Dr. Mikulec's deposition. (Px7).

Dr. Hullar testified that the Petitioner's audiometric testing results over time do not show a consistent gradual hearing loss, but rather show variability, and thus he determined Petitioner's baseline results at the start of his employment by extrapolation. For example, at 4,000 khz, testing from 1982 and 1988 showed what would be improved hearing at that level. Overall, there was less change over time on the right side versus the left, and he opined that the right side did not meet the criteria for noise-induced hearing loss, but could rather be explained by the aging process. He did opine that there was noise induced hearing loss on the left. (Px7).

Dr. Hullar testified that audiograms are inherently subjective, in terms of the examiner, the person subjectively responding, as well as variability in the testing equipment and environment. Because OSHA determinations regarding age-related hearing problems ends at age 60, which was the Petitioner's age in 2004, Dr. Hullar testified he could not give a definitive relationship of Petitioner's hearing loss and age after 2004, noting the Petitioner continued to work and be exposed to noise after 2004. (Px7).

Dr. Hullar was aware that the Petitioner used hearing protection, and testified that generally such protection should be "derated", i.e. that its actual hearing protection is about 75% of the published efficiency of the protection. He used an average 20 decibel protection in his calculations, and thus a 15 decibel derated protection rating. He did not have knowledge of the actual types of hearing protection the Petitioner used at work. (Px7).

On cross examination, Dr. Hullar agreed it is possible that all of the Petitioner's post-2004 hearing loss was due to age, but that this was unlikely given that he determined the prior noise exposure did contribute to his hearing

loss, and that that exposure continued after 2008. Asked about the discrepancy between the Petitioner's hearing on the left and the right, Dr. Hullar testified to scenarios where this could occur due to the direction of the noise, such as a truck driver with the driver's side window open to noise, or someone shooting where the firearm was closer to one ear than the other. (Px7).

Dr. Hullar agreed that his determinations of hearing loss in the Petitioner were at frequencies of 2,000, 3,000 and 4,000 cycles per second, and did not include 1,000 cycles per second. He also agreed that he had no knowledge of the specific time periods that the Petitioner was exposed to the various decibel levels listed in the Industrial Hygeine study. He agreed that the length of such exposure matters in determining if there is noise related hearing loss. Dr. Hullar testified that various medical conditions, such as diabetes and hypertension, can contribute to hearing loss, but that this was negligible in the Petitioner's case. Ultimately, Dr. Hullar testified that he was comfortable determining that the Petitioner has noise-related hearing loss based on the information he had available to review, but agreed that his conclusions would benefit from having more information. (Px7).

The Petitioner testified he was sent by the Respondent to Dr. Mikulec, who performed audiology testing, and the Petitioner believed he told him he wore hearing protection. Dr. Mikulec testified via deposition on 10/11/12. (Rx1). He is an associate professor of otolaryngology, with a specialty in otology and neurotology. The documentation he reviewed is noted in his 6/29/12 report (Rx2), and included Petitioner's audiograms going back to 1982, as well as a noise dosimetry analysis. This dosimetry analysis appears to document time-weighted noise averages that various Respondent employees were exposed to, some of which were indicated as having the same or a similar job as Petitioner. Dr. Mikulec indicated that the Petitioner reported that he began to wear hearing protection sometime in the 1980's, and that documents he reviewed indicated the Petitioner had no problems with using his ear protection devices. Dr. Mikulec opined that the Petitioner's initial 1982 audiogram testing reflected significant bilateral high-frequency sensorineural hearing loss was already present at that time. He also reported that, according to the dosimetry analysis, the noise dose the Petitioner was exposed to with the Respondent was within the allowable range even without ear plugs. (Rx1 & 2).

Dr. Mikulec agreed with Dr. McGrady questioning the possibility of Petitioner having noise induced hearing loss when he saw him, but that it did not appear that Dr. McGrady had dosimetry data available to him when he saw the Petitioner and issued his report. An audiogram performed via Dr. Mikulec reflected what he opined was mild loss at the 1,500 Hz level, and moderately severe to severe loss from 2,000 Hz to 8,000 Hz. (Rx1 & 2).

Dr. Mikulec's report indicated that Petitioner had suffered, per the Act's requirement of evaluation at the 1000, 2000 and 3000 Hz levels, 30% hearing loss on the right and 33% of the left. (Rx2). However, as noted, he opined that the Petitioner already had significant hearing loss by 1982 based on the audiometric testing at that time, and taking into account standard OSHA threshold shift calculations, the Petitioner had no hearing loss since 1982 beyond what would have been expected from aging. Dr. Mikulec opined that for any of the Petitioner's complaints of tinnitus to have been causally related to his work, there would have needed to be work-related hearing loss. (Rx1 & 2).

Dr. Mikulec evaluated the Petitioner on 6/29/12, and based on examination, he found no physical problems with the ear structures. Additionally, based on his review of the dosimetry documentation, he opined that the noise the Petitioner was exposed to at work was within allowable thresholds. Taking into account his use of ear protection, Dr. Mikulec opined that regardless of actual hearing loss, there thus was no impact on such loss by noise at work. (Rx1).

On cross exam, Dr. Mikulec indicated that both noise related and age related hearing loss would be very likely to be sensorineural in nature. He testified that the difference in Petitioner's hearing loss since 1982 between the

right and left ears was small. He testified that he did review the general Industrial Hygeine study in this case, but relied on the time-weighted average exposure documentation as opposed to the maximum exposure levels indicated in the Industrial Hygeine study. Additionally, he testified that, based on his findings of no noise related hearing loss since 1982, again relying on the OSHA standards of normal age related hearing loss over time, the actual noise exposure was "almost irrelevant." He had no knowledge of how long the Petitioner may have worked at various locations in the Respondent's facility other than the noted time-weighted average testing results. He agreed the Petitioner began his employment with Respondent in 1971. (Rx1). With regard to ear protection, Dr. Mikulec testified that he could not agree that there was a correction factor, 50% of the stated protection level or less, to be applied to such protection devices without reviewing any studies in this regard. He agreed that the Petitioner would benefit from the use of hearing aids. (Rx2).

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT; WITH RESPECT TO ISSUE (O), DID THE PETITIONER FILE HIS CLAIM WITHIN THE APPLICABLE STATUTE OF LIMITATIONS PERIOD / WAS THE PETITIONER EXPOSED TO AN OCCUPATIONAL DISEASE / DATE OF DISABLEMENT; and WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator believes that, based on the Occupational Diseases Act ("OD Act") and the case law in Illinois, the Petitioner failed to file a claim within the applicable statutorily required time period in this case. The Arbitrator finds that the Petitioner has sustained a noise exposure that would constitute an accident arising out of and in the course of his employment with the Respondent, but that this exposure ended as of the early 1990's, and he thereafter failed to file his claim within the applicable statutory limitations period of three years from the date of last exposure. Thus, while the Arbitrator believes that at least a portion of the Petitioner's hearing loss was due to his exposure to noise while working for the Respondent between 1971 and the early 1990's, the fact remains that he utilized hearing protection going back to the early 1990s at the latest. The Petitioner specifically testified that his claim was for noise exposure he had before hearing protection became available. After such protection became available, he testified that his hearing "seemed to stabilize". He testified that he wore the hearing protection regularly after it became available. He testified that he was exposed to significantly more noise prior to the use of hearing protection, and it was a lot less afterwards. He testified that as he gained seniority, he was exposed to less and less noise-involved jobs.

Pursuant to Section 1(f) of the Occupational Diseases Act, all claims for compensation must be brought within two years of the date of the last exposure. Pursuant to Section 6(d) of the Workers Compensation Act ("the Act"), a claimant must file a claim within 3 years from the date of accident. According to the Occupational Diseases Act, Section 6(c), the claim must be filed within 3 years from the date of disablement. According to case law in Illinois, the statute of limitations begins to run in a hearing loss case involving occupational exposure on the last date that the claimant was exposed to harmful noise levels. The date when a claimant begins to use hearing protection can reflect when a claimant's last date of exposure is, and thus the date when the Statute of Limitations begins to run. *Dresser Industries v. Industrial Commission*, 237 Ill.App.3d 150, 165, 604 N.E.2d 365, 374 (1992), citing *United States Steel Corp. v. Industrial Commission*, 132 Ill.App.3d 101, 477 N.E.2d 237 (1985).

According to Commission Rule 7130.10, the Commission shall use the rebuttable presumption that exposure to noise with an intensity of 90 decibels or more for 8 hours or its time weighted equivalent causes hearing loss, and exposure to noise below such level and time weighted equivalent does not cause hearing loss. Additionally, cases with a date of last exposure after 9/15/81 shall be determined pursuant to Section 8(e)(16) of the Act. Commission Rule 7130.20 indicates that audiometric testing must not be conducted before a claimant has been separated from the noise exposure for at least 16 hours.

Case law in Illinois indicates that the use of hearing protection can support the finding that a claimant was not subjected to noise at a level which exceeds the standards set out in WC Act Section 8(e)(16) and/or OD Act Section 7, and thus can establish a start date for the running of the applicable statute of limitations. See *Dresser Industries* and *United States Steel Corp*. While the Arbitrator believes that the case law indicates that this determination is a factual one within the discretion of the Arbitrator, here there has been no evidence presented that indicates the Petitioner's hearing protection was not working in the way it was intended. Instead, the Petitioner's testimony makes it pretty clear that the use of ear plugs significantly reduced the noise level the Petitioner had been previously subjected to.

Taking the testimony of Dr. Hullar with regard to assuming hearing protection works at about 75% of its rated protection range, the Petitioner's main ear plugs provided 24 to 25 decibels of relief. This hearing protection resulted in a net exposure to noise that does not appear to the Arbitrator to have fulfilled the statutory requirements of Section 7 of the OD Act and/or Section 8(e)(16) of the Workers' Compensation Act, at least after he began wearing ear plugs in the early 1990's. As such, the date of disablement occurred at least 11 years prior to the date the claim in this case was filed. Therefore, he has failed to timely file this claim, and the claim is barred as a result.

The opinions of both Dr. Hullar and Dr. Mikulec, with reference to the requirements of Illinois law as to both exposure and whether the Petitioner sustained hearing loss, each have their problems.

The problem with the opinions of Dr. Hullar are that they were based on a significant number of assumptions. While he assumed that the Petitioner was subjected to the 100 to 115 decibels in the fan room area or areas, he testified that he had no specific knowledge as to the specific periods of time the Petitioner was so exposed. He assumed that the Petitioner wore hearing protection rated at 20 NRR which, based on his testimony, would be "derated" to 15 NRR in the field versus the lab. This does not take into account that the Petitioner testified that the ear plugs he used most often were noted to block 33 decibels of noise. Based on his testimony that ear protection actually only provides 75% of the stated laboratory rating, the ear plugs would have provided 24.75 decibels of protection, not 15 decibels, which is a significant difference in exposure in this case given Illinois law. Dr. Hullar opined that the Petitioner had noise induced hearing loss in the left ear, but could not testify that the loss of hearing in the right ear was anything other than what would be due to his age. In explaining how this could occur he referenced a fireman with the left ear at the window closer to a siren and a soldier firing a gun that rests on one shoulder. However, he agreed he had no information with regard to the Petitioner's left ear being subjected to increased noise over the right ear in the workplace. Thus, it makes no sense, barring other evidence, that the Petitioner would only have noise-related hearing loss in one ear.

Dr. Hullar also determined hearing loss at the 2,000, 3,000 and 4,000 khz levels, when the Act requires the determination to be made at the 1,000, 2,000 and 3,000 khz levels. Because the audiometric testing he reviewed varied instead of showing a smooth, gradual decrease of hearing over time, he determined a baseline that differed from the actual initial audiometric testing results. He also determined that at least one audiometric testing result be thrown out because it did not fit the pattern he felt was occurring. Dr. Hullar acknowledged that there is not only a subjective element to audiometric testing based on the responses of the person being tested,

but also acknowledged that discrepancies could exist based on the hardware being used to test as well as the testing environment.

The Arbitrator agrees in noting that the results of Petitioner's audiometric testing over the years has been significantly variable, as noted by Dr. Hullar. The audiometric testing results over time appear to go up and down very often. Several entries of these testing results also state that testing was performed less than 16 hours after the last industrial noise exposure. This calls into question the credibility of the audiometric testing results, whether due to the lack of time passage after last noise exposure, problems with the testing equipment, etc.

The problem with Dr. Mikulec's opinions in this case, most importantly, are that they are based only on time weighted averages of noise exposure throughout the workday for other Respondent workers. Such averages do not exclude the possibility, for example, that the Petitioner may have been exposed to 110 decibels for a half hour or 115 decibels for 15 minutes, which would result in a compensable exposure. While he testified that he did review the industrial Hygeine survey, it is clear to the Arbitrator that he did not take into account the specific potential exposures the Petitioner faced as noted therein. While the Petitioner's attorney referenced OSHA statements which indicated that there would be variations of 50% versus the stated levels of protection on ear plugs, Dr. Mikulec disputed having any knowledge of studies which reflected this, and he did not take into account that hearing protection may not provide 100% of the level indicated in their packaging. Dr. Mikulec also relied on his determination that the Petitioner had already sustained significant hearing loss by 1982. This appears to have been based on the initial 1982 audiometric testing performed by the Respondent. However, this doesn't take into account that this baseline may not have been correct given the variety of findings that occurred on subsequent audiometric testing.

The Arbitrator thus believes that neither doctor has provided a very solid opinion with regard to whether the Petitioner was exposed to sufficient noise to cause industrial hearing loss, or whether any of the hearing loss was noise versus age related. This makes it very difficult for the Arbitrator to make a valid determination of this issue, as it is an issue that clearly requires expert testimony and/or opinions.

This case simply leaves too many "ifs" out there for the Arbitrator to find the case compensable based on the preponderance of the evidence. Even giving the Petitioner the benefit of the doubt as to the start of his use of ear plugs, the evidence reflects that the Petitioner would have needed to file his claim by the late 1990's at the latest. As the Petitioner did not file his claim until 2011, the Statute of Limitations had expired. The Petitioner must prove exposure of 90 decibels for eight hours or greater, or its time weighted equivalent, under Section 8(e)(16)(f) of the Act, and this minimum exposure after the early 1990's is just not supported by the evidence in the record. Petitioner has failed to prove entitlement to benefits under the Occupational Diseases Act as well as the Workers' Compensation Act. As a result of this finding, the Arbitrator finds that all other issues are moot.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's findings above, this issue is moot.

WITH RESPECT TO ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's findings above, this issue is moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF LaSalle)

☒ 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

Marsha Perez,

Petitioner,

vs. NO: 16WC 8043

Andy Skoog, LaSalle County Circuit Clerk's Office, 18IWCC0249

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical, notice and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 3, 2017, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

18IWCC0249

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 24 2018

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MJB/jrc
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Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

PEREZ, MARSHA
Employee/Petitioner

Case# **16WC008043**

ANDY SKOOG LaSALLE COUNTY
Employer/Respondent

18IWCC0249

On 7/3/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1097 SCHWEICKERT & GANASSIN LLP
SCOTT J GANASSIN
2101 MARQUETTE RD
PERU, IL 613524

0263 HERBOLSHEIMER DUNCAN EITEN
WILLIAM HINTZ
PO BOX 539
LaSALLE, IL 61301

STATE OF ILLINOIS)
)SS.
COUNTY OF LaSalle)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Marsha Perez,
Employee/Petitioner

v.

Andy Skoog, LaSalle County Circuit Clerk's Office,
Employer/Respondent

Case # **16** WC **8043**

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 **Robert Falcioni**, Arbitrator of the Commission, in the city of **Ottawa**, on **May 24, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [x] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [ ] 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 _____

18IWCC0249

FINDINGS

On the date of accident, **October 23, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned **$28,437.68**; the average weekly wage was **$546.88**.

On the date of accident, Petitioner was **47** years of age, ***married*** with **0** dependent children.

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**.

Respondent is entitled to a credit of **$425.52** under Section 8(j) of the Act.

ORDER

Respondent shall be given a credit of $425.52 for medical benefits that have been paid, and Respondent shall hold the petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act. Another $360.00 is reported as paid in Petitioner's Exhibit 1 but not reflected as so by Respondent. If paid, Respondent shall be credited the same at the Medical Fee Schedule and, if not, it shall provide payment for the same in addition to the bills ordered to be paid under Section 8(a).

Respondent shall pay reasonable and necessary medical services of $4,743.32 (Petitioner's out of pocket expense of $40.00 to Methodist Rehabilitation Services (Dr. Szymke) and Orland Park Orthopedics for $4,703.32), as provided in Sections 8(a) and 8.2 of the Act.

Pursuant to Section 8(a) of the Act, the Respondent shall provide direct and ancillary reasonable and necessary treatment related to Petitioner's bilateral carpal tunnel and cubital tunnel conditions, including surgery and physical therapy.

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.

18IWCC0249

Robert E Ahern
Signature of Arbitrator

June 9, 2017
Date

ICArbDec19(b)

JUL 3 - 2017

FINDINGS OF FACT 18IWCC0249

16 WC 8043

Marsha Perez, the Petitioner in this matter, on October 23, 2015, was employed by the Respondent, Andy Skoog, LaSalle County Circuit Clerk's Office. The Petitioner testified she remains employed with the LaSalle County Circuit Clerk's Office and now has been for 9 years.

At the hearing, Ms. Perez testified that she was 47 years of age, 5'3" in height, 145 pounds in weight and a non-smoker. The Petitioner testified to experiencing no known metabolic, weight or issue of any type with her elbows or hands prior to the present claim.

The Petitioner testified that she has been a file clerk with the Respondent for nine years. During the last seven years, she worked at the LaSalle County Circuit Clerk's Etna Road facility where criminal matters are addressed. The Petitioner described working the initial first two years of her career with the Circuit Clerk's Office at the downtown LaSalle County Courthouse where civil matters are heard. Comparing the work levels of the Circuit Clerk Offices, she described a low level of activity at the downtown Ottawa courthouse while the criminal facility on Etna Road is very active.

She further explained her job and indicated that for the last seven years at the LaSalle County Circuit Clerk's Office, criminal section she is busy all day. She reports her hands and arms as being in constant motion. Her typical day consists of receiving ticket packets issued by police officers. The tickets typically have four or five sheets to each packet. Rx 4. The Petitioner processes these packets in her office with all the information on the ticket being typed into a computer file, the bottom tab of the tickets is then torn off at the perforation by the Petitioner gripping the bottom of the ticket below the perforation with one hand and the other hand would grab the top of the ticket above the perforated area. She would then pull the opposite direction to

separate each of the four or five pages of the ticket. The ticket pages are then placed in a file jacket with one of the tickets being placed on a patch. A patch is a sheet that contains barcodes. The Petitioner, with a thin sheet of cardboard containing barcodes, quickly takes individual numbers out of rolls of self-stick numbers placed at her desk where she then uses one hand to pull on the number and the other hand to stop the roll from continuing to flow. Ms. Perez then takes the number and quickly places the numbers on the file to create the case file for an individual defendant. The Petitioner demonstrated her repetitive bilateral hand and arms movement experienced throughout her work day and the Arbitrator observed same. These demonstrated continuous flexion and extension of her hands, wrists and arms at a work station that could be modified for typing but the possible modifications did not appear to effect her core job duties of upper extremity gripping, twisting and pulling.

The Petitioner explained both of her hands are in operation at all times while performing her work. Ms. Perez reports doing this during her entire eight-hour shift. The only deviation from preparing files was for a half hour, typically at the end of the day, when she would switch with a co-employee and review the files created during the earlier part of the day. In that instance, she would quickly examine by hand and review the various parts of the file for quality control and accuracy.

Marsha Perez testified that on or about October 23, 2015, she reported upper extremity pain and discomfort she was then experiencing to her supervisor, Cathy Damann. Ms. Perez explained these symptoms had started in approximately January of 2015 and did not improve. She reports symptoms in both hands initially were intermittent but gradually worsened so that they were constant and included numbness and tingling throughout her hands and the right arm at the elbow. The Petitioner did not recall if her supervisor did an incident report at that time. On

or about the same day, October 23, 2015, Ms. Perez visited her family physician, Dr. Ricardo Calderon. PX.5. She wanted to address her issues and get a better understanding of what the condition was.

The medical records of the Petitioner from Dr. Calderon of the IVCH Medical Group indicate that on October 23, 2015, the Petitioner complained of a tingling and numbing sensation involving both hands that typically awakens her each night. Id. Dr. Calderon wrote that if the Petitioner shakes her hands, her symptoms resolve. Id. Dr. Calderon performed an examination where he found the Petitioner had normal strength in the upper extremities but a Tinel's sign that was positive on the left but negative on the right. Id. He also recorded bilateral positive Phalen signs. Id. Dr. Calderon ordered blood testing. Id. His records reflect that if laboratory tests come back normal, he would then recommend a nerve conduction test of both hands as she possibly was experiencing carpal tunnel syndrome. Id.

The Petitioner reports that she next followed up with Dr. Calderon on or about November 4, 2015 after obtaining the laboratory results. Id. At that visit, Dr. Calderon referred her to Dr. Thomas Szymke, a physiatrist, for an EMG/NCV. Px 3.

On January 14, 2016, the Petitioner met with Dr. Thomas Szymke for an EMG/NCV. Id. Ms. Perez testified that when she met with Dr. Szymke, she explained her symptoms experienced in her upper extremities and described the pain could reach 9 out of 10. However, at this appointment, she rated her pain level as a 5/10 in both hands and wrists. Id. Marsha Perez testified she explained the type of work she performed for the Respondent to Dr. Szymke at this visit. His January 14, 2016 report, provides that in about January of 2015, Ms. Perez began to experience symptoms in both hands and wrists and that grasping, among other things, produced pain. Id. He wrote the Petitioner is employed by LaSalle County as a 47 year old file clerk and

has pain that bothers her while at work. Id. As of her January 14, 2016 visit, she had yet to try injections, therapy or braces. Id. She reports never having any prior trauma to her hands or wrists and, at that time, was not dropping things. Id. She further reported all of her fingers were feeling numb. Id.

Dr. Szymke recorded the Petitioner was being studied for complaints of bilateral nocturnal paresthesias. Id. The right hand is far more effected than the left. Id. Along with paresthesia, she has complaints of aching in her wrist. Id. Ms. Perez awakens up to four times a night. Id. She has no radiculer symptoms and she does not have a medical history of diabetes, thyroid or chronic kidney disease. Id. Ms. Perez has a positive Tinel and Phalen testing at each wrist over the median nerve. Id. There is also a positive Tinel at the right elbow with tapping over the ulnar nerve. Id.

Dr. Szymke's EMG/NCV study found definite and moderately severe carpal tunnel syndrome on the right with motor nerve involvement. Id. He explained his findings on the right were a poor prognostic sign for the entrapment responding to conservative means. Id. Dr. Szymke also reported Petitioner's left hand also experiences median latencies at the upper level of normal. Id.

After Dr. Calderon received the report of Dr. Thomas Szymke, Ms. Perez states she was referred to Dr. Robert Mitchell, an orthopedic surgeon. On January 26, 2016, Ms. Perez first visited with Dr. Robert Mitchell. Px 2. He wrote "..Marsha Perez is a 47 year old right handed female with a chief complaint of wrist pain involving both the left and right dorsal wrist of gradual onset. Id. She had been seen by Dr. Calderon who provided no medical treatment with the exception of diagnostic studies which included an EMG/NCV. Id. Ms. Perez has had no surgical procedures and she reports her problem being intermittently present for approximately

one year.." Id. Dr. Mitchell wrote the problem in each wrist is described as pins and needles associated with finger numbness and pain at a 5 out of 10 on an average day. Id. The pain worsens with movement and increases at night. Id. The Petitioner's complaints were more expansive during her examination. Id.

On January 26, 2016, an examination by Dr.Mitchell found bilateral carpal tunnel syndrome with decreased sensation of the median nerve distribution, abnormal two point discrimination on the median nerve and paresthesia of the D5 digit and the ulnar side of the D4 digit. Id. Her right elbow has a positive Tinel sign over the cubital tunnel with the right hand experiencing muscle weakness. Id. Dr. Mitchell reported the Petitioner demonstrated both right and left carpal tunnel syndrome. Dr. Mitchell also explained the Petitioner suffered from right cubital tunnel syndrome with a lesion of the ulnar nerve. Id. At this initial visit, the Petitioner was prescribed wrist bracing that provided immobilization with a cock up wrist splint until her next visit. Id. She was also provided a prescription of Etodolac, 500 mg. Id. Potential surgical intervention was discussed but not recommended at that time, as this depended on the progress of her condition. Id.

At the Petitioner's follow up visit of February 18, 2016 with Dr. Mitchell, he indicated Ms. Perez continued to experience numbness and tingling in both hands at night and an achy feeling during the day while at work. Id. Her pain averaged a 5 out of 10 and that cock up splint use at night provided little relief. Id. He also reported she was unable to get the Etodolac prescription filled. Id.

Dr. Mitchell re-examined both upper extremities at this appointment and continued with his diagnosis of bilateral carpal tunnel syndrome and right cubital tunnel syndrome. Id. His records reflect the Petitioner was to continue splinting and try Mobic. Id. It was noted that if

numbness continued or worsened, the Petitioner was to follow up and discuss probable surgical intervention. Id.

At her appointment of March 3, 2016, the Petitioner met with Dr. Mitchell. Id. He appeared to concentrate on the Petitioner's right upper extremity and indicated she suffered from carpal tunnel syndrome and cubital tunnel syndrome and discussed the surgical release of each. Id. This was the Petitioner's last visit with Dr. Mitchell.

The Petitioner testified to a gap in treatment following her March 3, 2016 visit with Dr. Mitchell. She reported involvement in an unrelated motor vehicle accident shortly thereafter. The Petitioner explained that she treated for spinal injuries with Dr. Blair Rhode and while treating with him for her auto accident, she began treating with him on September 1, 2016 for her right and left hands. Px 4. On this date, Dr. Rhode wrote Marsha Perez was complaining of bilateral wrist pain with numbness and tingling to the index and long fingers. Id. He reported the Petitioner's EMG on the right hand was positive while on the left it was borderline. Id. Dr. Rhode reviewed the Petitioner's job, following which, he described the same as highly repetitive and included a significant amount of ripping of tickets, filing and typing with an exposure of approximately eight years. Id. He also explained the Petitioner has no history of diabetes or thyroid dysfunction and is not pregnant. He noted a body mass index of less than 30%. Id. After his examination, he recommended a conservative course of treatment and injected the Petitioner's right carpal tunnel with a steroid. Id.

At the Petitioner's Dr. Rhode visit of September 15, 2016, he reported Ms. Perez continued to suffer from bilateral carpal tunnel complaints. Id. The steroid injection provided only temporary relief. Id. She continued to experience paresthesia in the distribution of the median nerve in both hands with nocturnal symptoms. Id. He noted the Petitioner attempted

home stretching of the effected limbs but she continued to experience work related bilateral carpal tunnel syndrome. Id.

Dr. Rhode's appointment notes of September 15, 2016 reflect the Petitioner's conservative treatment efforts included splinting, oral medications, home stretching and injections, of which all failed. Id. He reported the patient was unwilling to live with her current symptoms and wished to proceed with bilateral carpal tunnel surgery. Id. While awaiting permission from the Respondent, the Petitioner was allowed to remain at full duty employment. Id.

On January 5, 2017, Ms. Perez followed up with Dr. Rhode who wrote the Petitioner reported continuing symptomology nocturnally and expressed she continues to shake her hands to wake them up. Id. He reiterated braces, anti-inflammatories, home stretching, icing and injections did not help her condition. Id. She continues to experience work related bilateral carpal tunnel syndrome and continues to await surgical authorization. Id.

On February 16, 2017, the Petitioner again followed with Dr. Blair Rhode for her bilateral carpal tunnel syndrome. Id. He reported the Petitioner also continues to experience left lateral elbow pain as well. Id. He wrote the activity performed by the Petitioner with tickets is primarily driven by her left hand. Id. He reviewed her work activity with and wrote he understood her left hand moved with a flip and an external rotation maneuver throughout the day. Id. The Petitioner also demonstrated this same maneuver during her testimony and explained both hands required this movement throughout the work day.

The Petitioner had another follow up appointment on March 16, 2017. Id. At that visit, the Petitioner's symptomology continued. Id. The doctor explained he continues to seek

authorization for surgical intervention of this work related condition. Id. In the interim, he provided an injection of cortisone to the left elbow. Id.

Dr. Rhode during his April 6, 2017, noted the continuation of the bilateral carpal tunnel syndrome and left lateral elbow pain. Id. He also reported some improvement from the elbow injection. Id. At the Petitioner's follow up visit of April 13, 2017, she now reported bilateral elbow and wrist pain. Id. Dr. Rhode wrote the Petitioner's left elbow pain increased since the last visit. Id. He again reviewed the type of work performed by her and wrote the Petitioner suffers from work related bilateral carpal tunnel syndrome and lateral epicondylitis. Id. He requested surgical authorization to address each condition. Id.

The Petitioner's last visit with Dr. Rhode prior to the trial in this case occurred on May 11, 2017. At this visit, complaints of bilateral elbow and wrist pain continued. Id. The Petitioner's bilateral carpal tunnel syndrome was unchanged while the Petitioner's left elbow experienced some improvement since the last visit, but it remained an issue.Id. Her right elbow remained fully symptomatic. Id. Dr. Rhode continued to await surgical authorization as injections, bracing, oral medications, home stretching activity modifications have not cured the Petitioner.Id.

At the hearing in this matter, the Petitioner expressed her desire for bilateral hand and arm surgery. She reported ongoing complaints of pain and discomfort that occur continuously throughout her day while at work. She also continues to wake up from her sleep due to hand complaints.

Prior to her testimony, Ms. Perez reviewed a video that the Respondent introduced into evidence as Rx.7. This video, along with a job description, Rx.1, was created by OnCall Medical

Management Services, LLC. Marsha Perez explained that the person in the video is Diana LeBeau Gerber, Chief Deputy of the Circuit Clerk's Office. The Petitioner's direct supervisor is Amy Eitutis. In discussing the video, Ms. Perez explained the pace of her work, as depicted, is extremely slow and that if she were to perform at that level, it would take her a week to complete just one day's work.

Ms. Perez also testified she attended an IME established by the Respondent with Dr. Charles Carroll on October 7, 2016. At that appointment, Ms. Perez reports seeing Dr. Carroll for approximately five minutes. She explained Dr. Carroll asked in general about her job duties, her complaints of pain and examined her hands. During the same, he required her to hold her hands up and bent at the wrist with the palms facing him. He pushed back on her hands and further felt around her hands. She testified that was the full extent of the physical examination. Ms. Perez said Dr. Carroll told her he could not then provide her with an opinion as to whether her problems were work related as he first needed to see the job video.

Amy Eitutis next testified and indicated she is the Criminal Division office supervisor for the Respondent. She has been an employee of the Respondent for eleven years. During that time, she held the position of administration assistant for seven years and four years as a criminal office assistant. Ms. Eitutis indicated she is the direct supervisor of Ms. Perez and is familiar with her job description.

Ms. Eitutis explained the Petitioner receives tickets as they come in from arresting officers and her job is to then disassemble the tickets by hand and sort them. She adds patches to the main ticket, places other portions of the tickets into piles, runs the tickets through scanners, adds adhesive labels to file jackets the Petitioner creates and also completes limited data entry. When asked if the position is repetitive, Ms. Eitutis indicated it is "very much so". She also

viewed the job description created by the Respondent, Rx 5, and explained the same was not very specific as to the Petitioner's job duties and was only very general in nature.

This supervisor of the Petitioner also had the chance to review the job video, Rx 7, created by OnCall. Ms. Eitutis indicated the video demonstrated an incomplete depiction of the Petitioner's job. For the portion depicted, she explained the Petitioner's job was performed very slowly, probably one-quarter of the normal pace in which the Petitioner must work. On cross examination, Ms. Eitutis reported she also has her own pending worker's compensation claim where she alleges a repetitive work injury and that she is represented in that case by the same law firm that is representing Petitioner in the present case.

The Respondent called Diana LeBeau Gerber as a witness. Ms. Gerber explained she is the Chief Deputy for the LaSalle County Circuit Clerk's Office and is generally located at the downtown Ottawa, Illinois facility. She reported being friends with the Petitioner. She also testified to creating Respondent's Exhibit 5, a general job description for the Petitioner. Ms. Gerber testified the description does not explain the physical motions of the Petitioner nor is it detailed. This witness also testified that although she was the person in the video, Rx 7, she was asked to be in the same by OnCall.

On cross examination, Ms. Gerber agreed she is not aware of the Petitioner ever having any physical issues before the date of accident. She also agreed the Petitioner is a good, fast worker that performs her job quickly all day, every day. Ms. Gerber testified the video doesn't show all of the Petitioner's activities and is only a general overview that does not represent the actual speed of the work performed. She explained that an OnCall representative asked her to demonstrate in the video only the general activities of the job. She also reports viewing a job description prepared by OnCall and felt it was not a complete description. The job description,

was very brief and general in nature. Rx.1. Ms. Gerber testified she viewed the Employee Report of Injury. Rx 8. The report was filed January 28, 2016 by the Petitioner's direct supervisor, and lists a date of accident of January 1, 2015. Id. As to a time, it states " not applicable".Id. On the date of accident listed, Cathy Sullivan was the Petitioner's supervisor but she has since retired. The report indicates the injury came about "due to repetitive data entry, filing tickets into jackets, handling files, using hands, arms, and elbows being bent all day".

Dr. Charles Carroll, an orthopedic surgeon, was hired by Respondent to perform a medical evaluation of the Petitioner. Rx 2, 3 & 6. Dr. Carroll did this evaluation on October 7, 2016. Id. He explained the Petitioner is at a desk for eight hours a day where she files tickets, tears them apart, separates them, evaluates them for a file and subsequently puts them back together. Id. He notes the Petitioner developed bilateral wrist and hand complaints and first visited with her family physician, Dr. Calderon on October 23, 2015, the accident date. Id.

Dr. Carroll wrote in his report that the Petitioner experienced numbness and tingling that was more prominent on the right than the left and extended from the wrist and hand through the medial forearm to the elbow with the symptoms being less prominent on the left. Id. Attempts at conservative treatment were noted. Id. He reports an EMG of January 14, 2016 demonstrated severe right carpal tunnel syndrome and borderline on the left. Id. Dr. Carroll wrote Ms. Perez has been diagnosed with bilateral carpal and cubital tunnel syndrome.Id. He explained she has been advised by her physician to undergo a carpal tunnel and ulnar nerve release on the right followed by the same on the left side. Id.

Dr. Carroll explained the Petitioner is still doing her regular job but has limited use of her extremities and experiences pain, numbness and tingling in her digits with right elbow pain being more prominent than the left. Id. His examination demonstrated right greater than left carpal

tunnel syndrome with positive Phalen's, Tinel's and median nerve compression testing. Id. Right ulnar neuritis was worse than the left.Id. Dr. Carroll explained in his initial report he found no evidence of exacerbation of any pre-existing condition.Id. He wrote he wanted to review the job video before issuing a final report.Id.

As for treatment recommendations, Dr. Carroll reported a right carpal tunnel and ulnar nerve (cubital tunnel) release should occur. Id. Two to three months of therapy would then take place. Id. Following the same, he would then consider performing a left carpal tunnel and ulnar nerve (cubital tunnel) release, depending on the findings of the elbow at that time. Id. A additional two to three months of therapy would take place after that. Id. Dr. Carroll noted that approximately four to six weeks after surgery, the Petitioner could return to light duty and she would be expected to be at full duty three months after each procedure. Id.

He expressed other factors that might be considered a cause of the conditions reported appear not to be a factor here as she is not overweight and there are no medication issues.

Dr. Carroll issued an addenduam report on November 10, 2016. Rx 3. In this addendum to the original, he reports viewing a job analysis and video.Id. After viewing the same, he indicated the activities depicted in the video and job analysis would not cause or aggravate the carpal or cubital tunnel syndrome of the Petitioner. Rx 3 & 6. However, Dr. Carroll noted the Petitioner's description of her job varied from the material presented to him for further review. Id. He felt this may warrant further consideration by all parties.Id.

Dr. Carroll testified via deposition in this matter on February 13, 2017. Rx 6. He explained that if the work conducted by the person in the video was in reality performed by the Petitioner at a substantially increased rate, it might or could affect his opinions issued in this

matter. Rx 6, p.25. Dr. Carroll further noted that if the video is incorrect and did not actually show a full job description, this might also change his opinion. Id., p.26. line.13-21.

CONCLUSIONS OF LAW

C. Did an accident occur that arose out of an 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?

Marsha Perez, the Petitioner, worked approximately nine years for the Respondent, Andy Skoog, LaSalle County Circuit Clerk's Office. The clerk has two offices, one being the Civil Division at the downtown Ottawa, Illinois courthouse where the Petitioner worked for the initial two years of her employment. For the remaining seven or more years of her job with the Respondent, she has worked in the Criminal Division offices located on Etna Road in Ottawa, Illinois. The Petitioner reports the first two years of her employment was performed at a slow pace. She explained that after her move to the Criminal Division, her workload substantially increased and was highly repetitive.

The Petitioner testified that while employed at the LaSalle County Clerk's Office as one of two file clerks at its Etna Road location, she performed repetitive tasks at a fast and consistent pace throughout the day with the exception of the last half hour where work performed by Marsha Perez and her co-worker was quickly reviewed by the other to verify its accuracy.

The unrebutted testimony of the Petitioner indicated the she typically received daily tickets that were issued previously by sheriff's officers. She would type in all the information on the tickets into a computer file, the bottom tab of the ticket was then torn off by her gripping the same below a perforation with one hand and she then used the other hand to hold onto the other pages of the ticket when she forcibly pulled the opposite direction to separate each of the pages. These tickets were each placed into a cardboard file jacket and one ticket was placed onto a

patch, a sheet of cardboard containing bar codes. Ms. Perez would then quickly take self-stick numbers from boxes to her side and place them by hand onto each file created.

The Petitioner demonstrated her hand movements experienced throughout the day by separating the tickets and creating files. The movements of her hands and arms demonstrated continuous flexion and extension, as well as rotation of her hands, wrists and arms. The Petitioner's job description was supported by the testimony of her present supervisor, Amy Eitutis, who also described the work performed by the Petitioner as very repetitive and consistent throughout her work day.

Diana LeBeau Gerber, chief deputy of the LaSalle County Circuit Clerk's Office and a supervisor over both Marsha Perez and Amy Eitutis, described the Petitioner as being an honest individual who is a fast worker who does her job every day. The witness also testified to helping prepare a job description, at the request of OnCall Medical Management Services, LLC.Rx.1. She also prepared one on her own. Rx 5. She reported each was a very general description which lacked specificity. She also reported taking part in a video job description created by OnCall Medical Management. Rx 7. Ms. Gerber agreed the job performed in the video was done at a very slow pace and does not show all the work activities of the Petitioner.

This Arbitrator reviewed the video and finds the activities performed occur at a slow rate and notes the Petitioner testified it represents a speed of approximately 25% of the actual pace she performs it at. Also of note, her direct supervisor, Amy Eitutis, reports the video as being inaccurate and states the a pace of activity is approximately 25% of normal.

Ms. Perez explained that in approximately January of 2015, she began to notice pain and discomfort in both hands that was intermittent but gradually worsened. Her complaints included

numbness and tingling throughout the hands that initially extended to the right arm. It eventually involved the left arm as well. Ms. Perez explained her symptomology continued to increase as she performed her work in an unabated fashion. Without contradiction, she explains her problems were reported to her supervisor, Cathy Damann. On October 23, 2015 it was on this same date, the Petitioner first sought medical care and attention from her family physician, Dr. Ricardo Calderon. Px 5. This physician indicated the Petitioner may be experiencing bilateral carpal tunnel syndrome. Id. An EMG performed by Dr. Thomas Szymke, at Dr. Calderon's request and had positive results supporting this diagnosis. As a result, Dr. Calderon referred the Petitioner to Dr. Robert Mitchell. Px 2. 3 & 5.

Dr. Mitchell, an orthopedic surgeon, next met with the Petitioner in January of 2016. Px 2. He reported she experienced wrist pain bilaterally that was of gradual onset. Id. He described pain in each wrist as a needle and pin sensation along with pain and aching with finger numbness. Id. After the failure of conservative care that Dr. Mitchell ordered, he first recommended surgery on March 3, 2016. Id. Treatment was to begin on the right with carpal tunnel and cubital tunnel syndrome procedures. Id. This treatment was interrupted by an unrelated automobile accident. The Petitioner then sought an additional opinion with Dr. Blair Rhode, Px4. an orthopedic surgeon, who initially found bilateral carpal tunnel syndrome, more prominent on the right.Id. After reviewing her history, Dr. Rhode wrote the Petitioner's condition was work related from her repetitive employment in which she was involved, further considering she had no prior accidents or pre-diagnosed physical condition involving her upper extremities. Id. During his care, he also performed a right carpal tunnel injection. Id. This provided only short term relief. Id. Following multiple additional visits, the Petitioner's condition worsened to the point where she now suffering right and left lateral elbow pain along

with her bilateral carpal tunnel condition. Id. Dr. Blair Rhode reported all these were work related. Id. He also provided a left elbow cortisone injection in March of 2016 which provided some initial relief that eventually worsened. Id. As of Dr. Rhode's last visit of May 11, 2017, he reported bilateral elbow and wrist complaints continue and again requested surgical authorization for her bilateral hands and arms Id.

At the request of the Respondent, the Petitioner met with Dr. Charles Carroll, the Respondent's examining physician on October 7, 2016. Rx 2. Dr. Carroll produced an original and supplemental report. Rx 2, 3 & 6. He indicated no pre-existing conditions of concern and determined, Ms. Perez showed evidence of bilateral carpal tunnel syndrome and bilateral ulnar neuritis or cubital tunnel syndrome with the right being worse than the left. Id. In his initial IME, Dr. Carroll indicated he required a job description and a job video prior to issuing a causation opinion. Rx 2. After a review of the job description and video, he issued his supplemental report. Rx 1, 3, 5 & 7. Dr. Carroll stated he relied upon the job video and analysis prepared by the Respondent and found the job depicted was not forceful or repetitive and, therefore, the job depicted in the video was not the cause of the Petitioner's diagnosed condition. Id. Of importance, Dr. Carroll indicated the description provided by the Petitioner of her job duties varied from the material presented by the Respondent for his review. Id. He later testified in his deposition that his opinion as to whether or not the injuries reported by the Petitioner were job related assumed the veracity of the video provided. Rx 6. He stated that if the video was incorrect, it might change his opinion. Id.

During the testimony of Marsha Perez, the Petitioner, Amy Eitutis, the Petitioner's direct supervisor and Diana LeBeau Gerber, Chief Deputy of the LaSalle County Circuit Clerk's

Office, each testified to constant repetitive work performed by the in the Circuit Clerk's Criminal Division. The Petitioner's work activity, as described by her, Ms. Eitutis and Ms. LeBeau, is repetitious and fast paced and has Petitioner's hands and arms in constant movement of flexion and extension duting the majority of the work day. Each of the Petitioner's supervisors testified the job descriptions presented by the Respondent, Rx 1 & 5, were very general. Each also described the video created by OnCall Medical Management and which was provided to Dr. Carroll was only a general overview of the position that failed to cover all Petitioner's duties and lacked accuracy as to the speed of the work being performed. The Petitioner testified the pace in the video was approximately 25% of the norm. The Respondent's direct supervisor over the Petitioner, Amy Eitutis, indicated the video was at a pace that was approximately 25% of the norm.

Dr. Blair Rhode indicated in his reports created during multiple visits with Ms. Perez that he reviewed the job duties of the Petitioner with her and opined it was the performance of these duties that caused the Petitioner's condition of ill-being.Px4. Although Dr. Carroll, after reviewing the videotape and job description indicated an opinion that was contrary, he stated he would reconsider his opinions on causation if the video was inaccurate. All who testified about the video states it was inaccurate.

The Arbitrator notes and finds significant the following facts in this case, although the findings made herein are based on the record as a whole. First, Petitioner's testimony as to the scope and pace of her job duties was entirely supported by her direct supervisor, and to a certain extent, Respondent's witness, the supervisor of that supervisor. Second, the job video provided to Dr. Carroll, based on the above, was without question inaccurate as to the pace and scope of

Petitioner's job duties, and Dr. Carroll himself stated that his opinion on causal connection could be affected if the job duties of Petitioner were demonstrated to be different from those in the video in pace or scope. Third, Dr. Rhode, one of Petitioner's treating phkysicians, opined in his records that there was a causal connection between Petitioner's work activities and her present condition of ill being. It appears from the record that Dr. Rhode took a history of Petitioner's job duties that was detailed and consistent with the testimony of Petitioner's witnesses in this case. Fourth, the Arbitrator observed Petitioner demonstrate her job duties while on the witness stand, and notes that they required almost constant bending and flexion of the wrists and forearms. It appered that the force required to perform the job duties was not overly stressful, but the motions were constant and performed for about seven and one half hours of her eight hour workday. Again, based on the record as a whole and in consideration of the foregoing evidence, the Arbitrator finds that an accident did occur that arose out of and in the course of Petitioner's employment by Respondent due to the repititive nature of her employment with a date of accident being October 23, 2015, her first visit for care regarding this matter. This finding is consistent with *Peoria County Belwood Nursing Home v. Industrial Commission*, 138 Ill.App.3d880 (1995). Further, timely notice of the Petitioner's condition was provided to the Respondent by Ms. Perez on or about October 23, 2015 when she complained to her supervisor, Cathy Damenn of her condition. Damenn did not testify to dispute this testimony.

Following consideration of the testimony and evidence presented, this Arbitrator finds the Petitioner suffers from bilateral carpal tunnel and cubital tunnel conditions causally related to her repetitive work injury of October 23, 2015.

J. Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

The Petitioner has experienced medical bills of $5,832.32. Px 1. Her group insurance paid $785.52, insurance discounts of $303.48 have been received and the Petitioner has paid $40.00 out of pocket. Id. $4,703.312 remains outstanding. Id. All these balances are prior to application of the Medical Fee Schedule. For example, after the Fee Schedule is applied to the amount paid by the Respondent through its group insurance, the Respondent is entitled to a credit of $425.52 of the $785.52 it paid due to application of the Medical Fee Schedule. Of note, no argument has been made that the medical care and treatment has been excessive or unrelated to her medical needs. Therefore, as causation has been determined by this order for her bilateral carpal and cubital tunnel conditions, the Respondent shall pay the Petitioner's medical care and treatment as reflected in Px 1 to the extent of the Medical Fee Schedule. Respondent shall receive a credit, as requested in the amount of $425.52, the amount it is obligated to pay under the Medical Fee Schedule. The remaining outstanding bills of Orland Park Orthopedics / Dr. Rhode for $4,703.32 shall be paid by the Respondent at the Medical Fee Schedule rate.

K. Is Petitioner entitled to prospective medical care?

Pursuant to Section 8(a), the Petitioner has sought prospective medical care in the form of reasonable and related treatment for her diagnosed condition of bilateral carpal tunnel and cubital tunnel syndrome. As both Dr. Blair Rhode and Dr. Charles Carroll have recommended surgery, this Arbitrator finds the manner in which treatment should take place as indicated by Dr. Charles Carroll in his report of October 7, 2016 to be reason able and orders same to be provided by Respondent. Rx 2

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Marquella Redmond,
Petitioner,
vs.

NO: 14 WC 28573

Synergy Behavioral Healthcare,
Respondent.

18IWCC0250

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, causal connection, medical expenses, notice, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 29, 2017, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $63,000.00. 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: APR 25 2018
o032218
DLG/mw
045

David L. Gore

Stephen Mathis

DISSENT

I respectfully dissent from the Decision of the majority which affirmed and adopted the Decision of the Arbitrator awarding benefits. I would have found that Petitioner did not sustain his burden of proving that the

current condition of ill-being of his right foot was causally related to an incident on July 10, 2014, reversed the Decision of the Arbitrator, and denied compensation.

The medical record reveals that Petitioner had infections in his right foot at least since November 30, 2012, due to complications from diabetes. He had all five toes of his right foot amputated on October 28, 2013, due to the infections. He had more tissue removed on November 6, 2013. He was still treating for an infection in his right foot on May 27, 2014.

On July 10, 2014, Petitioner was a teacher of students with behavior difficulties. On that date, he was involved in restraining a student who was acting out. His right foot was still bandaged from the latest treatment for infection. He reported "tussling" with the student who fell onto his bed and then to the floor. There was no evidence that Petitioner's right foot was struck in the incident. Petitioner testified he did not notice any worsening of his foot immediately after the incident. He did not realize anything was amiss until he went home and noticed that the bandage on his foot was bloody. When he first sought treatment after the incident, July 15, 2014, he did not report the alleged accident and was diagnosed with recurrent infection of the right foot and it was noted that he had such infections since 2012.

In my opinion, Petitioner did not sustain his burden of proving that the current condition of ill-being of his right foot was causally related to the incident on July 10, 2014, as opposed to a natural progression of his underlying diabetic-related infections. I base that opinion on his continuingly developing diabetic infections since 2012, the infections were still being treated less than seven weeks prior to the incident, Petitioner did not seek treatment for four days after the incident, he made no mention of the incident when he did see a doctor, and no doctor opined that his current condition was causally related to the incident.

For these reasons, I would have found that Petitioner did not sustain his burden of proving that the current condition of ill-being of his right foot was causally related to an accident on July 10, 2014, reversed the Decision of the Arbitrator, and denied compensation. Therefore, I respectfully dissent from the majority.

DLS/dw
46

Deborah L. Simpson

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

REDMOND, MARQUELLE
Employee/Petitioner

Case# **14WC028573**

SYNERGY BEHAVIORAL HEALTHCARE
Employer/Respondent

18IWCC0250

On 8/29/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

2399 SILVERMAN, CLIFFORD A
18311 N CREEK DR
SUITE G
TINLEY PARK, IL 60477

1454 THOMAS & PORTELA
DANA DJOKIC
500 W MADISON ST SUITE 2900
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MARQUELLE REDMOND
Employee/Petitioner

v.

SYNERGY BEHAVIORAL HEALTHCARE
Employer/Respondent

Case # **14** WC **28573/GALE**

Consolidated cases: _____

18IWCC0250

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 **Gary Gale**, Arbitrator of the Commission, in the city of **Chicago**, on **August 12, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
   [ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On **July 10, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned **$22,177.48**; the average weekly wage was **$426.49**.

On the date of accident, Petitioner was **43** years of age, ***single*** with **0** dependent children.

Petitioner ***has not*** received all reasonable and necessary medical services.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $284.33/week for 108 5/7 weeks, commencing July 10, 2014 through August 12, 2016, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $255.59 per week for 125 weeks because the injuries sustained caused the 25% loss of the person as a whole, as provided in Section 8(d)(2) of the Act.

Respondent shall be given a credit of $0 for temporary total disability benefits that have been paid.

Respondent shall be given a credit of $0 for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act. Respondent shall reimburse Petitioner the sum of $360.00 as and for reimbursement for payments made by Petitioner for medical services.

Respondent shall pay to Petitioner penalties of $0, as provided in Section 16 of the Act; $0, as provided in Section 19(k) of the Act; and $0, as provided in Section 19(1) 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.

#001 Arb. George Andros
Signature of Arbitrator

8-28-17
Date

AUG 29 2017

MARQUELLE REDMOND V. SYNERGY BEHAVIORAL HEALTHCARE 14WC28573

FINDINGS OF FACT

Petitioner, 43, was employed by Respondent as an educator for students with behavioral issues. Respondent performs its services at Ingalls Memorial Hospital in Harvey, Illinois. Students would at times "act out" and would have to be physically restrained or physically handled. If one of Petitioner's co-employees asked Petitioner for help in doing so it was his job to assist. Each situation being different, Petitioner would use his discretion and judgment as per his training. On July 10, 2014 Annie, a co-employee, came to ask Petitioner's assistance with a student named Austin. Petitioner left his classroom and went with Annie to the "common room" or Milieu. When Petitioner arrived he observed Austin pacing back and forth and stepping on and off a couch. Petitioner stated Austin was "clearly agitated" and did not calm down. Annie decided to restrain Austin to bring Austin to his room. Petitioner and Annie each had an arm to start walking Austin to his room. Austin resisted going to his room and getting on his bed. Both Petitioner and Austin fell onto the bed and then onto the floor. Petitioner described the scene as chaotic. Austin was 6'2", 235-240 lbs. Petitioner was 6'3", 235-240 lbs. At the time of the occurrence Petitioner was wearing one street-type shoe on his left foot and an open-toe boot on his right foot due to his prior surgery for a diabetic condition. Debra Kozak, a nurse, gave Austin a shot to calm Austin. After the situation quieted down Petitioner went into the common room and sat on a couch because he was "winded". At that time he did not notice anything unusual about his right foot. Nadine Svetoff, Director of Clinical Services for Respondent, after being called to the scene, asked Petitioner if he was "ok" and "what happened". Petitioner explained what happened to Ms. Svetoff according to Petitioner's testimony. Nadine confirmed this by her testimony. Nadine testified that at that time Petitioner did not say he injured his right foot.

Petitioner worked the rest of the day; went home and in the process of changing his bandage on his foot saw that it was soaked with blood and had a tear on the right side of his foot. His right foot was not in this condition before he started his work day on July 10, 2014.

Michelle Conrad, a clinical therapist, was present and observed Austin which she described as "manic" jumping on the couch; got more aggressive when Petitioner arrived, and observed that Petitioner and Austin "got physical" when Petitioner was trying to get Austin to his room. Michelle saw them tussling on the bed but did not remember seeing them on the floor. Michelle confirmed that Debra had to give Austin a shot to calm Austin.

On July 14, 2014 Petitioner sought medical treatment with Dr. Robert LeVeau at the Cook County Health and Hospital System. On June 3, 2012 Dr. LeVeau had done a transmetatarsal amputation to Petitioner's right foot due to a diabetic condition. (Pet. Ex. No. 1, Resp. Ex. No. 2) After the June 2012 procedure, Petitioner came under the care of Dr. Dale Brink/Performance Foot and Ankle Center initially from December 1, 2012 through May 12, 2014. (Pet. Ex. No. 6) In May of 2014, Petitioner's on-going wound care was transferred to Oak Forest Hospital due to insurance benefits being terminated. At the time of Petitioner's discharge by Dr. Brink on May 12, 2014 the discharge note reflects:

> *Right foot wound stable* continues to reduce in size, has been ambulating with wound VAC on and still has a pretty good seal
>
> (Pet. Ex. No. 4)

The medical records of the Cook County Hospital emergency room attending Dr. Robert Feldman reflect that on July 14, 2014:

> The patient presents with right foot pain … with recent amputation of right foot with non-healing ulcer to lateral heel as well as *mild new ulceration over dorsal aspect of foot*
>
> (Resp. Ex. No. 2, p. 7)

An x-ray taken that day showed no plain film evidence of acute osteomyelitis with a large skin defect abutting the residual base of the right 5th metatarsal.

(Resp. Ex. No. 2, p. 17)

Petitioner was then admitted through the emergency room and was confined until July 24, 2014. On July 16, 2014 Dr. LeVeau did a bone debridement to the 5th metatarsal.

Petitioner testified that on his admission to the hospital on July 14, 2014 he called Nadine Svetoff and advised her that he needed surgery and could no longer work for Respondent. This was confirmed by Nadine on her cross-examination.

At the time of the hearing Petitioner testified that he is presently under the care of Dr. Yelena Boumendjel D.P.M./Foot & Ankle Associates, Ltd. whose $828.00 bill is introduced into evidence as Pet. Ex. 7 and on which Petitioner has paid $360.00 direct to the provider. Petitioner has not been released for work by Dr. Boumendjel.

A. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF EMPLOYMENT?

The Arbitrator adopts his findings of fact entered above and incorporates them herein by reference.

The record clearly shows that Petitioner injured himself in an attempt to physically restrain a student who was acting out in the Milieu or common room.

The student was physically resisting Petitioner in Petitioner's attempt to take him to his room. While attempting to put the student in his bed Petitioner and the student fell to the floor.

Several of Respondent's co-employees were present during the occurrence while Respondent disputed accident it put forth no evidence to dispute the occurrence of the event.

Based upon the totality of the evidence, the Arbitrator finds as a matter of fact and as a conclusion of law that the petitioner sustained an accident in the scope and course of his employment as alleged. No witness was called by Respondent to rebut the testimony of Mr. Redmond.

B. WAS TIMELY NOTICE GIVEN TO RESPONDENT?

The Arbitrator adopts his findings of fact above and incorporates them herein by reference.

From the record there can be no doubt that Respondent had actual notice of the incident. Further, Nadine Svetoff, the Director of Respondent, came to the common area after being called. She observed Petitioner on the couch who appeared out of breath. Petitioner testified that Nadine asked him what happened and that he told her. He did not mention any specific injury at that time and according to Ms. Svetoff Petitioner did not appear to be hurt. Ms. Svetoff confirmed Petitioner's testimony as to the conversation both on direct examination and on cross-examination.

Respondent's position is that Petitioner was required to give Respondent notice of the actual or specific injury under Section 6(c) of the Act. This is not the law. Section 6(c) of the Act does not require that notice of all injuries associated with an accident be given within 45 days of an accident. The Commission Decision and Opinion on Review in *Juarez v. Southwest Management,* 09WC05610 (1/6/11) is dispositive.

Based upon the totality of the evidence the Arbitrator finds the Petitioner provided notice under section 6c of the Act per applicable case law of long standing.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CASUALLY RELATED TO THE INJURY?

The Arbitrator adopts his findings and conclusions contained above with respect to the issue of accident and incorporates them herein by reference.

The sequence of events as shown by the record and the medical evidence supports the conclusion that Petitioner's present condition of ill-being of Petitioner's right foot is casually related to the incident of July 10, 2014. To obtain compensation under the Act, a claimant bears the burden of showing by a preponderance of the evidence that he has suffered a disabling injury which arose out of and in the course of his employment. *Baggett v. Industrial Commission*, 201 Ill.2d 187 (2002). The Petitioner must show that the injury had its origin in some risk connected with, or incidental to the employment so as to create a causal connection between the employment and the accidental injury. *Caterpillar Tractor Co. v. Industrial Commission*, 129 Ill.2d 52 (1989). A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his duties. *Caterpillar*, 129 Ill.2d at 58. Part of Petitioner's duties with Respondent was to assist co-employees with unruly students that would have to be physically restrained. Any such occurrence would clearly put Petitioner "at risk" of injury in any attempt to do so.

The record also clearly shows that Petitioner had a pre-existing condition to his right foot due to a diabetic condition which led to a transmetatarsal amputation in June 2012.

It is axiomatic that employers take their employees as they find them. *Baggett, supra.* Even though an employee has a pre-existing condition which may make him more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor *Caterpillar Tractor Co. Supra* at 36. Accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it was a causative factor in the resulting condition of ill-being, *Rock Road Construction Co. v. Industrial Commission*, 37 Ill.2d 123 (1967).

Our Supreme Court in *Sisbro, Inc. v. Industrial Commission*, 207 Ill.2d 193 (2003) held that recovery is allowed if it is shown that a work-related accidental injury aggravated or accelerated a pre-existing disease and was not simply the result of a normal degenerative process of the pre-existing condition.

Proof of a chain of events which demonstrates a previous condition of good health, an accident, and subsequent injury resulting in disability is sufficient circumstantial evidence to prove a causal nexus between accident and injury. *Union Starch & Refining Co. v. Industrial Commission*, 37 Ill.2d 139 (1967). An employer is liable for all injuries traceable to the accidental injury sustained. *Crow's Hybrid Corn Co. v. Industrial Commission*, 72 Ill.2d 168 and every natural consequence that flows from an injury. *National Freight Industries v. Illinois Workers' Compensation Commission*, 2013 Ill.App. (5th) 120043WC (2013).

Causation in a pre-existing injury may be established without medical opinion evidence and through circumstantial evidence i.e. a chain of events. *Corn Belt Energy Corp. v. Industrial*

Commission, 2016 Ill.App. (3d) 150311 WC. As long as there is a "but for" relationship between the work-related injury and subsequent condition of ill-being the employer remains liable. *Dunteman v. Illinois Workers' Compensation Commission*, 2016 Ill.App. (4th) 150543WC.

The Petitioner has sustained his burden of proof by a preponderance of the evidence that his present condition of ill-being is casually related to the incident of July 10, 2014. Of significance is the fact that Dr. Brink in his discharge note of May 12, 2014 stated that Petitioner's "wound was stable and continues to reduce in size" (Pet. Ex. No. 1). The emergency room physician Dr. Robert Feldman noted a mild new ulceration over the dorsal aspect of the foot as of July 14, 2014 (Resp. Ex. No. 2) which had not been previously found in any of the other medical records and was a new condition.

Also of significance was that Petitioner's condition with respect to his right foot did not preclude him from doing his regular duties with Respondent for the six months prior to July 10, 2014 as shown in Petitioner's time records. (Resp. Ex. No. 3).

Based upon the totality of the evidence the Arbitrator finds causal connection in favor of the Petitioner. The Arbitrator notes that in reaching his conclusion that the Respondent presented not one scintilla of medical evidence that Petitioner's condition of ill-being was not causally related.

J-K. MEDICAL SERVICES/T.T.D. BENEFITS

The Arbitrator adopts his findings of fact entered above with respect to the issue of accident and causal connection and incorporates them herein by reference.

From the record the medical services rendered to Petitioner were reasonable and necessary and causally related to the accident of July 10, 2014.

From the totality of the evidence the Arbitrator finds as a matter of fact and law Petitioner has been temporarily and totally disabled from work from July 11, 2014 to the date of hearing on August 12, 2016 and continues to follow up with Dr. Boumendjel for his wound care.

L. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

The Arbitrator adopts his findings and conclusions of law contained above with respect to the issues of accident causal connection and incorporates them herein by reference.

With regard to Section 8.1b(b) of the Act:

(i) The Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator therefore gives no weight to this factor;

(ii) The Arbitrator notes that the record reveals that Petitioner was employed as an educator at the time of the accident and that he is not able to return to work in his prior capacity as a result of the injury and gives great weight to this factor;

(iii) The Arbitrator notes Petitioner was 43 years old at the time of the accident and that his condition is lifetime and gives great weight to this factor;

(iv) The Arbitrator notes that Petitioner's future earning capacity will likely be limited due to his condition of ill-being and gives great weight to this factor. The Arbitrator further notes Petitioner is receiving disability payments from Social Security; and

(v) The Arbitrator notes evidence of disability is correlated by the treating medical records that were introduced as Exhibits and gives great weight to this factor.

Based on the above factors, and the totality of the evidence, , the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 25% loss of use of person as a whole pursuant to §8d(2) of the Act as a result of the injury sustained on July 10, 2014 as such injury has partially incapacitated Petitioner from pursuing his usual and customary line of employment..

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mose Hawkins,

Petitioner,

vs. NO: 16 WC 26174

ASG Staffing - Berwyn,

Respondent.

18IWCC0251

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, penalties, fees and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 14, 2017, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $4,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 25 2018
o032218
DLG/mw
045

David L. Gore

Stephen Mathis

DISSENT

Hawkins v ASG Staffing 16 WC 26174

I respectfully dissent from the Decision of the majority which affirmed and adopted the Decision of the Arbitrator. I would have reversed the Arbitrator on the issue of imposing penalties and fees against Respondent and vacated that portion of the award.

The record indicates that Petitioner did not attend a Section 12 medical examination requested by Respondent. It was originally scheduled for August 22, 2016, but Petitioner asked that it be continued because of a death in the family. Respondent acquiesced and rescheduled the examination to September 2, 2016. Respondent's nurse case manager testified that she sent Petitioner a letter memorializing the reschedule, verbally informed Petitioner of the change, and she left him messages on several occasions prior to the rescheduled appointment. She was not able to produce the letter at Arbitration. Petitioner denied he received notification prior to the rescheduled appointment. Respondent suspended temporary total disability benefits for 5&3/7 weeks after the missed appointment. That suspension is a basis for the imposition of penalties and fees.

The Arbitrator did not find Respondent's nurse case manager credible. While, I personally found her testimony credible, I do not believe that is the ultimate issue here. Clearly, there was a misunderstanding regarding the rescheduled appointment. Even if Respondent did not provide Petitioner sufficient notice of the rescheduled appointment, there is no evidence that any such failure was in any way malicious. Workers' Compensation is a no-fault system. That principle applies to employers as well as employees. In my opinion, Respondent's temporary suspension

of benefits after the missed appointment did not rise to the level of unreasonable or vexatious conduct, which is a criterion for imposition of penalties and fees.

For these reasons, I would have reversed the Arbitrator on the issue of imposing penalties and fees against Respondent and vacated that portion of the award. Therefore, I respectfully dissent from the majority.

DLS/dw
46

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

HAWKINS, MOSE
Employee/Petitioner

Case# **16WC026174**

ASG STAFFING-BERWYN
Employer/Respondent

18IWCC0251

On 8/14/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.14% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

5755 COSTA IVONE LLC
JORDAN BROWEN
6847 W CERMAK RD
BERWYN, IL 60402

0159 FRANCIS J DISCIPIO LAW OFFICE
1200 HARGER RD
SUITE 500
OAK BROOK, IL 60521

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Mose Hawkins
Employee/Petitioner

v.

ASG Staffing - Berwyn
Employer/Respondent

Case # **16** WC **26174**

Consolidated cases: **d/n/a**

18IWCC0251

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 **Gary Gale**, former Arbitrator of the Commission, in the city of **Chicago**, on **December 8, 2016**. After Arbitrator Gale left the Commission, the parties agreed to have another arbitrator decide the claim based on a review of the transcript and evidence. The Commission assigned the claim to Arbitrator Mason for this purpose. After reviewing the transcript and 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. X What temporary benefits are in dispute?
☐ TPD ☐ Maintenance X TTD
M. X Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?

O X Other **Did Petitioner refuse to attend or unnecessarily obstruct a rescheduled Section 12 examination?**

18IWCC0251

FINDINGS

On the date of accident, **7/8/16**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned **$18,947.24**; the average weekly wage was **$364.37**.

On the date of accident, Petitioner was **50** years of age, ***married*** with **0** dependent children.

Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$3,955.93** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$3,955.93**. Respondent did not pay temporary total disability benefits during the disputed period, between September 6, 2016 and October 14, 2016.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

RESPONDENT SHALL PAY PETITIONER TEMPORARY TOTAL DISABILITY BENEFITS IN THE AMOUNT OF $253.00 PER WEEK (THE APPLICABLE MINIMUM RATE) FROM SEPTEMBER 6, 2016 THROUGH OCTOBER 14, 2016, A PERIOD OF 5 4/7 WEEKS.

RESPONDENT IS LIABLE FOR SECTION 19(L) PENALTIES IN THE AMOUNT OF $2,400.00 ($30/DAY X THE 80 DAYS BETWEEN 9/20/16 (PX 2) AND 12/8/16), SECTION 19(K) PENALTIES IN THE AMOUNT OF $704.73 (50% OF THE AWARDED TEMPORARY TOTAL DISABILITY BENEFITS) AND SECTION 16 ATTORNEY FEES IN THE AMOUNT OF $281.89 (20% OF THE AWARDED TEMPORARY TOTAL DISABILITY BENEFITS).

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Molly C Mason

Signature of Arbitrator

8/14/17
Date

ICArbDec19(b)

AUG 14 2017

Mose Hawkins v. ASG Staffing – Berwyn
16 WC 26174

Procedural History

Petitioner filed an Application for Adjustment of Claim on August 26, 2016, alleging a lifting-related lower back injury of July 8, 2016. Arb Exh 2. Petitioner filed a Section 19(b) petition and a petition for penalties and fees on November 18, 2016, asserting that Respondent acted unreasonably and vexatiously in refusing to pay temporary total disability benefits from September 6, 2016 through October 14, 2016. Arb Exh 3.

Former Arbitrator Gale conducted a 19(b) hearing in this case on December 8, 2016. Arbitrator Gale did not issue a decision prior to leaving the Commission. The parties agreed to have a different arbitrator decide the case based on the transcript and exhibits. In July 2017, the Commission assigned the case to Arbitrator Mason for this purpose.

Summary of Disputed Issues

At the 19(b) hearing held on December 8, 2016, the parties stipulated to accident, notice, causation, earnings and an underpayment of temporary total disability benefits. They also agreed that Petitioner was temporarily totally disabled as of the hearing. The disputed issues include: whether Respondent is liable for temporary total disability benefits from September 6, 2016 through October 14, 2016, based on Petitioner's alleged refusal to attend or obstruction of a rescheduled Section 12 examination, and whether Respondent is liable for penalties and fees. Arb Exh 1.

Arbitrator's Findings of Fact Based on Review of Transcript and Exhibits

Petitioner testified he injured his back while working for Respondent on July 8, 2016. He underwent treatment for this injury throughout July, August and September 2016. T. 15. Records in PX 1 reflect that Petitioner underwent treatment with Dr. Goldvekht between August and November 2016, with the doctor diagnosing "lumbar disc with bilateral radiculitis" secondary to the work accident, prescribing a lumbar spine MRI, medication and therapy, securing a surgical consultation with Dr. Rosenthal and continuously keeping Petitioner off work through December 14, 2016.

Petitioner identified Exhibit A (attached to Arb Exh 3) as a letter he received from Underwriters Safety & Claims directing him to attend an independent medical examination with Dr. Edward Goldberg at 9:00 AM on August 22, 2016. Petitioner identified Exhibit B (also attached to Arb Exh 3) as a copy of a $22.60 travel expense check he received from "Phyllis" in connection with the examination. He testified he cashed this check. T. 18.

Petitioner acknowledged he did not attend the scheduled examination on August 22nd. He was scheduled to undergo an MRI the same day. After he received the letter informing him of the examination, he called Ms. Majka at Underwriters and informed her of the conflict. He told Ms. Majka he planned to go to the MRI facility, since it was closer. T. 19. Ms. Majka told him she would reschedule the examination and get back to him with the new date. T. 20. She did not call or E-mail him thereafter. T. 20-22.

Petitioner identified Exhibit C (also attached to Arb Exh 3) as a letter he received from Ms. Majka. The letter, dated September 6, 2016, informed him that the examination with Dr. Goldberg had been rescheduled for September 2, 2016. In the letter, Majka stated she had made "multiple attempts" to reach Petitioner by telephone "since Wednesday, September 1, 2016." Petitioner testified that, before he received this letter, he had no idea the examination had been rescheduled for September 2nd. T. 22-23.

On September 13, 2016, Petitioner's counsel E-mailed Respondent's counsel, referencing Majka's letter of September 6, 2016 and indicating Petitioner received no prior notice of the rescheduled examination. He asked Respondent's counsel to reset the examination. On September 20, 2016, Petitioner's counsel sent another E-mail, indicating Petitioner had received no benefits since September 6th and again asking Respondent's counsel to reset the examination. PX 2. Arbitrator Gale overruled Respondent's hearsay and relevancy objections to PX 2. T. 55-57.

Petitioner testified the examination was reset, after he received Exhibit C. He attended the rescheduled examination. T. 24. Exhibit D, also attached to Arb Exh 3, is a report from Dr. Goldberg dated October 14, 2016 reflecting that he examined Petitioner that day, diagnosed herniated discs with stenosis at two lumbar levels, viewed Petitioner's condition as causally related to the work accident and recommended surgery at the two affected lumbar levels.

Under cross-examination, Petitioner testified he first met with Phyllis Majka on July 20, 2016. They met at an occupational health center. T. 24. Majka did not set up an appointment for him to undergo an MRI on August 15, 2016. There was a death in his family around August 15, 2016. T. 25.

Phyllis Majka testified on behalf of Respondent. Majka, a registered nurse, testified she previously worked as a corporate consultant for General Mills. Her job at General Mills involved teaching human resource managers how to manage pre- and post-injury conditions. T. 27. After she left General Mills, she started her own case management business. T. 27.

Majka testified she has no financial interest in Petitioner's claim. She received Petitioner's file on July 15, 2016 and acted as his case manager thereafter. She first met with Petitioner on August 15, 2016. They met at an occupational clinic where Petitioner was scheduled to undergo an MRI. T. 28-29.

Majka identified Respondent's Exhibit 1 as a letter and transportation expense check she sent to Petitioner. The letter, dated July 22, 2016, advised Petitioner to attend an independent medical examination on August 22, 2016. T. 29-30.

Majka testified Petitioner did not undergo an MRI on August 15, 2016. The MRI was cancelled. Petitioner called her to advise her of a sudden death in his family. Petitioner told her he was very upset. He asked her to reschedule both the MRI and the independent medical examination. She agreed to do this. T. 30-31. She rescheduled the MRI for August 22nd and rescheduled the examination, which was with Dr. Goldberg, for September 2nd. T. 31-32. Petitioner underwent the MRI on August 22nd. T. 32. The MRI facility contacted her to confirm this. To the best of her knowledge, this facility provided Petitioner with the MRI disk so he could give this to Dr. Goldberg. T. 32. On August 24th, she spoke with Petitioner, confirmed his MRI attendance and reminded him to bring the MRI disc to Dr. Goldberg's office on September 2nd. T. 33. Nothing had changed since her letter of July 22nd. Dr. Goldberg was the same physician referenced in that letter and the time of the appointment was the same. T. 33.

Majka testified it was always her policy to contact a claimant "the night before or several days before" a scheduled independent medical examination. She testified she began calling Petitioner on August 25th. She called him again on August 29th and 31st and left messages, reminding him to attend the examination and bring the disk. T. 34. By that time, she was "very concerned" because she had not heard back from Petitioner. In the past, he usually had responded to messages. T. 34.

Majka testified that Petitioner failed to appear at Dr. Goldberg's office on September 2, 2016. On September 6, 2016, she sent Petitioner a letter directing him to call her in connection with the missed appointment. T. 35. Petitioner called her on September 12th. Petitioner told her he had received her certified letter. He apologized for missing the appointment. He told her he forgot about it and did not receive her messages because his phone was defective. T. 36.

Majka testified that, to the best of her knowledge, the insurance carrier had to pay Dr. Goldberg a fee in connection with the missed appointment of September 2nd. The carrier directed her to reschedule the appointment. She rescheduled the examination for October 14, 2016. Petitioner attended the examination on that date. T. 37.

Under cross-examination, Majka testified she first learned there had been a death in Petitioner's family when she spoke with Petitioner via telephone on August 18, 2016. T. 37-38. She spoke with Petitioner about the MRI being rescheduled for August 22nd but she cannot recall exactly when they talked about this. She went through a provider called "Align" to arrange for the MRI. It is "Align" that takes care of setting up the MRI appointment. She cannot recall when she called "Align." Petitioner told her he missed an MRI appointment that had been set up for August 15th. When Petitioner called her to inform her of the death in his family, he told her he had missed this appointment. T. 40. Petitioner asked her to reschedule both the MRI and the independent medical examination. T. 40-41. By the time she spoke with Petitioner on August 18th, she had already confirmed a rescheduled examination date with Dr. Goldberg's office. T. 43. She did not inform Petitioner of the new date during their phone conversation of August 18th. She told him she would reschedule the appointment and get back to him. She sent him another letter with the rescheduled date. T. 44. It is "absolutely" her practice to send a claimant a letter when an examination is rescheduled. She did not send another check, however, because she had already sent Petitioner a check to cover his travel expenses. [The transcript reflects that, at this point in the hearing, former Arbitrator Gale asked the witness to look in her file to see if she could find the letter she sent Petitioner advising him of the September 2nd appointment. The transcript also reflects that Majka looked through her file but was unable to find this letter. T. 44-45.] Majka testified it is not possible she did not send this letter. She indicated "we always keep pretty good records." T. 45. She usually receives something from an examiner's office, confirming the scheduling or rescheduling of an examination. She did not bring any such confirmation from Dr. Goldberg's office. T. 46. She has a record of each phone contact with Petitioner, along with the letters she sent to Petitioner on July 22nd and September 19th but the one thing she is missing is the letter she sent him advising him of the rescheduled appointment of September 2, 2016. T. 46.

Majka testified that, in the course of running her business, no claimant has outright refused to attend a Section 12 examination. T. 47.

On redirect, Majka testified she spoke with Petitioner via telephone on August 24, 2016. She initiated this call. T. 48. Petitioner identified himself. T. 49. She sent Petitioner a letter advising him of the rescheduled September 2nd examination. She followed up that letter with a phone call. T. 50-51.

Under re-cross, Majka testified that, at no point during her conversation with Petitioner, did he indicate he would not attend the rescheduled September 2nd examination. T. 52.

Arbitrator's Credibility Assessment

Phyllis Majka was not credible as to the critical issue in this case, i.e., the adequacy of the notice of the rescheduled September 2, 2016 examination. Her testimony concerning the timeline of events was confusing and contradictory. She offered two different scenarios as to her late August 2016 contacts with Petitioner. On the one hand, she testified she informed Petitioner of the rescheduled Section 12 examination via telephone on August 24th. T. 32-33. She went on to state she "started" calling Petitioner concerning this examination on August 25th, leaving several messages over the days that followed. T. 34. Her letter of September 6, 2016 offers yet another scenario. In that letter, she told Petitioner she had made attempts to reach him by phone "since Wednesday, September 1, 2016." Wednesday, September 1st, was the **day before** the rescheduled examination.

Majka set a high standard for her recordkeeping but ultimately failed to meet that standard. She claimed it is "absolutely" her practice to send a claimant a letter anytime an appointment date changes, and "always keeps pretty good records." T. 45. However, she was unable to produce a copy of the letter she purportedly sent to Petitioner informing him of the rescheduled September 2, 2016 examination, despite the fact she had her file with her. T. 29, 44-46.

Arbitrator's Conclusions of Law

Did Petitioner refuse to submit himself to a rescheduled Section 12 examination or unnecessarily obstruct the same? If not, is Petitioner entitled to temporary total disability benefits from September 6, 2016 through October 14, 2016 and is Respondent liable for penalties and fees?

The dispute in this case is narrow. Respondent agrees that Petitioner was off work, undergoing medical care for a compensable injury from September 6, 2016 through October 14, 2016, but maintains it was entitled to suspend the payment of benefits during this time. Essentially, Respondent argues that its representative, Phyllis Majka, made Petitioner aware of a rescheduled Section 12 examination set for September 2, 2016, that Petitioner refused to attend, or otherwise obstructed, said examination and that it thus owes no benefits until October 14, 2016, the date Petitioner underwent the examination. Respondent concedes it owes benefits after the examination, based on its examiner, Dr. Goldberg, who found causation and recommended two-level lumbar surgery. See Exhibit D attached to Arb Exh 3.

Section 12 of the Act provides, in relevant part, that a claimant "shall be required" to submit himself for examination "at any time and place reasonably convenient" for him, so long as the employer advances the expenses associated with attendance. Section 12 permits an employer to "temporarily suspend" the payment of weekly benefits until the examination takes places "if the employee refuses so to submit himself to examination or unnecessarily obstructs the same."

Petitioner testified that, when he told Majka he could not attend the original examination, on August 22nd, due to a death in his family, Majka told him she would reschedule the examination and get back to him. Majka corroborated this testimony. T. 43-44. Petitioner also testified he first learned of the rescheduled September 2nd date via Majka's letter of September 6th. He denied receiving any calls or E-mails from Majka prior to receiving this letter. T. 20-23. While Majka testified she informed Petitioner

of the new date via telephone on August 24th, left messages for him thereafter and sent him a confirmatory letter, she did not produce any documents to support these contentions. Majka brought her file to the hearing, as Arbitrator Gale noted (T. 29), but Respondent offered only one exhibit, namely Majka's letter of July 22, 2016, informing Petitioner of the original August 22nd examination date and enclosing an expense check. RX 1. This exhibit has no bearing on the issue at hand. There is no dispute that Petitioner asked Majka to reschedule the August 22nd examination due to a death in his family and that Majka agreed to do so. Majka's claim that she began trying to reach Petitioner on August 24th to advise him of the September 2nd examination conflicts with her own letter of September 6, 2016, in which she stated she began trying to reach Petitioner on September 1st, the day before the examination. [See Exhibit C attached to Arb Exh 3].

The Arbitrator finds no credible evidence that Petitioner refused to attend the rescheduled examination. Under re-cross, Majka acknowledged Petitioner never told her he would not attend a rescheduled examination. T. 52. There is also no credible evidence that Petitioner unnecessarily obstructed the rescheduled examination. The parties agree Petitioner requested the rescheduling, with Majka agreeing and telling him she would get back to him with the new date. They also agree that Petitioner made this request due to a significant event, i.e., a death in his family. The request was reasonable, in the Arbitrator's view. Petitioner also exhibited good faith by proceeding with a Respondent-scheduled MRI during the period in question. Majka did not describe him as an obstructionist.

The Arbitrator finds that Petitioner was temporarily totally disabled from September 6, 2016 through October 14, 2016. This is a period of 5 4/7 weeks. The Arbitrator bases this finding on the records in PX 1 and the opinions Dr. Goldberg rendered on October 14, 2016 (Exhibit D attached to Arb Exh 3). The Arbitrator further finds that Respondent acted unreasonably and vexatiously in refusing to pay temporary total disability benefits between September 6 and October 14, 2016. Petitioner contacted Majka after receiving her letter of September 6th and submitted to an examination by Dr. Goldberg on October 14th, as directed. The opinions Dr. Goldberg rendered on October 14th were entirely favorable to Petitioner. Respondent failed to meet its burden of showing it acted in a reasonable manner, under all of the existing circumstances, in withholding benefits during the period in question. The awarded temporary total disability benefits are equivalent to $1,409.46 ($253.00/week [the applicable minimum rate] x 5 4/7 weeks). The Arbitrator finds Respondent liable for Section 19(l) penalties in the amount of $2,400.00 (representing $30/day x the 80 days between September 20 (the date on which Petitioner's counsel made a demand for payment, PX 2) and December 8, 2016), Section 19(k) penalties in the amount of $704.73 (representing 50% of the awarded $1,409.46) and Section 16 attorney fees in the amount of $281.89 (representing 20% of $1,409.46).

STATE OF ILLINOIS)
) SS.
COUNTY OF ROCK ISLAND)

☒ 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

Artemio Madrigal,

Petitioner,

vs. NO: 11 WC 7213

Kaiser's Contract Cleaning,

Respondent.

18IWCC0252

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, temporary total disability, notice, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 14, 2017, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 25 2018
TJT:yl
o 4/16/18
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

MADRIGAL, ARTEMIO
Employee/Petitioner

Case# **11WC007213**

KAISER'S CONTRACT CLEANING
Employer/Respondent

18IWCC0252

On 2/14/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.62% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1367 HOPKINS & HUEBNER PC
PAUL SALABERT JR
100 E KIMBERLY RD SUITE 400
DAVENPORT, IA 52806

0264 HEYL ROYSTER VOELKER & ALLEN
CRAIG S YOUNG
PO BOX 6199
PEORIA, IL 61601-6199

18IWCC0252

STATE OF ILLINOIS)
)SS.
COUNTY OF Rock Island)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Artemio Madrigal
Employee/Petitioner

v.

Kaiser's Contract Cleaning
Employer/Respondent

Case # 11 WC 7213

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 **Michael Nowak**, Arbitrator of the Commission, in the city of **Rock Island**, on **10/6/16**. 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 _____

18IWCC0252

FINDINGS

On the date of accident, **2/11/10**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$27,594.32**; the average weekly wage was **$530.66**.

On the date of accident, Petitioner was **27** years of age, ***married*** with **3** dependent children.

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$4,599.01** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$4,599.01**.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of $34,607.49, as set forth in Petitioner's Exhibit D, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of $8,587.75 for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall authorize and pay for prospective medical care as recommended by Dr. Freedberg, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $353.77/week for 162 6/7 weeks, commencing 3/29/10 through 6/27/10 (12 6/7 weeks), and 7/17/10 through 6/1/13 (150 weeks), as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $4,599.01 for temporary total disability benefits that have been paid.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Michael K. Nowak, Arbitrator

2/2/17
Date

ICArbDec19(b)

FEB 14 2017

FINDINGS OF FACT

Petitioner did not present an Exhibit list so, for purposes of clarity, the Arbitrator notes that Petitioner withdrew Petitioner's Exhibits A and B. Petitioner's exhibits C through F and the subparts thereof constitute the totality of Petitioner's exhibits.

Petitioner began working for Respondent on March 10, 2005. He worked fulltime and in the year before his injuries he averaged 45 to 53 hours per week. Petitioner's job consisted of deep cleaning the kill floor of the Tyson meat processing facility. The job required Petitioner to spend an hour and a half of his day using a scoop shovel to shovel fat and skins Tyson employees left behind on the ground. He would lift the material onto different belts that varied in height from chest level to waist level. Petitioner described having to extend his arms above a 90 degree angle while shoveling material onto the belts.

Petitioner also had to load 20 gallon containers of chemicals onto a cart. He would move the cart to where the chemicals were needed and then take the containers off a cart and drag them to a 5 to 6 foot square plastic tote. Petitioner testified he would use both hands to lift the chemical container to near chest level to dump it into the tote.

Petitioner would then spend 5 to 6 hours of his work day pressure washing the entire kill floor area from floor to ceiling. Petitioner presented a segment of the hose and the nozzle used while pressure washing. (Px. F) The hose is approximately 2 inches in diameter and made of heavy rubber. The opposite end of the hose would be connected to a valve which supplied very hot pressurized water. The lengths of hose would be 25 feet, but two segments would be connected to clean. Due to the hot water running through the hose, Petitioner would have to use two pairs of gloves to hold it. Petitioner demonstrated how he would hold the nozzle in a baseball type grip with the hose draped over his shoulder and hold his arms flexed over 90 degrees as he cleaned machine belts, floors, ceiling and walls. The pressure of the water coming out could be felt on both his hands and shoulders. Petitioner testified that the pressure hose had to be held at or above shoulder height and away from his body to avoid the pressure causing the hose and nozzle to kick back and strike him in the face.

Petitioner also used a spatula and scraper to remove waste from the equipment and walls of the kill room. Finally, Petitioner used a ten foot pole to which hi pressure air hoses were attached to dry the ceiling after washing it. He had to lift the pole above shoulder height in order to reach the area to be dried.

Petitioner's brother, Froylan Madrigal, testified that he worked in the same department as Petition on the kill floor. Froylan testified that he performed the same activities as Petitioner. He described having to pick up meat, scraping, and hosing consistent with Petitioner's testimony.

Ruben Mojica, Respondent's safety director, testified that he has been employed by the Respondent for 7 years. He testified that his job duties in 2010 were to train employees, enforce policies, do safety audits, provide first aid, transport injured employees, and fill out injury reports. He acknowledged that Petitioner's job required him to pick up fat and skins with a shovel, and that the waste was shoveled onto 2 belts. Mr. Mojica testified that the belts were at his waist and chest level. At trial, the Arbitrator noted that Mr. Mojica, at 6 feet tall, was about 6 inches taller than Petitioner. Mr. Mojica also acknowledged that Petitioner used the pressure hose for 6 hours during his shift and that the hose was held using a baseball type grip. Mr. Mojica disputed Petitioner's testimony only in that he claimed that the hose would be held below shoulder height without extending his

elbows. The Arbitrator noted that while demonstrating the use of the hose in this fashion, Mr. Mojica would move the demonstrative hose with the cut end moving inward toward his chest and face. Mr. Mojica acknowledged that there was a lot of force in using the high pressure hose upon the arms and hands.

Finally, Respondent presented a general job description which indicated that Petitioner must be able to lift 20 to 80 pounds for long periods of time, perform tasks while standing, and crouching for long periods of time. (Rx. 2, p. 1)

Petitioner testified he began experiencing symptoms bilaterally in his hands, extending into his right arm up to his neck. On February 11, 2010, Petitioner was seen by Melissa Van Sickel, PA-C at Community Health Care. (Px. C, 1) Petitioner reported numbness and tingling from the elbows to the fingertips when he is working and at night. It was noted that Petitioner did repetitive motion at work and cleans for hours without a break. He was given restrictions limiting repetitive motions and provided with braces. It was suspected he had carpal tunnel syndrome or ulnar tunnel syndrome.

Petitioner testified that he went to work after his evaluation. At that time, he told his supervisor, Salvador Avila, of his restrictions. At some time thereafter, Petitioner testified that he was asked filled out an injury report. Mr. Mojica confirmed that in February of 2010, Petitioner brought him restrictions from his doctor and told him he was having issues with his hands and tingling from his right hand and extending up his right arm up to his neck. He also acknowledged that an incident report was given to Petitioner and that he took it home to fill out. Froylan Madrigal testified that he helped Petitioner fill out the injury report since Petitioner could not write.

Petitioner was again seen at Community Health Care on February 25, 2010. (Px. C, 1) The Arbitrator notes that although it is apparent that the facility was treating both arms and hands in the February 10 note. However, the note for the February 25, 2010 visit only refers to the right upper extremity. His wrist pain was noted to be 7/10 and it was noted that his work had not changed his tasks to allow him to avoid performing repetitive motions at work. (Px. C, 1) Petitioner was again given restrictions avoiding repetitive motion of his "hands and wrists."

On February 26, 2010, Petitioner presented to Gomez Chiropractic. (Rx. 11) A body chart was filled out demonstrating Petitioner had pain from the right wrist radiating to the neck. (Rx. 11, p.11) Although the body chart indicates symptoms only on the right, the notes indicate Petitioner had "wrist pain on both wrists but a lot more on [right] wrist." (*Id.*, at 12) Petitioner underwent chiropractic treatment at that time and again on March 1, 2010.

Petitioner returned to Community Health Care on March 9, 2010 with continued hand difficulties. (Px. C, 1) He was then referred for an EMG nerve conduction study. He was given a slip indicating that he had been seen for chronic arm and wrist pain. (Px. C, 1) Petitioner underwent an EMG/NCV on March 11, 2010. (Px. C, 2) The EMG/NCV revealed that Petitioner had bilateral carpal tunnel syndrome with the right side being more affected than the left. (Px. C, 2) Petitioner was then referred to orthopedic surgeon, Peter Alward, M.D., for further evaluation and treatment.

On March 29, 2010, Petitioner was seen by Dr. Alward. (Px C, 3) Dr. Alward noted Petitioner had been working for a cleaning service with repetitive use of a hose and frequent twisting motions including

flexion/extension of his wrists. (Px. C3) It was also noted that he gets pain and some tingling up to his shoulder area and arm. (Px. C, 3) After reviewing the EMG/NCV study and performing a physical examination, Petitioner was diagnosed with bilateral carpal tunnel syndrome. (Px. C, 3) Dr. Alward opined that the type of work that Petitioner was doing with the use of a hose and frequent flexion/extension of the wrist is correlated with causing carpal tunnel syndrome. (Px. C, 3) He recommended Petitioner remain of off work and undergo surgery. (Px. C, 3) Petitioner presented to Dr. Alward on April 21, 2010 for a pre-surgical consult. (Px. C, 3) Again, Dr. Alward noted Petitioner was having shoulder and elbow discomfort, but indicated he intended to "**hold off on any further workup** since his arms will be at rest for the next few weeks" following carpal tunnel releases. (Px. C, 3, emphasis added)

Petitioner underwent a right carpal tunnel release performed by Dr. Alward on April 23, 2010. (Px. C, 4) Postoperatively, Petitioner continued to follow-up with Dr. Alward. On May 24, 2010, Petitioner underwent a left carpal tunnel release performed by Dr. Alward. (Px. C, 4) Petitioner remained off work per Dr. Alward after each surgery. (Px. C, 3) On June 24, 2010 Petitioner followed up with Dr. Alward's physician assistant. She initially ordered Petitioner to remain off work, but apparently Respondent's insurance carrier contacted the doctor and indicated light duty, which had previously been denied, was now available. The physician assistant therefore drafted a "new return to work note with restrictions of no lifting, twisting, pushing, or pulling with the left hand until the next office visit." (*Id.*)

On July 7, 2010, Petitioner presented to Dr. Alward with continued right shoulder pain. (Px. C, 3) Specifically, Dr. Alward noted that Petitioner was:

> [C]omplaining of ongoing right shoulder pain that has been present for five to six months. He has had these symptoms all along and has had pain with work. He has even had pain on light duty with some minor shuffling. He is localizing that he pain anteriorly in the shoulder and up into the neck and down the arm. (Px. C, 3)

Dr. Alward's impression was that of right shoulder and arm pain. He was not sure if this was radicular or if he had mild tendonitis or neck pain. Dr. Alward ordered physical therapy and restrictions of light duty with limited lifting, twisting, and torqueing. (Px. C, 3)

Petitioner was seen on July 16, 2010 by Dr. Alward. (Px. C, 3) At that time, Dr. Alward noted that "[he is] having neck and shoulder problems which [are] worse with his work activity. He has pain when he reaches up overhead. He does not have any history of another activity or injury and has been doing the same job for about five years. He notices pain when he reaches up, lifting anything above shoulder height, or reaching out to the side. His pain is in the neck laterally and extends down toward the anterior part of his shoulder. He has numbness and tingling into the arm and he has symptoms occasionally that extend all the way down to his ulnar two fingers." (Px. C, 3) Dr. Alward noted Petitioner was released to return to work without restriction "with regard to the carpal tunnel syndrome." A cervical MRI was then ordered. Petitioner had a cervical MRI done on July 23, 2010, which was grossly unremarkable. (Px. C, 6)

Petitioner testified that Respondent would not provide light duty work. He testified that never returned to work for Respondent following his surgeries. Petitioner's wage records were admitted by Respondent. Although the records are very difficult to read it does not appear Petitioner had any earnings following his carpal

tunnel surgeries. (Rx. 9) Petitioner was then terminated from employment with Respondent for having exceeded FMLA leave time. (Rx. 8, p. 122) The form indicates that the last day of work was July 16, 2010 and the date of termination was October 13, 2010. It appears to the Arbitrator that when Dr. Alward released Petitioner without restriction "with regard to the carpal tunnel syndrome" Respondent began to treat Petitioner's time off as FMLA leave and terminated his employment when that leave time was used.

Petitioner underwent physical therapy at Rock Valley Physical Therapy from July 14 through August 2, 2010. (Px. C, 5) On August 4, 2010, Petitioner returned to Dr. Alward. It was noted at that time that "[h]e attempted to go back to work at light duty, but was unable to even do light duty with no use of his right arm because of his cramping pain. The patient does feel that his shoulder and neck problem is work-related." (Px.C, 3) Dr. Alward's impression was that he was "not sure exactly what is going on with this patient's arm. He is still quite symptomatic." (Px. C, 3) An MR arthrogram of his shoulder was ordered. Petitioner had a right shoulder arthrogram on August 13, 2010, which revealed a bright signal being present in the distal supraspinatus suggestive of tendinopathy but no evidence of a full-thickness tear. (Px. C, 6) Petitioner saw Dr. Alward on August 18, 2010 and it was noted he had some improvement with a steroid injection he had into the shoulder. (Px. C, 3) He was noted to have positive impingment findings. The doctor further indicated the presence of tendinitis. Dr. Alward recommended another course of physical therapy. Petitioner underwent physical therapy from August 20 through November 3, 2010. (Px. C, 8) On September 15, 2010, Petitioner underwent another steroid injection into the shoulder and continued physical therapy. (Px. C, 3) Petitioner was last seen by Dr. Alward on October 6, 2010. (Px. C, 3) Dr. Alward noted he suspected that Petitioner may have thoracic outlet syndrome and referred him to a vascular surgeon. (Px. C, 3)

Petitioner was seen and evaluated by Afzal Abdullah, M.D. on November 19, 2010. (Px. C, 9) Petitioner presented with bilateral shoulder and neck pain primarily on the right. (Px. C, 9) Upon physical examination, Dr. Abdullah noted that he had tenderness along the shoulder anteriorly over his deltoid muscle at the acromioclavicular joint and that it could represent some element of rotator cuff related tendinitis. (Px. C, 9) Dr. Abdulla recommended continued physical therapy and referred Petitioner to the pain clinic.

On December 9, 2010, Petitioner was seen by Archana Wagle, M.D. at the Trinity pain center. (Px. C, 11) Petitioner underwent a right trigger point injection and right supraspinatus tendon infiltration. (Px. C, 11)

Petitioner last saw Dr. Abdullah on January 21, 2011with continued symptoms in his right arm and shoulder. (Px. C, 9) Dr. Abdullah noted that Petitioner only had three days of improvement from his injections. (Px. C, 9) After re-examining Petitioner, Dr. Abdullah was not willing to diagnose petitioner with thoracic outlet syndrome and recommended he return to Dr. Alward and Dr. Wagle. (Px. C, 9) Finally, Dr. Abdullah authored a later dated January 7, 2011 wherein he opined that he could not be sure of the etiology of Petitioner's problem, but that it certainly could be from repetitive work issues at his job, but cannot say it was definitively from that. (Px. C, 9)

Petitioner testified that he attempted to return to Dr. Alward. However, his office told him he could not be seen due to his unpaid medical bills with their office. Petitioner also testified that he did not have health insurance.

Petitioner returned to Dr. Wagle on January 6, 2011 and underwent two more injections. (Px. C, 11) He underwent two more injections on February 10, 2011. (Px. C, 11) Additionally, Dr. Wagle recommended physical therapy, an orthopedic evaluation at the University of Iowa, and prescribed a T.E.N.S. unit. (Px. C, 11)

Petitioner underwent physical therapy from February 1, through April 20, 2011. (Px. C, 12) Petitioner went to the University of Iowa on March 21, 2011. But due to the fact that he did not have insurance, the doctor refused to see him. (Px. C, 13) On April 14, 2011, Dr. Wagle noted that the University of Iowa orthopedics would not see him for lack of insurance. (Px. C, 11) Dr. Wagle further noted that the T.E.N.S. unit did not help and that Petitioner was not working at the time. (Px. C, 11) Finally, Dr. Wagle referred Petitioner to Dr. Abdullah Foad, an orthopedic surgeon, for further evaluation and treatment. (Px. C, 11) Petitioner testified that Dr. Foad would not see him.

At the request of the Respondent, Petitioner was seen for a Section 12 examination on August 2, 2011 by Jay Pomerance, M.D.. (Px. C, 14) Dr. Pomerance reviewed Petitioner's medical records, took a history from Petitioner, and performed a physical examination. (Px. C, 14) Dr. Pomerance noted that when lifting his right arm away from his side, he stated it caused him numbness and tingling. (Px. C, 14) Dr. Pomerance stated that "[w]ith the present information I have to work with, I would not be able to address questions regarding the relationship of his upper extremity symptoms to his job duties since those duties are not clear." (Px. C, 14) Additionally, Dr. Pomerance said Petitioner's current diagnosis was not clear. Dr. Pomerance opined that Petitioner could work, however he should avoid forceful and heavy lifting of items over 25 pounds "or more especially if they are handled in an overhead posture." (Px. C, 14) Dr. Pomerance pointed out that the medical records do appear to document global bilateral upper extremity pain complaints at or about the time of his initial evaluation as noted in the hand written note form his primary care doctor dated March 9, 2010. (Px. C, 14) Respondent provided Dr. Pomerance with additional medical records. In a letter dated September 11, 2011, Dr. Pomerance recommended a possible repeat injection with fluoroscopic control. (Px. C, 14) The doctor again would not comment on causation or "theories" proposed by Respondent. (Px. C, 14) In a third attempt to elicit an opinion on causation, Respondent presented Dr. Pomerance with additional information. In his letter dated December 14, 2011, Dr. Pomerance noted that Petitioner worked 45 hours per week and would use his arms to move a hose around and scrub metal frame work. (Px. C, 14) He also noted that Petitioner had to shovel meat product. For the third time, Dr. Pomerance stated he could not provide an opinion on causation. (Px. C, 14)

On April 9, 2012, Petitioner returned to Dr. Wagle with continued right shoulder pain. (Px. C, 11) Dr. Wagle again attempted to refer Petitioner to Dr. Foad. (Px. C, 11)

Petitioner testified that due to ongoing shoulder pain, he presented to the emergency department of Genesis Medical Center on May 22, 2012. It was noted in the triage records that he had no re-injury of his right shoulder for 3 years. (Px. C, 15) He was diagnosed with chronic right shoulder pain/strain and recommended he follow up with his primary physician or an orthopedic doctor. (Px. C, 15)

On July 6, 2012, Dr. Wagle saw Petitioner and noted he still complained of severe pain in his right shoulder. (Px. C, 11) Dr. Wagle reviewed Dr. Pomerance's independent medical evaluation an ordered a nerve conduction study. (Px. C, 11) Petitioner underwent a nerve conduction study on October 5, 2012. (Px. C, 16) The study was normal. Petitioner was last seen by Dr. Wagle on October 31, 2010. (Px. C, 11) At that time,

Petitioner continued with right shoulder pain and was again referred to Dr. Foad. (Px. C, 11) Petitioner testified that he attempted to see Dr. Foad. However, Dr. Foad would not see him.

At hearing Petitioner testified that due to a lack of insurance and money, he found a seasonal landscaping job in June of 2013 with J.C. Landscaping. (Rx. 3) Petitioner testified that he primarily operated a lawn tractor. He was able to maneuver the tractor with his arms to his side and only need to move levers, which he could do.

According to Petitioner, once he saved enough money he went to orthopedic surgeon, Howard Freedberg, M.D. Petitioner was first seen by Dr. Freedburg on June 9, 2014. (Px. C, 17) Dr. Freedberg noted that Petitioner had bilateral shoulder complaints from a work injury of February 11, 2010. (Px. C, 17) He further noted Petitioner worked for a cleaning company, and used a large high pressure hose to clean use a scraper to clean the rust and blood at the Tyson Meat plant. (Px. C, 17) Petitioner, who is right handed, presented with more pain in his right shoulder than his left shoulder. (Px. C, 17) Dr. Freedberg performed a physical examination of Petitioner and reviewed bilateral shoulder x-rays. His impression at that time was that Petitioner had a right shoulder rotator cuff tear and cervical radiculitis. (Px. C, 17) Dr. Freedberg also noted that the cause/mechanism was overuse from work. (Px. C, 18) He ordered an MRI of the C-spine and bilateral shoulders and allowed Petition to work without restrictions. (Px. C, 17)

Petitioner underwent a cervical MRI and bilateral shoulder MRI's on June 14, 2014. (Px. C, 18) The cervical MRI revealed minimal disc bulges at the C5-C6 and C6-C7 disc levels without spinal canal stenosis or significant foraminal stenosis. (Px. C, 18) The right shoulder MRI revealed bicipital tenosynovitis distally without a tear and moderate supraspinatus tendinopathy with a 50% partial thickness bursal surface tear distally and anteriorly adjacent to the rotator cuff interval. (Px. C, 18) The left shoulder MRI revealed moderate supraspinatus tendinopathy with a 50% partial thickness bursal surface tear distally and anteriorly adjacent to the rotator cuff interval. (Px. C, 18)

On June 19, 2014, Petitioner returned to Dr. Freedberg for further evaluation and treatment. He underwent an injection into his right shoulder. (Px. C, 17) On July 17, 2014, Dr. Freedberg noted that the cortisone injection in the right shoulder did not help. (Px. C, 17) Dr. Freedberg then injected the left shoulder. (Px. C, 17) Petitioner was last seen by Dr. Freedberg on August 14, 2014. (Px. C, 17) At that visit, Petitioner presented with worsening right shoulder pain and had difficulty sleeping on either side due to bilateral shoulder pain. (Px. C, 17) Petitioner continued to take Tylenol and ibuprofen for pain. Dr. Freedberg recommended Petitioner undergo a right shoulder arthroscopic biceps tenotomy vs. tenodesis, and possible open distal clavicle excision first and then the same for the left shoulder. (Px. C, 17)

Petitioner presented the evidence deposition of Dr. Freedberg. (Px. E) Dr. Freedberg testified consistent with his aforementioned office notes. Dr. Freedberg further testified within a reasonable degree of medical certainty that Petitioner's shoulder problems are causally connected to his work for the cleaning company wherein he uses a hose, does lifting, and other tasks. (Px. E, p.18) According to Dr. Freedberg, it is a cumulative, repetitive, overuse injury. (Px. E, p. 19) Finally, Dr. Freedberg testified that Petitioner's complaints as memorialized in the medical records from 2010 were consistent with the complaints when he first saw Petitioner in 2014. (Px. E, p. 41)

At the request of Respondent, Petitioner was seen by Brian Forsythe, M.D., pursuant to section 12, on July 9, 2015. (Rx. 13) Dr. Forsythe testified by deposition as well. Dr. Forsythe testified that there was no causal relationship between Petitioner's bilateral shoulder partial thickness tears and his work for Respondent. (Rx. 13, p. 15) Dr. Forsythe testified that his opinion was based on the fact that four or five years had passed, so there is no strong temporal relationship between his complaints of shoulder pain and pathology and the August 2010 arthrogram showed no evidence of a tear. (Rx. 13, p. 15-16) Dr. Forsythe further testified that the basis of his opinion was that it was very unlikely that he would have been living with this pain for four or five years or so without seeking treatment. (Rx. 13, p. 17) Dr. Forsythe testified that he agrees Petitioner has bilateral partial thickness rotator cuff tears and requires surgery as prescribed by Dr. Freedberg. On cross examination, Dr. Forsythe testified he did not review the IME reports of Dr. Pomerance. (Rx. 13, p.19) Dr. Forsythe acknowledged that MRIs are only 90 to 95% accurate, leaving room for a missed condition. (Rx. 13, p. 22) Finally, Dr. Forsythe testified that he did not know whether the hose Petitioner used was pressurized or not. (Rx. 13, p. 23)

Finally, Petitioner testified that his bilateral shoulder pain is constant. Petitioner testified that he wishes to undergo surgery as prescribed by Dr. Freedberg.

CONCLUSIONS

The parties stipulated that Petitioner's bilateral carpal tunnel syndrome arose out of and in the course of his employment with Respondent and that the condition of his wrists were causally related to his employment with Respondent. Respondent however disputes the issues of accident and causation with respect to Petitioner's shoulder conditions. (Arb. Ex. 1)

Issue (C): Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

Issue (F): Is Petitioner's current condition of ill-being causally related to the injury?

The Arbitrator finds the testimony and opinions of Dr. Freedberg more persuasive than those of Dr. Forsythe. The Arbitrator further notes that Dr. Forsythe agreed with Dr. Freedberg's diagnosis of bilateral partial thickness rotator cuff tears and the need for surgical intervention. In addition Petitioner's shoulder complaints have been consistent throughout his treatment and that Dr. Alward noted his medical decision to hold off on any further workup of Petitioner's shoulders until after the carpal tunnel syndrome had been treated.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met his burden of establishing that he sustained accidental injuries to his bilateral hands and shoulders arising out of and in the course of his employment with Respondent and that the current condition of Petitioner's shoulders is causally related to the accident.

Issue (E): Was timely notice of the accident given to Respondent?

Mr. Mojica confirmed that in February of 2010, Petitioner brought him restrictions from his doctor and told him he was having issues with his hands and tingling from his right hand and extending up his right arm up to his neck. The Arbitrator notes that the shoulder is located between the hand and the neck. Respondent's claim that notice is defective because Petitioner did not specifically mention the shoulder is without merit.

Clearly Respondent was aware Petitioner claimed symptoms from his hands up to his neck, including his shoulders, as a result of his work activities when he spoke with Mr. Mojica in February of 2010.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner provided adequate notice as required by the Act.

Issue (J): Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

Issue (K): Is Petitioner entitled to any prospective medical care?

Petitioner submitted medical expenses of $34,607.49. (Pet. Ex. D) Respondent does not dispute its liability for the charges related to treatment of Petitioner's bilateral carpal tunnel syndrome. Although Dr. Forsythe opined the condition of Petitioner's shoulders was not related to his employment, He agreed with Dr. Freedberg's diagnosis of bilateral partial thickness rotator cuff tears and the proposed treatment. Having found Petitioner's shoulder condition is causally related to the accident the Arbitrator finds the medical expenses incurred by Petitioner during the course of his treatment for his injuries, were necessary and reasonable and that Petitioner is entitled to prospective medical care.

Respondent shall pay reasonable and necessary medical services of $34,607.49, as set forth in Petitioner's Exhibit D, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit of $8,587.75 for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall further authorize and pay for prospective medical care as recommended by Dr. Freedberg, as provided in Sections 8(a) and 8.2 of the Act.

Issue (L): What temporary benefits are in dispute?

Respondent does not dispute liability for TTD benefits from March 29, 2010 through June 27, 2010. Petitioner claims he is entitled to additional benefits from July 17, 2010 through June 1, 2013.

On June 24, 2010 Dr. Alward's physician assistant, after being advised that light duty was available by Respondent's insurance carrier, allowed Petitioner to return to work with restrictions of no lifting, twisting, pushing, or pulling with the left hand until the next office visit. On July 7, 2010 Dr. Alward continued restrictions of light duty with limited lifting, twisting, and torqueing. On July 16, 2010 Dr. Alward noted Petitioner was released to return to work without restriction "with regard to the carpal tunnel syndrome." On August 4, 2010 Dr. Alward noted Petitioner was unable to even do light duty with no use of his right arm due to his shoulders.

Petitioner testified that Respondent did not provide light duty work at any time following his carpal tunnel releases. He testified that never returned to work for Respondent. Petitioner's wage records were admitted by Respondent. Although the records are very difficult to read it does not appear Petitioner had any earnings following his carpal tunnel surgeries. (Rx. 9) However Petitioner claims additional benefits commencing July 17, 2010. (Arb. Ex.. 1)

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner is entitled to TTD benefits from March 29, 2010 through June 27, 2010 and from July 17, 2010 through June 1, 2013 when he went to work for J.C. the landscaping company.

Respondent shall pay Petitioner temporary total disability benefits of $353.77/week for 162 6/7 weeks, commencing 3/29/10 through 6/27/10 (12 6/7 weeks) and 7/17/10 through 6/1/13 (150 weeks) , as provided in Section 8(b) of the Act. Respondent shall be given a credit of $4,599.01 for temporary total disability benefits that have been paid

STATE OF ILLINOIS	)	☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
	) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF SANGAMON	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ronald Stewart,

Petitioner,

vs.

NO: 15 WC 35135

18IWCC0253

Illinois Department of Revenue,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, permanent partial disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 10, 2016, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

DATED: APR 2 5 2018
TJT:yl
o 4/16/18
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

STEWARD, RONALD
Employee/Petitioner

Case# **15WC035135**

ILLINOIS DEPARTMENT OF REVENUE
Employer/Respondent

18IWCC0253

On 11/10/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.53% 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:

1909 ACKERMAN LAW OFFICE
JAMES W ACKERMAN
2601 S 5TH ST
SPRINGFIELD, IL 62704

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

4138 ASSISTANT ATTORNEY GENERAL
WARREN WILKE
500 S SECOND ST
SPRINGFIELD, IL 62706

0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601-3227

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62794-9255

CERTIFIED as a true and correct copy
pursuant to 820 ILCS 305/14

NOV 10 2016

RONALD A. RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

18IWCC0253

STATE OF ILLINOIS)
)SS.
COUNTY OF Sangamon)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

RONALD STEWARD
Employee/Petitioner

v.

ILLINOIS DEPARTMENT OF REVENUE
Employer/Respondent

Case # 15 WC 035135

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Springfield**, on **September 28, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☐ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☐ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **9/23/15**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did not* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned **$107,676.00**; the average weekly wage was **$2070.69**.

On the date of accident, Petitioner was **57** years of age, *single* with **0** dependent children.

Petitioner *has* received all reasonable and necessary medical services.

Respondent *has* paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**.

Respondent is entitled to a credit for all medical expenses paid through its group health carrier under Section 8(j) of the Act.

ORDER

Petitioner failed to meet his burden of proof showing that his accident occurred during the course and arose out of his employment with Respondent. Therefore, Petitioner's claim for benefits is denied.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Edward Lee — Signature of Arbitrator

11/4/16 — Date

NOV 10 2016

The Arbitrator hereby makes the following findings of fact: 18IWCC0253

Petitioner is a geographical information specialist who has been employed by the State of Illinois for 25 years, and has been at his current position since 2000. (T. 9). Petitioner claims to have been injured on his work premises when he stepped off a curb outside of the building where he works. (T. 12); (RX5); (PX 5). Neither on direct, nor on cross did Petitioner testify as to the date of the accident. However, Petitioner's date of accident is documented in the medical records and accident report, all of which consistently indicate that the accident in question occurred on September 23, 2015. (RX 1, 2); (PX 2 pg. 1). The medical records show that Petitioner suffered a quadriceps tear, which was correct with surgical intervention and post-operative physical therapy. The only disputes in this matter are accident, compensation for benefits (medical, TTD, PPD) contingent on Petitioner meeting his burden of proof regarding accident compensability, and PPD valuation should Petitioner meet his burden of proof with regard to accident compensability.

The medical records show that Petitioner was admitted to the E.R. immediately after the fall. *Id.* Petitioner's testimony confirmed that an ambulance took him to the hospital shortly after his fall. (T. 34). Eventually, Petitioner was diagnosed with a quadriceps rupture. (PX 2 pg. 8, 10). Petitioner underwent right knee surgery on September 29, 2015 to correct his injury. (PX 2 pg. 42, 53-54). Following his surgery, Petitioner participated in conservative post-operative rehabilitation which consisted primarily of physical therapy beginning October 15, 2015 and continuing through March 15, 2016. (PX 2 pg. 291-370). Petitioner's final two physical therapy records indicate he was no longer limiting his activities because of his knee, *no longer had any complaints he regarding his knee, and that as of March 15, 2016 he had not been thinking about his knee for the past couple of weeks and had been neglecting his home exercise program.* (PX 2 pg. 322, 371-372)(*emphasis added*).

Some of Petitioner's testimony contradicts his statements to the medical providers. While Petitioner claimed he never had any problems with his knee before the accident, and there is certainly no evidence to the contrary, Petitioner's trial statements regarding his knee after the accident indicate lingering issues that exceed what he reported to his therapist and physician at the time he was declared to be at MMI. At trial, Petitioner discussed an inability to feel, walk on uneven ground, and issues with sustained activity. (T.37-38). While Petitioner claimed to have discussed these issues with his physician the medical records leading up to Petitioner's discharge show no such complaints. Conversely the final treatment records show Petitioner being almost asymptomatic. Petitioner's final medical treatment record, as discussed above, indicated that Petitioner no longer had any complaints he regarding his knee, and that as of March 15, 2016 he had not been thinking about his knee for the past couple of weeks and had been neglecting his home exercise program. (PX 2 pg. 371-371). These statements sharply contradict one another; but, they are not the only instance where Petitioner offered conflicting statements. Even petitioner's own testimony was fraught with logical inconsistencies. Petitioner described an inability to use, or a fear of using, a treadmill despite the recommendations of his physical therapist. (T. 39). While Petitioner suggests that his inability or fear to use the treadmill stems from his accident, and that prior to the accident he used the treadmill quite frequently, he also indicated that he spent a substantial amount of time mowing his large lawn. (T. 39). To be clear, Petitioner never discussing running on a treadmill, he stated he generally walked on an incline about an hour each day at a 10 degree incline. (T. 21). And, while Petitioner's testimony stated he could no longer do this, he did

say that he will spend 10 hours or more mowing the lawn on weekends. (T. 40). While Petitioner indicated that mowing the lawn only used to take him 4 hours before the accident, it is not clear if Petitioner's limitations are self-limiting or imposed by his injury. To illustrate by comparison, and returning to the treadmill issue, Petitioner claims to no longer do treadmill exercises due to fear or inability while simultaneously spending nearly ten hours per weekend mowing the lawn, which incidentally works out to more than an hour per day per week (which is more than he used to spend on the treadmill), while also claiming an inability walk on uneven ground. Treadmills are not made with uneven surfaces, whereas lawns typically are. While prior to the accident Petitioner used to spend about 7 hours per week on the treadmill, he now spends 10 hours per week, or more, mowing his lawn which he completes in blocks of 1 to 2 hours. Petitioner's complaints of an inability to exercise or use the treadmill are subjective complaints which are directly refuted by the recommendations of his therapist that he use a treadmill. Absent medical corroboration, they appear to be purely self-limiting and without objective medical support.

At trial, Petitioner indicated the pictures submitted in to evidence clearly showed the location of his fall. (T. 11-12). In particular Petitioner reference a "sloped" curb that was painted yellow and gradually rose to a height measured in Respondent's Exhibit 6 as being slightly less 6 inches. Petitioner indicated that he fell at point that, when measuring from the lowest point of the curb (where the height of the curb is identical to that of the drive-way), appears to be one third of the way from the lowest point of the curb to the highest appoint of the curb. (RX 5); (PX 5). The height of the curb at the point where Petitioner fell appears to be slightly less than 1.5 inches. For comparison, Respondent included pictures of the curb that adjoins the public street in front of the building where Petitioner worked. The photos of the curb that adjoins the street indicate the height of the curb to be nearly 2 inches. (RX 5). Although higher, the public curb is not marked yellow. *Id.*

At trial, Petitioner testified that he has fallen on the painted yellow curb multiple times. (T. 13). Petitioner indicated that he only goes over the curb when he is in a hurry, and that otherwise he followed the sidewalk all the way down the pictured ramp about half of the time. (T. 13-15, 29, 37). Petitioner stated that he was exiting the building and looking to the left and that, unlike other times, his left foot twisted such that he was unable to put his weight on it and he wound up falling on his right knee on the ground. (T. 15-16). On cross, Petitioner reiterated that he was leaving work and that he was walking from the curb to the driveway when he fell. (T. 26-27). In other words, Petitioner did not stub his foot and fall forward, but rather stepped forward expecting the ground to be higher than it was. (T. 27-28). Petitioner's testimony, and the evidence submitted a trial indicate that the change in elevation caused by the curb being a different height (approximately 1.5 inches higher than the drive way) as the cause of Petitioner's fall. Petitioner testified, and Respondent's Exhibit 4 demonstrates that the weather on the date of the accident was clear; there was no rain, and no reduced visibility. (RX 4); (T. 34). Petitioner indicated that the surface was not slick, or defective in any way that caused his fall. (T. 33).

Petitioner testified that he did not have an assigned parking spot, that he rented a private parking spot, and that he was leaving work to walk to that spot at the time of the accident (T. 28). Petitioner indicated that, like the times fell before, was in a hurry. (T. 29). While he could not say for certain why he was in a hurry, but he was certain that he was not hurrying because of work. (T. 29). Petitioner indicated that that the driveway ran through a parking lot with visitor spaces, and that People

frequently drove through the driveway and lot (T. 30-31). Petitioner indicated that, at the time he suffered his injury, most of the traffic involving people picking up employees who worked in the building. (T. 31). This indicates that the driveway was open to the public. Moreover, Petitioner testified that the entrance to the building at the Jefferson St. driveway is open to the public. (T. 35).

Petitioner indicated that he frequently used the entrance where his accident occurred. (T. 31-32). While he did not always use the entrance, he did indicate that the Jefferson St. entrance was his primary point of accessing the building. Assuming Petitioner only used the entrance three times per week and twice per day, and that Petitioner took two weeks of vacation every year it would mean that Petitioner used that entrance on average 300 times per year. It would also mean that, per Petitioner's "in hurry" estimates, he crossed the painted curb at least 150 times per year. Petitioner has been at his position for approximately 15 years, meaning that in this time he has used the entrance approximately 4,500 times and has crossed the yellow curb approximately 2,250 times. If Petitioner has worked in the Willard Ice building throughout his career with the state, those numbers jump to 3,750 and 7,500 respectively. According to Petitioner's testimony, he has fallen on this curb approximately "half a dozen times" in addition to the fall that caused his accident. (T. 15). On the high end, falling 7 times out of 2,250 crossings of the yellow curb equates to a fall percentage of 0.31% (0.0031); and, on the high it equates to 0.1867% (0.001867). When including all uses of that particular entrance the rates fall to 0.15% (0.0015) and 0.093% (0.00093) respectively. Petitioner testified that despite his stumbles, he never adjusted or modified his behavior, and despite it crossing his mind he never notified anyone at work of his falls on the yellow curb. (T. 33).

As noted above, Petitioner did not always use the Jefferson St. entrance, and that he would sometimes use the West entrance when we was not in a hurry. (T. 32) because the street traffic at the West entrance was heavier and would lead to delays when going to and from work. *Id.* In other words, Petitioner was not directed to choose one entrance or the other, and appears to have made his entrance decisions based solely on how much of a hurry he was in. For example, Petitioner appears to have chosen the Jefferson St. entrance because he was in a hurry, and he chose to cross the yellow curb at that entrance because he was in a hurry:

> Q. Just to clarify this for the record, I hate to beat a dead horse, but the reason why you crossed that yellow line there on the day of the accident is because you were in a hurry; there was no other reason?
>
> A. Yeah, it was to facilitate my getting across the street in a timely manner.

(T. 36). Petitioner's choice, to use the Jefferson St. entrance and cross the yellow curb, on the date of the accident, as it was on the dates of his prior falls, was not dictated by his employer but was of his own choosing while he was off work and for a personal purpose.

Petitioner began working for the Illinois Department of Revenue in the summer of 2013. (T. 10). Petitioner's job duties include editing and maintaining maps of property tax districts. *Id.* Petitioner indicated that Respondent's Exhibit 6, titled position description, was an accurate general description of his job. *Id.* To clarify, Petitioner used the term "general," because some aspects, such that the references to use of Unix and Windows NT were out of date. (T. 11). Other than the out of date

references, Petitioner stated that his basic job description and duties have remained unchanged, and that he mainly deals with the editing and maintaining of spatial data; point lines; and polygons associated with electronic maps which are then printed, converted to .pdf files, and/or uploaded to interactive web-based maps. *Id.* Lastly, Petitioner indicated that he his job generally does not require lifting, and that the only lifting he could recall doing while at work was when he was moving offices. (T. 11-12).

Respondent's witness, David Klintworth, works for the State of Illinois in Human Resources as a Workers' Compensation Coordinator for the Illinois Department of Revenue. (T. 45). Pursuant to his duties he is required to know the facilities of the Willard Ice Building. (T. 46). Mr. Klintworth provided testimony that clarified the descriptions of the accident in question as well as the accident location.

On his direct, Mr. Klintworth reviewed the photos submitted in to evidence and confirmed that the driveway pictured is a public driveway open to members of the public. (T. 46). Mr. Klintworth testified that he Jefferson St. entrance is open to the public. *Id.* To his knowledge he was unaware of any other accidents involving any slip trip or falls on the yellow curb in question. *Id.* Moreover, he testified that there have been no complaints registered complaining of the curb in question. (T. 46-47). Mr. Klintworth confirmed that there are several parking spaces adjoining the driveway, and that those parking spaces are for members of the public. (T. 47).

On Cross, Mr. Klintworth stated that the Jefferson St. entrance was open to the public until 5:00pm. (T. 48-49). Meaning, that at the time of the accident, members of the public were free to drive up and down the driveway, park in the available parking spots, and enter and exit the building. (T. 49). While Mr. Klintworth stated that the building could be busy at 4:30pm, he it really depended on the time of the season, and that during tax season the building is very busy around the clock. *Id.*

Conclusions of Law

Accident

Proving that an accident occurred during the course and arose out of employer is Petitioner's burden of proof and is necessary for a finding that an accident is compensable. *Baggett v. Industrial Comm'n*, 201 Ill.2d 187, 266 Ill.Dec. 836, 755 N.E.2d 908 (2002). The "in the course of" component contemplates the time and place of the accident; meaning that an accident must occur at work. *Lee v. Industrial Comm'n*, 167 Ill.2d 77, 656 N.E.2d 1084 (1995). Similarly, to satisfy the "arising out of" component, Petitioner must show that the accident must be connected with, or incidental to, employment so as to create a causal connection between the employment and the accident. *Id.* Petitioner has neither proved that his accident occurred in the course of, nor that it arose out of his employment with Respondent. The following analysis will first address the in the course of requirement followed by the arising out of requirement.

Employees who have fixed hours and fixed places of work are in the course of their employment at such times and places. However, such employees are generally not considered to be acting within the

course of their employment when leaving work to go home. Generally, when an employee is leaving work, they are rendering no service for their employer and are not considered to be acting within the course of their employment until returning to their post.

In *Williams v. Country Mutual Insurance Co.*, 28 Ill.App.3d 274, 328 N.E.2d 117, 120 – 121 (1st Dist. 1975), the court determined that an "on-premises" accident was compensable so long as the location where the accident occurred was "not used by members of the public at large but primarily facilitated employee traffic inside the expansive areas of the hospital complex." In fact, *Williams v. Country Mutual Insurance Co.* distinguishes itself from an earlier Illinois Supreme Court case wherein the petitioner's claim was found to not be compensable when the petitioner was hit by any automobile, driven by the petitioner's coworker, while the petitioner was crossing a street that separated the employer's factory and employer's parking lot because the street was not controlled by the employer and the employee was not acting on behalf of the employer while crossing the street. *Osborn v. Indus. Comm'n*, 50 Ill. 2d 150, 151, 277 N.E.2d 833, 834 (1971). While Respondent did have control over the driveway in question, its openness to the public and Petitioner's access to multiple points of egress obviates a finding that the accident occurred in the course of employment as there appears to be no defect caused by Respondent which would differentiate the driveway they controlled from any other public driveway, sidewalk, or road. Extension of property rules, which permit recovery when an employee is injured by a public risk when an employee is leaving work, are not applicable here as those rules require that the entrance used be the sole entrance available to the Petitioner. *See, Chicago Tribune Co. v. Industrial Commission of Illinois*, 136 Ill.App.3d 260, 483 N.E.2d 327, 91 Ill.Dec. 45 (1st Dist. 1985); *see also, McField v. Lincoln Hotel*, 35 Ill.App.2d 340, 182 N.E.2d 905 (1st Dist. 1962). In other words, the "course of" Petitioner's employment did not necessitate his use of the Jefferson entrance, nor did it necessitate that he cross the yellow curb such his employment implicitly required that route.

Notwithstanding the above, Petitioner must also prove his accident arose out of his employment with Respondent. An injury "arises out of" employment only when there is some risk connected with, or incidental to, Petitioner's employment so as to create a causal connection between the employment and the accidental injury. (*Jewel Cos. v. Industrial Comm'n*, 57 Ill.2d 38, 40, 310 N.E.2d 12; Chmelik v. Vana (1964), 31 Ill.2d 272, 277, 201 N.E.2d 434. (1974)) Frequently this occurs when the employee was performing acts he was instructed to perform by his employer, or when the employee had a common law or statutory duty to perform certain acts, or when employee might reasonably be expected to perform certain acts within the scope his assigned duties. (*Howell Tractor & Equipment Co. v. Industrial Comm'n*, 78 Ill.2d 567, 573, 38 Ill.Dec. 127, 403 N.E.2d 215. (1980)). A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his duties. *Fisher Body Division, General Motors Corp. v. Industrial Comm'n*, 40 Ill.2d 514, 516, 240 N.E.2d 694(1968). "If an employee is exposed to a risk common to the general public to a greater degree than other persons, the accidental injury is also said to arise out of his employment." *Caterpillar Tractor Co. v. Indus. Comm'n*, 129 Ill. 2d 52, 58, 541 N.E.2d 665, 667 (1989).

This issue primarily focuses on resolving two questions:

1. Was Petitioner was acting in furtherance of his employers interest?
2. And, did the action, taken in furtherance of that interest, place Petitioner at an increased risk of suffering the claimed accident and injury versus that of the general public?

In resolving the first question, the ruling in *Martin v. Kralis Poultry Co.*, 12 Ill.App.3d 453, 297 N.E.2d 610 (5th Dist. 1973) clearly dictates that "[E]ven though an accident happens on the employer's premises, if it occurs while the employee is doing something there for his own personal benefit, it does not arise out of his employment. *Id.*, at 616. This logic is echoed in *Spees v. Stapleton*, 111 Ill.App.2d 254, 250 N.E.2d 181 (5th Dist. 1969) where an employee who was injured while attempting to extricate a co-employees car that was stuck in snow in the company parking lot 30 minutes before work started was found to be not compensable. In the instant matter, Petitioner was acting for his own personal benefit. By using the Jefferson entrance, as opposed to the West entrance, and by crossing the yellow hazard line to illegally cross the street to reach his car, as opposed to following the sidewalk down to the legal cross walk, Petitioner was attempting to reach his car as soon as possible. This was of no benefit to Respondent. Although Petitioner could not recall the purpose of his hurried egress, he was certain it was not work related. Under the rule of *Martin v. Kralis Poultry Co.*, Petitioner's accident cannot be said to have occurred during the course of his employment because the purpose behind his actions were beyond the scope of his employment with Respondent and therefore Petitioner's claim is not compensable.

Notwithstanding the above, in resolving the second question, Petitioner was exiting work, after his shift, and although he was on his employer's premises he was on a portion that was open to the general public. Accordingly, Petitioner must not only show that he encountered a risk any risk or defect Petitioner encountered was a risk that the general public was exposed to, and the burden is on Petitioner to show that his employment with respondent forced him to encounter that risk in a manner that increasing Petitioner's risk of suffering an accident versus that of the general public. Such compensability findings require that the risk be peculiar to employment. *See Fisher Body Division, General Motors Corp. v. Industrial Commission*, 40 Ill.2d 514, 240 N.E.2d 694 (1968), (employee was injured in employer's parking lot when his automobile battery exploded due to inclement weather, the court held "neither the duties of his employment nor the fact that his car was in the parking lot significantly increased the danger of injury from working on his own car, a strictly personal activity."); *see also Jones v. Industrial Commission*, 78 Ill.2d 284, 399 N.E.2d 1314, 35 Ill.Dec. 786 (1980) (an employee that accidentally closed a car door on his hand did not suffer a compensable injury because the risk of the accident was not peculiar or the result of his employment, and moreover the risk to which the employee was exposed was not greater than that to the general public). Ambulation alone is not necessarily a risk distinctly associated with employment such that the accident of the Act requirement is satisfied. Absent additional risk imposed by employment, there cannot be a finding for Petitioner on the issue of Accident. *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Commission*, 407 Ill.App.3d 1010, 944 N.E.2d 800, 348 Ill.Dec. 559 (1st Dist. 2011) is influential in the matter and will be discussed in greater detail below.

Illinois workers' compensation law contemplates three types risk to which an employee may be exposed - (a) risks distinctly associated with the employment, (b) personal risks, and (c) neutral risks that have no particular employment or personal characteristics. *Illinois Institute of Technology Research Institute v. Industrial Commission*, 314 Ill.App.3d 149, 731 N.E.2d 795, 247 Ill.Dec. 22 (1st Dist. 2000); *Potenzo v. Illinois Workers' Compensation Commission*, 378 Ill.App.3d 113, 881 N.E.2d 523, 317 Ill.Dec. 355 (1st Dist. 2007). In *Metropolitan Water*, an accounting clerk was required to walk from her office to the bank two or three times per week to deposit checks. *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Commission,* 407 Ill.App.3d 1010, 944 N.E.2d 800, 348 Ill.Dec. 559 (1st Dist. 2011). While on one of these walks, she stumbled in a dip in the sidewalk on Erie Street in downtown Chicago. Although the appellate court reasoned that the case involved a neutral risk, which is typically not a compensable type risk in that it a risk that everyone is potentially exposed to and thus not related to employment, The Court found that the petitioner was exposed to that risk to a greater extent than the general public because she was required to traverse that route multiple times per week as required by her job. *Id.* The analysis in *Metropolitan Water* evaluates the nature of the risk that created accident in question. *Id.*

The entirety of the analysis in *Metropolitan Water* was to determine whether Petitioner's employment placed her at a greater risk of suffering the accident question such that it satisfied the arising out of employment requirement of a workers' compensation claim. *Id.* In *Metropolitan Water* the Petitioner was found to be exposed to a risk that the public at large was exposed to. While a dipped sidewalk certainly posed a greater risk than the average sidewalk, it was a greater risk that the general public was also exposed to. However, unlike the public at large, the Petitioner in *Metropolitan Water* provided specific testimony and evidence that her job duties forced her to encounter the risk in question at a frequency much greater than the general public such that the likelihood of her injuring herself while encountering that risk was, over time, much greater than the general public. Essentially there are two parts to the *Metropolitan Water* analysis.

In the instant matter the activity/risk contemplated walking across a curb. Unlike *Metropolitan Water,* there is no evidence that the curb was defective. The case at hand is most similar to *Caterpillar Tractor Co. v. Indus. Comm'n*, 129 Ill. 2d 52, 61, 541 N.E.2d 665, 668 (1989) where it was determined that Worker was not subjected to risk greater than that of the general public when he twisted his ankle when stepping off curb while walking from plant to private employee parking lot. Of particular importance is the fact that the parking lot in *Caterpillar* was private. *Id.* The public nature of the driveway and parking lot in question only push Petitioner's instant claim further out of the realm of possibility. In either event, had the driveway in the instant matter been private, Petitioner's claim would still fail.

In *Caterpillar*, Petitioner contended,

> . . . and the appellate court found, that the injury occurred both as the result of a condition on the employer's premises and because he was exposed to a greater degree of risk than the general public. The court noted that since there was evidence of a slight slope between the curb and the driveway, and since there was no evidence that the claimant tripped or fainted, or that

> the fall was idiopathic in nature, the Commission could properly have inferred that the cause of claimant's injury was the existence of the slope. The court further held that since Price was required to step off the curb to reach his vehicle, and there is no such requirement of the general public, he was subjected to a risk not required of the general public.

Caterpillar Tractor Co. v. Indus. Comm'n, 129 Ill. 2d 52, 59, 541 N.E.2d 665, 668 (1989). In *Caterpillar*, much like the instant matter, the question was whether a slight slope in the curb could be considered a defective or hazardous condition. In particular, the court found:

> The evidence presented at the hearing established that the curb was seven to eight inches in height and that there was a slight cement slope, apparently for drainage, between the curb and the driveway. The claimant testified that at the time of the injury, the pavement was dry and there were no holes, obstructions or rocks on the pavement. He did not trip, slip or fall; he simply stepped off the curb and twisted his ankle.

Id. In applying the facts of the case, to Illinois Workers' Compensation Law, the Supreme Court held:

> In our opinion, the only reasonable inference which can be drawn from the evidence in the record is that the condition of the premises was not a contributing cause of Price's injury. Liability for workers' compensation cannot rest on imagination, speculation or conjecture, but must be based solely upon the facts contained in the record. (Schroeder Iron Works v. Industrial Comm'n (1967), 36 Ill.2d 519, 523, 224 N.E.2d 233.) As there is nothing in the record to indicate that the curb was either defective or hazardous, a conclusion that the injury was caused by the slope is not supported by the record, and is no more than mere speculation.

Id. Much like in *Caterpillar*, there is no evidence of any defect or hazard that differentiates the curb in the instant matter from any number of curbs, sloped or otherwise, and caused the injury in question. To rephrase, Petitioner stepped off a curb approximately 1.5 inches high. The fact that the curb was sloped had no effect on the nature of Petitioner's fall. The only factor was the height, which according to the pictures was lower than the street curbs found outside the building.

The court in *Caterpillar* also addressed whether the claimant was subjected to a greater degree of risk than the general public because of his employment. *Id.*, 668-669. Petitioner contended that he was exposed to a risk greater than the general public due to the frequency with which he had to traverse the curb. The court in *Caterpillar* rejected this argument and found that the claimant did was not exposed to a risk not common to the general public. In so holding the court reasoned that:

> [t]he object of comparing between the exposure of the particular employee to a risk and the exposure of the general public to the risk is to isolate and identify the distinctive characteristics of the employment. (See 1 A. Larson, The Law of Workmen's Compensation § 8.42 (1985).) Curbs, and the risks inherent in traversing them, confront all members of the public. The claimant is no more liable to twisting his ankle than he would have been had he been engaged in any other business. While it is true that he regularly crossed this curb to reach his car, there is nothing in the record to distinguish this curb from any other curb. As noted previously, the mere fact that the duties take the employee to the place of the injury and that, but for the employment, he would not have been there, is not, of itself, sufficient to give rise to the right to compensation. (See *State House Inn v. Industrial Comm'n* (1965), 32 Ill.2d 160, 163, 204 N.E.2d 17; *Schwartz v. Industrial Comm'n* (1942), 379 Ill. 139, 145, 39 N.E.2d 980.) The claimant has the burden of establishing, by a preponderance of the evidence, some causal relation between the employment and the injury. *Quality Wood Products Corp. v. Industrial Comm'n* (1983), 97 Ill.2d 417, 423, 73 Ill.Dec. 571, 454 N.E.2d 668; *Horath v. Industrial Comm'n* (1983), 96 Ill.2d 349, 356, 70 Ill.Dec. 741, 449 N.E.2d 1345.

Id. The facts of the instant matter are even more favorable to Respondent than those in *Caterpillar*. In the instant matter, the curb was a public curb, which means that it was not merely analogous to the average curb encountered by the general populace, but was in fact one of the average curbs encountered by the general populace. Moreover, the expediency with which Petitioner was leaving work, takes his actions beyond those which might be attributable to his employment. Finally as there was no defect, and Petitioner's fall appears to be the result of the height of the curb, Petitioner's case is not distinguishable from *Caterpillar* and is not analogous to the ruling in *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Commission*.

Based on the forgoing, the Arbitrator finds that Petitioner cannot meet his burden of proof with regard to Accident. As Petitioner has not met his burden of proof regarding accident, all other disputed issues are rendered moot.

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

Robert Ayres,

Petitioner,

vs. NO: 13 WC 31778

Global Brass & Copper,

18IWCC0254

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of medical expenses, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 5, 2017, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

18IWCC0254

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 2 5 2018
TJT:yl
o 4/16/18
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

AYRES, ROBERT
Employee/Petitioner

Case# **13WC031778**

GLOBAL BRASS & COPPER
Employer/Respondent

18IWCC0254

On 7/5/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

4463 GALANTI LAW OFFICE PC
LESLIE N COLLINS
PO BOX 99
E ALTON, IL 62024

0299 KEEFE & DePAULI PC
ANDREW J KEEFE
2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

18IWCC0254

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)

Robert Ayres
Employee/Petitioner

v.

Global Brass & Copper
Employer/Respondent

Case # 13 WC 31778

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **McCarthy**, Arbitrator of the Commission, in the city of **Collinsville**, on **05/18/2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Reasonableness and necessity of medical treatment**

FINDINGS

On the date of accident, **08/09/2013**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned **$89,993.51**; the average weekly wage was **$1,729.49**.

On the date of accident, Petitioner was **50** years of age, ***married*** with **0** dependent children.

Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$20,424.38** for TTD, **$1,420.34** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$21,844.72**.

Respondent is entitled to a credit of **group insurance payments** under Section 8(j) of the Act.

ORDER

Respondent is ordered to pay the charges contained in PX 8 as they are in line with the requirements of Section 8 (a) of the Act. The payments should be made pursuant to the fee schedule.

Petitioner failed to establish the L4-5 disc replacement and L5-S1 fusion proposed by Dr. Matthew Gornet is reasonable and necessary. Therefore, prospective medical treatment as related to Petitioner's lumbar spine is hereby denied.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

D. Dyas McCarty

JUL 5 - 2017

6/29/201

ICArbDec19(b)

18IWCC0254

The Arbitrator finds the following Facts:

Petitioner, now 52 years of age, has been employed as an electrical technician for Respondent since 1992. Job requirements include working from ladders and scaffolds to install, maintain or repair electrical wiring, equipment and fixtures. The job requires lifting, pushing, pulling, squatting, standing and crawling to maintain electrical wiring. On August 9, 2013, Petitioner sustained an accident arising out of and in the course of his employment. A scaffolding collapsed causing Petitioner and a co-worker to fall 6 or 8 feet to the ground. Petitioner testified that he landed on his feet. The incident was immediately reported. Petitioner was taken to Alton Memorial Hospital.

Petitioner acknowledged at trial that he had a prior episode of low back pain resulting in the need for x-rays and possible therapy. He did not recall the date of injury.

Alton Memorial Hospital records reflect Petitioner reporting pain everywhere, with a primary concern of neck pain, numbness in his arms, hands, lips and teeth. Petitioner underwent multiple x-rays, including a cervical CT. Petitioner was diagnosed with cervicalgia, shoulder pain and neck sprain. Work restrictions were imposed. Petitioner was released to the care of Olin's Medical dispensary. (PX 1). A lumbar x-ray was taken August 16, 2013 that was interpreted to reveal degenerative endplate changes of the lumbar spine but no evidence of fracture or malalignment. (PX 4).

Petitioner testified that he was referred to Dr. Mitchell Rotman for his neck, shoulder and hand symptoms. Dr. Rotman's records are not included as exhibits.

Petitioner testified he subsequently developed low back, hip and knee pain. He was referred to Dr. Russell Cantrell on September 5, 2013. Dr. Cantrell documented Petitioner reporting diffuse pain complaints that had evolved in multiple locations. He recommended a total body bone scan. Based on examination and review of the medical records, Dr. Cantrell could not offer a clear explanation for Petitioner's subjective complaints of numbness in both hands. Dr. Cantrell noted the lower back, sacral, groin, and bilateral lower extremity complaints appeared to be symptoms with a delayed onset. He opined the degenerative changes noted in Petitioner's cervical and lumbar spine pre-existed the work accident. He opined there was no clinical evidence to suggest significant injuries sustained as a result of the work accident. He anticipated Petitioner could resume working his regular duties in 4-6 weeks. (PX 2, RX 5). Physical therapy and continued work restrictions were prescribed.

Petitioner underwent a total body bone scan on September 9, 2013. The radiologist noted minor activity in the feet and right patella, suggestive of degeneration versus post-traumatic in nature. The bone scan was otherwise deemed normal. (PX 4)

Petitioner underwent three days of therapy at PRORehab. As of September 16, 2013, the therapist documented that Petitioner continued to report subjective complaints of pain despite minimal objective findings. (PX 3).

Petitioner testified he hired an attorney who arranged for treatment with chiropractor Eavenson at Multicare Specialists. Petitioner acknowledged he received therapy and chiropractic care at Multicare Specialists from September 19, 2013 through November 21, 2013. He testified he received no other therapy for his lumbar spine thereafter.

Chiropractor Eavenson referred Petitioner to Dr. Matthew Gornet for an initial spine evaluation on October 8, 2013. Dr. Gornet documented Petitioner's symptoms were improving with chiropractic treatment and therapy. Petitioner reported his low back and groin were the major issue, and neck symptoms were present, but secondary to the low back. Dr. Gornet documented review of a cervical MRI and a lumbar MRI taken on September 25, 2013. The Arbitrator notes the cervical MRI report was contained in the exhibits (PX 4), but the lumbar MRI report was not. Dr. Gornet did not offer a firm diagnosis. He recommended continued therapy, chiropractic care and work restrictions. (PX 5).

As of November 21, 2013, Dr. Gornet recommended injections at C5-7 and L4-S1. Petitioner was to continue working light duty. No additional therapy or chiropractic care was ordered despite reported improvement with symptoms. (PX 5).

Records reflect Petitioner underwent cervical injections on December 2, 2013 and December 16, 2013. He underwent lumbar injections on January 20, 2014 and February 3, 2014. (PX 6).

Dr. Gornet's January 23, 2014 office note reflects the injections provided Petitioner temporary but no sustained relief. (PX 5). Petitioner testified the injections provided no relief. Dr. Gornet proposed a CT myelogram to be followed by disc replacement at C5-7. He did not offer treatment recommendations for the lumbar spine. Petitioner was to continue working light duty. (PX 5).

Petitioner underwent a Section 12 examination with Dr. Robert Bernardi on April 29, 2014.
Dr. Bernardi reviewed medical records covering August 9, 2013 through February 3, 2014.
Dr. Bernardi reviewed the September 25, 2013 lumbar MRI, interpreting the study to reveal multilevel degenerative disc disease manifested by slight disc bulging. He noted a subtle loss of disc hydration at L4-5. He noted loss of disc height and hydration at L5-S1. He did not identify any clinically significant central, lateral recess, or foraminal stenosis and no more than minor degenerative facet disease at any level. Dr. Bernardi did not identify any changes that could legitimately be considered acute or post-traumatic. There was no study revealing skeletal trauma. There was no evidence of ligamentous injury. Dr. Bernardi believed the etiology of Petitioner's low back was uncertain and his complaints unusual. No less, Dr. Bernardi attributed Petitioner's purported symptoms to the August 9, 2013 incident. He also suggested that findings from examination could be related to nervousness/anxiety. Dr. Bernardi agreed Petitioner should undergo a CT myelogram of the cervical spine to identify whether Petitioner had significant central stenosis. He did not believe additional lumbar treatment was indicated. He proposed Petitioner could attempt transitioning back to full duty.

Dr. Bernardi did not believe both chiropractic treatment and physical therapy to date were reasonable and necessary, nor did he believe the injections were reasonable and necessary. (RX 2: 04/29/14 report).

Dr. Gornet's May 5, 2014 note indicates low back treatment would be put on hold. Dr. Gornet dictated a similar note on August 18, 2014 and September 25, 2014. Physical examination remained unchanged. Petitioner was referred to Dr. Tanaka for left shoulder treatment while waiting for surgical authorization on the cervical spine. (PX 5).

Dr. Bernardi authored an addendum report dated August 4, 2014 having reviewed the CT myelogram results. Based on the previous examination and CT results, Dr. Bernardi had mixed feelings regarding the proposed cervical surgery. No less, he believed the recommendation was reasonable. He opined Petitioner could resume light duty 4-6 weeks after the two level disc replacement and resume full duty at 12 weeks. (RX 2: 08/04/14 report).

Petitioner underwent cervical surgery on October 29, 2014. The operative report was not contained in the exhibits. Petitioner testified that he was ordered and remained completely off work through March 2015.

Petitioner testified on direct examination he believed the cervical surgery was successful. However, on cross-examination he confirmed that he continues having nerve irritation and tingling in his arms and hands to date.

Petitioner resumed working his regular duties without restrictions beginning March 2, 2015. He testified that his employer has been accommodating and no longer requires him to do the heavier demand activities required of an electrical technician. He testified his current work requirements are far less demanding than before the work accident and he has not reported any complaints to his supervisor or Respondent's medical dispensary. He shows up for work every day and completes all tasks required.

Petitioner returned to Dr. Gornet on May 11, 2015. Dr. Gornet recommended an updated MRI of Petitioner's low back and mid-back to determine whether there was any progression. Dr. Gornet stated Petitioner understood the threshold to treat the low back should be much higher because there is much more residual in doing this. (PX 5).

Petitioner underwent a thoracic and lumbar MRI on July 27, 2015. Reportedly the lumbar MRI was compared to the September 25, 2013 study. (PX 4). Dr. Gornet interpreted the lumbar MRI to reveal a significant annular tear at L5-S1, fluid in the facet joints at L4-S1, some facet hypertrophy and foraminal stenosis at L4-5. No herniation was documented. There was no progression of lumbar pathology documented. Dr. Gornet opined the thoracic MRI revealed no significant disc pathology. Dr. Gornet recommended steroid injections at L4-S1. Petitioner was permitted to continue working without restriction. (PX 5).

Dr. Gornet's October 12, 2015 note documents that the lumbar injections helped Petitioner's low back, but the pain had slowly returned. Dr. Gornet believed observation was the best course. Dr. Gornet also referred Petitioner to Dr. George Paletta for right shoulder complaints. Following a December 18, 2015 right shoulder MRI, Dr. Paletta recommended surgery. (PX 5).

Petitioner underwent a second Section 12 examination with Dr. Bernardi on January 5, 2016. Petitioner reported he continued to have persistent interscapular pain following the cervical surgery. He reported having persistent aching and numbness in both hands and elbow pain. He reported the residual symptoms to be tolerable. He also reported continued low back complaints with intermittent testicular and foot pain. At that juncture, Petitioner was not interested in pursuing surgery on his low back. Dr. Bernardi reviewed medical records covering August 18, 2014 through December 18, 2015. Dr. Bernardi's interpretation of the July 27, 2015 lumbar MRI identified no difference from the September 25, 2013 study. Dr. Bernardi indicated Petitioner's low back and neck complaints remained unchanged from his prior evaluation. Dr. Bernardi placed Petitioner at maximum medical improvement for the cervical and lumbar spine. He stated the more recent lumbar injections were neither reasonable nor necessary.

Regarding the lumbar spine, Dr. Bernardi did not question Petitioner's reported symptoms. He reiterated the etiology was unclear and complaints unusual. He identified no objective physical/neurological findings that correlated with the complaints. He identified no correlating findings on the imaging studies. Dr. Bernardi did not believe Petitioner was a candidate for lumbar surgery. Under the best scenario, the outcome of lumbar surgery would be unpredictable. He could not justify the surgery in that Petitioner was less than enthusiastic about considering low back surgery; was suffering from degenerative disc disease whose natural history is favorable; who is working without restrictions; and, had low scores on the PDQ completed during the examination. Dr. Bernardi opined the risks associated with surgery are outweighed by the benefits. Surgery would not be in Petitioner's best interest. (RX 2: 01/05/2016 report).

Dr. Gornet placed Petitioner at maximum medical improvement regarding the cervical spine on January 25, 2016 after commenting on Dr. Bernardi's report. Dr. Gornet recommended Petitioner hold off on low back treatment while receiving shoulder treatment. (PX 5)

Petitioner underwent right shoulder surgery in late April 2016. He returned to Dr. Gornet on May 9, 2016. Dr. Gornet recommended an MRI spectroscopy and CT discogram of the lumbar spine. Petitioner was permitted to continue working without restrictions. (PX 5).

Dr. Gornet's August 8, 2016 office note documents the discogram revealing an obvious annular tear with a central disc protrusion at L4-5. He noted the facets to be normal and the disc was not painful when injected. He noted a severely provocative disc at L5-S1. The MRI spectroscopy reviewed October 20, 2016 purportedly revealed severe painful chemicals at L5-S1 with moderate chemicals at L4-5. Based on the studies, Dr. Gornet recommended L5-S1 fusion and L4-5 disc replacement. In the interim, he believed Petitioner could continue working without restrictions. (PX 5).

Dr. Bernardi generated an addendum report dated November 27, 2016 following review of updated medical records and imaging studies. Dr. Bernardi stated Dr. Gornet's January 25, 2016 report was laughable. Dr. Bernardi did not believe the additional testing performed was reasonable or necessary. Specifically, Dr. Bernardi stated there were no peer-reviewed articles that had proven the utility of the MRI spectroscopy in the treatment of a lumbar spine condition. To his knowledge, Dr. Gornet was the only spine surgeon to use MRI spectroscopy for clinical purposes.

Dr. Bernardi also found Dr. Gornet's treatment recommendations following the discogram results intriguing. Specifically, an injection at L4-5 was non-provocative and an injection at L5-S1 produced pain identical to Petitioner's typical discomfort. Dr. Bernardi did not understand why Dr. Gornet would propose surgery at the L4-5 level if the discogram was negative. He also did not understand why the discogram was performed if the results were not going to affect surgical decision making.

Dr. Bernardi reiterated that Petitioner's low back symptoms were work-related strictly from subjective information provided. There was no objective evidence supporting Petitioner's ongoing complaints. He did not believe the surgery proposed by Dr. Gornet was reasonable, necessary or in Petitioner's best interest. Dr. Bernardi noted the success rate from fusions performed to treat single level discogenic low back pain hover around 50 percent in the general population and only at 23 percent in the workers' compensation population. He opined these were daunting odds for an individual whose condition's natural history is favorable. (RX 2: 11/27/16 report).

Dr. Gornet's deposition was taken January 26, 2017. On direct examination, Dr. Gornet testified Petitioner had done extremely well from the two-level cervical disc replacement, albeit residual tingling in Petitioner's arms and hands. (PX 7 at 8). He testified the proposed lumbar surgery would be a larger surgery, and with that larger surgery, the bar to perform that surgery should be somewhat higher than the cervical spine, which is quicker recovery. (PX 7 at 10). Dr. Gornet testified there are potential treatments that may help Petitioner's lumbar condition, but he would proceed cautiously. (PX 7 at 13). As of the deposition date, he was a proposing Petitioner undergo L5-S1 fusion and L4-5 disc replacement. He anticipated the recovery period would be 6 to 8 months. Should Petitioner undergo the procedure, Dr. Gornet anticipated an 80 percent chance of Petitioner returning to work without restriction. (PX 7 at 14-15). He stated it is just a matter of time before Petitioner will not be able to work full duty as his problem is progressing. He stated Petitioner was rapidly heading toward loss of productivity and work status and an intervention appropriately timed would give Petitioner the best chance of remaining productive in the workforce. (PX 7 at 15). Petitioner admitted at trial his condition was not rapidly deteriorating. Dr. Gornet described the utility of the MRI spectroscopy. (PX 7 at 15-18). He opined Petitioner's current symptoms and requirement for treatment was causally related to the August 9, 2013 work accident. (PX 7 at 23-24).

On cross-examination, Dr. Gornet did not know whether restrictions he initially imposed on October 8, 2013 were based on Petitioner's lumbar or cervical condition. (PX 7 at 28). He agreed focusing on Petitioner's cervical spine as of January 23, 2014. (PX 7 at 29). He agreed an MRI cannot identify pathology as acute or not acute. (PX 7 at 30-31). He stated there is a 100 percent correlation between annular tears/disc herniation and degeneration, but that does not mean degeneration causes the conditions. (PX 7 at 31-32). Dr. Gornet testified the results of the cervical procedures are much more predictable than lumbar surgeries, given the size of the incision required for a cervical procedure is smaller and carries less baggage. (PX 7 at 37-38). He testified the threshold to treat the low back is much higher because of residual problems. (PX 7 at 40).Dr. Gornet admitted that as of January 25, 2016 there were no objective signs of Petitioner's low back condition progressing or deteriorating. (PX 7 at 45). He confirmed he is the only spine surgeon in the area that uses the MRI spectroscopy. He testified that he was one of lead investigators as to the utility of the equipment. He

testified there is no single diagnostic test that predicts the surgical outcome of anything. (PX 7 at 47-49). Dr. Gornet admitted Petitioner's L4-5 level was not a pain generator, but L5-S1 was. (PX 7 at 53). He further said that the Petitioner did not have any severe nerve compression, and that he did not have any significant radicular issues. (Id at 33) He also said that the Petitioner did not have a major neurological deficit. (Id at 40) Dr. Gornet explained other surgical options could be considered, but he would have to review the case. (PX 7 at 54-55). He agreed that there is no indication in the medical records that Petitioner has had a significant increase in symptoms or deterioration in physical condition as of October 21, 2016. (PX 7 at 56-57).

Dr. Bernardi's deposition was taken March 31, 2017. On direct examination, Dr. Bernardi testified that Petitioner's low back complaints were entirely inconsistent with an acute disc herniation. He testified that Dr. Gornet's use of the term "annular tear" was not recommended by multiple spine societies because the term tear implies acuity, and in this case, the "tear" was a "fissure" resulting from degeneration. (RX 2 at 11). Dr. Bernardi testified the findings on radiographic studies were consistent with Petitioner's age, much like wrinkly skin or gray hair. (RX 2 at 12). He stated it would be impossible to identify the etiology of Petitioner's reported axial low back pain. (RX 2 at 13). Dr. Bernardi testified Petitioner's January 5, 2016 physical examination of the lumbar spine revealed most of the neurological findings from the initial April 24, 2013 examination were no longer present. He believed Petitioner was back to normal neurologically. (RX 2 at 18). He testified Petitioner's symptoms were entirely incompatible with L4 nerve root irritation as far as physical findings. He was not impressed by any facet disease, and based on medical literature, facet disease has nothing to do with reported pain. (RX 2 at 21). As of the January 5, 2016 examination, Dr. Bernardi believed Petitioner had reached maximum medical improvement as related to the lumbar spine condition. He stated the surgery proposed by Dr. Gornet was at best unpredictable, perhaps 50/50 success rate and as low as 2 percent. He stated studies show there would be no difference between people who are treated surgically and people who are treated conservatively. As such a very invasive procedure really has no benefit. (RX 2 at 22-23). Dr. Bernardi stated that Dr. Gornet's proposition of an 80 percent success rate for the proposed surgery was not supported by medical literature. (RX 2 at 24). Dr. Bernardi explained why he did not believe the epidural injections Petitioner received were reasonable and necessary. (RX 2 at 25-26). Dr. Bernardi elaborated on the reasons why he did not believe the lumbar discogram and MRI spectroscopy were reasonable or necessary. (RX 2 at 28-29). He had no explanation for the reason Dr. Gornet was proposing lumbar surgery. (RX 2 at 29-30). Regarding Dr. Gornet's testimony that "it's just a matter of time before Petitioner is not able to work full duty and rapidly heading towards loss of productivity and work status," Dr. Bernardi testified and explained why he did not understand the comment in the slightest. (RX 2 at 31-32).

On cross-examination, Dr. Bernardi agreed that Petitioner struck him as a credible individual and provided accurate information. (RX 2 at 33). He testified that there are some conditions that surgery can fix, and some things it cannot, and that would be the reason why Petitioner should avoid surgery. (RX 2 at 34). Dr. Bernardi did not believe Petitioner's condition is going to deteriorate to some point that is absolutely going to require surgery. (RX 2 at 36).

Petitioner's Exhibit 8 suggests that Dr. Gornet has outstanding charges from January 25, 2016 through present in the amount of $8,506.48. No evidence was submitted demonstrating charges for Special Report/Form or Interest charges with code 99080 were appropriate. Petitioner's Exhibit 8 also suggests MRI of Chesterfield has an outstanding charge of $4,509.00 concerning right shoulder diagnostics. Respondent does not dispute liability for the right shoulder diagnostic studies, but contests liability for charges of excessive chiropractic/physical therapy treatment, lumbar injections, and all medical bills post-dating January 2016, including charges for the lumbar discogram, MRI spectroscopy, and follow up visits with Dr. Matthew Gornet.

Respondent's Exhibit 3 reflects medical payments made to date.

At trial, Petitioner was equivocal when stating that he wished to undergo the lumbar surgery proposed by Dr. Gornet. He testified "I think I might" want the surgery, but also acknowledged successful reduction of his symptoms was not guaranteed. He acknowledged the results of his cervical surgery were not as successful as documented in Dr. Gornet's records and that he continues having numbness and tingling in his arms and hands.

Therefore, the Arbitrator concludes:

The employer is required to pay the necessary medical expenses of the employee injured while working. 820 ILCS 305/8(a). For a medical expense to be paid for under the Workers' Compensation Act, the treatment must be reasonable and necessary to cure or relieve the effects of the work related injury. The employee can only recover expenses that are reasonable and causally related to the work accident. The award of medical expenses should only cover services that are necessary to diagnose, cure or relieve the effects of the employee's injury. *University of Illinois v. Industrial Comm'n,* 232 Ill.App. 3d 154, 596 N.E.2d 823 (1992). Reasonableness of medical services is defined as those services that are usual and customary for similar services in the community in which they were rendered. *General Tire & Rubber C. v. Industrial Comm'n,* 221 Ill. App. 3d 641, 582 N.E.2d 744 (1991)

F. Is Petitioner's current condition of ill-being causally related to the injury?

Petitioner's condition of ill-being as related to the lumbar spine is causally related to the August 9, 2013 work accident. The preponderance of the evidence demonstrates Petitioner had underlying degenerative disc disease that pre-existed the work accident. He did sustain a significant traumatic injury when he unexpectedly feel six to eight feet. All of the medical records from the accident date through Dr. Gornet's examination of January 21, 2014 document consistent complaints of lower back pain with some intermittent radiation down both legs to the feet. While the initial MRI report of September 25, 2013 was not offered into evidence, both doctors whom testified reviewed the films and made interpretations. Dr. Gornet characterized the findings at L4-5 and L5-S1 in terms of herniations and protrusions, while Dr. Bernardi characterized them as degenerative bulges. The Arbitrator believes that under either scenario, the findings are compatible with the Petitioner's complaints of lower back pain.

The Petitioner understandably took a break from his lumbar treatment to treat his more pressing problems in the cervical spine. When he resumed his lumbar treatment with Dr. Gornet in May 2015, his complaints of lumbar pain remained about the same. A second MRI was performed on July 27, 2015 and, while the doctors again had differing opinions as to the pathology, they both agreed that there was some mild foraminal narrowing at the level of L4-5 on the left. (PX 5; RX 2 at 21) The Petitioner has continued to experience symptoms consistent with Dr. Bernardi's reading of said MRI, and testified credibly concerning his ability to perform his job with some assistance.

Based upon the above findings, the Arbitrator finds the Petitioner's current condition of ill being to be causally related to his 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?

The Arbitrator finds that lumbar treatment has been reasonable and necessary. It was reasonable for Dr. Gornet to continue to workup the Petitioner's lumbar condition after he resumed treatment in May 2015. His symptoms had not resolved. Dr. Gornet's office note of May 11, 2015 explains his rationale for ordering the second MRI, and the Arbitrator finds it to be in line with the language contained in Section 8 (a) of the Act. The Arbitrator further finds the subsequent treatment to also be reasonably necessary to cure or relieve the Petitioner of his symptoms. The Arbitrator does not accept Dr. Bernardi's opinions concerning the spectroscopy. When the test was ordered, both doctors opined that the MRI contained some positive findings regarding at least disc at one level. The test, according to Dr. Gornet, was ordered to help him determine the extent of the disc damage. Just because Dr. Bernardi did not use the test or know of other physician's who do, does not mean that it was unreasonable.

Petitioner is seeking payment for two sets of charges contained in PX 8. The Arbitrator orders the Respondent to pay said charges, to the extent they remain unpaid, pursuant to the fee schedule.

K&O Is Petitioner entitled to any prospective medical care? Is the prospective medical care reasonable and necessary?

Petitioner failed to establish that prospective medical treatment is reasonable and necessary to cure or relieve symptoms associated with his lumbar condition. Again, the Arbitrator finds Dr. Bernardi's opinions more persuasive than Dr. Gornet's, and the surgery proposed by Dr. Gornet is not in Petitioner's best interest. Therefore, the request for prospective surgery is hereby denied.

Dr. Bernardi believes the surgery proposed by Dr. Gornet was at best unpredictable, perhaps there would be a 50/50 success rate and as low as 2 percent. He stated studies show there would be no difference between people who are treated surgically and people who are treated conservatively. As such a very invasive procedure really has no benefit. Dr. Bernardi stated that Dr. Gornet's proposition of an 80 percent success rate for the proposed surgery was not supported by medical literature. Dr. Bernardi noted the success rate from fusions performed to treat single level discogenic low back pain hover around 50 percent in the general population and only at 23 percent in the workers' compensation population. He opined these were daunting odds for an individual whose condition's natural history is favorable.

Dr. Bernardi testified that there are some conditions that surgery can fix, and some things it cannot, and that would be the reason why Petitioner should avoid surgery. Dr. Bernardi did not believe Petitioner's condition is going to deteriorate to some point that is absolutely going to require surgery.

More importantly, both doctors agree that the Petitioner does not have any nerve compression or true radiculopathy coming from the lumbar spine. The surgery recommendation, which Dr. Gornet said was invasive and apt to produce more residuals, is not reasonable under the circumstances.

Petitioner's equivocal testimony regarding his wanting the proposed lumbar surgery and his testimony of limited success from the cervical surgery (in that he continues having nerve irritation and tingling in his arms and hands to date) also factor into the denial of the major low back surgery with daunting success odds.

Petitioner resumed working his regular duties without restrictions beginning March 2, 2015. He testified that his employer has been accommodating and no longer requires him to do the heavier demand activities required of an electrical technician. He testified that his current work requirements are far less demanding than before the work accident and he has not reported any complaints to his supervisor or Respondent's medical dispensary. He shows up for work every day and completes all tasks required.

Finally, the Arbitrator notes the surgery proposed by Dr. Gornet is not supported by pre-operative testing.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WINNEBAGO

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tracena Simpson,

Petitioner,

vs.

NO: 13 WC 7336

State of Illinois Department of Human Services,

18IWCC0255

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, temporary total disability, permanent partial disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 6, 2017, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

DATED: APR 25 2018
TJT:yl
o 4/16/18
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SIMPSON, TRACENA
Employee/Petitioner

Case# **13WC007336**

ST OF IL-DEPT OF HUMAN SERVICES
Employer/Respondent

18IWCC0255

On 6/6/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

2489 BLACK & JONES
JASON ESMOND
308 W STATE ST SUITE 300
ROCKFORD, IL 61101

5946 ASSISTANT ATTORNEY GENERAL
HELEN LOZANO
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1745 DEPT OF HUMAN SERVICES
WORKERS' COMPENSATION MANGER
PO BOX 19208
SPRINGFIELD, IL 62794-9208

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62794-9255

CERTIFIED as a true and correct copy pursuant to 820 ILCS 305/14

JUN 6 - 2017

Ronald A. Peria
Ronald A. Peria, Acting Secretary
Illinois Workers' Compensation Commission

18IWCC0255

STATE OF ILLINOIS)
)SS.
COUNTY OF Winnebago)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Tracena Simpson
Employee/Petitioner

v.

State of Illinois-Dept. of Human Services
Employer/Respondent

Case # **13** WC **07336**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Rockford**, on **April 18, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **July 17, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$47,009.11**; the average weekly wage was **$904.02**.

On the date of accident, Petitioner was **52** years of age, ***single*** with **0** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent has paid **$0.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$2,633.73** for other benefits.

Respondent has paid **$0.00** under Section 8(j) of the Act.

ORDER

BECAUSE PETITIONER FAILED TO PROVE BY A PREPONDERANCE OF THE EVIDENCE THAT SHE SUSTAINED ACCIDENTAL INJURIES ARISING OUT OF AND IN THE COURSE OF HER EMPLOYMENT WITH RESPONDENT ON JULY 17, 2010 AND FURTHER FAILED TO PROVE BY A PREPONDERANCE OF THE EVIDENCE THAT HER CONDITION OF ILL BEING WAS CAUSALLY CONNECTION TO HER WORK ACTIVITIES WITH RESPONDENT, PETITIONER'S CLAIM FOR COMPENSATION IS DENIED.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

June 5, 2017
Date

JUN 6 - 2017

Statement of Facts

Petitioner Tracena Simpson testified that on July 17, 2012, she was a 52 year-old, right hand dominant employee of Respondent Illinois Department of Human Services. She worked as an office coordinator in the Child Support Department. Petitioner had worked with the Department of Human Services for approximately thirty years. She typically worked five days per week, 7.5 hours per day from 8:30 a.m. to 5:00 p.m. with one hour lunch. Petitioner was entitled to two fifteen minute breaks per day in addition to her lunch. She testified that she only took her breaks once or twice a week.

Petitioner testified that her work station was a desk with a monitor and a pullout keyboard at waist height. She did not use a wrist pad. Petitioner's duties included keyboarding tasks such as data entry and filling out forms, answering phones without a headset, opening and sorting mail daily, distributing daily mail, and face to face interactions with customers. She testified she typed six hours per day, did approximately forty five minutes of mail distribution, saw approximately thirty customers in office per day, made about five to ten outgoing telephone calls per day, and answered calls throughout the day. She testified she fills out applications and forms and types some letters. Petitioner completed these tasks using both hands. When she was on the phone, Petitioner would hold it between her right shoulder and right ear with her head tilted to the side while she continued to type. Petitioner would occasionally fill out forms by hand 5-10 times a day. She testified that if a customer came into the office, or she was opening and sorting mail, or needed to make or take a call, she would stop typing in order to engage in those tasks. While meeting with customers, she would find them in the system and enter notes to send to someone else. While distributing mail, she was away from her keyboard. Petitioner had no regular travel for work except for a period of about three months when Petitioner was required to travel once a week to the courthouse. The Job Description for Office Coordinator, "Use of hands for fine manipulation (typing, good finger dexterity)" was done for 6-8 hours per day. Lifting 1-10 pounds was done 0-2 hours per day. Lifting 10-20 pounds was done less than three times per day. Heavier lifting was never required (RX 2).

Petitioner testified that she began to notice symptoms or their hands while typing at work around May of 2013. She experienced tingling at night in her hand and it would wake her from sleep at night. Petitioner was seen by her primary care physician, Dr. Kent. Dr. Kent's records were admitted at Petitioner's Exhibit 1. Petitioner was first seen by Dr. Kent as a new patient on August 11, 2011. Her complaints were back pain from a fall a few years ago as well as a depressed mood that she felt was work related. She described it as more of a rut that depression (PX 1, p 33). Petitioner was evaluated for depression on February 1, 2012. The problem list on that date also included hyperlipidemia, osteoporosis and impaired fasting glucose (PX 1, p 14-17).

On May 11, 2012, Petitioner presented for follow up on depression. In addition she had complaints of possible carpal tunnel. She described right arm and forearm symptoms for years. She stated she wore wrist splint at work; seems to worsened symptoms. She reported a nerve test on the right "a long time ago." She was assessed with carpal tunnel syndrome and prescribed an EMG (PX 1, p 19-21). On June 7, 2012, she underwent an EMG test of the right hand which revealed mild right carpal tunnel syndrome (PX 2, p 97-98). Petitioner testified that Dr. Kent referred her to an orthopedic, Dr. Dannenmaier.

Dr. Dannenmaier's records were admitted at Petitioner's Exhibit 2. Petitioner was seen on July 17, 2012. Petitioner advised that she was a secretary. She complained of tingling and numbness in her right hand. She never had left handed symptoms. Her hand bothers her during the day. Activity aggravates it. Driving or

reading bothers her. Dr. Dannenmaier diagnosed right carpal tunnel syndrome and recommended a cock-up splint. If this does not improve, he recommended a carpal tunnel release (PX 2, p 93-94).

Petitioner testified that Dr. Dannenmaier informed her that her condition was related to her job. She reported her injury to her employer at that time. Petitioner prepared a Workers' Compensation Employee Notice of Injury dated August 23, 2012 (RX 2). She noted the date of injury was 2-3 years ago. The injury was carpal tunnel right hand. No duties or detail of the injury was provided (RX 2). The Supervisor's Report of Injury or Illness was prepared by Trudi Gleasman on July 24, 2012. It notes symptoms of carpal tunnel syndrome have developed over the course of the past 2-3 years. No unsafe condition was noted. The report states that he keyboard is on a typing height table and wrist supports are available (RX 20.

Petitioner returned to Lundholm Orthopedics on October 8, 2012 and saw Dr. Anton in Dr. Dannenmaier's absence. He reviewed her EMG and recommended she undergo a second EMG as her previous test was not convincing for carpal tunnel. Dr. Anton noted that there may be other processes such as arthritic pain in the hand which could be contributing (PX 2, p 85-86). On October 12, 2012, Petitioner saw Dr. Kent for a follow up on her depression, pre-diabetes and hyperlipidemia. Dr. Kent notes Petitioner's A1C is worse and that she is to work on diet and exercise. Dr. Kent notes Petitioner has mild carpal tunnel on right by EMG but clinical symptoms are not consistent with this (PX 1, p 8-9).

On November 15, 2012, Dr. Dannenmaier noted splints did not improve her symptoms. He recommended either injections or carpal tunnel and de Quervain release surgery. Petitioner asked for surgery (PX 2, 79-80). Petitioner underwent the surgical procedure on February 11, 2012. The preoperative and postoperative diagnosis was right carpal tunnel syndrome and de Quervain disease (PX 2, p 102-103).

She testified that was taken off work following surgery, returning to her employment on a full duty basis on April 1, 2013. Petitioner underwent physical therapy following surgery for approximately 4 weeks which also improved her symptoms. Petitioner testified she was released from medical care on April 19, 2013.

Petitioner denied being diagnosed with or being treated for diabetes. She did not recall being diagnosed with pre-diabetes. She denied having arthritis. She has osteoporosis in her back. Petitioner testified that the surgery did improve the numbness and tingling in her hand. Her hand still bothers her, but not nearly as much as before the surgical procedure. She returned to her regular job without restrictions. Petitioner testified that she continues to experience some ongoing symptoms in her hands after typing for long periods of time. She has some decreased grip strength in her fingers that she notices when washing dishes. Occasionally she has pain in her hand that comes out of nowhere. She has had no further treatment for her right wrist and does not take any prescription medication. She does not have any follow up appointments scheduled for her right wrist.

Petitioner was examined by Dr. Jeffrey Coe on January 26, 2015 at her attorney's request (PX 3, ex 2). Dr. Coe testified by evidence deposition taken July 18, 2016 (PX 3). Dr. Coe testified that he is Board certified in Occupational Medicine. Dr. Coe testified that he took a work history from Petitioner. She described her duties as an office coordinator as a receptionist and office support. She answered phones and performed computer data entry. He testified that Petitioner described her workstation. A computer was placed on a desk with a mouse. No ergonomic assessment or modifications have been made. She entered data on the keyboard and uses a mouse repeatedly with her right hand and arm. She is right handed. Dr. Coe reviewed Petitioner's treating medical records and performed a physical examination. He noted a BMI of 33. Petitioner had some tenderness adjacent to her surgical scar. He noted pillar tenderness. Petitioner had some mild stiffness in the

right wrist. She had a mildly positive Tinel's sign on the right. Finkelstein test was positive on the right. She had a little weakness in right handed grip strength (PX 3).

Dr. Coe opined that Petitioner's work activates were a factor in causing the development of right carpal tunnel syndrome and de Quervain tenosynovitis. Obesity may be a risk factor. He found no other risk factors such as cigarette smoking, diabetes, thyroid disease, collagen or vascular disease, intensive non-work activities. Dr. Coe testified that carpal tunnel syndrome can be idiopathic. It can be caused by direct trauma, repetitive motion mechanism, significant vibration, or medical systemic conditions. It is more common in women and as people get older. The dose required, frequency and force, has never been answered. Standard teaching is that repetitive micro trauma is a factor causing carpal tunnel syndrome. Computer use causing carpal tunnel syndrome is controversial (PX 3).

Petitioner was examined by Dr. James Williams on December 16, 2015 at Respondent's request (RX 4). Dr. Williams testified by evidence deposition taken October 27, 2016 (RX 5). Dr. Williams is a Board certified orthopedic surgeon and holds an additional CAQ in Hand and Upper Extremity Surgery. 99% of his practice is hand and upper extremity surgery. He testified he reviewed the treating medical records. He also reviewed the Form 45, Employee and Supervisor injury reports and the job description. Dr. Williams testified he took a history from Petitioner including her job duties and a description of her workstation. The workstation description is an L-shaped desk configuration. Her chair has armrests and raises and lowers. There is a drop down keyboard. Dr. Williams testified that the workstation was ergonomically okay (RX 5).

Risk factors for carpal tunnel are body mass over 30, hypertension, diabetes, and age in the 40s or 50s. It is more common in females than males and someone who is post menopausal. The largest percentage is someone with some type of inflammatory arthritis. De Quervain's risk factors are inflammatory arthritis, diabetes, smoking, and vibratory activities. Petitioner was female and in her 50s and post menopausal. She had an A1C of 6 noting diabetes. Her body mass 32.69 is classified as obese. Dr. Williams opined that Petitioners condition is not causally related to her job duties. He testified her work station was ergonomic, her typing was intermittent rather than non-stop, and she did not do anything requiring forceful, repetitive grasping, pinching and/or repetitive work. He felt her condition was related to her risk factors or could be idiopathic (RX 5).

Dr. Williams testified that on examination Petitioner had less strength on the right than the left. Carpal tunnel or de Quervain cannot be caused by phone use. Carpal tunnel or de Quervain can be caused by constant typing over 5-6 hours a day. Carpal tunnel or de Quervain is less likely to be caused by using a computer mouse. Opening mail could be causative if done with sufficient force for 5-6 hours. Causation does not look at a single activity. It can be cumulative.

Conclusions of Law

In support of the Arbitrator's decision with respect to (C) Accident, (D) Date of Accident, and (F) Causal Connection, the Arbitrator finds as follows:

To obtain compensation under the Act, a claimant must show, by a preponderance of the evidence, that she suffered a disabling injury that arose out of and in the course of the claimant's employment. An injury occurs "in the course of' employment when it occurs during employment and at a place where the claimant may reasonably perform employment duties, and while a claimant fulfills those duties or engages in some incidental employment duties. An injury "arises out of" one's employment if it originates from a risk connected with, or incidental to, the employment and involves a causal connection between the employment and the accidental injury. Petitioner in this matter has alleged that she suffered carpal tunnel syndrome as a result of the repetitive activities of her job duties with a date of manifestation on July 17, 2012. An employee who suffers a repetitive-trauma injury still may apply for benefits under the Act, but must meet the same standard of proof as an employee who suffers a sudden injury. In a repetitive trauma case, issues of accident and causation are intertwined. Therefore, a review of the evidence allows both issues to be resolved together." *Boettcher v. Spectrum Property Group and First Merit Venture Realty Group*, 97 W.C. 44539, 991.I.C. 0961.

The date of an accidental injury in a repetitive-trauma compensation case is the date on which the injury 'manifests itself.' 'Manifests itself' means the date on which both the fact of the injury and the causal relationship of the injury to the claimant's employment would have become plainly apparent to a reasonable person." The standard for determining the manifestation date in a repetitive trauma case is flexible and fact-specific and is guided by considerations of fairness. Because repetitive trauma injuries are progressive, the employee's medical treatment, as well as the severity of the injury and particularly how it affects the employee's performance, are relevant in determining objectively when a reasonable person would have plainly recognized the injury and its relation to work. Courts considering various factors have typically set the manifestation date on either the date on which the employee requires medical treatment or the date on which the employee can no longer perform work activities. Petitioner's choice of July 17, 2012, the date she met with Dr. Dannenmaier and testified that he told her that her condition was work related is an appropriate choice for the alleged date of accident in this matter.

An employee who suffers a repetitive trauma injury must meet the same standard of proof as an employee who suffers a sudden injury. In cases relying on the repetitive-trauma concept, the claimant generally relies on medical testimony establishing a causal connection between the work performed and claimant's disability. Petitioner submitted the opinions of Dr. Coe. Respondent presented the opinions of Dr. Williams. The proponent of expert testimony must lay a foundation sufficient to establish the reliability of the bases for the expert's opinion. Expert testimony shall be weighed like other evidence with its weight determined by the character, capacity, skill and opportunities for observation, as well as the state of mind of the expert and the nature of the case and its facts. If the basis of an expert's opinion is grounded in guess or surmise, it is too speculative to be reliable. Expert opinions must be supported by facts and are only as valid as the facts underlying them. A finder of fact is not bound by an expert opinion on an ultimate issue, but may look 'behind' the opinion to examine the underlying facts.

Neither treating physician, Dr. Kent nor Dr. Dannenmaier presented an opinion on causation. Both recorded a history of symptoms developing over 2-3 years. Dr. Coe opined that sustained repetitive strain injuries to her upper extremities from her work activities were a factor in the development of her carpal tunnel syndrome and

de Quervain's. The activities noted in his report and in his testimony were day long hand use in computer data entry with mouse manipulation. However, he admitted that he did not know exactly how many hours each day Petitioner was typing. He notes she also performed other tasks. She described her job as receptionist and office support person. His description of her workstation is simply a desk with a keyboard and mouse. He does not note the drop down keyboard location referenced by all the remaining evidence. He does not describe any particular forces exerted and notes that the causal connection of carpal tunnel syndrome with computer use is controversial.

Dr. Williams testified that the workstation was ergonomically okay. He noted multiple non-occupational risk factors. The Arbitrator notes that Dr. Coe also acknowledged these as risk factors. Dr. Williams opined that Petitioner's work activities were not a cause of her condition of ill being but rather the carpal tunnel syndrome and de Quervain's were related to her non-occupational factors including age, sex, post menopausal, diabetes, and obesity or were idiopathic. Dr. Williams's characterization of her typing as intermittent coincides with Petitioner's description of her duties and data entry combined with greeting customers, opening and distributing mail, and answering telephones. She testified she fills out applications and forms and types some letters. This is not sustained keyboarding for 5-6 hours straight per day.

Dr. Coe has essentially opined that frequent typing throughout the day alone without further detail of the exact duration, awkward hand position, and the forces exerted or other further risks is sufficient to find causation. This has been rejected by recent Commission case law. *Ramona Davis v. Winnebago County States Attorney*, 14 IWCC 0609, 14 Ill. Wrk. Comp. LEXIS 570, affirmed 16 Ill. App. 2d 150275WC-U, 2016 Ill. App. Unpub. LEXIS 212 (We do not believe it is true that a claimant could never successfully prove causal connection between certain clerical activities and carpal tunnel syndrome, but we believe that the Petitioner in this case did in fact fail to prove such a causal nexus. More than mere "frequent" keyboarding must be shown; we further note the importance of factors such as sustained hand positioning, force exerted and the duration of continuous keyboarding.); *Brandi Brooks v. Illinois-American Water*, 16 IWCC 0152, 2016 Ill. Wrk. Comp. LEXIS 201 (The Commission is not persuaded that work activities comprised only of substantial typing, using a computer mouse, and using a telephone with a headset significantly contributes to the development or aggravation of CTS.). See also *Stuart Whitson v. State of Illinois-Secretary of State*, 16 IWCC 0756, 10 WC 44094. Based upon the evidence presented as to the details of Petitioner's job duties included in her testimony and medical histories to the treating and examining doctors, the Arbitrator finds the opinions of Dr. Williams more persuasive than those of Dr. Coe.

Based upon the record as a whole, the Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that she sustained accidental injuries arising out of and in the course of her employment with Respondent and has further failed to prove by a preponderance of the evidence that the condition of ill being in her right hand is causally connected to her work activities with Respondent.

In support of the Arbitrator's decision with respect to (J) Medical, (K) Temporary Compensation, and (L) Nature and Extent, the Arbitrator finds as follows:

Based upon the Arbitrator's findings with respect to Accident and Causal Connection, the issues of Medical, Temporary Compensation, and Nature and Extent are moot.

Petitioner's claim for compensation is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify DOWN	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

YASMIN SANDERS,

Petitioner,

vs. NO: 13 WC 00933

HEARTLAND CORP.,

Respondent.

18IWCC0257

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, temporary disability, medical expenses, and prospective treatment, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327, 399 N.E.2d 1322 (1980).

I. Causal Connection

In finding Petitioner's condition of ill-being is causally related to her undisputed fall, the Arbitrator afforded greater credence to Dr. Weinzweig than Dr. Stogin. We affirm the Arbitrator's causation determination but provide further reasoning to address the parties' arguments.

Before us, Respondent highlights shortcomings in Dr. Weinzweig's records and argues Dr. Stogin's opinion is more credible. Petitioner's Response Brief counters that Dr. Weinzweig is more credible and emphasizes Dr. Weinzweig's credentials, including educational background and

authorship of published articles. Notably, Petitioner fails to cite to the record to support these statements, presumably because there is no evidence regarding the doctor's credentials in the transcript. The Commission will not consider argument dehors record and that portion of Petitioner's Response Brief is hereby disregarded.

The Commission recognizes Dr. Weinzweig's causation opinions primarily take the form of generic boilerplate in the treating records ("To a reasonable degree of medical certainty, the patient's symptoms and findings are directly related to the injuries sustained and/or tasks performed on a chronic basis at their place of employment"). We emphasize, however, in his September 10, 2013 record, Dr. Weinzweig documented he "reviewed Dr. Stogin's IME report and disagree with the causaltiy (sic) of this patient's symptoms as they could easily have resulted from her initial injury. She has a full blown picture of [right carpal tunnel syndrome] that warrants carpal tunnel release." PX4. Dr. Weinzweig's conclusion that Petitioner's specific mechanism of injury is a competent cause of traumatic carpal tunnel syndrome is consistent with the medical records, and we find it persuasive.

Moreover, the Commission observes a foundational weakness with Dr. Stogin's causation opinion in that the doctor does not appear to have been provided with all the relevant medical records. In his March 19, 2013 report, Dr. Stogin recorded the "most recent office note" he reviewed was from February 2, 2013. RX1. Therefore, as of his initial report, Dr. Stogin did not have Dr. Weinzweig's March 8, 2013 office note. It is the March 8 note which documents Petitioner's complaints of numbness and tingling, positive provocative testing for carpal tunnel syndrome, and the diagnosis of acute right carpal tunnel syndrome with recommendation for carpal tunnel release. PX4. Analysis of Dr. Stogin's addendums demonstrates the doctor was never provided with the March 8, 2013 note nor any of Dr. Weinzweig's office notes from the dates of service thereafter. As Dr. Stogin had an incomplete medical picture, his causation conclusion is diminished. See, *e.g.*, *Sunny Hill of Will County v. Illinois Workers' Compensation Commission*, 2014 IL App (3d) 130028WC, ¶36, 14 N.E.3d 16 (Expert opinions must be supported by facts and are only as valid as the facts underlying them.)

The evidence establishes Petitioner suffered an acute trauma to her wrist in the undisputed accident; shortly thereafter, she experienced an onset of symptoms indicative of carpal tunnel syndrome; objective diagnostic testing confirmed the diagnosis; and Dr. Weinzweig credibly opined the condition is related. Therefore, the Commission affirms the Arbitrator's finding of a causal connection between the January 6, 2013 accident and Petitioner's condition of ill-being.

II. Temporary Total Disability

There are two periods of temporary total disability involved herein: January 7, 2013 through March 21, 2013 and March 22, 2013 through July 15, 2014. The evidence establishes that on January 6, 2013, the emergency room physician authorized Petitioner off work for two days; when Petitioner was evaluated at Respondent's company clinic later that same day, the clinic physician imposed modified duty restrictions effective as of the January 8, 2013 return to work.

The evidence further demonstrates accommodated duty was not available, and Respondent commenced payment of temporary total disability benefits. Respondent paid TTD benefits until it received Dr. Stogin's March 21, 2013 Section 12 report, and the parties stipulated Respondent is entitled to a credit of $2,376.00 for the undisputed TTD benefits paid.

The disputed period of temporary total disability is March 22, 2013 through July 15, 2014. In *Holocker v. Illinois Workers' Compensation Commission*, 2017 IL App (3d) 160363WC, 82 N.E.3d 658, the Appellate Court clarified *Interstate Scaffolding* does not mandate an award of TTD, as a matter of law, if the claimant has not reached maximum medical improvement:

> Near the beginning of its analysis in *Interstate Scaffolding*, the supreme court states that, when a claimant seeks TTD benefits, the "dispositive inquiry is whether the claimant's condition has stabilized, *i.e.*, whether the claimant has reached [MMI]." *Interstate Scaffolding*, 236 Ill. 2d at 142. However, later in its analysis, the supreme court clarified that an injured employee is entitled to TTD benefits "if [he] is able to show that he continues to be temporarily totally disabled as a result of his work-related injury" (*id.* at 149) and that "when determining whether an employee is entitled to TTD benefits, the test is whether the employee remains temporarily totally disabled as a result of a work-related injury *and whether the employee is capable of returning to the work force*" (*id.* at 146). *Holocker*, ¶40 (emphasis in original).

Dr. Weinzweig continued to authorize Petitioner completely off work through the date of his last evaluation in 2014. While the Commission finds Dr. Weinzweig's causation opinion persuasive, we are not swayed by the doctor's conclusion that unilateral carpal tunnel syndrome completely prohibited Petitioner from work for over a year. Rather, we find Dr. Stogin's March 21, 2013 conclusion that Petitioner's symptoms would not prevent her from working in an unrestricted capacity, coupled with Petitioner's 13 months of employment at Jewel, confirm Petitioner has been and remains capable of returning to the workforce.

The Commission finds Petitioner was temporarily and totally disabled from January 7, 2013 through March 21, 2013, a period of 10 4/7 weeks, with Respondent receiving the stipulated credit of $2,367.00 for benefits paid. The Commission vacates the award of TTD from March 22, 2013 through July 15, 2014.

III. Medical Expenses

The Arbitrator's decision awards "the medical bills contained in Petitioner's Exhibit 1." On review, Respondent argues the bills include multiple dates of service for clearly unrelated conditions; specifically, Respondent identifies treatment at Little Company of Mary Hospital on March 13, 2013; May 1, 2013; May 25, 2013; and November 12, 2013. Petitioner does not directly respond to Respondent's argument and instead simply states the Arbitrator was correct in awarding the medical bills contained in Petitioner's Exhibit #1.

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The Commission agrees the four dates of service cited by Respondent are unrelated to Petitioner's wrist condition; however, we note Petitioner's Exhibit 1 contains corresponding bills for only the May 1, 2013 and May 25, 2013 dates of service. We further note the cover sheet attached to the bills exhibit does not accurately reflect the bills contained therein. Having analyzed the medical records and bills, the Commission finds the following services reasonable and necessary under Section 8(a) and causally related to Petitioner's work injury:

Provider	Dates of Service
Little Company of Mary	January 6, 2013
Evergreen Care Center	January 6, 2013 and January 8, 2013
Radiology Imaging Specialists	January 6, 2013
Evergreen Emergency Services	January 6, 2013
Dr. Jeffrey Weinzweig	January 11, 2013 through January 14, 2014
Instant Care Medical Group	May 13, 2013 and May 21, 2013
Evergreen Park Same Day Surgery Center	September 19, 2013

Respondent is ordered to pay the expenses associated with these services, subject to Section 8.2, with Respondent having credit for amounts previously paid. The bills submitted for unrelated treatment rendered at Little Company of Mary on May 1, 2013 and May 25, 2013 are denied.

The Commission feels compelled to address the handling of the medical records and bills in this case. There is no question the dates of service Respondent identified are unrelated to Petitioner's claim and no reasonable argument can be made to the contrary. As such, we are troubled by Petitioner's continued pursuit of these expenses on review. The Commission is further troubled by the offering of unquestionably unrelated, and highly personal, treatment records into evidence. These records were neither relevant nor probative of any disputed issue and we advise Petitioner's Counsel to be more judicious regarding claimants' medical records in the future.

IV. Prospective Medical

Petitioner sought approval for the carpal tunnel release and Guyon canal release recommended by Dr. Weinzweig. While the Commission affirms Petitioner's condition of ill-being is causally related to her work accident, the obvious concern is the unexplained 30-month delay between Petitioner's last evaluation by Dr. Weinzweig and when the matter was brought to trial. The Commission is not inclined to award surgery based on a four-year-old recommendation. Rather, the Commission finds the most reasonable course of action is for Petitioner to be re-evaluated by Dr. Weinzweig, and if Dr. Weinzweig concludes Petitioner remains a surgical candidate, Respondent shall provide and pay for same.

All else is affirmed.

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IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $198.00 per week for a period of 10 4/7 weeks, representing January 7, 2013 through March 21, 2013, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay reasonable and necessary medical expenses set forth herein as provided in §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall provide and pay for prospective medical treatment as recommended by Dr. Weinzweig as provided in §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $7,700.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 24 2018

L. Elizabeth Coppoletti

LEC/mck

O: 2/28/18

43

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

SANDERS, YASMIN
Employee/Petitioner

Case# **13WC000933**

HEARTLAND CORP
Employer/Respondent

18IWCC0257

On 2/14/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.62% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1067 ANKIN LAW OFFICE LLC
JILL WAGNER
10 N DEARBORN ST SUITE 500
CHICAGO, IL 60602

0011 LAW OFFICES OF EDWARD J. KOZEL
MARCY SINGER
333 S WABASH AVE 25TH FL
CHICAGO, IL 60604

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Yasmin Sanders
Employee/Petitioner

v.

Heartland Corp.
Employer/Respondent

Case # 13 WC 00933

Consolidated cases: N/A

18IWCC0257

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **July 13, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **January 6, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned **$10,926.00**; the average weekly wage was **$198.00**.

On the date of accident, Petitioner was **26** years of age, ***single*** with **0** dependent children.

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$2,376.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$2,376.00**.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

Respondent shall pay for the medical treatment/ services received by the Petitioner to date as it has been reasonable and necessary medical services, pursuant to the medical fee schedule, Little Company of Mary Hospital, Radiology Imaging Specialists, Evergreen Emergency Services, Ltd., to Dr. Jeffrey Weinzweig, and Elmwood Park Same Day Surgery Center, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for any medical treatment that has been previously paid for by the Respondent. Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay the Petitioner $198.00/week for 68 6/7 weeks, commencing March 21, 2013 through July 15, 2014, as provided in Section 8(b) of the Act. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from March 21, 2013 through July 15, 2014, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $2,367.00 for TTD that has been previously paid by the Respondent.

The Respondent shall authorize and pay for prospective medical care in the form of a right carpal tunnel release and Guyon's release and continued rehabilitative care as directed by Dr. Jeffrey Weinzweig.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Deborah L. Simpson

Signature of Arbitrator

February 10, 2017
Date

ICArbDec19(b)

FEB 14 2017

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Yasmin Sanders,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 13 WC 0933**
	)	
Heartland Corp.,	)	
	)	**18IWCC0257**
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on January 6, 2013, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that Petitioner sustained accidental injuries that arose out of and in the course of Petitioner's employment and that the Petitioner gave the Respondent timely notice of the accident which is the subject matter of this dispute. They agree further that in the year preceding the injuries, the Petitioner earned $10,296.00, and that her average weekly wage was $198.00.

At issue in this hearing is as follows: (1) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (2) Is the Respondent liable for the unpaid medical bills outlined in the attachment to Joint Exhibit #1; (3) Is Petitioner entitled to TTD from March 21, 2013 through July 15, 2014; and (4) Is Petitioner entitled to Prospective Medical treatment.

STATEMENT OF FACTS

The Petitioner, Yasmin Sanders (hereinafter referred to as the "Petitioner"), is a 30 year old woman who injured her right hand on January 6, 2013 while working at Burger King (hereinafter referred to as the "Respondent"). The Petitioner testified that she was a cashier for the Respondent working 25 hours a week earning $8.25 per hour. The Petitioner testified that while working on January 6, 2013, she was instructed to take a customer's food order out to the parking lot where he was parked waiting for his food. The Petitioner testified that she was walking the food out to the customer's car when she slipped and fell on ice, landing onto her right hand. She felt immediate pain in her right hand and told her supervisor, Marissa Humphrey. She then went to Little Company of Mary Hospital where she was diagnosed with a right hand contusion, given pain medications, and taken off of work. Pet. Ex. #2. She testified

that Marissa Humphrey called her back into work so that she could complete an incident report. She complied and went back to the Respondent to fill out the incident report where she was then directed to the company clinic, Evergreen Care Center. The Petitioner testified that she went to Evergreen Care Center where Dr. George Thomas diagnosed her with a right wrist sprain, gave her pain medications, and light duty work restrictions of no heavy lifting over five pounds with her right hand. Pet. Ex. #3. The Petitioner testified that Marissa Humphrey informed her that the Respondent did not have light duty work available for her.

The Petitioner then presented to the Chicago Center for Plastic and Reconstructive Surgery on January 11, 2013 where she saw Dr. Jeffrey Weinzweig for a consultation. Pet. Ex. #4. Dr. Weinzweig noted the same history of injury and diagnosed her with a work related right wrist contusion and took her off of work. Pet. Ex. #4. The Petitioner followed up with Dr. Weinzweig on February 1, 2013 and he prescribed a wrist splint and continued her off work restrictions. Pet. Ex. #4. On March 8, 2013 Dr. Weinzweig noted that the Petitioner had persistent pain, numbness, and tingling in her right hand and diagnosed her with acute right carpal tunnel syndrome, which he casually related to her work injury on January 6, 2013. Pet. Ex. #4. As such, he recommended a right carpal tunnel release and kept her off of work. Pet. Ex. #4.

The Petitioner then presented to Dr. John Stogin at the Northwestern Center for Surgery of the Hand on March 21, 2013 for an Independent Medical Examination at the request of the Respondent. Resp. Ex. #1. Dr. Stogin reported a consistent history and indicated that she never had any problems or injuries to her right wrist before her work injury on January 6, 2013. Resp. Ex. #1. Dr. Stogin indicated that the Petitioner was being recommended for a surgery, but neither he nor the Petitioner knew which surgery was being recommended. Resp. Ex. #1. Dr. Stogin diagnosed the Petitioner with a right wrist sprain but noted that he could not test for carpal stability because of the Petitioner's discomfort. Resp. Ex. #1. He also recommended an MRI in order to further evaluate the Petitioner's injury. Resp. Ex. #1. Despite this recommendation for further testing, he indicated that she was at maximum medical improvement and opined that she did not need surgery. Resp. Ex. #1.

The Petitioner underwent the recommended MRI to the right wrist on May 21, 2013 with Dr. George Kuritza at Instant Care Medical Group, which was deemed to be unremarkable. Pet. Ex. #4. Based on this test alone, Dr. Stogin prepared an Independent Medical Examination addendum on June 3, 2013 where he again opined that she did not need surgery and put her on full duty work restrictions. Resp. Ex. #2. He argued that there was no objective evidence to support an injury to the right wrist. Resp. Ex. #2.

The Petitioner presented to Dr. Weinzweig on June 11, 2013 and he diagnosed her with severe right carpal tunnel syndrome, recommended a right carpal tunnel release, and took her off of work until the surgery was performed. Pet. Ex. #4. Dr. Weinzweig continued to see the

Petitioner over the next few months and recommended that she undergo an EMG of her right upper extremity. Pet. Ex. #4. On September 10, 2013 Dr. Weinzweig reviewed the IME report and disagreed with its finding stating that her symptoms and findings are consistent with right carpal tunnel syndrome and did result from the initial injury. Pet. Ex. #4.

The Petitioner underwent the right wrist EMG with Dr. Gregory Thurston at Elmwood Park Same Day Surgery on September 19, 2013. Pet. Ex. #4. The EMG showed right median sensory neuropathy at the wrist, carpal tunnel syndrome without axonoapthy, right ulnar motor neuropathy with mild-moderate axonopathy without active denervation noted consistent with injury at the wrist. Pet. Ex. #4. Dr. Weinzweig reviewed the EMG on October 4, 2013 and noted that it showed positive carpal tunnel syndrome and compression of the ulnar nerve in the Guyon's canal. Pet. Ex. #4. On November 5, 2013, Dr. Weinzweig noted that she had progressive right carpal tunnel and compression of her ulnar nerve at the wrist in the Guyon's canal with a positive Phalen's test, positive forearm and carpal compression tests, thenar atrophy, 3/5 motor strength, and significant weakness of his intrinsic muscles. Pet. Ex. #4. He opined that these findings confirmed that she had right carpal tunnel syndrome that required surgery. Pet. Ex. #4.

Dr. Stogin completed another IME addendum on November 14, 2013. Resp. Ex. #3. Dr. Stogin reviewed the EMG report and admitted that it showed mild right carpal tunnel syndrome and mild right ulnar motor neuropathy, but questioned its findings. Resp. Ex. #3. Dr. Stogin went on to state, "Nevertheless, I think it would be reasonable for the Petitioner to undergo decompression of those nerves at the wrist if she has carpal tunnel injection that results in complete or nearly complete temporary relief of her symptoms." Resp. Ex. #3 pg. 2. He further stated that even if she did respond to the carpal tunnel injection, he does not relate her median or ulnar neuropathy to her fall at work. Resp. Ex. #3. The Petitioner never received an injection.

The Petitioner followed up with Dr. Weinzweig on December 3, 2013 and again on January 4, 2014 where he continued to diagnose her with progressive right carpal tunnel syndrome and compression of the ulnar nerve of the Guyon's canal which required surgery. Pet. Ex. #4. On January 4, 2014, he indicated that the Petitioner was experiencing numbness, tingling, and was awakened from sleep due to the pain. Pet. Ex. #4. Dr. Weinzweig continued her off work restrictions. Pet. Ex. #4.

The Petitioner testified that she did receive temporary total disability benefits until she saw the Independent Medical Examiner on March 21, 2013. She testified that as of the date of trial, her medical bills had not been paid. She testified that she never went back to work for the Respondent, but sought employment at Jewel in order to earn income and pay her bills. She testified that she worked in the deli department from July 15, 2014 through August 2015 cutting meats and preparing food for customers. She testified that she would often use a meat slicer that

operated in a forwards and backwards manner and did not include any twisting of her wrist. She testified that her job duties at Jewel did cause her pain in her right hand.

The Petitioner testified that she never had any right hand or wrist pain or treatment before her injury on January 6, 2013. She testified that as of the date of trial, she was still experiencing intermittent pain, numbness and tingling in her right hand. At times, the pain would be so severe that she had trouble dressing herself and could not open a jar. She testified that she wants to undergo the surgery that Dr. Weinzweig is recommending and she could not get the recommended treatment as of the date of trial because the Respondent did not offer her group health insurance.

CONCLUSIONS OF LAW

The burden is upon the party seeking an award to prove by a preponderance of the credible evidence the elements of his claim. *Peoria County Nursing Home v. Industrial Comm'n*, 115 Ill.2d 524, 505 N.E.2d 1026 (1987).

Longstanding Illinois law mandates a claimant must show that the injury is due to a cause connected to the employment to establish it arose out of employment. *Elliot v. Industrial Commission*, 153 Ill. App. 3d 238, 242 (1987).

The burden of proof is on a claimant to establish the elements of his right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. *Board of Trustees v. Industrial Commission*, 44 Ill. 2d 214 (1969).

The burden of proving disablement and the right to temporary total disability benefits lies with the Petitioner who must show this entitlement by a preponderance of the evidence. *J.M. Jones Co. v. Industrial Commission*, 71 Ill.2d 368, 375 N.E.2d 1306 (1978)

Proof of an employee's state of good health prior to the time of injury, and the change immediately following the injury, is competent as tending to establish that the impaired condition was due to the injury. *Westinghouse Electric Co. v. Industrial Commission*, 64 Ill. 2d 244,356 N.E. 2d 28 (1976).

WITH REGARD TO ITEM (F), WHETHER THE PETITIONER'S CURRENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE WORK ACCIDENT, THE ARBITRATOR RENDERS THE FOLLOWING FINDINGS OF FACT AND CONCLUSIONS OF LAW:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

The Arbitrator finds that the Petitioner's current condition of ill-being is causally related to her work accident. A causal connection between work duties and a condition of ill being may be established by a chain of events including petitioner's ability to perform the duties before the date of the accident, and inability to perform the same duties following that date. *Pulliam Masonry v. Industrial Comm'n.*, 77 Ill.2d 469, 471 (1979).

The Petitioner injured her right hand on January 6, 2013 while working for the Respondent. She testified that she was walking a customer's food out to his car when she slipped and fell on ice in the Respondent's parking lot. She testified that she fell backwards with all of her weight landing onto her right hand. She felt immediate pain and told her supervisor, Marissa Humphrey. She went to the Little Company of Mary Hospital on the same day where she was diagnosed with a right hand contusion and given pain medications. Pet. Ex. #2. The Petitioner's supervisor also sent her to the Evergreen Care Center the same day, where Dr. George Thomas diagnosed her with a right wrist sprain and gave her pain medications. Pet. Ex. #3.

Shortly thereafter, the Petitioner presented to Dr. Jeffrey Weinzweig for continued treatment. Pet. Ex. #4. Dr. Weinzweig noted that the Petitioner had pain, numbness and tingling in her right hand and diagnosed her with right carpal tunnel syndrome. Pet. Ex. #4. Dr. Weinzweig opined that her carpal tunnel syndrome was causally related to her work injury on January 6, 2013 and gave her a wrist splint and pain medications. Pet. Ex. #4. Dr. Weinzweig continued to see the Petitioner monthly and when the conservative measures failed and her symptoms persisted, he recommended a right carpal tunnel release. Pet. Ex. #4. He also ordered an EMG of the right upper extremity which was completed on September 19, 2013 by Dr. Gregory Thurston. Pet. Ex. #4. The EMG revealed right median sensory neuropathy at the wrist, right ulnar neuropathy, and right carpal tunnel syndrome. Pet. Ex. #4. Dr. Weinzweig reviewed the EMG and agreed it confirmed his diagnosis of right carpal tunnel syndrome. Pet. Ex. #4. The Petitioner continued to treat with Dr. Weinzweig on a monthly basis through January 4, 2014 where he continued to diagnose her with progressing carpal tunnel syndrome and continued to recommend she undergo a right carpal tunnel release and release of the Guyon's canal. Pet. Ex. #4.

The Petitioner underwent an Independent Medical Examination from Dr. John Stogin at the Northwestern Center for Surgery of the Hand on March 21, 2013. Resp. Ex. #1. Dr. Stogin relayed a consistent history of injury and noted that the Petitioner was being recommended for a surgery, but that neither he nor the Petitioner knew which type of surgery her doctor was recommending. Resp. Ex. #1. After his exam, Dr. Stogin diagnosed her with a wrist sprain, but indicated that the diagnosis was difficult to ascertain due to her discomfort. Resp. Ex. #1. He recommended an MRI to try and explain her ongoing symptoms. Resp. Ex. #1. He opined that he could not presently determine a causal link between her complaints and the injury, but that an MRI may change his opinion. Resp. Ex. #1. Despite this recommendation for further treatment

and admitting that he did not know what type of surgery was being recommended, he came to the conclusion that she did not need surgery and had reached maximum medical improvement. Resp. Ex. #1.

The first IME addendum was completed on June 3, 2013 following an MRI which was performed on May 21, 2013. Resp. Ex. #2. Dr. Stogin simply stated that because the MRI was normal and there was no objective evidence of a right wrist injury, she did not need surgery. Resp. Ex. #2. At this point, the Petitioner had not yet undergone the EMG. The second IME addendum was completed on November 14, 2013, after the EMG test was completed on September 19, 2013. Resp. Ex. #3. In this report, Dr. Stogin acknowledged the EMG findings of right carpal tunnel syndrome and right ulnar motor neuropathy but questioned its findings. Resp. Ex. #3. He went on to state that it would be reasonable for her to undergo decompression of those nerves at the wrist if she had a carpal tunnel injection that resulted in completed or nearly complete temporary relief of her symptoms. Resp. Ex. #3. The Petitioner never received an injection to her right wrist. He maintained that this treatment was not causally related to her work injury, but did not provide an explanation as to why. Resp. Ex. #3.

The Arbitrator gives the opinion of Dr. Weinzweig more weight over Dr. Stogin's opinion. Dr. Weinzweig gave consistent diagnoses and treatment plans for the Petitioner. Pet. Ex. #4. He first attempted to alleviate her pain with conservative measures such as splinting, pain medications, and off work restrictions. Pet. Ex. #4. When her pain complaints, numbness, and tingling persisted, he recommended surgery. Pet. Ex. #4. He ordered an EMG which confirmed his diagnosis and proves that she has carpal tunnel syndrome that needs surgery. Pet. Ex. #4. On the other hand, Dr. Stogin gave a tentative diagnosis without seeing all of the evidence and opinions regarding causation without explanation. In his initial visit, he recommended that she get further objective testing yet denied causation and further care before seeing the results of those tests. Resp. Ex. #1. He later based his denial on the fact that there were no objective tests that confirmed the diagnosis of carpal tunnel syndrome. Resp. Ex. #1. However, when confronted with an EMG that proves she has carpal tunnel syndrome, he acknowledged its findings but still denied causation without reason. He simply said, "Yet even if the conclusions are accepted, the diagnoses put forth do not typically cause the type of complaints that Ms. Sanders has." Resp. Ex. #3, pg. 2. Dr. Stogin completely ignored her subjective complaints of pain, numbness, and tingling and the fact that these symptoms persisted for eight months after his initial Independent Medical Examination in March of 2013 when coming to his conclusions. These reports are given little weight as they merely question treatment and deny causation without explanation or support from the medical records and tests. Thus, the Petitioner has proven that the Petitioner's current condition of ill being is causally related to her January 6, 2013 work injury.

WITH REGARD TO ITEM (J), WERE THE MEDICAL SERVICES PROVIDED TO THE PETITIONER REASONABLE AND NECESSARY AND HAS THE RESPONDENT PAID ALL APPROPRIATE CHARGES, THE ARBITRATOR RENDERS THE FOLLOWING FINDINGS OF FACT AND CONCLUSIONS OF LAW:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

The Arbitrator finds that the medical services provided to the Petitioner have been reasonable and necessary. Due to the Petitioner's work related injury, she has required treatment in the form of doctor's visits, diagnostic testing, medication, and splinting.

After her work injury on January 6, 2013, the Petitioner sought emergency care at Little Company of Mary Hospital. Pet. Ex. #2. She was also sent by the Respondent to Evergreen Care Center on the date of injury. Pet. Ex. #3. Shortly thereafter, she sought treatment at Chicago Center for Plastic and Reconstructive Surgery with Dr. Jeffrey Weinzweig who diagnosed her with work related right carpal tunnel syndrome. Pet. Ex. #4. While there, Dr. Weinzweig ordered a wrist splint, pain medications, and diagnostic tests. Pet. Ex. #4. When the conservative measures failed, Dr. Weinzweig recommended a right carpal tunnel release and Guyon's release. Pet. Ex. #4.

Initially, the Independent Medical examiner diagnosed the Petitioner with a wrist sprain and recommended an MRI to further evaluate her injury. Resp. Ex. #1. After reviewing the MRI, Dr. Stogin authored a second report which said that there was no objective evidence of an injury to the right wrist. Resp. Ex. #2. After that report, the Petitioner completed an EMG which confirmed the diagnosis of right carpal tunnel syndrome and right ulnar neuropathy. Pet. Ex. #4. Dr. Stogin reviewed the EMG in his third report, but merely questioned the EMG's accuracy and did not definitively dispute its findings. Resp. Ex. #3. He indicated that it would be reasonable for her to undergo a decompression of her nerve at the wrist if a carpal tunnel injection resulted in complete temporary relief of her symptoms. Resp. Ex. #3. He opined that this treatment would not be causally related to her fall at work, but does not give any explanation as to why. Resp. Ex. #3.

Dr. Weinzweig's opinion should be given greater weight than that of Dr. Stogin as it was consistent and is supported by the Petitioner's subjective complaints and objective findings. Dr. Stogin never gave an opinion as to the reasonableness and necessity of Dr. Weinzweig's treatment, but only denied further care. In coming to his conclusion about prospective care, Dr. Stogin gave opinions before reviewing all of the evidence and repeatedly mentioned that he needed objective evidence in order to determine if she had carpal tunnel syndrome. When he was given that objective evidence confirming her carpal tunnel, he still disputed causation without providing any basis for his opinion. Resp. Ex. #3. On the other hand, Dr. Weinzweig's

opinions took into account the objective evidence, the Petitioner's subjective complaints, and remained consistent throughout her treatment. As of the date of trial, the Petitioner still had pain complaints, thereby proving that she needs further care. As such, Dr. Weinzweig's opinion should be given more weight and his treatment should be found to be reasonable and necessary.

Accordingly, the preponderance of credible evidence establishes that the Petitioner has right carpal tunnel syndrome, has failed conservative medical care, and now needs a right carpal tunnel release and Guyon's release. The Petitioner testified that her medical bills have not been paid as of the date of trial. At trial, the Petitioner produced an itemization of all medical bills that the Respondent has refused to pay. Pet. Ex. #1. The Arbitrator finds that the Respondent has not paid all appropriate charges. The Arbitrator therefore finds that the Petitioner's medical care has been reasonable and necessary. Since the treatment she received is deemed reasonable and necessary, the Arbitrator hereby awards the Petitioner the medical bills contained in Petitioner's Exhibit #1 and attached to Joint Exhibit #1.

WITH REGARD TO ITEM (K), IS THE PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR RENDERS THE FOLLOWING FINDINGS OF FACT AND CONCLUSIONS OF LAW:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

The Arbitrator awards the Petitioner prospective medical care in the form of a right carpal tunnel release and Guyon's release as recommended by Dr. Jeffrey Weinzweig. The Petitioner has shown that her current condition of ill-being is causally related to her work injury and that she has not yet achieved maximum medical improvement.

At the last date of treatment, Dr. Weinzweig noted that the Petitioner had numbness and tingling in her right hand and was being woken up at night from her pain. Pet. Ex. #4. He continued to recommend surgery. Pet. Ex. #4. The Petitioner has already undergone conservative measures of splinting and pain medications, but her symptoms have persisted. Pet. Ex. #4.

The Respondent's Independent Medical Examiner, Dr. Stogin agreed that the Petitioner needs more treatment. Resp. Ex. #3. He opined that a decompression of the nerves would be reasonable if she had a carpal tunnel injection and it completely alleviated her symptoms. Resp. Ex. #3. However, the Respondent never authorized an injection or the right carpal tunnel release. Resp. Ex. #3. This is an undisputed right hand injury where all doctors agree that she needs further care. Accordingly, the Petitioner has proven by a preponderance of the evidence that she has not reached maximum medical improvement for her work injury and she is therefore

awarded a right carpal tunnel release and Guyon's release and continued follow up care with Dr. Weinzweig.

WITH REGARD TO ITEM (L), ARE TTD BENEFITS OWED TO PETITIONER, THE ARBITRATOR RENDERS THE FOLLOWING FINDINGS OF FACT AND CONCLUSIONS OF LAW:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

The Arbitrator finds that the Petitioner is entitled to TTD benefits from March 21, 2013 through July 15, 2014, a period of 68 6/7 weeks. The Petitioner has shown by a preponderance of credible evidence that her current condition of ill-being is causally related to her work injury. The Petitioner was initially taken off of work from the Little Company of Mary Hospital and then placed on light duty work restrictions by Evergreen Care Center on the date of the injury, which the Respondent could not accommodate. Pet. Ex. #2, #3. The Petitioner testified that her supervisor, Marissa Humphrey, told her that there was no light duty work available.

Immediately after the injury, the Petitioner began receiving temporary total disability benefits from the Respondent. The Petitioner began treatment with Dr. Jeffrey Weinzweig at the Chicago Center for Plastic and Reconstructive Surgery as of January 11, 2013. Pet. Ex. #4. The Petitioner treated with Dr. Weinzweig on a monthly basis from January 11, 2013 through January 4, 2014, where he diagnosed her with work related right carpal tunnel syndrome and took her off of work from January 11, 2013 through the date of surgery that he is currently recommending. Pet. Ex. #4.

The Petitioner testified that she stopped receiving temporary total disability benefits from the Respondent after her Independent Medical Examination with Dr. Stogin on March 21, 2013. She testified that she began work at Jewel in order to earn income since she was not being paid from the Respondent. She worked as a deli clerk from July 15, 2014 through August 2015.

The Petitioner's medical records establish that he has been either on a light duty work status or has been off of work since the date of injury through July 15, 2014. Therefore, the Arbitrator finds the Petitioner is entitled to TTD benefits for the time period of March 21, 2013 through July 15, 2014.

ORDER OF THE ARBITRATOR

Respondent shall pay for the medical treatment/ services received by the Petitioner to date as it has been reasonable and necessary medical services, pursuant to the medical fee

schedule, Little Company of Mary Hospital, Radiology Imaging Specialists, Evergreen Emergency Services, Ltd., to Dr. Jeffrey Weinzweig, and Elmwood Park Same Day Surgery Center, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for any medical treatment that has been previously paid for by the Respondent. Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay the Petitioner $198.00/week for 68 6/7 weeks, commencing March 21, 2013 through July 15, 2014, as provided in Section 8(b) of the Act. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from March 21, 2013 through July 15, 2014, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $2,367.00 for TTD that has been previously paid by the Respondent.

The Respondent shall authorize and pay for prospective medical care in the form of a right carpal tunnel release and Guyon's release and continued rehabilitative care as directed by Dr. Jeffrey Weinzweig.

Deborah L. Simpson

Signature of Arbitrator

Feburary 10, 2017

Date

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☒ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LASHAUNNA TAYLOR,

Petitioner,

vs.

NO: 14 WC 13298

DUPAGE COUNTY SHERIFF'S DEPARTMENT,

Respondent.

18IWCC0256

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 disability, and permanent disability and being advised of the facts and law, affirms the Arbitrator's finding that Petitioner's March 11, 2014 fall was not compensable but applies different reasoning to reach its conclusion.

Petitioner is a deputy sheriff in the DuPage County Sheriff's Department. At the time of her alleged accident, her duty assignment was courtroom deputy in the 505 Judicial Center (hereinafter referred to as the "505 building") on the DuPage County governmental campus.

On March 11, 2014, Petitioner arrived at the DuPage County campus between 6:30 and 6:45 a.m. and parked her personal vehicle in the parking garage east of the 505 building (hereinafter referred to as the "509 garage"). Petitioner testified she exited the 509 garage and proceeded toward the front door of the 505 building; as she walked across the vehicle turnaround, she slipped on ice and fell.

A satellite image of the relevant portion of the DuPage County complex was admitted as Respondent's Exhibit 1. At the Arbitrator's direction, Petitioner marked the exhibit to illustrate her exit point from the 509 garage, route to the 505 building, and the location of her fall. Notably, Petitioner indicated she fell in the roadway.

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When an employee slips and falls, or is otherwise injured, at a point off the employer's premises while traveling to or from work, her injuries are ordinarily not compensable under the Act. *Butler Manufacturing Co. v. Industrial Commission*, 85 Ill. 2d 213, 216, 422 N.E.2d 625 (1981). However, two exceptions to this "general premises rule" have been recognized. First, recovery has been permitted for off-premises injuries when "the employee's presence at the place where the accident occurred was required in the performance of his duties and the employee is exposed to a risk common to the general public to a greater degree than other persons." *Illinois Bell Telephone Co. v. Industrial Commission*, 131 Ill. 2d 478, 484, 546 N.E.2d 603 (1989). This exception is inapplicable as the record is devoid of evidence establishing Petitioner's presence in the traffic circle was necessitated by the performance of her duties. As the first condition of the exception is not satisfied, we need not address the second.

Recovery has also been permitted where the employee is injured in a parking lot provided by and under the control of the employer. *Illinois Bell Telephone Co.*, 131 Ill. 2d at 484. This exception, known as the "parking lot exception," applies in circumstances where the employee's injury is caused by some hazardous condition in the parking lot. *Vill v. Industrial Commission*, 351 Ill. App. 3d 798, 803, 814 N.E.2d 917 (2004). The rationale for awarding workers' compensation benefits when an employee is injured because of the conditions of an employer-provided parking lot is that the "employer-provided parking lot is considered part of the employer's premises." *Mores-Harvey v. Industrial Commission*, 345 Ill. App. 3d 1034, 1038, 804 N.E.2d 1086 (2004). Once the parking lot is considered part of the employer's premises, any injury on the parking lot is compensable if it would be compensable on the employer's main premises. *Id.*

The Arbitrator found Petitioner failed to prove she sustained a compensable accident. As detailed in the Arbitrator's decision, there was a great deal of testimony regarding whether Respondent had directed Petitioner where to park. The Arbitrator's analysis and the parties' argument in their respective briefs before us concentrate on whether Petitioner was required to park in the 509 garage. To be clear, though, Petitioner did not fall in the parking lot: Petitioner's testimony as well as her illustration of her route on Respondent's Exhibit 1 conclusively prove Petitioner fell while walking through the traffic circle:

Q. And you began walking across the turnabout?

A. Yes.

Q. And before the curb what happened?

A. I fell. T. 31.

As such, the Commission finds the focus on the parking lot exception is misplaced.

Rather, the Commission finds *Reed v. Industrial Commission*, 63 Ill. 2d 247, 347 N.E. 2d 157 (1976), to be directly on point. In *Reed*, the claimant was an employee of Burnham City Hospital; hospital employees were permitted to park at a reduced rate in a public parking lot directly across the street from the hospital. On the date of her alleged accident, the claimant

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completed her workday, exited the hospital, and proceeded to the parking lot across the street. From the building exit, she walked north on the paved crosswalk which led across the east-west public sidewalk; after the claimant passed the public sidewalk, she slipped on a patch of ice and fell. The north property line of the hospital terminated at the south edge of the sidewalk, so the place where the claimant fell was not on the employer's property. The Supreme Court of Illinois rejected the claimant's attempt to invoke the parking lot exception:

> The plaintiff relies upon an exception to this general rule under which recovery has been permitted by an employee who slips and falls while in a parking lot which the employer has provided for its employees, and which is being used by the employee for that purpose at the time. (Citations) The present accident, however, did not occur within a parking lot. There is a metered public parking lot, owned by the city, directly across Stoughton Street from the hospital, and there was testimony that an arrangement existed whereby hospital employees were allowed to use the lot at a reduced rate. The accident, however, did not take place in the lot but on a public way between the lot and the claimant's place of employment. In such circumstances an employee's injuries are not compensable. *Osborn v. Industrial Com.* (1971), 50 Ill.2d 150; cf. *Browne v. Industrial Com.* (1967), 38 Ill.2d 193. *Reed*, 36 Ill. 2d at 249 (Emphasis added).

As in *Reed*, Petitioner's accident did not take place in an employer-provided parking lot; instead, Petitioner encountered ice as she walked through the traffic circle between the 509 garage and the 505 building. As Petitioner had already exited the parking lot and was in a public street when she fell, the parking lot exception is inapplicable. Therefore, the Commission finds Petitioner's fall was not compensable.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 2, 2017 as modified is hereby affirmed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

The bond requirement in Section 19(f)(2) is applicable only when "the Commission shall have entered an award for the payment of money." *820 ILCS 305/19(f)(2)*. Based upon the denial of compensation herein, no bond is set by the Commission.

18IWCC0256

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: APR 25 2018

L. Elizabeth Coppoletti

LEC/mck

O: 2/28/18

Charles J. DeVriendt

43

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

TAYLOR, LaSHUANNA
Employee/Petitioner

Case# **14WC013298**

DuPAGE COUNTY SHERIFF'S DEPARTMENT
Employer/Respondent

18IWCC0256

On 2/2/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.62% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1357 RATHBUN CSERVENYAK & KOZOL LLC
NICKOLAS M JERDE
3260 EXECUTIVE DR
JOLIET, IL 60431

0560 WIENDER & McAULIFFE LTD
CATHERINE M LEVINE
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPAGE)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Lashaunna Taylor
Employee/Petitioner

v.

DuPage County Sheriff's Department
Employer/Respondent

Case # 14 WC 13298

Consolidated cases: N/A

18IWCC0256

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Wheaton**, on **November 21, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **March 11, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment as explained *infra*.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being ***is not*** causally related to the accident as explained *infra*.

In the year preceding the injury, Petitioner earned **$76,000.08**; the average weekly wage was **$1,461.54**.

On the date of accident, Petitioner was **45** years of age, ***married*** with **1** dependent child.

Petitioner ***has*** received all reasonable and necessary medical services as explained *infra*.

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services as explained *infra*.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner failed to establish that she sustained a compensable injury on March 11, 2014 as claimed. By extension, all other issues are rendered moot and all requested compensation and benefits are denied.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

January 20, 2017
Date

ICArbDec19(b) p. 2

FEB 2 - 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*

Lashaunna Taylor
Employee/Petitioner

v.

DuPage County Sheriff's Department
Employer/Respondent

Case # 14 WC 13298

Consolidated cases: N/A

FINDINGS OF FACT

The issues in dispute at this hearing include whether Petitioner sustained a compensable accident on March 11, 2014, whether there is a causal connection between Petitioner's right knee or low back conditions and a compensable accident on March 11, 2014, Respondent's liability for payment of Petitioner's medical bills, Petitioner's entitlement to temporary total disability benefits commencing on March 11, 2014 through April 10, 2014, and the nature and extent of Petitioner's injury. Arbitrator's Exhibit[1] ("AX") 1. The parties have stipulated to all other issues. AX1.

Background

Lashaunna Taylor (Petitioner) testified that she was employed by the DuPage County Sheriff's Department (Respondent) as a Deputy Sheriff on March 11, 2014. In this position, Petitioner is responsible for maintaining the safety and security of the courthouse. She has been employed by Respondent in various positions over 20 years before she began her current position six years ago in the 505 building.

Petitioner testified that she underwent training when she first became a Deputy Sheriff. She explained that the training began with Corporal Shannon, head of the training unit, who trained her for her job in the courthouse. The training with Corporal Shannon was one week followed by a six-week "JOF" judicial training program that involved going through every security post in the courthouse. At that point, Petitioner could work "on her own." Petitioner believed that while she was in training, she could come into the 505 building and by-pass security with her identification, but she testified that she and the other trainees usually met at the front desk of the 505 building located beyond the security desk.

Petitioner testified that Corporal Shannon told her when she began the training program that she had to park in the 509 parking garage. She denied that Corporal Shannon met her, or other trainees, in the parking garage every day so that he could walk her into the building to bypass security while she was in training. Petitioner testified that a security access card allowed her to enter the building or access locked areas in the 505 building and her identification allowed her to access the jail. At the time of training, Petitioner testified that she had her key card which allowed her to have access to the 505 building.

Petitioner testified that parking is limited in the 509 parking garage because there are reserved spaces and gated areas that require a key pass (i.e., for judges). However, the area in which she parked in the 509 parking garage is open to the public.

[1] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party.

Petitioner acknowledged that there are other parking garages and uncovered, open-air parking lots in the government complex located next to other buildings, but these parking locations were further away from the 505 building in which she worked than the location of the 509 parking garage. Petitioner testified that she has never parked in the other parking locations to go to work at the 505 building.

On cross examination, Petitioner maintained that she parked in the 509 parking garage because she was told to park there by Corporal Shannon. She also testified that she parked in the 509 parking lot because it is the closest and most convenient parking location in the government center complex to the 505 building in which she was allowed to park (i.e., not reserved for judges or restricted to employees). Petitioner acknowledged that there was no punishment for failing to park in the 509 parking garage and parking in one of the other available locations in the government complex. However, Petitioner also testified that she did not have the option to park in any other garage and that she was told to park in the 509 garage.

March 11, 2014

Petitioner testified that she drove her personal vehicle to work and arrived between 6:30 a.m. and 6:45 a.m. Petitioner described that it was dark, cold, and there was precipitation on the ground.

Petitioner testified that she parked in the 509 parking garage and was assigned to work in the 505 building. Petitioner testified that that she exited the 509 parking garage and traversed a traffic circle when she fell forward on ice in the street before getting to the curb and sidewalk leading to the 505 building. *See also* RX1[2]. Petitioner acknowledged that she did not land on her back when she fell, but rather fell forward. Petitioner testified that she noticed a burning sensation in her right knee.

After she fell, Petitioner testified that she got up and a maintenance person who was nearby came over and asked her if she was ok. Petitioner testified that she responded that she "ha[d] it" and then went into the 505 building. Petitioner then reported the incident to Corporal Townsend, the officer in charge of screening people coming into the courthouse.

Medical Treatment

Petitioner sought medical treatment at Cadence Health on March 11, 2014. Petitioner testified that she felt pain in her right side lower back and right knee.

The medical records reflect that Petitioner saw Stephen Headley, D.O. (Dr. Headley) and reported that she "slipped on ice and fell on right side, injuring her right lumbar and right knee." PX2. She described "pain to her lower back and around to her lateral side. She described her back pain as a 'hot', constant throbbing pain, 7 out of 10 on a pain scale. Right knee has a small ab[]rasion just inferior to the patella, and is described as a sore pain 3 or 4 out of 10 on a scale. The patient was favoring her leg after the fall." *Id.* Petitioner also reported "pain located in the right lumbar paraspinous region. She describes it as aching. She considers it to be medium. Her second problem is pain located in the right knee. She describes it as burning. She considers it to be large." *Id.*

On physical examination of the right knee, Dr. Headley noted an abrasion and mild pain to palpation with

[2] Respondent's Exhibit 5 is an aerial photograph of 509 parking garage, traffic circle, and 505 building. At the hearing, Petitioner marked the route she took walking from the 509 parking garage to the 505 building and the location where she fell.

normal range of motion and strength and no bruising, pain on motion, or swelling. *Id.* On physical examination of the low back, Dr. Headley noted pain on motion at PVM on right, pain to palpation present at PVM on right, and normal range of motion. *Id.* Dr. Headley diagnosed Petitioner with a right knee contusion/abrasion and low back strain. *Id.* He placed Petitioner on light duty work, prescribed pain medication, and scheduled a follow up visit in two days. *Id.*

Petitioner returned to the clinic on March 13, 2014. PX2. She reported that her "right knee is 100%. Patient states her pain is not as intense but its [sic] there, her lumbar area she getting [sic] popping or cracking when she is bending. Patient states her pain is four out of ten. Pain radiates to right side. Pain is a constant and throbbing pain. Patient is currently not working. aa 9:38 am Not taking any medications for the pain." *Id.* The physical examination of petitioner's right knee was normal with no abrasion. *Id.* On physical examination of the lumbar spine, petitioner continued to exhibit low back pain on motion at PVM on the right as well as pain to palpation at PVM on the right. *Id.* Dr. Headley diagnosed that petitioner's right knee contusion/abrasion was resolved and her low back strain was improved. *Id.* He maintained petitioner's work restrictions, advised that she use cold packs, continued use of naproxen as needed, and scheduled a follow up to five days. *Id.*

Petitioner acknowledged that she reported to Dr. Headley that her knee was "100%." She also testified that she returned to work on light duty.

On March 18, 2014, Petitioner saw Dr. Headley and reported that her "[k]nee pain is gone. Back has no improvement since last visit. Yesterday 3/17 as patient was laying down she felt tingling in both legs. Pain is rated at a 4/10. Taking medication sat [sic] that were given from COH. Patient is not working at this time. Pain is in the lower mid section of back. Radiates around the right side of body." PX2. Dr. Headley maintained Petitioner's work restrictions and ordered physical therapy for the low back strain. *Id.* On March 18, 2014, Petitioner also underwent an initial consultation for outpatient physical therapy. PX2. Petitioner testified that she did not undergo physical therapy until she saw Dr. Love.

On April 10, 2014, Petitioner first saw Scott Love, M.D. (Dr. Love). PX3-PX4. Petitioner reported "[p]ain in located in the lower R side area. Sxs started March 11 after she slipped and fell on ice going into work. Her pain has been 3/10 presently in severity. It seems constant. There are radiating sxs down the R leg of numbness. No noted weakness. No bowel or bladder dysfunction." *Id.* On physical examination, Dr. Love noted a normal right knee examination and straight leg raise to 90 degrees with minimal pain. *Id.* He diagnosed petitioner with lumbar back pain, ordered physical therapy, and kept Petitioner on work restrictions. *Id.*

Petitioner underwent physical therapy from April 24, 2014 through June 3, 2014. PX4. Petitioner testified that the physical therapy helped.

On June 5, 2014, Petitioner returned to Dr. Love for follow up of her back pain. PX4. She reported "[s]xs started March 11 after she slipped and fell on ice going into work. She has completed PT and is doing better. She is nearly 100 %. No noted weakness. No bowel or bladder dysfunction." *Id.* Dr. Love diagnosed petitioner with lumbar back pain, instructed her to continue her home exercise program, and follow up as needed. *Id.* Petitioner testified that she was doing better at this time when Dr. Love released her from his care. On cross examination, Petitioner acknowledged that she reported being nearly 100% and that she did not return for further medical treatment.

Chris Shannon

Corporal Chris Shannon (Corporal Shannon) testified that he is the Training and Coordination Manager employed by Respondent in this position since July of 2012. He testified that he has been employed for Respondent for 21 years in several positions. Corporal Shannon also testified that, among other responsibilities, he oversees all of the training schedules for courtroom deputies that transfer from various positions within the complex.

Corporal Shannon testified that it is his practice to tell trainees to report on the first day of training at the east entrance door of the 505 building. He referred to this first day as "orientation day" where the trainees become familiarized with the 505 building and general matters. Corporal Shannon testified that he tells trainees where to park on the first day so that he can let them in because they do not have access to enter the security doors. He testified that Petitioner did not have clearance to get into the 505 building yet because she previously worked for the jail in the position from which she was transferring to become a Deputy Sheriff. Corporal Shannon testified that once trainees come in, he explains where they are supposed to go and they are issued swipe cards and IDs.

Corporal Shannon testified that he parks in the 509 parking garage in an assigned space because of his position, and he does not park in other parking locations further away from the 505 building. To his knowledge, all of the officers working in the 505 building park in the 509 garage as it is the most reasonable location to park, but not all officers can park there.

On cross examination, Corporal Shannon testified that after the first day of training, he does not tell trainees that they have to park in the 509 garage and he acknowledged that there is no penalty for parking elsewhere. However, he maintained that there is no mandate to park in the 509 parking garage and he testified that members of the general public can also park in the 509 parking garage. Corporal Shannon also noted that there are different entrances/exits at the 509 parking garage, but every person must traverse the turnabout to get to the 505 building.

Additional Information

Regarding her current condition of ill-being, Petitioner testified that she experiences low back pain on the right side. Petitioner described the pain as "labor" pain, but with a burning sensation. Petitioner testified that she pushes through the pain. Petitioner also testified that she experiences pain when the weather changes, especially with cold weather, and that she experiences flare-ups. Petitioner explained that her pain varies. Petitioner testified that she never had low back or knee pain before her accident at work.

Petitioner testified that she continues to work for Respondent in the same position as she had before her alleged accident at work. Petitioner now transports inmates to and from the courthouse.

ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at hearing as follows:

In support of the Arbitrator's decision relating to Issue (C), whether Petitioner sustained an accident that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

The dispute between the parties centers on whether Petitioner was instructed to park in the 509 parking garage, as she explained in her testimony, or whether Petitioner was only instructed to park in the 509 parking garage during orientation when she did not have security access to the 505 building as explained by Corporal Shannon in his testimony. Petitioner also asserts that she was required to be at the place where the accident occurred and that she was exposed to a greater risk than the general public when she went from the 509 parking garage through the traffic circle and into the 505 building.

"An employee's injury is compensable under the Act only if it arises out of and in the course of the employment." *University of Illinois v. Industrial Comm'n*, 365 Ill. App. 3d 906, 910 (1st Dist. 2006). A claimant must prove both elements were present (i.e., that an injury arose out of and occurred in the course of her employment) to establish that her injury is compensable. *University of Illinois*, 365 Ill. App. 3d at 910. The "in the course of employment" element refers to "[i]njuries sustained on an employer's premises, or at a place where the claimant might reasonably have been while performing his duties, and while a claimant is at work...." *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill. App. 3d 1010, 1013-14 (1st Dist. 2011). "[A]ccidental injuries sustained on an employer's premises within a reasonable time before and after work are generally deemed to arise in the course of the employment." *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 57 (1989). The "arising out of" element refers to the origin of the claimant's injury and requires a risk caused by or incidental to the employment linking it to the accidental injury. *Caterpillar*, 129 Ill. 2d at 58. However, where an employee is exposed to a risk no greater than that to which the general public is exposed, it does not arise out of the employment and it is not compensable. *Id.* That is, a claimant must demonstrate that the risk of injury was peculiar to or increased by her work duties and the "increased risk may be either qualitative, such as some aspect of the employment which contributes to the risk, or quantitative, such as when the employee is exposed to a common risk more frequently than the general public." *Metropolitan Water Reclamation District*, 407 Ill. App. 3d at 1014 (*citations* omitted).

The type of risk to which a claimant is exposed must be assessed before determining whether the injury arose out of the employment. *Baldwin v. Illinois Workers' Compensation Comm'n*, 409 Ill. App. 3d 472, 478 (4th Dist. 2011). "There are three categories of risk to which an employee may be exposed: (1) risks distinctly associated with her employment; (2) personal risks; and (3) neutral risks which have no particular employment or personal characteristics." *Springfield Urban League v. Illinois Workers' Compensation Comm'n*, 2013 IL App (4th) 120219WC, ¶ 27, 990 N.E.2d 284, 371 Ill. Dec. 384. "Injuries resulting from a neutral risk generally do not arise out of the employment and are compensable under the Act only where the employee was exposed to the risk to a greater degree than the general public." *Id*; *see also Orsini*, 117 Ill. 2d 38, 45 (1987) ("For an injury to have arisen out of the employment, the risk of injury must be a risk peculiar to the work or a risk to which the employee is exposed to a greater degree than the general public by reason of his employment."); *Illinois Institute of Technology Research Institute v. Industrial Comm'n*, 314 Ill. App. 3d 149, 162 (1st Dist. 2000) ("...claimant's risk is to be compared to the general public.")

When an employee slips and falls at a point off the employer's premises while traveling to or from work, the resulting injuries do not arise out of and in the course of the claimant's employment and are not compensable under the Act. *Joiner v. Industrial Comm'n*, 337 Ill. App. 3d 812, 815 (3rd Dist. 2003). Notwithstanding, "[r]ecovery has been permitted for off-premises injuries when 'the employee's presence at the place where the accident occurred was required in the performance of his duties and the employee is exposed to a risk common to the general public to a greater degree than other persons.'" *Joiner v. Industrial Comm'n*, 337 Ill. App. 3d at 813 (*citation* omitted).

After careful consideration of the evidence in its entirety, the Arbitrator finds that Petitioner did not sustain a compensable accident at work as claimed. In so concluding, several undisputed, or uncontroverted, facts are relevant. Petitioner was parked in the 509 parking garage on the morning that she fell in the turnabout which she traversed before entering the 505 building. The 509 parking garage was open to the public with the exception of certain parking spaces reserved for judges or other personnel including Corporal Shannon. Sections of the 509 parking garage required entry with a security pass. There are several other open-air and covered parking lot locations throughout the government complex in which Petitioner could have parked. Petitioner did not have an assigned parking space in any parking area. The other parking locations in the complex were further away from the 505 building and, thus, less convenient to access the 505 building. Petitioner and other employees[3] working in the 505 building generally parked in the 509 parking garage.

Petitioner and Corporal Shannon's testimony differs with respect to whether she was instructed to park in the 509 parking garage throughout her employment with Respondent. Corporal Shannon explained that only trainees are instructed on their first day of orientation to park in the 509 parking garage. New employees do not have security clearance or the associated IDs or passes to access to the building. Petitioner recalled being instructed to park in the 509 garage by Corporal Shannon when she began the training program. Her testimony comports with Corporal Shannon's testimony to the extent that they agree that new employees are instructed to park in the 509 parking garage during orientation. Petitioner asserts that she was never given further instructions and that she continued to park in the 509 parking garage as it was the most logical and convenient location by the 505 building. However, Petitioner's retrospective conclusion that she was required to park in the 509 parking garage because no one ever told her not to park there after orientation fails to consider that Respondent clearly assigns parking spaces to certain employees (i.e., Corporal Shannon) and does not do so for other employees (i.e., Petitioner).

In this case, the Arbitrator finds the testimony of Corporal Shannon to be more credible than that of Petitioner regarding whether she had been instructed to park in the 509 garage, in perpetuity, and whether she had security access to the 505 building when she began her employment as she claims. Granting appropriate security access to new employees—or new employees coming from other governmental positions, such as Petitioner—and orienting them to the 505 building and general employment matters are a part of Corporal Shannon's regular duties. Corporal Shannon credibly testified about his practice with regard to instructing new employees during orientation and granting them the necessary access to restricted portions of the building.

Based on all of the foregoing, the Arbitrator finds that Petitioner has failed to establish that she sustained a compensable injury at work as claimed. Thus, all remaining issues are rendered moot and Petitioner's claim for any benefits and compensation is denied.

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[3] While there was no direct testimony from any witness with regard to the employers of these other employees, the Arbitrator infers from the testimony of both Petitioner and Corporal Shannon that other governmental employees working in the 505 building were also employed by other governmental agencies (i.e., judges).

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ruben Franco,
Petitioner,

vs. No. 13 WC 22533

18IWCC0258

W-2 Enterprises, LLC,
Respondent.

DECISION AND OPINION ON REVIEW PURSUANT TO §19(B)

Timely Petition for Review, under Section 19(b), having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective medical care and temporary total disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission 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).*

Petitioner testified he was involved in a motor vehicle accident while working for Respondent on June 7, 2013. First responders to the scene reported finding Petitioner in no distress, though complaining of pain to his head, neck and right leg. They transported him to MacNeal Hospital where he reported he had struck his head on the windshield but denied loss of consciousness. He complained of headaches, dizziness and pain in his right foot and ankle. He underwent x-rays of his right foot and CT scans of his head and cervical spine, but not his thoracic and lumbar spines. Petitioner's discharge diagnosis was: closed fracture of his right 3rd metacarpal, a contusion to his forehead and a cervical strain. No low back complaints, symptoms or injuries were documented.

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Petitioner returned to Stroger Hospital later that day due to ongoing complaints of pain and swelling in his right foot. During that visit, no cervical or lumbar spine complaints were documented. In the following weeks, Petitioner received treatment for his right foot at Stroger's Podiatry Clinic. At his June 11, 2013 foot appointment, he first reported having some neck and back pain from the crash. He was referred for follow-up of those complaints to the hospital's Ambulatory Screening Clinic or the Emergency Department, but he never went.

Petitioner returned to work on June 24, 2013. He was terminated on July 11, 2013 for disruptive behavior unrelated to his accident, according to Respondent's witness, Daniel Vargas, whose testimony the Commission finds credible. Petitioner has not worked anywhere since. Two weeks after the accident, Petitioner retained counsel, who filed an Application for Adjustment of Claim alleging injury only to his "right foot." In August 2014 Petitioner amended his Application by adding, "spine," as an additional body part affected.

One month after his accident and upon the referral of his attorney, Petitioner was seen at New Life Medical Center, where he began a 2-year course of thrice-weekly chiropractic treatments to his neck and spine. Although Petitioner underwent no treatment or tests due to lumbar complaints for the first month following his accident, he began complaining of lumbar pain to his chiropractor there, Dr. Irene Ma. He told her he had lost consciousness at the time of his accident, and that he was fired because of his accident. Dr. Ma referred Petitioner to specialists including a podiatrist, neurosurgeon and a pain management physician. They provided ancillary treatments consisting primarily of epidural steroid injections, diagnostic testing and physical therapy. Lumbar MRI's revealed a bulging or herniated L5-S1 disc, for which Petitioner was told he requires spine surgery. He now wishes to proceed with that surgery.

On November 14, 2013 and on July 30, 2014, Petitioner was examined by Respondent's Section 12 foot expert, George Holmes, MD. At his first examination, Dr. Holmes ordered and reviewed right foot x-rays which showed no Lisfranc injury, misalignment, evidence of ongoing fractures, arthritic changes, bone spurs or abnormal alignment. Dr. Holmes opined Petitioner's condition was status-post metatarsal fracture, completely healed. Dr. Holmes reported Petitioner's physical exam was benign; he found Petitioner required only one month of physical therapy and desensitization techniques but no further diagnostic studies. Dr. Holmes expected Petitioner to reach maximum medical improvement (for his foot) within one month of his exam.

At his July 2014 exam, Dr. Holmes updated his opinions and reported that Petitioner's 3rd metatarsal fracture had healed without complication or residual disability, and only his treatment through approximately November 14, 2013 was necessary and related to the work injury. Dr. Holmes again found Petitioner able to return to his usual customary duties without restrictions or limitations; and needed no further treatment or bone stimulators. He again found Petitioner had reached maximum medical improvement about one month after his November 14, 2013 exam.

On May 19, 2014, Petitioner was examined by Respondent's Section 12 spine expert, Avi Bernstein, MD. Dr. Bernstein found Petitioner's neurological function to be completely normal with good strength, sensation, reflexes and cervical spine range of motion. He reviewed Petitioner's radiographic studies dated October 21, 2013 and November 25, 2013, noting only mild degenerative changes but no stenosis, nerve root compression or disc herniation. He opined that

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Petitioner suffered strains and sprains as a result of his work accident; he should have been at maximum medical improvement (for his spine) twelve weeks after his accident, and Petitioner should return to full time, full duty work without restrictions.

The Arbitrator found the following: Petitioner was not a credible witness because he was not accurate or reliable in providing his history to his treating physicians. Through May 1, 2015, Petitioner underwent 182 therapy sessions for his back and 156 therapy sessions for his right foot and ankle with no significant improvement noted. The opinions of Dr. Bernstein and Dr. Holmes were more credible than those of Petitioner's treaters, whose opinions were dependent on the accuracy and reliability of Petitioner's complaints and reported symptoms. The only injuries Petitioner proved as a result of his accident were a fractured right 3rd metatarsal; sprains and strains to his cervical and lumbar spine, and a forehead contusion. Petitioner failed to prove reasonable and necessary: medical care and bills related to his neck and spine after September 1, 2013, and medical care and bills related to his right foot and ankle after December 14, 2013.

The Commission affirms and adopts each of the above findings of the Arbitrator. In concurring that Petitioner lacked credibility, the Commission notes inconsistencies in his description of the vehicle he was in at the time of accident, variously reporting it to have been a full-sized car, a work truck, and his own Toyota Corolla. Petitioner told the emergency room personnel that he did not lose consciousness following the accident, but reported to Dr. Irene Ma that he did. He provided conflicting reports of how his accident occurred – that he was hit when his vehicle was coming out of a parking lot, when it was stopped, and when it was travelling 20-30 mph. At different times he reported his vehicle had been: T-boned and completely spun around; rear-ended; sideswiped, and struck in the front driver's side. He told Dr. Holmes on November 14, 2013 that he had not been evaluated for his back, when in fact he was beginning his 5th month of chiropractic back treatment.

The Commission finds Dr. Holmes' opinions regarding Petitioner's foot injury more persuasive than Dr. Anderson's. Dr. Anderson ordered a bone stimulator on November 20, 2013, and diagnosed a non-union of Petitioner's fracture on December 18, 2013. However, Dr. Holmes took x-rays on November 14, 2013 and noted they showed the fractures in Petitioner's right foot were "completely healed." Also, Dr. Anderson diagnosed Petitioner with a Lisfranc injury, which neither Dr. Holmes nor any other treater found.

The Commission acknowledges that certain diagnostic tests taken after Petitioner's accident suggest he may have a bulging disc or lumbar and cervical radiculopathies. Dr. Bernstein opined those represented only minor degenerative changes, and that Petitioner suffered only strains and contusions to his neck and back as a result of his June 7, 2013 accident. The Commission finds Dr. Bernstein's opinions more persuasive than Petitioner's treaters. The only neck and spine injuries Petitioner proved related to his work accident were sprains and strains, which had fully resolved by September 1, 2013. The Commission finds that any other spine conditions are not causally related to his work accident.

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The Commission modifies the award of medical expenses made by the Arbitrator. With regard to Petitioner's right foot and ankle injuries, the Commission finds Petitioner attained maximum medical improvement on December 14, 2013, the date Dr. Holmes found Petitioner reached maximum medical improvement. The Commission adopts Dr. Holmes' opinion that only Petitioner's right foot and ankle treatment incurred on and before December 14, 2013 was reasonable, necessary and causally related to his work accident. The Commission affirms the Arbitrator's denial of all bills from Gray Medical and New Life Medical Center, except for those New Life Medical Center bills incurred solely for treatment to Petitioner's right foot and ankle on or before December 14, 2013.

With regard to Petitioner's neck and spine injuries, the Commission finds Petitioner attained maximum medical improvement on September 1, 2013. That date is twelve weeks after Petitioner's accident, and is the date on which Dr. Bernstein opined Petitioner should be at maximum medical improvement for those injuries. The Commission finds that opinion of Dr. Bernstein credible, persuasive and not speculative. The Commission affirms the Arbitrator's denial of all bills from Gray Medical and New Life Medical Center, save those addressed in the preceding paragraph. The Commission allows as reasonable, necessary and causally related, all other bills for neck and spine treatment incurred on or before September 1, 2013.

With regard to prospective medical care, the Commission affirms the Arbitrator's denial of prospective medical care, including but not limited to lumbar spine surgery.

The Commission modifies the Arbitrator's award regarding temporary total disability benefits. The Commission finds that Petitioner proved entitlement to TTD only for 22-3/7 weeks, from July 11, 2013 through December 14, 2013, the date Dr. Holmes found him at maximum medical improvement and able to return to unrestricted full duty work. Respondent is entitled to a credit for any and all amounts paid or overpaid.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 9, 2016, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the only injuries Petitioner proved to be related to his accident were: temporary headaches, a forehead contusion, a fractured right 3rd metatarsal, and sprains and strains to his cervical spine, lumbar spine, right foot and right ankle.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of temporary total disability benefits is modified, and that Respondent pay Petitioner the sum of $466.67 per week, commencing July 11, 2013 through December 14, 2013, totaling 22-3/7 weeks, that being the period of temporary total incapacity from work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of medical expenses is modified. The Commission affirms and adopts the Arbitrator's denial of all bills from Gray Medical and from New Life Medical Center, except for treatment to Petitioner's right foot and ankle from New Life Medical Center which was incurred on or before December 14, 2013. the Commission also affirms and adopts the award of reasonable and necessary medical expenses to treat Petitioner's right foot and ankle incurred on or before December 14, 2013, from all other providers. With regard to Petitioner's neck and spine, the Commission affirms and adopts the Arbitrator's award of reasonable and necessary medical expenses incurred from all other providers incurred on and before September 1, 2013.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's denial of prospective medical care is affirmed.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $5,000.00. 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: APR 25 2018

o-02/28/18
jdl/mcp
68

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

FRANCO, RUBEN
Employee/Petitioner

Case# **13WC022533**

W2 ENTERPRISES LLC
Employer/Respondent

18IWCC0258

On 9/9/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.47% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

2553 LAW OFFICE OF JAMES P McHARGUE
BRENTON M SCHMITZ
123 W MADISON ST SUITE 1000
CHICAGO, IL 60602

2837 LAW OFFICE OF JOSEPH MARCINIAK
MATTHEW A WRIGLEY
TWO N LASALLE ST SUITE 2510
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Ruben Franco
Employee/Petitioner

Case # **13 WC 22533**

v.

W2 Enterprises, LLC
Employer/Respondent

18IWCC0258

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago** on **7/30/2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?

N. ☐ Is Respondent due any credit?

O. ☐ Other _____

FINDINGS

On the date of accident **6/7/2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$15,400.00**; the average weekly wage was **$700.00**.

On the date of accident, Petitioner was **36** years of age, ***married*** with **2** dependent children.

Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$ 29,466.88** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$ 29,466.88**.

Respondent is entitled to a credit of **$0** under §8(j) of the Act.

ORDER

Petitioner's 3rd metatarsal fracture, cervical spine sprain/strain, lumbar spine sprain/strain, and forehead contusion are causally related to the accident.

Petitioner failed to prove that medical care and bills for neck and spine treatment incurred after September 1, 2013 from any medical facility were reasonable or necessary. Respondent is entitled to a credit for amount paid.

Petitioner failed to prove that medical care and bills for right foot and right ankle treatment incurred after November 14, 2013 from any medical facility were reasonable or necessary. Respondent is entitled to a credit for amount paid.

Petitioner failed to prove that he is entitled to prospective medical care for injuries claimed as a result of his accident on June 7, 2013.

Petitioner failed to prove that he is entitled to any additional TTD benefits. Respondent is entitled to a credit for amounts overpaid.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

September 7, 2016
Date

SEP - 9 2016

INTRODUCTION

This matter proceeded to hearing before Arbitrator Steven Fruth. The disputed issues were: ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; ***K:*** Is Petitioner entitled to prospective medical care and services?; ***L:*** What temporary benefits are in dispute? *TTD*

FINDINGS OF FACT

Petitioner Ruben Franco testified that on June 7, 2013 he was an employee of Respondent W-2 Enterprises. Respondent is a temporary staffing agency. Petitioner was a driver whose job duties included taking temporary employees to and from various job sites. He was also responsible for picking up and delivering pay checks to the various employees of Respondent at their work sites.

Petitioner testified that on June 7, 2013 was driving a Toyota Corolla as part of his job duties when he was involved in a motor vehicle accident with another car. The EMS report (PX #4) noted that Petitioner was walking about at the scene without apparent distress. The EMS report noted that Petitioner was Spanish speaking but that an interpreter was on the scene. The EMS report documented Petitioner's statement that he had been the passenger and that his driver and the other vehicle fled. Petitioner testified at arbitration that he was the driver and insisted that he was not a passenger. The EMS report noted Petitioner's complaints of head, neck, and right leg pain.

Petitioner was taken by ambulance to MacNeal Memorial Hospital (PX #4). In the MacNeal Emergency Department Petitioner repeated that he was a passenger. He was noted as giving a good history. He reported that his vehicle was travelling 20-30 mph when T-boned by another car. He reported that he was restrained and that airbags had deployed. He reported that he had hit his head on the windshield, although his head and face were atraumatic. He denied loss of consciousness. The neurological exam was within normal limits. Petitioner had cervical muscle pain and pain over the right foot and ankle. X-rays demonstrated an oblique fracture of the 3rd metatarsal into the proximal articular surface.

Petitioner was diagnosed with a closed foot fracture, a forehead contusion, and cervical strain. He was fitted with a post mold splint and discharged with directions to follow with orthopedist Dr. Andrzej Wojewoda.

Upon his return home, Petitioner continued to feel worse. Petitioner went to Stroger Cook County Hospital (PX #3) later on June 7. It was noted that he walked into

the emergency department alone. He complained of pain and swelling in his right foot. He stated that he is involved in motor vehicle accident in the morning and was seen at "Rice" hospital, where he was told he had a foot fracture. The clinical examination and x-rays confirmed a 3rd metatarsal fracture of the right foot. His foot was splinted and wrapped appropriately. He was discharged with a referral to the foot clinic.

Petitioner was seen by Dr. Jennifer Suffern at the Stroger Podiatry Clinic on June 11, 2013. He reported a history of a car accident on June 6 and went to "Rice" hospital for care. He was told there to follow up at Stroger. Petitioner complained of right foot pain and also neck and back pain. He reported that during the crash he was hit while his right foot was on the accelerator. A new cast was applied to his right foot.

Petitioner returned to the Podiatry Clinic on June 25, 2013. He reported that his foot pain was improved, now 1/10. There were no documented complaints of neck or back pain. On July 9, 2013 Petitioner returned with reports that his pain continued to be improved. The clinical assessment was that he was progressing as expected. On July 23 Petitioner reported only very mild pain and was issued a CAM walker.

There are no clinical notes for a clinic visit on August 6, 2013.

Petitioner presented to the emergency department of Stroger Hospital on July 14, 2014. His presenting complaint was wound infection on the left thigh for about two weeks but right foot pain was also noted. Petitioner reported that the original site had been present for two years and had just begun to bleed. Petitioner believed that it was caused by a trauma during an accident two years before. He was discharged with a referral to dermatology. He followed in dermatology through September 2014.

There were no clinical notes in the 2014 Stroger records documenting that Petitioner mentioned or complained of right foot or neck or back injuries or continuing pain in the foot or neck or back or ongoing medical care for the right foot, neck, or back.

Petitioner signed an Application for Adjustment of Claim, dated 6/21/13, claiming an injury to the right foot only (RX #6).

On July 10, 2013, Petitioner saw chiropractor Dr. Irene Ma of New Life Medical Center for treatment (PX #1). Petitioner reported neck, mid-back, foot, and head pain after a motor vehicle accident. He marked a diagram indicating neck and low back pain and pain down both arms and legs. Petitioner reported he lost consciousness at the time of the accident and was fired due to this accident. The intake form dated July 10 lists "The Hartford" with claim number and also lists Petitioner's attorneys name, address, and telephone number. Petitioner completed a "Patient Information" form dated July 10, in which he noted that he had been referred to New Life by "abogado." He stated he had been the driver in a car stopped for a traffic light when a truck struck his car on the driver's side and totaled the vehicle. It was noted Petitioner's right foot was casted. Dr. Ma noted Petitioner advised at the time of the accident his right foot depressed on the brake pedal and the impact caused a fracture of his toe. Petitioner complained only of right foot pain.

Dr. Ma's evaluations on July 10 were to Petitioner's right foot and also the neck and back. The examination of the right foot was limited by the cast. For the spinal evaluation Dr. Ma noted Petitioner's complaints of 7/10 pain in the neck, mid-back, low back, both arms, and both legs. He also complained of generalized numbness and tingling in the arms and legs. The neurological exam of the cervical, thoracic, and lumbar spine was essentially normal. Cervical and lumbar ranges of motion were limited by pain. Foraminal compression of the cervical spine was positive for severe pain, as well as shoulder depression: positive for bilateral radicular pain. Cervical distraction was also positive for severe pain. Various lumbar spine and pelvic testing was positive for severe pain. Bilateral pain at 70° on straight-leg raise was also noted.

For the foot Dr. Ma diagnosed lower extremity fracture, CPT 905.4; toe fracture, CPT 826.0; ankle pain, CPT 719.47; and ankle stiffness, CPT 719.57. For the spine Dr. Ma diagnosed cervical, thoracic, and lumbar sprain/strain. She recommended therapy for all.

Dr. Ma forwarded her clinical notes for the right foot to The Hartford. She addressed her clinical notes on the spine to American Access Casualty.

On July 11, 2013 Petitioner began chiropractic care with Dr. Ma at New Life. Petitioner had 182 therapy sessions for the back through May 1, 2015, without any significant improvement noted (PX #1). Petitioner had 156 therapy sessions for the right foot and ankle through May 1, 2015, without any significant improvement noted (PX #1). Dr. Ma drafted periodic clinical notes to The Hartford and American Access Casualty. Those periodic follow-up reports tended to be verbatim copies of the initial July 10, 2013 notes. The foot reports to The Hartford did note the gradual reduction of Petitioner's reported pain, from 7/10 to 5/10. The spine reports to American Access Casualty noted Petitioner's fluctuating complaints of pain but gradually improving ranges of motion. On December 7, 2013 Dr. Ma revised her diagnoses to lumbar disc herniation and cervical disc herniation. She did not document the bases for the altered spinal diagnoses.

Petitioner saw Dr. Joel Anderson, DPM, on August 26, 2013 for his right foot (PX #2). Dr. Anderson took Petitioner's history of being rear-ended in a car accident while driving a work truck and his prior treatement. He diagnosed a 3rd metatarsal fracture of the right foot, right foot sprain with possible Lisfranc injury, and peroneal tendinitis. Dr. Anderson ordered an MRI based on his suspicion of a Lisfranc joint or peroneal tendon injury. He also recommended that Petitioner continue with the CAM boot.

Petitioner had a non-contrast MRIs of the right foot and ankle on September 19, 2013. The ankle MRI showed abnormal bone marrow edema in the cuneiforms, suggestive of a bone contusion or occult fracture. The foot MRI was suggestive of nondisplaced fractures of the 2nd and 3rd metatarsals and suspected contusion of the 4th metatarsal. The MRIs were otherwise unremarkable. The reports were noted to have been sent to Dr. Anderson as customarily done for the referring physician.

Petitioner returned to Dr. Anderson on September 28, 2013, still complaining of

right foot pain. On examination range of foot and ankle motion was painful. There was pain on palpation of the ankle. Dr. Anderson noted that Petitioner had not had the MRI and that he should start therapy.

Petitioner returned to Dr. Anderson on October 30, 2013, again with continued right foot pain. The clinical examination was that same as before. Dr. Anderson noted plain x-rays showed the metatarsal fracture was healing well. He noted that Petitioner had not started physical therapy for the foot despite the records of New Life (PX #1) documenting that Petitioner had already had several therapy sessions beginning October 4.

The foot and ankle MRIs were repeated on November 11, 2013. These scans noted fluid in the tibiotalar joint space, along with mild osteoarthritic changes at the talonavicular joint. The metatarsal fractures were again noted. The reports were noted to have been sent to Dr. Anderson.

Dr. Anderson apparently ordered a lumbar spine MRI. That scan was performed on November 15, 2013, showing a 1.5 mm central disc protrusion with canal narrowing. The report was noted to have been sent to Dr. Anderson as customarily done for the referring physician.

On November 20, 2013 Dr. Anderson noted that the fractures did not appear to be healing. He recommended a bone growth stimulator as well as orthotics. Petitioner continued receiving physical therapy care and utilizing the bone growth stimulator for his foot for some time.

On December 4, 2013 The Hartford, upon Utilization Review, approved that bone growth stimulator. On January 2, 2104 The Hartford, upon Utilization Review, denied authorization for a continuous passive motion (CPM) durable medical device for Petitioner's right ankle (RX #3). The appeal for approval of the CPM was denied January 16, 2014 (RX #3).

On April 28, 2014 Dr. Anderson noted that Petitioner's condition was not resolving. He recommended and performed a cortisone injection, which Petitioner reported was helpful for about one week. A third MRI of the foot on May 20, 2014 indicated a decrease in bone marrow edema at the fracture sites. Dr. Anderson gave another cortisone injection on September 3, 2014.

Dr. Anderson placed Petitioner at MMI for the right foot on September 17, 2014, noting no foot pain. He released Petitioner to return to work with regard to the foot injury. Despite this release Petitioner continued with chiropractic care for his foot at New Life through May 1, 2015. Petitioner saw Dr. Anderson once more on December 1, 2014 because of increased pain. Dr. Anderson recommended additional physical therapy but continued with his OK for return to work.

Chiropractor Dr. Terence Patrick at New Life ordered lumbar and cervical MRIs (PX #1). These scans were done at Archer Open MRI on October 21, 2013. The lumbar MRI showed diffuse spondylosis with annular disc bulging and hypertrophy from L2 to S1. The cervical MRI showed diffuse disc bulging from C3 to C7. There multilevel facet

hypertrophy and spinal and bilateral neural foraminal stenosis. The C4-5 disc abutted the cord. Based upon the MRI results, Petitioner was referred for pain management to Dr. Krishna Chunduri.

Petitioner was referred to Dr. Krishna Chunduri on December 11, 2013 for a pain management consultation (PX #1). Petitioner gave a history of a motor vehicle accident when he was coming out of a parking lot. Since the accident Petitioner had aching and stiffness in his low back along with pain, numbness, and tingling down his left arm to the hand. He also complained of occasional shooting pain in his legs but only at night.

On physical examination Dr. Chunduri noted reduced range of motion in the neck and the low back. Both the neck and back were tender to palpation. Left hand grip and left arm strength were reduced compared to the right. Spurling's test reproduced left arm pain. Straight-leg raise was positive for back pain. Dr. Chunduri reviewed the MRI scans of the lumbar and cervical spine, and diagnosed cervical spondylosis with left-sided radiculitis, as well as lumbar spondylosis with bilateral radiculitis. He prescribed medication and recommended a C6-7 epidural steroid injection (ESI), based upon the MRI findings. He noted that the diagnoses were related to Petitioner's work accident.

Dr. Chunduri performed the first of three ESIs on December 16, 2013 at Rogers Park One Day Surgery. The first ESI was at C6-7. Petitioner reported only four days of relief. Cervical pain and radicular symptoms returned to the left arm, and began in the right arm. The second ESI, at C5-6, was on January 20, 2014, again at Rogers Park One Day Surgery. On February 26, 2014 Petitioner reported complete relief of cervical pain, but complained of continued weakness in the upper extremities. Dr. Chunduri performed an L5 ESI on March 3, 2014, again at Rogers Park One Day Surgery.

On referral from Dr. Chunduri, Petitioner saw Dr. Robert Erickson on February 25, 2014 (PX #2). Petitioner presented with 8/10 low back pain and 8/10 neck pain. He reported that he was in a motor vehicle accident on June 7, 2013, when his car was struck in the rear at 25-30 mph. He complained that his low back pain extended into the top of the right foot. The neck pain extends into both hands, including all fingers. Petitioner reported that he hit the back of the head in the accident but probably did not lose consciousness. Petitioner had also received extended physical therapy but without significant improvement.

Dr. Erickson reviewed the cervical MRI of October 2013 and noted spondylosis without nerve compression and small disc herniations at C3 through C7. He reviewed the November 2013 lumbar MRI and noted a small L5-S1 disc herniation measuring 1.5 mm. There are no notes indicating that Dr. Erickson conducted a clinical physical examination. Despite the lack of a clinical examination Dr. Erickson diagnosed cervical and lumbar disc disease. He recommended SSEP (somatosensory evoked potential) testing. He noted that the testing was a "consequence" of the June 7, 2013 injury. Dr. Erickson also took Petitioner off work.

Petitioner's Exhibit #13 is billing charges for Dr. Erickson from American Center

for Spine and Neuro. Petitioner was billed for Dr. Erickson's services on March 25, 2014 and May 28, 2014. There were Dr. Erickson clinical notes dated February 25, 2014 but no clinical notes for May 28 were offered in evidence.

Dr. Shakuntala Chhabria performed the SSEP on March 11, 2014. It showed delayed responses of the right and left S1 nerve roots.

Petitioner's testified that Dr. Erickson left the clinic sometime after February 25 and that he was then seen by another spine surgeon, Dr. Geoffrey Dixon. Dr. Dixon first examined Petitioner on July 11, 2014 (PX #2). Petitioner gave a history of a motor vehicle accident where his car was struck broadside. Petitioner complained of mid-back pain radiating into both legs. There were no documented complaints of neck pain radiating into the arms and hands. Petitioner had not improved with injections, physical therapy, or medication.

On examination Dr. Dixon found "Mr. Amedin" [sic] with normal strength in both the arms and legs. Deep tendon reflexes and sensation were intact. Cranial nerves 2 through 12 were intact. Dr. Dixon reviewed the November 25, 2013 lumbar MRI and the SSEP. He noted that the MRI demonstrated degeneration with a disc bulge and grade 1 spondylolisthesis at L5-S1 with some lateral recess compression. The SSEP was suggestive of S1 radiculopathy. He recommended a lumbar discogram to evaluate for discogenic pain prior. Petitioner was to return with his MRI upon completion of the discogram.

Dr. Chunduri performed the discogram on July 17, 2014 from L2-S1. L2-3 was injected as a control. There was no pain at any level. A post-discogram CT scan indicated no significant issues from L2 to L5, but was read as showing a Dallas class III 3-4 mm disc herniation at L5-S1.

On August 19, 2014 Pettioner filed an Amended Application for Adjustment (RX #6), bearing the date of 6/21/13, claiming injuries to the right foot and spine.

Petitioner returned to Dr. Dixon on August 22, 2014 (PX #2). The history and complaints were identical to those on July 11, excepting that neck pain was noted. The findings on examination were the same as on July 11. He noted the SSEP suggested S1 radiculopathy. He noted the discogram suggested L5-S1 etiology for the ongoing pain. Dr. Dixon ordered new MRIs of the cervical and thoracic spines to evaluate complaints in the neck and mid-back. The thoracic spine MRI on August 26, 2014 was normal; the cervical MRI on August 26, 2014 showed mild bulging from C4-5 and C5-6, with mild effacement of the thecal sac and significant narrowing of the central cord.

On September 5, 2014 Petitioner was still complaining of mid-back pain radiating into his legs, as well as neck pain. The physical exam was the same as all others before by Dr. Dixon. Dr. Dixon recommended an L5-S1 laminectomy and transforaminal fusion with instrumentation in order to resolve Petitioner's lumbar complaints. Dr. Dixon did not document his clinical bases for recommending surgery. For the first time Dr. Dixon took Petitioner off work. Dr. Dixon's notes from November 24, 2014, January 16, 2015, and February 28, 2015 were essentially unchanged from all before, except for

noting 4/5 strength in the EHL (extensor hallucis longus) on January 16 without specifying whether bilateral or otherwise.

Petitioner testified that he had no problems with his neck, back, or right foot prior to the June 2013 accident. Petitioner testified at trial that he wishes to undergo this surgery.

The Arbitrator also heard testimony from Daniel Vargas, Respondent's safety manager. Mr. Vargas was Petitioner's supervisor. He testified that he knows Petitioner, and that Petitioner's employment was terminated on July 11, 2013 for cause a few weeks after the accident. Petitioner came to Respondent's premises and attempted to incite other employees to leave Respondent's employ because Respondent had not hired Petitioner's brother.

George Holmes, M.D. (RX #5)

Dr. Holmes examined Petitioner pursuant to §12 of the Act at Respondent's request on November 14, 2013. In addition to his clinical exam Dr. Holmes reviewed Petitioner's August 28, 2013 records from Advanced Foot and Ankle Centers of Illinois. Dr. Holmes also reviewed x-rays taken at the time of his exam.

Pettioner reported that he had been rear-ended in a motor vehicle crash on June 7, 2013. He was diagnosed in the emergency room with a foot fracture and was casted for two months. He was then fitted with a CAM walker and had physical therapy.

At the IME Petitioner complained of pain in the dorsal aspect of the mid-foot, as well as back pain. He also complained of swelling when standing for more than 30 minutes.

Dr. Holmes reviewed Advanced Foot and Ankle Centers records and noted Petitioner's history of right foot injury from an accident while driving on June 7, 2013. Petitioner related that he had been rear-ended at that time. On examination Petitioner's ankle was neurovascularly intact. There were no signs of deficit. There was pain on palpation along the peroneals and over the posterior lateral aspect of the ankle. Muscle strength was normal. Dr. Joel Anderson diagnosed a fracture of the 3rd metatarsal, right foot sprain, and perineal tendinitis. Dr. Anderson also recommended an MRI.

Dr. Holmes found full range of motion in the subtalar and ankle joints. There was pain on palpation of the dorsal aspect. The foot was neurovascularly intact. X-rays showed no malalignment and no active or ongoing fracture of the metatarsals. There was no Lisfranc injury.

Dr. Holmes diagnosed completely healed fractures and no arthritic changes related to fracture. Although Dr. Holmes opined that there was a causal relationship between the accident and Petitioner's accident the exam was essentially benign. He found that medical care up to the time of the IME was reasonable and necessary. He did not believe any further medical care was indicated or necessary. He opined that

Petitioner should reach MMI within a month. Dr. Holmes also believed that Petitioner could work at light duty with lifting restrictions and limited standing.

Dr. Holmes conducted a second §12 IME of Petitioner on July 30, 2014. He noted his findings from the prior IME on November 14, 2013. Dr. Holmes noted that Petitioner was using a bone growth stimulator and was continuing with physical therapy. Petitioner had a repeat MRI on May 20, 2014. The MRI showed decreased bone edema in the 2nd and 3rd metatarsals. Petitioner also reported that he had had an injection one month before the IME. Petitioner also presented with a new complaint of knee pain for the previous three months.

Petitioner presented with complaints of constant foot pain. The pain was worse with weight-bearing activities but was relieved by rest. Dr. Holmes noted the May 20 MRI was limited by patient motion. Lisfranc articulation and metatarsophalangeal joints were intact. On examination Petitioner had full range of motion in the ankle, subtalar, and foot joints. He still complained of pain on palpation over the dorsal aspect in the area of the 3rd metatarsal. However, Petitioner was neurovascularly intact. Plain x-rays demonstrated no evidence of fracture or dislocation or arthritic changes.

Petitioner presented with complaints of constant foot pain. The pain was worse with weight-bearing activities but was relieved by rest. Dr. Holmes noted the May 20 MRI was limited by patient motion. Lisfranc articulation and metatarsophalangeal joints were intact. On examination Petitioner had full range of motion in the ankle, subtalar, and foot joints. He still complained of pain on palpation over the dorsal aspect in the area of the third metatarsal. However, petitioner was neurovascularly intact. Plain x-rays demonstrated no evidence of fracture or dislocation or arthritic changes.

Dr. Holmes found that the fracture of the third metatarsal had healed without complication or residual disability. He noted the objective factors of the current exam and the previous exam were consistent with a healed fracture. He again noted the causal relationship between the accident and the injury. He noted that Petitioner could return to his usual customary duties, including full duty work, without restrictions or limitations. He found that Petitioner should have reached MMI by January 1, 2014, and was currently at MMI.

Dr. Holmes further opined that medical care up to the November 14, 2013 IME was necessary for care for the injury. However, he found that ongoing physical therapy shoe modification orthotics, and bone stimulator work completely unnecessary for treatment of the June 7, 2013 injury. Finally, Dr. Holmes opined that Petitioner did not require further medical treatment or surgical intervention for his injury.

Avi Bernstein, M.D. (RX #4)

Dr. Bernstein examined Petitioner pursuant to §12 of the Act at the request of Respondent on May 19, 2014. In addition to a clinical examination Dr. Bernstein

reviewed cervical spine and lumbar spine imaging. Petitioner was accompanied by a professional translator.

Petitioner reported that he was involved in a work-related injury on June 7, 2013. He was employed as a driver. He was injured in a motor vehicle accident in which his car was T-boned and spun around completely. Petitioner reported that he was wearing his seatbelt at the time. He was x-rayed in the ER. He was diagnosed with a right metatarsal fracture and had complaints of low back pain. Petitioner followed up at Cook County Hospital for casting of his right foot. He reported that he was fired from his job which led to him hiring a lawyer. Petitioner also reported that he had been referred to a chiropractor as well as Dr. Chunduri, a pain doctor, on the advice of his attorney. He had completed physical therapy but chiropractic care was ongoing. Petitioner reported four epidural injections without improvement.

Petitioner complained of neck pain radiating into his low back. Pain radiated into both legs, with the right being worse than the left. He has a sensation of weakness in his legs. Prolonged walking and standing increased symptoms. Dr. Bernstein noted that Petitioner's pain was diffuse and nonspecific.

On examination Dr. Bernstein noted that Petitioner arose to standing without difficulty. There was no apparent discomfort while seated although while walking Petitioner exhibited a slight wide-based gait, which to Dr. Bernstein seemed exaggerated. Petitioner was able to get up on heels and toes. He complained of diffuse pain over the spine with the range of motion assessment. He was able to forward flex at the waist to get his fingers to mid shin. There was no reversal of rhythm upon straightening. He was not tender over his spine. Petitioner had completely normal neurological function with good strength, sensation, and reflexes. He had a full range of motion of the cervical spine.

Dr. Bernstein reviewed radiographic studies from October 21, 2013. Dr. Bernstein opined that these studies were benign with mild degenerative changes. He noted that the lumbar discs appeared healthy. There was no stenosis, nerve root compression or disc herniation. A scan from November 25, 2013 showed identical findings. The imaging did not show any evidence of a structural injury.

Dr. Bernstein described the examination as benign except for some internal rotation and hip stiffness. Dr. Bernstein found that Petitioner had sustained strains and contusions as a result of the work-related accident. Dr. Bernstein opined that Petitioner should have been at MMI with his back in about 6 to 12 weeks from the time of the incident and that care beyond then had been excessive, unindicated, and unnecessary.

Dr. Bernstein found Petitioner to be at MMI and without permanent injury. He opined that Petitioner could return to full-time full duty work without restriction. He felt there was no further need for therapeutic modalities or diagnostic work workups.

CONCLUSIONS OF LAW

F: Is Petitioner's current condition of ill-being causally related to the accident?

After considering the testimony of Petitioner, as well as the records of treating physicians and reports of §12 examinations in evidence, the Arbitrator finds that Petitioner proved that he sustained a fracture of the 3rd metatarsal in his right foot and a sprain/strain in his right ankle. The Arbitrator finds that the evidence established that these injuries resolved by January 1, 2014, at which time Dr. Holmes determined Petitioner was at MMI for those injuries. The Arbitrator further finds that Petitioner proved that he sustained sprains and strains to his cervical and lumbar spines that resolved by May 19, 2014, at which time Dr. Bernstein determined Petitioner was at MMI. Finally, the Arbitrator finds that Petitioner failed to prove that he sustained any continuing condition of ill-being causally related to the June 7, 2013 work accident in his right foot and ankle beyond January 1, 2014 or in his neck and back beyond May 19, 2014.

As the primary bases for these findings the Arbitrator finds the opinions of Drs. Holmes and Bernstein more persuasive than the findings and opinions of Petitioner's treating physicians. The Arbitrator notes that Drs. Holmes and Bernstein conducted thorough and extensive examinations. The Arbitrator also notes that Petitioner's treating physicians, particularly Drs. Ma, Erickson, and Dixon did not document anything approximating thorough clinical exams. In fact, there is no documentary evidence that Dr. Erickson conducted a clinical exam at all.

Also, the opinions of Petitioner's treating physicians were dependent on the accuracy and reliability Petitioner's reports of his symptoms and complaints. The Arbitrator finds that Petitioner was not credible and, therefore, finds he was not an accurate or reliable reporter of fact to his treating physicians.

Petitioner gave many different accounts of the facts of the accident to his healthcare providers. He reported through a translator to the responding EMTs and MacNeal Memorial Hospital personnel that he was a passenger in the vehicle involved in the crash. He told those care providers that his driver fled the scene of the accident and that the other driver fled in his vehicle. He told Dr. Ma at New Life that the car he was driving had been T-boned and totaled. He told Dr. Anderson that his car was rear-ended. He embellished this version to Dr. Erickson by adding that he had been hit at 25 to 30 mph. This account is seemingly inconsistent with the EMTs note of moderate damage to Petitioner's car. Petitioner told Dr. Chunduri he was hit while coming out of a parking lot. He told Dr. Bernstein that his car was spun around when it was T-boned. Finally, he once reported that he was travelling at 20 to 30 mph when the crash occurred but reported other times that he was stopped when the crash occurred.

In addition, Petitioner denied loss of consciousness to the responding EMTs and MacNeal emergency room staff but told later treating physicians that he had lost

consciousness. Further, Petitioner initially followed up with medical care a Stroger Cook County Hospital. On June 23, 2013 he reported 1/10 foot pain. On July 23, 2013 his pain at Stroger was noted as very mild. Yet, he complained of 7/10 foot pain to Dr. Ma at New Life on July 10.

The Arbitrator also takes note that Petitioner sought care at Stroger on July 14, 2014 for medical concerns unrelated to his claimed accident injuries. There was no documentation that he reported that he had been injured the year before or that he had continuing foot and back pain from the accident or that he had been under care for his claimed injuries for almost a year.

Petitioner presented evidence through medical records in support of his claim of causal connection. The causation opinions of Petitioner's treating physicians are undermined by his lack of credibility and his lack of accuracy and reliability as a historian. Moreover, there are inconsistencies in the findings and opinions of Petitioner's treating physicians.

Various imaging of Petitioner's right foot showed a fracture of the 3rd metatarsal while other imaging showed a fracture of the 2nd metatarsal also, as well as a suggestion of a fractured 4th metatarsal. No one treating physician explained the apparent inconsistency. Dr. Anderson alternatively described poor healing of the metatarsal fracture, despite imaging showing the fracture completely healed, and good healing.

Imaging of Petitioner's lumbar spine also yielded unexplained inconsistencies. The November 25, 2013 MRI was read as showing a 1.5 mm protrusion at L5-S1. Dr. Dixon read the image as showing degeneration with a disc bulge and grade 1 spondylolisthesis at L5-S1. Dr. Erickson read the same image as showing a disc herniation at L5-S1. Dr. Bernstein saw no abnormalities on that same imaging. A lumbar MRI on October 21, 2103 was read as showing diffuse disc bulging from L2 through S1. A post discogram CT showed a 3-4 mm L5-S1 herniation indenting the thecal sac but without noted nerve root impingement. No one physician reconciled these disparate interpretations. It is incumbent for Petitioner to bear his burden with coherent and consistent evidence that any of the interpreted imaging findings were causally connected to Petitioner's accident. In light of the foregoing, the Arbitrator finds that Petitioner failed to prove he sustained anything more than a sprain/strain in his spine.

The Arbitrator notes that Dr. Bernstein opined that Petitioner should have achieved MMI for his neck and back within 6 to 12 weeks of the injury. This opinion was speculative. Dr. Bernstein's definitive MMI opinion was expressed at the time of his May 19, 2014 §12 exam on May 19, 2014. Despite the persuasiveness of Dr. Bernstein's opinions the dispositive evidence is that Petitioner reached MMI with his back and neck.

J: Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

The Arbitrator has previously adopted the causation and MMI opinions of Respondent's §12 examining physicians: Dr. George Holmes and Dr. Avi Bernstein. The Arbitrator also finds the opinions of Drs. Holmes and Bernstein regarding necessary and reasonable medical care to also be persuasive.

On November 14, 2013 Dr. Holmes anticipated that Petitioner should reach MMI with his foot and ankle within the next month. He further opined that Petitioner did not require further medical care from that date for his right foot and ankle. On July 30, 2014 Dr. Holmes opined that Petitioner had reached MMI by January 1, 2014. He further opined then that treatment for Petitioner's right foot and ankle were reasonable and necessary up November 14, 2013.

Dr. Bernstein opined on May 19, 2014 that Petitioner was at MMI with regard to the spine. He speculated that Petitioner should have reached MMI within 6 to 12 weeks after that accident. While the Arbitrator does not accept Dr. Bernstein's speculation that Petitioner reached MMI by early September 2013 the Arbitrator does find Dr. Bernstein's opinion that medical care beyond the first of September was not reasonable or necessary.to be persuasive.

The Arbitrator also finds that, on its face, the chiropractic care by Dr. Ma at New Life Medical Center was not reasonable or necessary. Dr. Ma rendered 156 chiropractic manipulations for Petitioner's right foot and ankle for more than a year and a half with no documented progress. She administered 182 chiropractic manipulations to Pettioner's neck and back for almost two years without documented progress. On July 10, 2013 Dr. Ma initially diagnosed cervical, thoracic, and lumbar sprain/strain, along with the toe fracture. On

Dr. Chunduri performed a truly impressive series of epidural and facet injections. He did not document the clinical bases or necessity for administering those injections. Dr. Chunduri performed the discogram on July 17, 2014. A discogram is ordinarily performed to confirm or rule out discogenic pain. There was no concordant pain at any lumbar level that was tested. Aside from the persuasive opinion of Dr. Bernstein based on the clinical record Petitioner failed to prove that any of the care and treatement provide by Dr. Chunduri was reasonable or necessary.

The evidence established that Petitioner obtained excessive and ineffective chiropractic and medical intervention initiated by a referral by his attorney. Petitioner noted in his registration documents with New Life Medical Center that he had been referred by his "abogado". He confirmed this to Respondent's §12 examining physician, Dr. Bernstein. The chiropractors at New Life engaged in an awe inspiring course of chiropractic of ineffective chiropractic care for Petitioner's neck and back and right foot into May 2015 with no documented progress. The chiropractors that New Life referred Petitioner to Dr. Chunduri, a pain management specialist, who promptly undertook a series of extensive spinal injections. The Arbitrator notes that there was no referral to a

general medical doctor for evaluation of the need for prescriptive analgesics prior to the pain management referral.

The chain of treatment initiated by the lawyer's referral then took Petitioner to Dr. Robert Erickson, who apparently conducted no clinical examination and submitted billing for which no clinical notes were produced. Following contact with Dr. Erickson Petitioner came under the care of Dr. Geoffrey Dixon. Dr. Dixon, on clinical examination note after note, documented normal strength, sensation, and reflexes in Petitioner's lower extremities. He documented diffuse, nonspecific radicular pain which did not fall into a recognizable dermatomal pattern. He did not order an EMG/NCV, a generally accepted diagnostic tool to objectively assess radiculopathy. He did not note finding any instability in Petitioner's lumbar spine and yet based only on the nonspecific findings of an SSEP and Petitioner's subjective complaints recommended fusion surgery. The Arbitrator has previously found that Petitioner was not credible. His questionable subjective complaints cannot reasonably be a basis for such excessive and unnecessary medical care.

The course of chiropractic and medical interventions at New Life and with Drs. Chunduri, Erickson, and Dixon was dependent on Petitioner's nonspecific and often normal clinical exams and, most importantly, Petitioner's subjective complaints. The Arbitrator has found that Petitioner was not a credible witness. A chiropractic or medical diagnosis and treatment plan must be based on reliable and accurate reports from the patient. Due to Petitioner's lack of credibility the diagnoses and treatement plans of the healthcare providers set in motion by Petitioner's lawyer also lack credibility and persuasion.

In light of all the evidence the Arbitrator finds that Pettioner failed to prove that the chiropractic and medical care he received for his foot and ankle injury after November 14, 2013 was reasonable or necessary to cure or relieve the effects of his injury from the June 7, 2013 work accident. In addition, in light of all the evidence the Arbitrator finds that Pettioner failed to prove that the chiropractic and medical care he received for his neck and back after September 1, 2013 was reasonable or necessary to cure or relieve the effects of his injury from the June 7, 2013 work accident.

Petitioner's Exhibits #7, Exhibit # 10, and #11 relate to emergency medical care provided on the date of the Jun 7, 2013 accident. This care was obviously reasonable and necessary. Additionally, even if Petitioner had proved that his care was reasonable and necessary the Arbitrator notes that Petitioner's Exhibit #8, Gray Medical Group, for CPM, was not authorized per Utilization Review. The Arbitrator finds the reasoning of the Utilization Review persuasive and adopts those opinions of lack of medical necessity. Also, Petitioner's Exhibit #13, American Center for Spine & Neuro, for Dr. Erickson, has billing entries that do not correspond to clinical notes, and therefore are not reasonable. The remainder of Petitioner's billing exhibits are, based on prior findings, not reasonable due the lack of proof that the underlying medical care was necessary.

K: Is Petitioner entitled to prospective medical care and services?

The Arbitrator has previously found that Petitioner failed to prove that his claimed current condition of ill-being is causally related to his work accident on June 7, 2013. It follows that Petitioner failed to prove that he is entitled to the prospective medical care recommended by Dr. Geoffrey Dixon.

The Arbitrator also notes that Dr. Dixon did not set forth his rationale or the clinical basis for the recommended surgery. Given the inconsistencies in Petitioner's clinical presentations and the nonspecific and unreliable nature of his subjective complaints it would be incumbent for Dr. Dixon to justify his surgical recommendation.

L: What temporary benefits are in dispute? *TTD*

The parties stipulated that Respondent paid $29,466.88 in TTD benefits. This represents 63 weeks of benefits, from July 11, 2013 through July 31, 2014.

In light of previous findings above that Petitioner had reached MMI, it follows that Petitioner failed to prove that he is entitled to any additional TTD benefits. Respondent is entitled to a credit for amounts overpaid.

Steven J. Fruth, Arbitrator

September 7, 2016

STATE OF ILLINOIS)
) SS.
COUNTY OF)
JEFFERSON

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jennifer Staley,

Petitioner,

vs. NO: 16 WC 02443

Odin Healthcare Center,

Respondent.

18IWCC0259

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, causal connection, medical expenses and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 6, 2017, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

18IWCC0259

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 25 2018
o040518
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

STALEY, JENNIFER
Employee/Petitioner

Case# **16WC002443**

ODIN HEALTHCARE CENTER
Employer/Respondent

18IWCC0259

On 9/6/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0384 NELSON & NELSON
NATHAN C LANTER
420 N HIGH ST
BELLEVILLE, IL 62220

2795 HENNESSY & ROACH PC
DAVID A DOELLMAN
415 N 10TH ST SUITE 200
ST LOUIS, MO 63101

STATE OF ILLINOIS)
)SS.
COUNTY OF JEFFERSON)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)/8(a)

JENNIFER STALEY
Employee/Petitioner

v.

ODIN HEALTHCARE CENTER
Employer/Respondent

Case # 16 WC 02443

Consolidated cases: _____

18IWCC0259

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **May 4, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

18IWCC0259

FINDINGS

On the date of accident, **October 29, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned **$21,884.72**; the average weekly wage was **$420.86**.

On the date of accident, Petitioner was **29** years of age, ***single*** with **3** dependent children.

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$N/A** for TTD, **$N/A** for TPD, **$N/A** for maintenance, and **$N/A** for other benefits, for a total credit of **$N/A**.

Respondent is entitled to a credit of **$12,067.26** under Section 8(j) of the Act.

ORDER

The Arbitrator finds that the greater weight of the evidence indicates that the Petitioner has sustained her burden of proof that her right SI joint dysfunction is causally related to the accident.

Respondent shall pay Petitioner temporary total disability benefits of **$319.00 per week**, the minimum allowable statutory rate, for **15-2/7 weeks**, commencing **January 18, 2017 through May 4, 2017**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of for any of the awarded temporary total disability benefits that have been paid prior to hearing.

Respondent shall pay reasonable and necessary medical expenses contained in Petitioner's Exhibit 5, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for any of the awarded medical benefits that have been previously paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall authorize the minimally invasive right SI joint fusion that has been recommended by Dr. Kovalsky.

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.

18IWCC0259

STATEMENT OF INTEREST RATE: If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

August 21, 2017
Date

SEP - 6 2017

STATEMENT OF FACTS

This claim involves an alleged injury to Petitioner's low back and right sacroiliac joint. At issue are causation, medical expenses, temporary total disability benefits claimed from 1/18/17 to 5/04/17, and prospective medical care. The parties specifically stipulated that the issue of whether any additional periods of TTD or TPD are owed is reserved.

Petitioner graduated from Centralia High School as a certified nursing assistant (CNA) in 2004. She began working for Respondent as a CNA on 5/1/15. In the months before 10/29/15, she testified she was not experiencing any significant pain in her low back, right leg, pelvic region, or right thigh, and was not receiving any medical treatment for any such conditions. She was under no medical restrictions before 10/29/15 and was able to fully perform her job duties. Before she began working for the Respondent, Petitioner passed a pre-employment physical.

The Respondent operated a nursing home and retirement center, and Petitioner's job as a CNA involved helping elderly and disabled persons perform activities of daily living. On 10/29/15, Petitioner testified she was transferring a woman weighing over 200 pounds from her toilet to her wheelchair with use of a gait belt. While doing so, she said the woman panicked and her legs buckled. As Petitioner re-gripped to get a better hold of the woman, she felt a pull in her lower back with a sharp burning pain, and moving her right leg made the pain worse. She testified she had never experienced anything similar to this prior to 10/29/15.

Petitioner testified that she notified multiple supervisors of the injury and completed an incident report. She sought medical attention that same day at the Salem Township Hospital emergency room. The report notes a consistent history of the accident, and Petitioner reported back pain that was noted to be diffuse in the paraspinals with minimal pain over the spine. She noted no prior back problems. She was diagnosed with a back sprain/strain, prescribed medication, advised to stay off work until 11/2/15 and to follow up with her primary doctor. (Px1).

Petitioner followed up on 11/2/15 at SSM Health St. Mary's with Physician Assistant Karen Hummel. PA Hummel also noted a consistent history of the accident. Petitioner reported 8/10 pain across the low back that was aching and sharp. She again reported no history of prior symptoms. Petitioner was diagnosed with bilateral

low back pain without sciatica, and, following negative x-rays, on 11/9/15 PA Hummel prescribed physical therapy, which Petitioner testified was performed at the Work Safety Institute. (Px2).

Petitioner was initially evaluated for therapy on 11/10/15. Following a review of symptoms and examination findings, the therapist's assessment was of signs and symptoms consistent with right SI joint dysfunction. (Px2). Therapy was performed through 12/16/15. The therapist consistently noted after the initial evaluation that Petitioner had good SI alignment both before and after treatment.

On 11/23/15, Petitioner reported minimal improvement since starting therapy, and PA Hummel prescribed continued light duty (no lifting over 10 pounds, and no bend/stoop/push/pulling) and requested a lumbar MRI. The therapy notes indicated Petitioner missed her session on 11/20/15 because she was working, but the Arbitrator did not find a note reflecting a light duty release prior to 11/23/15. On 11/23/15, the therapist notes Petitioner stated the Respondent informed her she would need to return to work by a date in December or she would be terminated, so she wanted to improve quickly. The 12/4/15 therapy note indicates Petitioner reported no improvement with therapy, but that she worsened when she missed a day. It appears she attended 8 out of 12 sessions at that point. Therapy and work restrictions were continued by PA Hummel on 12/7/15, who noted MRI still had not been approved. On 12/11/15, therapy indicated Petitioner had a pain increase to 8/10 with a prolonged drive and it had not abated since, leading her to leave work early. On 12/14/15, Petitioner again reported no improvement and that she was thinking about seeing another doctor in Carlyle, IL that her attorney advised her to consider. (Px2).

At the last therapy visit of 12/16/15, Petitioner reported ongoing constant back pain between 6/10 and 10/10, which increased with prolonged sitting and lying down. The therapist noted she had done very well, performing with greater resistances and reps and showing no difficulty in doing so. She had met a few of her goals, but failed to obtain significant pain relief. (Px2). Lumbar MRI was performed on 12/17/15 and the impression was mild disc bulging at L3/4 without foraminal or canal stenosis. (Px3). PA Hummel continued light duty and referred Petitioner to orthopedic physician, Dr. Kovalsky. (Px2).

Petitioner testified she reported complaints of sharp low back, hip and pelvis pain into the right leg to Dr. Kovalsky. At the initial visit of 1/21/16, Petitioner reported she had been off work since 12/29/15, as the Respondent would no longer allow her to work light duty. Dr. Kovalsky's report indicates complaints of persistent pain in the right lower back and buttocks with no worsening or improvement since the accident date, and no radicular symptoms. Examination reportedly was positive for right SI joint dysfunction, noting various positive provocative tests, with normal neurological testing and no specific spine findings. Dr. Kovalsky indicated lumbar x-rays were normal with mild sclerosis bilaterally in the SI joints with no erosions or widening. He noted the lumbar MRI was of good quality and was basically unremarkable, as the mild L3/4 disc bulge was clearly not causing her condition. Dr. Kovalsky goes on to explain that SI joint dysfunction is "a diagnosis of exclusion", including normal lumbar MRI, that the practitioner has to have a high level of suspicion, and that the only way to confirm the diagnosis is via SI joint injections with an arthrogram. He states: "At this point I don't feel that we need to do that", and prescribed physical therapy with a specialized therapist "trained in manipulation." He also prescribed medication, including steroids, and allowed her to work with restrictions of 20 pounds lifting and no repetitive bending, lifting or twisting, noting if Respondent did not accommodate this, she could work regular duty. (Px4).

The 1/27/16 initial therapy evaluation indicates Petitioner complained of generally 6/10 to 7/10 aching and occasionally sharp pain, and located her pain to the right SI joint around to the L5 nerve root distribution. (Px4). On 2/18/16, Dr. Kovalsky noted he had previously diagnosed a minor lumbosacral strain and SI joint dysfunction. Petitioner reported 70% improvement in her buttocks and leg pain, and while she still had low back

pain, she clearly was improved. Petitioner reported that Respondent would not let her work light duty, but did not indicate if she was thus working regular duty or not. Therapy was continued, adding work conditioning. (Px4). By 3/21/16, the therapist noted Petitioner had started work conditioning. She reported she did not feel she could perform regular duty, and while the therapist noted improvement in ROM and strength, Petitioner still had pain and did not feel her back was improving with therapy. (Px4). On 3/23/16, Dr. Kovalsky noted Petitioner was working light duty. She stated that she really thought therapy was helping her, and that her back and SI joint pain had improved and she was progressing in work conditioning. Light duty and therapy were continued. (Px4).

On 4/20/16, Dr. Kovalsky noted Petitioner had not obtained any further sustained improvement and was at a plateau, and referred Petitioner to Dr. Smith for SI joint injection and arthrogram. Dr. Kovalsky stated that the injections would be both diagnostic and therapeutic, noting there were no scans that could be obtained which would confirm whether the SI joint was a source of pain or not. Light duty was continued, and Petitioner indicated the Respondent was no longer providing accommodated work. (Px4).

The injection was performed on 5/17/16. Petitioner reported her pain went from 5/10 prior to the injection to 0/10 afterwards. On 6/9/16, Dr. Kovalsky noted positive clinical findings and that Petitioner had 100% improvement with the injection and thus that she clearly had SI joint dysfunction and was a candidate for right SI joint minimally invasive fusion surgery. Petitioner reported there was no real improvement with therapy, but she had been exercising and trying to lose weight. Her back strain had completely resolved and she was left with right buttocks pain. Dr. Kovalsky indicated that a second lidocaine-only injection would need to be performed to confirm the diagnosis, so Petitioner was again referred to Dr. Smith. If Petitioner had 50% or greater improvement, she would be scheduled for surgery. (Px4).

On 8/23/16, Dr. Smith performed the injection, reporting that Petitioner indicated she had 7/10 pain pre-injection, and felt she had 70% improvement afterwards. However, Dr. Smith noted significant extravasation of contrast dye, and recommended: "CT pelvis to better assess the SI joint configuration and then repeat right SI joint injection with lidocaine only to make sure to obtain the best arthrogram of the right SI joint." (Px4).

The 9/6/16 pelvic CT scan reflected left SI joint sclerosis involving the sacrum and iliac bone, but normal findings at the right SI joint. The report also noted it was being compared to a right hip MRI from 10/11/13. Dr. Smith on 9/27/16 noted the CT showed "bridging osteophyte at posterior inferior aspect of the right SI joint." The lidocaine injection was performed, and Petitioner reported 80% pain reduction following same. (Px4).

Based on this, on 10/12/16 Dr. Kovalsky indicated Petitioner now had met all of the criteria for SI joint fusion and requested authorization to perform same. He indicated Petitioner would likely be able to return to light duty within 4 weeks, and to full duty within 8 weeks after surgery. This was the first indication the Arbitrator saw in the records where Hydrocodone was prescribed to Petitioner. (Px4).

Petitioner was examined on 11/21/16 by Dr. Mirkin at Respondent's request pursuant to Section 12 of the Act. His findings are outlined below per his deposition, but it was his opinion that the Petitioner did not have SI joint dysfunction and that the recommended surgery was not reasonable and necessary.

On 1/11/17, Dr. Kovalsky reported that Petitioner said Dr. Mirkin only examined her for 5 or 6 minutes, and did not perform any of the provocative SI joint exam testing that Dr. Kovalsky had performed. Surgical authorization had been denied by Respondent. Dr. Kovalsky also stated that a CT scan would be needed to help plan the surgery but "its not part of the diagnosis", and that a new MRI would also be needed to make sure there was no lumbar nerve compression." Hydrocodone and light duty were continued. (Px4). Dr. Kovalsky issued a final report on 3/8/17 which explained the basis for his surgical recommendation, and indicated that Dr. Mirkin

"really doesn't believe in SI joint dysfunction, and does not personally do SI joint fusion surgery." He noted Dr. Mirkin's report noted Petitioner had undergone an epidural injection with 100% pain relief when it was his understanding Petitioner had never had an epidural. Dr. Kovalsky also states that he has performed over 300 of these procedures, that most people are pain free within 4 to 6 weeks post-surgery, and that "I've never seen anyone that's had a positive outcome with surgery ever deteriorate or have problems with the SI joint again in the future." He opined Petitioner would likely be able to return to full duty in 8 to 10 weeks. (Px4).

Petitioner testified the conservative care, including the physical therapy and injections, did not provide her with any real lasting relief. Petitioner testified currently she has significant pain in her low back and right hip that is sharp and stabbing. As such, she wishes to undergo the right SI joint fusion recommended by Dr. Kovalsky.

Petitioner testified she did receive TTD benefits for a time, and worked for a time for Respondent on light duty which accommodated Dr. Kovalsky's restrictions, but since 1/18/17 the Respondent placed her on medical leave and she has not worked or received any TTD benefits since that time. Petitioner testified she did attempt to return to work on 12/15/16 following her Section 12 examination with Dr. Mirkin, but began to experience increased pain while walking up and down the halls, transferring residents and lifting. She reported this to her supervisor who gave her permission to leave work. She testified that she remains under the restrictions given by Dr. Kovalsky, and that he was still recommending surgery at her last visit in May 2017. Petitioner testified that she has had no intervening injuries to her low back, pelvis or right leg from 10/29/15 up through the hearing date.

On cross examination, Petitioner testified that at the time of the work accident, she felt a pull all across the bottom of her back at the time of the accident, but it was worse when she moved her right leg. She was able to work light duty until about 12/17/15. She agreed that Dr. Kovalsky discussed the SI joint and possible treatment for it at the initial visit of 1/21/16. She did have pain into her leg and thigh at that time. Therapy did provide some pain relief, and she did not dispute that her back pain resolved, but that she continued to have hip and leg pain. During the therapy prescribed by Dr. Kovalsky, Petitioner was not working her regular full duty job.

Petitioner agreed that she completed a pain diagram for Dr. Mirkin indicating a pins and needles sensation across her entire back, right hip and both the front and back of the right leg. She returned to her regular job following Mirkin's exam, but left after less than 8 hours due to an increase in pain, and Respondent then allowed her to work light duty until about 1/18/17. Petitioner has 12, 10 and 5 year old children, and testified she is unable to lift her 5 year old, who weighs about 30 pounds.

Board certified orthopedic surgeon Dr. Kovalsky testified via evidence deposition on 4/19/17. He testified that over the course of his practice, he's performed more than 300 sacroiliac joint fusions. Petitioner informed Dr. Kovalsky that she never had the relevant symptoms until the accident at issue here, never previously treated for back problems or lumbar problems, and hadn't missed any time from work before the accident due to back problems. Dr. Kovalsky testified that there are six examination tests which are provocative for SI joint dysfunction, considered provocative because the maneuvers stretch or create motion in the SI joint: Fortin Finger pointing, Patrick's, thigh thrust, pelvic compression, and pelvic distraction. The Fortin finger pointing, Patrick's and pelvic distraction tests were positive on the right and negative on the left. She had a positive Gaenslen's sign which causes pain in her right SI joint, but not quite as positive as the other tests. The pelvic compression test was negative, but Dr. Kovalsky testified the pelvic compression test is rarely positive. He testified, according to the literature and his personal involvement in some studies on the subject, the examiner would like to see the Fortin finger pointing to be positive and either the pelvic distraction test or the Patrick's test to at least be positive, and the examiner would have to have a third test that's also positive in order to confirm the diagnosis. (Px6).

Dr. Kovalsky testified that both regular and flexion/extension/lateral lumbar x-rays were unremarkable. Lumbar MRI was also, for the most part, unremarkable other than a slight foraminal disc bulge at L3-4 on the left that was not causing significant nerve compression, and is on the opposite side of where Petitioner's pain was, so not clinically relevant. Dr. Kovalsky testified SI joint dysfunction is a diagnosis of exclusion, meaning you have to rule out the lumbar spine as a cause. He opined SI joint dysfunction is basically a syndrome because there's no pathological anatomy on imaging studies, but imaging studies are necessary to rule out a disc herniation, spinal stenosis, or fracture, i.e. a lumbar cause. The most common cause of buttock pain would be the lumbar spine, and SI joint dysfunction is the second most common cause. He believed Petitioner has work-related SI joint dysfunction based on her history, physical exam, positive provocative testing, and lack of relevant pathological anatomy on the imaging studies. He also believed she had a minor lumbosacral strain. He placed Petitioner on light duty with a 20-pound lifting restriction with no repetitive bending, lifting, or twisting. (Px6).

Dr. Kovalsky testified that between her being off work, manual physical therapy and the medication, she had moderate to significant pain improvement as of 2/18/16. However, she continued to have positive findings on provocative exam testing and by 4/20/16, Dr. Kovalsky noted that Petitioner felt her improvement had plateaued. On physical exam, she had four out of the six positive SI joint provocative testing. Dr. Kovalsky's assessment was chronic sacroiliac dysfunction on the right that had failed conservative treatment. Minimally invasive right SI joint fusion was discussed, but Dr. Kovalsky noted that an initial injection of steroid and lidocaine would need to provide at least 50% improvement and, if improved, due to placebo effect, a second lidocaine injection would have to be performed to confirm the diagnosis. (Px6).

Dr. Smith administered the initial injection on 5/17/16, which provided 100% but only temporary relief for two to three days. On 6/09/16 Petitioner returned to Dr. Kovalsky, who noted she basically felt the same with 8/10 pain. The SI joint provocative tests were all positive, except for the pelvic compression test. The second injection was first attempted by Dr. Smith on 8/23/16, but due to some extravasation of the injection dye, a CT scan was performed to determine the proper needle placement for the small space in the SI joint. Following the scan, Dr. Smith repeated the injection on 9/27/16, noting the needle was clearly in the SI joint, and it provided 80% improvement which was temporary, which Dr. Kovalsky opined confirmed the diagnosis of SI joint dysfunction. (Px6).

Dr. Kovalsky felt Petitioner had met all the criteria for a minimally invasive SI joint fusion based on Petitioner having all the other conservative methods of treatment, which provided short-term relief and no long-term benefit, her pain rating and provocative tests being relatively the same as it was before. He believed this would be the fastest way to get her back to regular duty work. In the meantime, her restrictions were continued along with hydrocodone. On 1/11/17, Dr. Kovalsky noted 7/10 pain in the right SI joint and minor referral into the right leg. Petitioner continued to have positive provocative testing except the pelvic compression test and Gaenslen sign were mildly positive, and she remained a surgical candidate. Dr. Kovalsky noted about 40% of people that have SI joint dysfunction get groin pain and leg pain above the knee, which typically resolves post-surgery along with the buttock pain. Again, light duty and hydrocodone for pain were continued pending surgical approval. Dr. Kovalsky noted that he was not aware at that time that Dr. Smith had obtained the pelvic CT scan, and that his plan to obtain same to plan for surgery as noted in this report would no longer be needed. (Px6).

Dr. Kovalsky opined that Petitioner's lumbrosacral strain had resolved. The basis for the right SI joint dysfunction diagnosis was lack of MRI findings; no evidence of right sided neurocompression of her lumbar spine to account for the buttocks pain; consistent physical exam, including the markedly positive four major tests (Fortin finger pointing, thigh thrust, Patrick's test, and pelvic distraction) on every physical exam;

Petitioner never having symptoms on the left side; no evidence of lumbar radiculopathy; and Petitioner having two injections with lidocaine that gave her greater than 50 percent relief of her pain. Based on Petitioner's history of no prior similar symptoms, and symptoms starting immediately after the 10/29/15 work injury which has been persistent since then, Dr. Kovalsky opined that there is a causal relationship of the condition to the accident. The symptoms and physical exam findings have been consistent since his first examination of Petitioner in January 2016. (Px6).

Dr. Kovalsky opined that Petitioner would not improve further without the surgery, but with surgery he expected the pain to resolve and that she would be able to return to unrestricted work. He testified the care and treatment he's provided thus far was reasonable and necessary, as would be the planned fusion surgery. With regard to Petitioner's credibility, Dr. Kovalsky believed Petitioner to be honest, noting she never presented with any inconsistencies in her physical examination or any history that would lead him to believe that she was malingering or trying to magnify her problem. He testified that "a lot of patients kind of know what sciatica is and sometimes people get coached. It's hard for them to coach somebody about SI joint dysfunction because it's not something that the general public knows a lot about." (Px6).

Dr. Kovalsky testified that he reviewed Dr. Mirkin's report and issued his 3/8/17 report in response, noting Mirkin "did not really come up with a plausible explanation for why she was having chronic right buttocks pain." He agreed the 10/29/15 pain diagram from Salem Township Hospital indicated bilateral buttock pain with no indication of leg pain. He was also shown a copy of the pain diagram completed by Petitioner for Dr. Mirkin, and testified the pain diagrams do not change his causation opinion. Dr. Kovalsky testified he has a lot of patients that refer to SI joint pain as low back pain, and they usually don't say buttocks pain or SI pain unless they are referred from someone else who has already diagnosed this. He testified most people identify it as low back pain, so the fact that the emergency room records and primary care physician care physician's office's records indicate low back pain does not change his opinions on diagnosis, causation, and/or treatment. Plus, Petitioner also had a lumbosacral strain. (Px6).

On cross-examination, Dr. Kovalsky agreed he first saw the Petitioner on 1/21/16, about 3 months post-accident. He had not reviewed the physical therapy records from before this initial visit, and agreed Petitioner is where he obtained the knowledge that she had not improved with the initial therapy. He diagnosed SI joint dysfunction at the initial visit based on nothing in the lumbar MRI supporting the spine as the source of her pain, the positive provocative examination tests and no evidence of lumbar radiculopathy on exam. He agreed that Petitioner didn't initially note leg symptoms, and complained of symptoms mostly in her right buttocks. (Px6).

The injection to the SI joint is "the only test that we can really rely on with any consistency" to diagnose the dysfunction condition. Dr. Kovalsky testified that he has been involved in a bunch of studies regarding this "because this is a diagnosis not readily accepted by the majority of the spine community and it's not accepted because of a lack of education", and because it cannot be seen in any objective scans. (Px6).

At some point the Petitioner started to complain of radiating pain and numbness and tingling into the right leg. About 40% of the people with the diagnosis have pain and/or numbness and tingling in the leg to the knee, and he testified that 5%-10% of his patients with SI joint dysfunction have symptoms that go all the way down to the ankle or feet. It is in a nondermatomal pattern and thus not radicular. Noting the pain diagram from Dr. Mirkin's office, Dr. Kovalsky testified that he thought it was a little uncommon for a patient to have symptoms to the foot, especially in the front and back of the leg. Once Petitioner had plateaued, after six months, the injection protocol was prescribed. Again, Dr. Kovalsky testified that Petitioner had four positive provocative tests during exam at basically every visit, but agreed that both these provocative tests as well as the injections required

subjective responses from the Petitioner. He testified he's been performing SI joint fusions since 2011, that 80% of the patients he diagnoses with SI joint dysfunction have the fusion procedure, and that 10% to 15% of those are involved in either workers' compensation or personal injury litigation. The majority are middle aged women, who often seem to get it as they get older, while most men who have the problem started to have issues after a trauma of some sort. He testified that SI joint dysfunction is a difficult condition to diagnose because many physicians don't understand how to identify it, and he acknowledged that there has been difficulty getting insurance companies to approve the procedure, "because the majority of spine doctors don't think this problem exists", but that they are doing so more and more. Dr. Kovalsky testified that he has a success rate with the fusion procedure "in excess of 90%", and most people are pain free within four weeks of surgery. With people with heavier jobs, they may need 6 to 10 weeks of conditioning before returning to work. (Px6). On redirect examination, Dr. Kovalsky testified that the failure rate of an SI joint fusion is very low and none of his patients are worse after surgery, so of the ten percent who don't get better, not one of them is worse. (Px6).

Dr. Mirkin, also a board certified orthopedic surgeon, testified on 4/24/17. Dr. Mirkin testified he examined Petitioner at Respondent's request on 11/21/16, and she gave a consistent history of the accident. He testified the Petitioner initially reported right low back pain above the hip bone area at the ER, and a pain diagram was in the records confirming this. The ER records noted a diagnosis of a low back strain, and her examination was essentially normal. At the 11/21/16 Section 12 exam, Petitioner claimed she developed some right leg pain about a month later. Petitioner complained of sharp low back and right hip pain that went into the buttocks and right leg along the entire circumference of the leg, which he noted to be "very odd." He noted Petitioner underwent physical therapy, medications and some SI joint injections. (RxA).

In reviewing Dr. Kovalsky's records, Dr. Mirkin noted Kovalsky felt Petitioner had SI joint dysfunction, based on the normal MRI, gave her large amounts of narcotic analgesics, some physical therapy and injections, and then recommended SI joint fusion surgery. Dr. Mirkin noted his report referenced a 3/16/16 therapy note where Petitioner said her back pain was not improving with therapy, and didn't indicate that she had any pelvic pain or SI joint pain. (RxA).

Dr. Mirkin performed a physical exam of Petitioner. He testified the Gaenslen test was negative. He noted the 12/17/15 MRI showed a clinically insignificant very slight bulge at L3/4, while the 9/6/16 pelvic CT was normal with no evidence of SI joint abnormality, disruption, arthritis, fracture or dislocation. He testified that the SI joint is probably the strongest joint in the body and that it takes a huge amount of force to tear it apart or cause significant injury to it. While arthritis is a possibility, it is generally seen in people older than 30. Dr. Mirkin opined that most orthopedists would require a disruption of the SI joint before considering fusion, but that various companies are pushing for the fusion procedure for people with SI joint discomfort. He believed Petitioner's description of her right leg pain was in a nonorganic or nonanatomic pain pattern and was not consistent with a nerve issue, hip issue, or SI joint issue. Dr. Mirkin opined Petitioner's diagnosis from the work incident was a lumbar strain, and that physical therapy and some non-narcotic analgesics were indicated as treatment. While Petitioner had subjective right leg complaints, "I'm not sure you can isolate those to the SI joint, but the SI joint has been examined and, on radiological studies and on my examination, there's no significant abnormality." He did not feel Petitioner required any further treatment for the work injury, and that she had reached maximum medical improvement within two to six weeks after a course of therapy and medication. He did not believe that the recommended SI joint fusion was indicated given the normal x-rays/CT scan and exam findings, testifying: "I don't know why anybody is recommending fusing, which is a pretty radical procedure on a 30 year old's SI joint without a disruption or abnormality of the SI joint." He did not believe Petitioner needed any work restrictions because of the 10/29/15 work injury. (RxA).

On cross-examination, Dr. Mirkin reiterated his belief that the work-injury had caused a lumbar strain, but that by the time of his examination the lumbar strain had resolved itself. While Petitioner had complaints that sometimes had some signs of radiculopathy, she did not have any clinical or radiographic findings consistent with radiculopathy. He noted that the injections by Dr. Smith provided only temporary limited relief (for 10 to 20 minutes). Petitioner was cooperative during his examination, during which she had complaints of pain on compression on both sides of her pelvis. Dr. Mirkin was not aware of any records predating the work injury which indicated she was experiencing episodes of significant low back pain or buttocks pain. He performs one or two SI joint fusions a year. He did not perform the Forten finger pointing test. He did not perform the Patrick's test but he did perform a variation of it. He did perform the pelvic distraction test and the result was normal. The results of the thigh thrust test were negative. He results of the pelvic compression test were normal. Ultimately, his testimony was that several of these provocative maneuvers were "just variations of putting the hip in certain positions and compressing or distracting." He performed the testing as indicated by the company that markets the fusion devices. Dr. Mirkin agreed he opined Petitioner could return to unrestricted duty, but did not know what happened when Petitioner attempted to return to work without restrictions following his exam. He agreed his report does not state that the Petitioner was exaggerating or malingering. (RxA)

On re-direct, when asked if the provocative testing he performed during his exam adequately addressed Petitioner's SI joints, Dr. Mirkin said that they had, and that while they are given different names, they all essentially put the hips into a flexed position, the knee into a flexed position, and then used different thrusts, rotations, compression or distraction. On further cross-examination, regarding Petitioner's current low back, buttocks, and right leg symptoms, Dr. Mirkin opined that Petitioner may have some persistent residual from the lumbar strain caused by the work incident. He believed that everything's been reasonably done to treat Petitioner. For her current complaints, he recommended exercise, weight loss, and to "get on with her life." He opined she could exercise on her own or with physical therapy. His recommendation for home exercise or physical therapy would be causally related to everything, including the lumbar strain that she sustained at work 10/29/15. (RxA)

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The parties in this case do not dispute that the accident occurred as testified to by Petitioner on October 29, 2015. Initial treatment for a back and right hip injury following the work incident also was authorized by Respondent. Instead the dispute in this case lies with the experts and their diagnoses with recommendations for further treatment for Petitioner's alleged ongoing back and right hip/buttocks pain. Dr. Kovalsky has testified that he believes Petitioner has right SI joint dysfunction and based on his testing and the response of Petitioner to injections that she requires an SI joint fusion. Dr. Mirkin, on the other hand, does not believe Petitioner has any SI joint issues whatsoever based on his normal physical exam and lack of any findings on Petitioner's MRI and CT scans. Therefore he believes that Petitioner only suffered a lumbar strain from the work accident and is at maximum medical improvement.

The Arbitrator finds Petitioner to be a credible witness. Nothing rebuts Petitioner's testimony that she did not experience any significant pain in right low back, buttocks and pelvis areas in the months prior to 10/29/15. The evidence reflects she had been able to perform her job duties, which were heavy at times, and was under no restrictions. The 10/29/15 work incident appears to have caused a significant change in Petitioner's physical

condition. Neither Dr. Kovalsky nor Dr. Mirkin felt there was an indication of symptom magnification of malingering.

Petitioner's testimony, the relevant medical records, and the persuasive testimony of Dr. Kovalsky support the diagnosis of SI joint dysfunction and a lumbar strain as a result of the 10/29/15 incident. Dr. Kovalsky's opinions are more persuasive than those of Dr. Mirkin with regard to Petitioner's SI joint injury. Both experts agree Petitioner suffered a lumbar strain as a result of the 10/29/15 injury. Dr. Kovalsky opined Petitioner also suffered an injury to her right SI joint and he provided a persuasive and thorough explanation of the SI joint dysfunction diagnosis and the causal relationship between the 10/29/15 injury and that diagnosis. The 11/10/15 assessment of the physical therapist indicated Petitioner presented with signs and symptoms consistent with right SI joint dysfunction.

The determination of this issue in this case was difficult for the Arbitrator, as there really is a lack of significant objective evidence of an SI problem per MRI. In fact, the only positive finding per pelvic MRI was on the left SI joint. However, the injections performed and Dr. Kovalsky's explanation of their purpose was persuasive in the Arbitrator's view. Given that neither physician found the Petitioner to lack credibility, and the fact that she has ongoing symptoms with no apparent lumbar spine pathology to explain it, the greater weight of the evidence supports that there is a right SI joint dysfunction that is causally related to the accident.

The Arbitrator concludes Petitioner current condition of ill-being is causally related to the 10/29/15 work injury.

The Arbitrator also specifically finds that the lumbar strain that the Petitioner also sustained as a result of the 10/29/15 work accident has resolved. This is supported by the testimony of both Dr. Kovalsky and Dr. Mirkin.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

The Petitioner is entitled to the medical expenses contained in Petitioner's Exhibit 5. The Arbitrator finds that the treatment to date has been reasonable and necessary pursuant to the Act. Respondent is liable for the medical expenses contained in Px5 pursuant to Sections 8(a), 8(j) and 8.2 of the Act. Respondent is entitled to credit for any of the awarded expenses which were paid prior to the hearing date, and shall hold the Petitioner harmless with regard to same.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

As with causation, the issue of prospective medical is complicated in this case.

With regard to SI joint dysfunction, as found by Dr. Kovalsky, the doctor himself testified that it is a diagnosis not readily accepted by the majority of the spine community "because the majority of spine doctors don't think this problem exists." However, he also testified that such spine doctors are considering this diagnosis more often. Dr. Kovalsky also testified that he has a success rate with the fusion procedure "in excess of 90%", and that most people are pain free within four weeks of surgery. He further testified that the procedure is minimally invasive, that the failure rate of an SI joint fusion is very low, and that none of his patients ended up worse after surgery. He testified that he has performed 300 or so of these procedures. He also testified that the procedure involves relatively low costs.

Dr. Mirkin, on the other hand, testified that most orthopedists would want to see a disruption of the SI joint before considering a fusion, that various companies involved in the fusion hardware are leading the push for the procedure, and that Dr. Kovalsky is somewhat involved in that push. He testified as follows:

"I don't know why anybody is recommending fusing, which is a pretty radical procedure on a 30 year old's SI joint without a disruption or abnormality of the SI joint." This does give the Arbitrator pause. At the same time, he testified he has performed SI joint fusions at the rate of 1 or 2 per year, but did not testify with regard to whether he meant on an open basis or on a minimally invasive basis. Dr. Mirkin described the multiple types of SI fusions that can be performed, but he didn't really pinpoint the specific surgery that Dr. Kovalsky recommends.

Overall, the Arbitrator believes that Dr. Kovalsky's testimony was more persuasive than that of Dr. Mirkin. It should be noted that Dr. Kovalsky's testimony sets a very high bar, as he has indicated that 90% of his SI joint fusion patients are pain free shortly after surgery and that none of them are left worse than before the surgery. The Arbitrator strongly hopes that this testimony is accurate.

The Arbitrator finds that the Respondent shall authorize the minimally invasive right SI joint surgery recommended by Dr. Kovalsky.

With regard to the pelvic CT scan and lumbar MRI that Dr. Kovalsky recommended prior to surgery, these procedures are denied. As he noted, the CT scan has already been performed and is no longer necessary. With regard to the lumbar MRI, the Arbitrator fails to see how a new scan would provide any further information as to the SI joint procedure. It was quite clear from the prior scan and the testimony of both Dr. Kovalsky and Dr. Mirkin that there was nothing in the lumbar spine that was causing the Petitioner's symptoms.

WITH RESPECT TO ISSUE (L), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the Petitioner remained temporarily and totally disabled from 1/18/17 through 5/4/17, as the Respondent could not accommodate the restrictions issued during that time by Dr. Kovalsky.

STATE OF ILLINOIS)
) SS.
COUNTY OF ADAMS)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Cynthia S. Willis,

Petitioner,

vs. NO: 14 WC 00548

Niemann Foods, Inc,

Respondent.

18IWCC0260

DECISION AND OPINION ON REVIEW

Timely Petition for Review under having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, causal connection, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 11, 2017, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $53,000.00. 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: APR 25 2018
o040518
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WILLIS, CYNTHIA S
Employee/Petitioner

Case# **14WC000548**

NIEMANN FOODS INC
Employer/Respondent

18IWCC0260

On 10/11/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.22% 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:

0834 KANOSKI BRESNEY
CHARLES N EDMINSTON
129 S CONGRESS
RUSHVILLE, IL 62681

0554 SCHOLZ LOOS PALMER ET AL
JENNIFER A WINKING
625 VERMONT ST
QUINCY, IL 62301

STATE OF ILLINOIS)
)SS.
COUNTY OFADAMS)

☐ 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

Cynthia S. Willis
Employee/Petitioner

v.

Niemann Foods, Inc.
Employer/Respondent

Case # 14 WC 00548

Consolidated cases:

18IWCC0260

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Quincy**, on **September 6, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ 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

18IWCC0260

FINDINGS

On **March 4, 2013** , Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$32,136.00** ; the average weekly wage was **$618.00** .

On the date of accident, Petitioner was **44** years of age, ***single*** with no dependent children.

Petitioner ***has*** received all reasonable and necessary medical services to date.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$6,637.82** for TPD paid, and the parties stipulate that this is the correct amount due for the period of temporary partial disability suffered by Petitioner, if accident and causation are found in Petitioner's favor.

ORDER

Based upon the testimony of Petitioner and the testimony of Dr. Glanton, the Arbitrator finds that the Petitioner has not yet reached maximum medical improvement and therefore an award of permanent partial disability is premature, and this issue remains open for further proceedings.

Respondent shall pay reasonable and necessary medical services of $53,678.64, as provided in Sections 8(a) and 8.2 of the Act and subject to reductions under the Medical Fee Schedule or negotiated rate, whichever is less. Respondent shall receive credit for any amounts paid under it's group medical plan on any awarded bills.

As Petitioner has been found to not be at MMI, her right to further medical care and further awards of temporary and permanent disability shall remain open for further hearing.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

D. Glenn McEnerty

Signature of Arbitrator

9/27/17

Date

OCT 11 2017

18IWCC0260

In support of the issues in dispute in this case, the Arbitrator finds the following facts:

Petitioner worked as a dog groomer for the Respondent, a job which she began in 2003. On March 4, 2013, she said that she was assisting in lifting a large gold retriever that weighed approximately 60 to 80 pounds. Petitioner testified that she was standing at a table that was about level with the bottom of her ribcage and lifting with both arms on the dog, who was lying down on the table. As she lifted the dog up, she felt a sharp pain across her lower back from one side to the other. Petitioner testified that she told her supervisor, May, about the incident immediately but continued working and continued to experience pain. She testified that she delayed seeking treatment hoping the pain would resolve but as it continued she talked with her supervisor who told her to go to the walk in clinic at Quincy Medical Group for care.

Medical records confirm that the Petitioner was seen on March 12, 2013 by Dr. Wallace at Quincy Medical Group reporting a consistent history of injury while lifting a dog 8 days before in the course of her work duties as a groomer. (PX 6, pp. 38-40) Petitioner described the onset of instant pain with pain radiating into her right buttock. Petitioner acknowledged that she had a previous mid-back injury that had been improving with therapy. On examination, Dr. Wallace noted that she was in obvious discomfort and noted that this injury was in a different part of her back than her previous injury. He noted that it hurt to move or twist and there was pain over the lumbar spine on palpation. He diagnosed low back pain and prescribed Percocet, noting that she had tried hydrocodone without relief. He released Petitioner to work restrictions and she was advised to use Flexeril at home. She was advised to follow-up with Dr. Biggs and it was noted that she may require an MRI and therapy.

Petitioner was seen on March 26, 2013 by Dr. Biggs. (PX 6, pp. 34-37) He recorded a consistent history of onset of pain while helping a fellow employee move a 50 pound golden retriever in an awkward position. Petitioner complained of shooting pain across her back. Petitioner complained of pain originating in her mid lumbar spine and radiating in to her bilateral buttocks. On examination he noted increased lumbar lordosis and abnormalities in her ability to climb on the exam table and change positions. He noted tenderness to palpation over the spinous process, sacroiliac joint and paraspinals. Range of motion was abnormal with pain. Dr. Biggs' assessment was acute moderate low back pain. He reduced her work day to 4 hours per day and added restrictions. He prescribed a home TENS unit which she obtained on the following day. (PX 6, p. 33)

Petitioner returned to Dr. Biggs on April 2, 2013 for re-check reporting that she was doing better with the TENS unit. (PX 6, pp. 30-32) She still complained of pain in the right low back radiating in to the right buttock. Petitioner reported that she was working with restrictions. She continued to demonstrate abnormalities in her ability to climb on the exam table and range of motion and her spinous process, sacroiliac joint and paraspinals remained tender to palpation. Her work restrictions were reduced again and her hours remained reduced. She was advised to work on range of motion activities at home and return in two weeks.

Petitioner returned to Dr. Biggs for re-check on April 30, 2013 reporting persistent low back pain that was moving further down her right lower extremity to the level just below the hip and wrapping around

anteriorly. (PX 6, pp. 27-29) She continued to have trouble bending, twisting and lifting and had been off work for the past two weeks for an unrelated medical condition. She continued to have increased lumbar lordosis, tenderness in her spinous process, sacroiliac joint and paraspinals and abnormalities on range of motion. It was recommended at this point that she obtain an MRI of her lumbar spine and SI joints and her work restrictions were continued.

An MRI of her sacroiliac joints was obtained on May 28, 2013 and was read to be rather compromised due to prominent motion artifact but no significant bony or arthritic changes were identified. (PX 6, p.49) An MRI of her lumbar spine on the same date which was also compromised due to motion artifact, but showed spondylosis without significant canal or neural foraminal narrowing and age indeterminate T12 superior endplate deformity. (PX 6, p. 50)

Petitioner returned to Dr. Biggs on June 11, 2013. (PX 6, pp. 23-26) He reviewed her history and treatment to date. He noted that she reported initially shooting pain across her back that had become more constant and localized to her right SI joint area. Physical therapy had not provided significant relief. Her primarily relief was from heat and massage. He noted that her pain had been stable with radicular type symptoms into her right hip/glute aspect with some discomfort to her knee. She was working 4 hour days with lifting restrictions and was tolerating that. She continued to have discomfort with rest but also with bending, twisting and lifting. He did not feel that there were any MRI findings corresponding with her symptoms and suggested a second opinion.

Petitioner returned to Dr. Biggs on June 26, 2013. (PX 6, pp. 17-21) He reviewed her history of injury and noted that her symptoms had become more constant and localized to her right SI joint area. She reported at this time that she felt her pain was getting worse. She complained of pain down her right leg to her knee. She was working 4 hour days with additional lifting restrictions and was tolerating it. She reported pain at rest as well as with bending, twisting and lifting. He continued to note tenderness on palpation to the spinous process, sacroiliac joint and paraspinals, and her range of motion remained abnormal. Dr. Biggs commented that there was right SI joint tenderness with apparent motion restriction on forward flexion, being limited to about 60 percent, with greater discomfort in the right SI joint upon returning from flexion. He stated that her symptoms were out of proportion to her physical exam and radiology findings but acknowledged that at least some of her symptoms could be coming from an undetected SI joint dysfunction. He recommended a consultation with Dr. Newton. He also referred her for pain management at Blessing Hospital.

Petitioner saw Dr. Joseph Newton on July 31, 2013 on referral from Dr. Biggs. (PX 6, pp. 11-14) He recorded a consistent history of injury. Petitioner described her pain as an ache in the left low back/posterior hip and a pins and needles/stabbing pain on the right that can radiate into the lateral hip. She reported her pain was from a 3/10 level and increase with activities like lifting, throwing a ball or vacuuming. On examination, Dr. Newton noted significant tenderness to palpation along the lumbar spine over the spinous process and along the paraspinal musculature. He noted mild tenderness at the iliolumbar ligament attachment across the ileum, but no tenderness along the SI joint bilaterally. Posterior compression test for the hip and SI joint was negative bilaterally and FABRE test was negative bilaterally. There was moderate restriction in internal and external rotation of the lower extremities. He noted that the MRI taken in May 2013 showed spondylosis of the lumbar spine without significant central canal or neural foraminal narrowing, and there was no obvious arthritic change in the SI joints on MRI, though the image was compromised. Dr. Newton diagnosed low back pain and chronic lumbar strain with muscle spasm and somatic dysfunction of the lumbar and lower extremities. He noted that she had significant pain in the lumbar region that was greater than would be expected from the MRI and x-ray

results. He recommended flexion and extension views and if this was negative, a neurosurgical consult. He recommended an increase in Gabapentin. Flexion/extension films done that day showed no instability. (PX 6, p. 42) Dr. Newton provided her with a work restrictions slip that limited lifting to 15 pounds, pushing and pulling to 30 pounds and no repetitive pending of the low back. (PX 6, p. 46)

Petitioner was seen by Dr. Reynolds, a neurosurgeon, on August 14, 2013. (PX 6, pp. 9-10) he noted that Petitioner was being seen for low back pain related to a worker's compensation claim against Pampered Pets. She reported severe low back pain but reported that her MRI was normal. Petitioner reported pain in her low back, hip, leg and buttocks that she rated at 8/10. She reported that the pain went into both legs but the right was worst. She reported that her pain was worse when she stands, walks or lies down. He noted that the MRI of the low back was normal and the MRI of her pelvis was negative for arthritic changes to the SI joint. He felt that there was no surgery that would help and recommended weight reduction and core strengthening exercise.

Petitioner was seen by Dr. Joseph Meyer at Blessing Hospital Pain Management on August 26, 2013, on referral from Dr. Biggs. (PX 1, pp. 1368-1371) He recorded a consistent history of injury while lifting a 50 pound dog to a grooming table in the course of her work. She reported constant low back pain since her injury, located in her low back and going down both buttocks, worse on the right and radiating down to just below her knees on the lateral aspect of the thighs. She reported pain ranging from a 6/10 to 10/10, with pain on that day of 8/10. She reported pain with spasms happening frequently during the day, especially with sitting, lying , bending, lifting or turning wrong, that was somewhat better with repositioning and rest. He noted that flexion/extension x-rays of the low back on 7/31/13 had shown no instability and an MRI of the lumbar spine on 5/28/13 showed spondylosis of the lumbar spine without significant canal or neural foraminal narrowing. She reported that physical therapy and use of a TENS unit did not make a lot of difference in her pain. She reported use of Percocet and hydrocodone but did not like how these medications made her feel and did not help significantly with her pain. She had also tried Flexeril for quite some time and it was changed to Baclofen which did not help much after two dosages. Gabapentin had not helped . On examination, straight leg raising was noted to be positive at 35 degrees on the right and 40 degrees on the left in the supine position but essentially negative in the sitting position. Tender points were noted through the lower lumbar region just above the sacroiliac bilaterally, worse on the right. Dr. Meyer's diagnosis was low back pain with radiation, and he increased her dosage of Gabapentin and re-started Baclofen. He noted that he may try Tramadol and trigger point injections in the future. A second note on the same date from Dr. David Moore of Blessing Pain Management indicates that he felt that the MRI of May 13, 2013 showed some L5/S1 neuroforaminal narrowing that may be the source of her pain and performed an epidural steroid injection at that level. (PX 1, pp. 1373-1375) Records indicate that a second lumbar epidural steroid injection was performed on September 27, 2013. (PX 1, pp. 787-794)

Petitioner returned to Dr. Biggs on October 9, 2013, reporting about 60% improvement in her low back pain. (PX 6, pp. 5-7) He noted that she had been working with the Blessing pain center and was up to grooming six to eight dogs per day and wanted to get back to ten. She continued to have trouble getting comfortable at night. She reported no radicular symptoms and reported having a lumbar injection which had helped her discomfort. She also was having less muscle spasm and felt that the increase in her medication was helpful. On exam, Dr. Biggs continued to note tenderness of the spinous process but also noted no SI joint tenderness. Petitioner was advised to continue pain management and to continue her work restrictions and medications.

Petitioner was seen by Dr. Steven Weiss for a Section 12 examination at Respondent's request on November 19, 2013. (RX 2) He reviewed her treatment records to date. His examination showed flexion to 90 degrees, extension to 30 degrees and side bending to 30 degrees. Petitioner reported pain on returning to an upright position after being fully flexed. Her neurological evaluation was negative except for pain with straight leg raising on the left in the supine position. His diagnosis was pre-existing lumbar degenerative disc disease and lumbar strain secondary to the incident in question which he indicated was resolved. However, Dr. Weiss noted that since it had been only two months since her epidural steroid injection, her symptoms could recur during the next four months and this could cause him to reconsider his opinion. He opined that she could return to work currently with restrictions of no lifting over 25 pounds frequently or more than 50 pounds occasionally for 6 to 8 weeks and then increase her lifting to 70 pounds over the next two months. He noted that he was being cautious in returning her to work in light of the recent epidural steroid injection. He deferred putting her at maximum medical improvement or commenting on her permanent partial disability until after six months had run from her epidural steroid injection.

Petitioner saw her PCP Dr. Ginos on February 17, 2014 in follow up for a recently hospitalization for unrelated bronchitis. (PX 2, pp. 82-83) However, Petitioner also reported that she was taking Tramadol and Cyclobenzaprine for back pain and wanted to discuss a refill and referral for her back pain. She was kept off work for her lung issues but was directed to start aquatic therapy at the Kroc Center. Petitioner followed up with Dr. Ginos on March 3, 2013 regarding her back pain reporting no improvement and that the Tramadol and Cyclobenzaprine were not really helping. (PX 2, pp. 79-80) Hydrocodone was also not helping. She rated her pain at 7/10. She was noted to be suffering back pain and that standing and bending were bothersome. She had slow, limited movement of the lumbosacral spine and she was advised to see Dr. Espejo, a pain management doctor..

Dr. Weiss issued a supplemental report on March 19, 2014, at the request of Respondent's counsel. (RX 2) Dr. Weiss reviewed an additional record from November 21, 2013 which he relates refers to sleep, hygiene and cardiovascular level activity issues. He reports that the musculoskeletal examination was reported to be unremarkable. He does not state the name or specialty of the doctor involved. In response to a question as to whether Petitioner has reached MMI, Dr. Weiss responded "if this record is Ms. Willis's most recent examination, then it is my opinion that she has reached maximum medical improvement..." In fact, as noted above, this visit was not the Petitioner's last medical examination as she had been seen twice by Dr. Ginos since that time reporting continued pain and seeking further treatment, and the record cited was in fact for treatment prior to the doctor's November 19, 2013 examination of the Petitioner when he stated that he must reserve a determination of MMI until six months after her last epidural injection.

Petitioner did see Dr. Espejo on April 7, 2014. (PX 2, pp. 72-75) She reported having suffered low back pain for about a year which started when she lifted a dog at work. She reported that she had suffered immediate pain in the middle of her low back that initially referred to her buttock. She reported that her pain was worse with prolonged sitting of more than 10 minutes or standing more than ½ hour. She reported having one epidural injection about 4-5 months ago that helped for a couple of months. She reported that Flexeril and Tramadol did not really do much. She reported pain from 3-4/10 to 10/10 and on this date at 7/10. On examination, Petitioner had lower lumbar bilateral paraspinal and midline tenderness on palpation. He noted that she had fairly normal range of motion with pain on getting up from a flexed position. Neurological clinical testing was negative as was Waddell testing. Dr. Espejo read the May 2013 MRI to show only mild lumbar facet changes bilaterally and was otherwise unremarkable. His assessment was chronic low back pain and secondary myofascial pain and iliolumbar ligament

dysfunction. Dr. Espejo recommended trigger point injections and iliolumbar ligament injections to be coupled with a physical therapy program. He commended her for pursuing water therapy at the Kroc Center and directed her to continue.

On April 8, 2014, Dr. Espejo performed trigger point injections in four spots in her lower lumbar paraspinals at the L4/5 level bilaterally. (PX 2, pp. 69-70) Petitioner returned to Dr. Espejo on May 20,

2014, reporting that the injections had helped for two to three weeks and then her pain had started to return a couple of weeks prior to this appointment. (PX 2, p. 59-61) Her pain was aggravated by prolonged postures. The examination of her low back was unchanged, but she had trigger points in her right lower lumbar paraspinal muscles. Additional trigger point injections were performed in her right low back in three locations. Petitioner returned to Dr. Espejo on June 23, 2014, reporting that the last injection had not helped as much as the first ones. (PX 2, pp. 49-51) Dr. Espejo indicated that Petitioner was looking for other treatment options and noted that she had not had physical therapy. On examination, Petitioner had tenderness to palpation of her right lower lumbar paraspinal muscles and to some extent on the left. She was given trigger point injections in three locations in her low back, and she was advised to pursue physical therapy to optimize her low back function as well as use therapeutic ultrasound.

Records from Advance Physical Therapy show that Petitioner was seen on June 27, 2014 for an initial evaluation. (PX 5, pp 28-30) Petitioner reported that her pain had begun while lifting an 80 pound dog about a year before and had gradually increased over the past year. She was noted to have pain to palpation of the spinous process and transverse process and that her rotation to the right and side pending to the right were less than normal. A course of therapy was begun expected to last four weeks. Records show that she continued therapy through August 7, 2014, having attended 11 sessions, when it was noted that she continued to report 5/10 point and that her range of motion was now normal though she reported pain with flexion and right side bending. (PX 5, pp. 64-67)

Petitioner returned to Dr. Espejo on August 7, 2014 reporting that her low back had improved. (PX 2, pp. 45-47) She reported the most pain at 5/10. Dr. Espejo noted that she was in no apparent distress and appeared to be more comfortable. There was no tenderness to palpation of the back. Dr. Espejo stated that there was no need for further trigger point injections on that date but injections would be considered as an option in the future as well as medial branch blocks of her low facet joints. Petitioner returned to Dr. Espejo on October 8, 2014 reporting that she was not anywhere near where she was before the trigger point injections and therapy. (PX 2, pp. 34-36) However, she felt that she as at a standstill. Petitioner reported right low back pain that was improved but she was wanting something more interventional and definitive as treatment. Facet injections and medial branch blocks were discussed with a view of potential radiofrequency ablation. Petitioner reported that she was ready to pursue this alternative. She reported that she had run out of benefits for physical therapy and had been unable to work full time since the injury. Medial branch blocks were planned for the right L3, L4 and L5 to be done two times and, if positive, would proceed to radiofreuqency ablation. Petitioner was given a work restriction against pushing, pulling, lifting or carrying more than 15 pounds.

Petitioner returned to Dr. Espejo on November 17, 2014 after having had two sets of medial branch blocks first at L4/5 and then at L3/4. (PX 2, pp. 27-30) Petitioner reported 50-60% relief with the first blocks and 90% relief with the second. Petitioner was quite happy with the results and wanted to proceed to the next step. Dr. Espejo noted that they had good diagnostic information gleaned from the medial branch block sand it was reasonable to proceed with radiofrequency ablation (RFA) on the right at L3, L4 and L5. She opined that the pain generator is both the L4/5 and L5/S1 joints. Dr. Espejo

referred Petitioner to Dr. Glanton for the radiofrequency ablation procedure (RFA). Dr. Espejo indicated that Petitioner understood that this was not a fix but would give her longer-lasting relief of her back pain.

Petitioner was seen by Dr. Glanton initially on February 16, 2015 at Hannibal Regional Medical Group. (PX 4, pp. 2-5) Dr. Glanton was board certified in anesthesia and interventional pain management. (PX 7 at 6) Petitioner presented with low back pain which was a chronic pain condition. Petitioner described the onset as sudden following an incident at work and had persisted for two years and had been gradually worsening. She described the pain as a severe stabbing pain, aggravated by walking. On examination, moderate tenderness was noted to the medial low back with spasm in the surrounding tissue. Pain was reported at an 8/10 level, referring laterally to the right lower back. Dr. Glanton opined that the Petitioner had low back pain secondary to lumbar facet arthropathy and had undergone a successful medial branch block by Dr. Espejo in the recent past. Dr. Glanton discussed a right L3/4 median branch nerve radiofrequency ablation and right L5 primary dorsal ramus radiofrequency ablation. Petitioner testified that she was unable to proceed with that recommendation immediately because her insurance would not approve it. She testified that she kept in constant contact with Dr. Glanton's office during this period of delay following up on their efforts to obtain coverage.

Petitioner was again seen by Dr. Weiss for a second Section 12 examination on March 24, 2015, who noted that she had undergone median branch blocks in October or November 2014 and had over a three-quarters improvement that lasted about four months. (RX 2, Ex. 4) Petitioner related that she continued to have the same constant low back pain that was worse with bending, lifting, twisting and prolonged sitting or car rides. Dr. Weiss persisted in his diagnosis of pre-existing lumbar degenerative disc disease and also a lumbar strain, acknowledging that the strain was related to her work injury, but asserting that it had resolved. He again attributed her ongoing complaints to her pre-existing condition. He opined that she sustained no permanent partial disability as a result of her accident and that she had reached a point of maximum medical improvement.

She did not return to Dr. Glanton until February 23, 2016, slightly over a year after her initial visit. (PX 4, pp. 6-9) Petitioner testified that in the interim she had continued to suffer the same low back and buttock pain that she had experienced since work-related lifting accident. In his note on that date, Dr. Glanton noted that she continued to describe severe low back pain and that despite numerous contacts to both insurance and his office, the RFA had not yet been accomplished. Dr. Glanton again noted pain and spasm in Petitioner's low back, with 8/10 pain laterally to the right lower back. He again discussed an RFA procedure as previously discussed. Petitioner returned again on May 10, 2016 to discuss the procedure. (PX 4, pp. 10-13) Petitioner testified that she continued to have difficulty obtaining insurance coverage for the procedure. On June 7, 2016, the procedure was actually performed at Hannibal Regional Hospital. (PX 4, pp. 14-15) Petitioner followed up with Dr. Glanton on July 12, 2016. (PX 4, pp. 16-19) Petitioner's pain was now reported to be at a 6/10 level, though not the improvement hoped for. An MRI of the Petitioner's low back was ordered. The MRI was completed on July 27, 2016 and was read to show no significant disc bulge or foraminal narrowing. (PX 4, p. 41)

Petitioner returned to Dr. Glanton on August 2, 2016 reporting that the RFA done on June 7 had not given much pain relief. (PX 4, pp. 20-22) Her pain was described as in the right low back and radiating into the buttock and SI joint on the right. Gaenslen's Test and Sacroiliac Rocking Test was positive. Dr. Glanton concluded that Petitioner was suffering low back pain and right buttock pain consistent with right sacroiliitis and recommended a right SI joint injection. A right sacroiliac joint injection with fluoroscopic guidance was performed on August 12, 2016. (PX 4, p. 42) Petitioner returned to Dr.

Glanton on August 29, 2016, reporting that the injection had helped with her pain though her pain was now starting to return. (PX 4, pp. 23-25) Petitioner now described her pain as 4/10. Dr. Glanton concluded that the Petitioner was suffering from low back pain and right buttock pain due to right sacroiliitis and a repeat injection was discussed. Petitioner returned to see Dr. Glanton on October 12, 2016, indicating that her pain level was now 3/10, with pain in the right lower back and into the right anterior thigh. Petitioner had moderate tenderness to the right buttock and over the SI joint on the right.

Pain would increase with movement. Dr. Glanton noted that the SI injection had significantly improved pain symptoms to a tolerable level, though pain increased with activity and certain positions. He ordered a course of physical therapy.

Records from Advance Physical Therapy show that the Petitioner did attend therapy from October 21, 2016 through November 18, 2016, attending five sessions. She reported that her pain was overall better than it used to be but stated that it still hurts. (PX 5, pp. 4-24)

Petitioner returned to Dr. Glanton on November 15, 2016, reporting a pain level of 4/10 without reporting radiating pain. (PX 4, pp. 29-31) Petitioner reported that she had attended therapy and felt it was helping, though over the past 2 weeks she felt that her pain level ahd increased. She had not been using Flexeril or Tramadol for about a week and her pain was tolerable. Dr. Glanton indicated that if her pain persisted, he would consider a right SI RFA. Petitioner returned to Dr. Glanton's office on December 21, 2016, when a right SI RFA was discussed. (PX 4, pp. 58-60) That procedure was completed at Hannibal Regional Hospital on April 20, 2017. (PX 3, pp. 31-32) Petitioner returned to Dr. Glanton's office on May 31, 2017 reporting that the right SI RFA did not help her symptoms. (PX 4 , pp. 64-66) Dr. Glanton referred Petitioner for consideration of an SI joint fusion.

Respondent offered the deposition testimony of Dr. Weiss (RX 1) who testified consistent with his reports that the Petitioner had suffered a strain that resolved, and had pre-existing degenerative disc disease that was not caused by the work related accident. Dr. Weiss acknowledged that the Petitioner was complaining of back pain at the time of his examinations and that his testing for symptom magnification were negative so he did not consider that as a basis for her complaints. (RX 1, p. 36-37) He opined on cross-examination that her ongoing complaints were related to discogenic back pain related to her degenerative disc disease. (RX 1, p. 38) He did acknowledge, though, that her history was of a sudden onset of pain with a specific incident and persistent pain since that time. (RX 1, p. 38) He questioned the accuracy of her history of no prior back pain but acknowledged that he had not been provided with any records to contradict that history. (RX 1, p. 40) Dr. Weiss opined that lifting cannot cause herniated discs in the back. (RX 1, p. 41-42) Dr. Weiss that he had hedged on Petitioner's MMI date in his initial examination because the epidural injection that she had received could have masked symptoms that could have changed his opinion. (RX 1, pp. 43-44) He acknowledged that the opinions in his supplemental report of March 19, 2014, were based on the understanding that he had not returned for further treatment. (RX 1, pp. 44-45) Dr. Weiss testified that he has not been actively treating patients for the past almost ten years and his professional activities in that time have focused entirely upon conducting independent medical examinations. (RX 1, p. 46)

Petitioner offered the deposition of Dr. Glanton taken on August 17, 2017. Dr. Glanton testified that in his opinion within a reasonable degree of medical certain based upon the history provided by the Petitioner, his examination and prior treatment that he was aware of, that the condition that he was treating was more than likely related to the work related accident. (PX 7, pp. 8-11) Dr. Glanton testified that, "if you increase the load on the facet, so when you pick up something heavy and you try to extend your back fully, you're putting stress on the facet joints which can cause damage to the capsule at the 3-4 and 4-5

facet joint, thereby causing the pain. That pain or that joint is not only innervated, meaning that the nerves go to the joint, but they also go to the small multifidus muscles or paravertebral muscles and the spine in that area and so you can get muscle spasm as well as pain from the facet arthropathy basically." (PX 7, p. 11) Dr. Glanton described the radiofrequency ablation procedure in detail, and testified that by performing this procedure it is hoped that the patient will not perceive pain in that area until the nerve grows back, which takes from 6 to 18 months. (PX 7, pp. 14-15) In discussing his conclusion that the

Petitioner's pain may be coming from the sacroiliac joint and the injection that was done there, Dr. Glanton opined that "to a reasonable degree of medical certainty I would say that this injury that occurred with the dog could explain this SI joint pathology as well.". (PX 7, p. 19) Dr. Glanton explained that the SI joint is a "fairly unstable joint" that is strong posteriorly but weak anteriorly, so when you lift you can cause a slip of the joint and cause sacroiliitis or inflammation of the SI joint. (PX 7, pp. 20) Dr. Glanton testified that the Petitioner's complaints of right buttock pain early in her treatment would be consistent with an SI joint injury. (PX 7, p. 20) He testified that when the injection into the SI joint decreased from a 9/10 pain to a 4/10 pain, the injection would be considered successful and would confirm the diagnosis. (PX 7, p. 21) Dr. Glanton explained that the referral for consideration of a SI joint fusion was done because she had findings and history consistent with SI joint pathology, and had failed physical therapy and conservative management, had failed medication management, had failed injection therapy as well as radiofrequency ablation, but an SI joint fusion would correct the instability in her SI joint by fusing the joint so it would not move. (PX 7, p. 26) Dr. Glanton opined that these symptoms continue to be causally related to the Petitioner's original work injury. (PX 7, p. 28)

Dr. Glanton was asked on cross-examination about the negative findings of Dr. Reynolds, but stated on redirect that Dr. Reynolds, a neurosurgeon, would be looking for some type of nerve root impingement and would be focused upon different treatments. (PX 7, p. 51) Dr. Glanton was referred on cross examination to his note of May 10, 2016 that refers to the onset of low back pain as "gradual", and Dr. Glanton corrected that entry, saying "was gradually worsening is what it is". (PX 7, p. 42) He had previously testified that the initial history provided by the Petitioner that the onset of pain was with lifting a 50 pound dog and indicated that he had an independent recollection of that history from her. (PX 7, pp. 28-30) On re-direct he explained that his history note taking system is a "series of clicks" so if you click on "gradual" it could be "gradually worsening" rather than that the initial onset was gradual. He indicated that the system split up two terms that were supposed to go together. (PX 7, pp. 56) He later further affirmed that these apparent different histories did not indicate that the Petitioner changed her story but was an error resulting in the way that electronic medical records were created. (PX 7, p. 63) He repeatedly reaffirmed on re-re-cross that he did not recall her ever changing her history of onset from a specific incident to a gradual onset. (PX 7, pp. 64-65) Dr. Glanton testified that in evaluating patients they look at the patient's total picture to see if there is drug seeking behavior or they are looking for some secondary gain or is simply seeking medical help. (PX 7, p. 54) Dr. Glanton testified that he did not see anything in the Petitioner's presentation that caused him any concern about the reliability of her subjective complaints. (PX 7, p. 54) He also testified that he did not see anything in her behavior that caused him any concern about drug-seeking behavior or drug abuse. (PX 7, p. 53) He testified that he asked her about smoking because the government requires that he do so, but it was not be important to the treatments that he was providing. (PX 7, p. 55) Dr. Glanton reaffirmed that Petitioner's early complaints of buttock pain would be consistent with a sacroiliac problem as would a doctor noting that symptoms were localized to the right sacroiliac joint. (PX 7, p. 57) He acknowledged that it is not uncommon for doctors to have difficulty distinguishing whether symptoms are related to a low back injury as opposed to a sacroiliac injury. (PX 7, p. 58)

Petitioner testified that she continues to experience pain across her low back and into her buttocks. She described the pain at an intensity of 5-6/10 on a daily basis, and that it is made worse with lifting, bending, sitting more than 10 minutes, standing in one location for more than 20 minutes and too much walking. Petitioner testified that she utilizes a cart for support when walking in a store. Petitioner testified that she no longer gardens or performs landscaping in her yard. She can no longer operate the weed eater as that greatly exacerbates her pain. She does do laundry but must pick up smaller loads of clothes to do so She vacuums much less often than she used to and is "done for the day" when she attempts it. Petitioner testified that she used to perform mechanical work on her cars but no longer does so because she cannot lean over to work on a car and cannot pick up her tool box. Petitioner testified that she could no longer perform all of the work required in her previous job as a dog groomer, where she focused on grooming large dogs. She testified that she occasionally does some grooming at home now but only with small dogs and she has the customer or her son lift the dogs. She testified that she graduated from high school and has had training and certification as a auto and diesel mechanic. Before becoming a dog groomer, her work was in a factory setting which required lifting of at least 30 pounds. Petitioner acknowledged that she had continued working light duty for Respondent until she suffered unrelated health problems with COPD and has been off work due to that condition since. She testified that she has qualified for Social Security disability due to that condition. She testified that she is also attending junior college seeking an Associates degree in general studies.

Based on the foregoing facts, the Arbitrator makes the following findings on the disputed issues:

Accident: Petitioner testified to the onset of low back and buttock pain while lifting a large dog in the course of her work as a groomer for Respondent. She provided consistent histories to various medical providers. No contrary evidence was offered. While she did not seek medical care for eight days, her history and exam findings by Dr. Wallace on March 12 were consistent with her claim of a recent accident. The Arbitrator finds that the Petitioner suffered an accident arising out of and in the course of her employment by Respondent.

Causation:

In order to determine whether the Petitioner's current condition of ill being is causally related to her accident, it is helpful to determine the Petitioner's current condition. The Arbitrator is not saying that the Act requires the Petitioner to prove a specific current condition. One thing that is clear from all of the evidence presented is that it is difficult, to say the least, for the medical providers to determine the Petitioner's exact pain source. It is especially hard when you're dealing with injuries to the lower lumbar facets, the right iliolumbar ligament and/or the right SI joint. The Petitioner must simply prove that her current condition is causally related to her accident. However, the Petitioner is seeking treatment at this time to the right SI joint so the issue becomes in part whether that treatment is causally related.

Dr. Glanton, her current treating physician, testified that her pain was coming from her right SI joint. (PX 7 at 16, 17) He arrived at that conclusion after treating her on several occasions with the primary focus being her lumbar spine. He noted that ablation treatments in that area had failed to provide substantial symptom relief, and further noted that two injections into the SI joint reduced her pain to a level of zero on a ten point scale. (Id at 21, 22)

The medical records support the doctor's diagnosis and also support the Petitioner's claim of causation. On the Petitioner's first medical visit to Dr. Wallace, she complained of not only low back

pain but radiation to the right buttock. Dr. Biggs consistently noted tenderness on palpation of the SI joint on the right, during his five subsequent office visits. On June 30, 2013, he suggested that the Petitioner may have a SI joint dysfunction and referred her to Dr. Newton.

The Arbitrator notes that Dr. Newton, during his only examination of the Petitioner on July 31, 2013, had findings which were inconsistent with an injury to the SI joint. However, the Arbitrator also notes that the Petitioner did have mild tenderness at the iliolumbar ligament, an area which is very close

anatomically to said joint. Further, the Petitioner's complaints to her doctors both before and after Dr. Newton's visit consistently included complaints of pain over the area where the SI joint is located.

It appears that the Petitioner's treatment after that visit was focused on the lumbar spine. Dr. Biggs referred the Petitioner to pain management and for the next year plus she received various treatments to that area including physical therapy, injections and medications. However, the Arbitrator notes that Dr. Espejo, at her first visit with the Petitioner on April 7, 2014, assessed dysfunction of the iliolumbar ligament, suggesting injections of that ligament as part of her treatment.

Dr. Espejo's treatment over the next seven months did not provide any long term relief, so she referred the Petitioner to Dr. Glanton for the purpose of performing ablation treatment to the lumbar area. Dr. Glanton's initial office visit was focused on treatment to the right side of the lumbar spine and his care, as noted above, was primarily aimed at those parts of the body. However, when he found on July 12, 2016 that the treatment to the lumbar spine was not working, his focus turned to the SI joint. His focus has remained there and he is now recommending consideration of an SI joint fusion.

Though the Petitioner's symptoms have waxed and waned with treatment, responding at times to therapy and injections, her pain complaints have never gone away. Petitioner denied having this pain prior to her work injury and no records of prior treatment for low back pain have been offered.

Respondent's argument that the right SI joint was cured as of the Petitioner's visit with Dr. Newton is inconsistent with her complaints of right sided pain to the many doctors she has seen since that visit. Respondent's reliance on the opinions of Dr. Weiss also is not persuasive. It appears from his office visits that Dr. Weiss never examined to any extent the Petitioner's SI joints, focusing instead on her lower back. Dr. Weiss also lacks credibility in asserting that the Petitioner reached a point of maximum medical improvement in early 2014 when the medical records of her treating providers, particularly Drs. Ginos and Espejo, show that her complaints were ongoing at that time.

Dr. Glanton provided a plausible basis for his opinion that the lifting of the dog could have caused inflammation and subsequent injury to the SI joint. (PX 7 at 20) He also explained how the lifting event could have caused an injury to the lower facet joints, and his explanation made sense and was unrebutted. (Id at 11) Respondent argues that Dr. Glanton's causation opinions are based upon speculation, and the Arbitrator tends to agree with that argument. The doctor admitted knowing very little about the accident itself and even less about her various treatments and results over the nearly two years before he was able to see her. He was also not given any hypothetical facts upon which to base his opinions. However, his opinions concerning the mechanism of injury do make sense and are persuasive to the Arbitrator..

In summary, you have a Petitioner with no prior lower back or right sacroiliac injuries who suffers immediate symptoms while lifting a heavy dog while in an awkward position. You have fairly immediate treatment which continues in an unbroken chain over the next four and a half years. The

only gap in treatment came after Dr. Glanton's prescribed ablations were denied by the Respondent, presumably after they received the report from Dr. Weiss after his second examination. Dr. Glanton testified that it is not uncommon for doctors to confuse symptoms coming from the low back and the sacroiliac area. Petitioner testified that the pain that was relieved by injections to the sacroiliac area was the same pain that she had been experiencing since her injury. Based upon the Petitioner's credible testimony and the medical records documenting persistent and consistent complaints, the Arbitrator finds that the Petitioner has established, by a preponderance of the evidence, a causal

connection between her work related accident and both her low back and sacroiliac injuries and conditions.

Medical expenses: Having found in the Petitioner's favor on accident and causation, the Arbitrator awards payment of the medical bills offered into evidence as Petitioner's Exhibit 8, subject to the medical fee schedules and the stipulation of the parties. Respondent shall first reimburse any payments made by Petitioner on any medical bills, second reimburse or satisfy any government liens from Medicare or Medicaid, third take any 8J credit for payments by employer sponsored health insurance and fourth, pay the remaining balances of medical bills subject to the medical fee schedules or negotiated rates, whichever is less.

Having found in favor of the Petitioner on the issue of causation, the Respondent is further ordered to pay for the treatment prescribed by Dr. Glanton.

Nature and extent: This hearing was held pursuant to a Notice of Motion and Order and Request for Hearing filed by Respondent. Petitioner disputed whether the case was ripe for resolution of permanent partial disability in light of Dr. Glanton's opinion that the Petitioner was not yet at maximum medical improvement pending a referral for consideration of a sacroiliac fusion. Having found the opinions of Dr. Glanton to be more credible, including his opinion that further treatment requires evaluation and that the Petitioner is not yet at maximum medical improvement, the Arbitrator finds that this claim is not yet ripe for resolution of that issue and declines to address permanency.

The claim therefore must be returned to the Arbitration docket and remains open for further awards of medical expenses and temporary and permanent disability.

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

Jerry Hight,
Petitioner,

vs. NO: 15 WC 42193

St. Clair County,
Respondent.

18IWCC0261

DECISION AND OPINION ON REVIEW

Timely Petition for Review, under Section 19(b), having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, temporary total disability, prospective medical expenses and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 7, 2016 is hereby affirmed and adopted.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 26 2018

o-04/10/18
jdl/wj
68

Joshua D. Luskin

Charles J. DeVriendt

18IWCC0261

SPECIAL CONCURRING OPINION

I concur. I write separately to clarify the standard utilized in arriving at our decision in light of the recent decision of *Shanklin v. Illinois Workers' Compensation Commission*, 2017 IL App (4th) 160440WC-U. The Commission agrees with the Arbitrator's assessment to afford greater weight to the opinions of Dr. Strecker over those of Dr. King. Dr. Strecker possessed a better understanding of the manner and method in which Petitioner performed his job. Certainly, there is no legal requirement that Petitioner present evidence as to the percentages of a day a certain task is performed. *Edward Hines Precision Components v. Industrial Commission*, 356 Ill. App. 3d 186, 194 (2005). The Commission, though, must consider the evidence, or lack thereof, as to whether Petitioner's job duties are sufficiently repetitive to support a finding of accident. Petitioner failed to present sufficient evidence to support a finding of a compensable accident based upon a repetitive trauma theory of recovery.

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

HIGHT, JERRY
Employee/Petitioner

Case# **15WC042193**

ST CLAIR COUNTY
Employer/Respondent

18IWCC0261

On 12/7/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.61% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

4463 GALANTI LAW OFFICE
LESLIE N COLLINS
PO BOX 99
E ALTON, IL 62024

0810 BECKER HOENER THOMPSON ET AL
AARON J CHAPPELL
5111 W MAIN ST
BELLEVILLE, IL 62226

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)/8(a)

JERRY HIGHT
Employee/Petitioner

v.

ST. CLAIR COUNTY
Employer/Respondent

Case # **15** WC **42193**

Consolidated cases: ____

18IWCC0261

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Collinsville**, on **July 21, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 ____

18IWCC0261

FINDINGS

On the date of accident, **January 6, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.

Timely notice of this alleged accident *was* given to Respondent.

Petitioner's current condition of ill-being ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$68,687.22**; the average weekly wage was **$1,320.91**.

On the date of accident, Petitioner was **69** years of age, ***married*** with **0** dependent children.

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**.

ORDER

Denial of benefits

The Petitioner failed to prove that he sustained accidental injuries arising out of and in the course of his employment on January 6, 2015. The Petitioner failed to prove that his right cubital tunnel condition is causally related to a January 6, 2015 accident.

No benefits are awarded.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

December 2, 2016
Date

ICArbDec19(b)

DEC 7 - 2016

STATEMENT OF FACTS

The Petitioner has worked for the Respondent as a correctional officer for over 13 years. His job duties include performing a head count 3 times per day, feeding prisoners, opening and closing gates and pick up/deliver laundry. Health and welfare checks are done every 25 minutes, which is approximately 28 times per shift. These duties have remained the same throughout his tenure.

The Respondent houses 375 to 450 inmates on average. Steel cell doors weigh about 200 pounds, and gates weigh about 150 pounds. These are manually unlocked and opened, closed and relocked. How frequently this is performed varies by cell block. He could open steel doors 162 to 300 times per shift, and gates 54 to 112 times per shift. Two cell blocks have sliding instead of hinged steel doors.

With regard to the job description entered into evidence (Px1), the Petitioner testified that it is generally accurate. He indicated that the first two paragraphs include duties performed by booking officers, and that he performs the duties listed in paragraphs 3 (jail security), 4 (meal supervision), 5 (first aid), 7 (custodial supervision), 8 (inmate supervision) and 9 (other duties). Petitioner also testified that the job description doesn't include his door opening duties, which he believes is causing his right upper extremity issues. The Arbitrator notes that a review of the job description does not reflect the frequency with which any activities are performed. The inmates do the laundry and perform the janitorial work at the prison, but officers take the mops, brooms and buckets to/from them once or twice a shift.

The Petitioner testified that he started having right arm problems in January 2015, and he reported this to the Respondent. Initially his arm went numb, and he then developed pain and three of his fingers would lock up.

He initially sought treatment with Dr. Rawdon, his primary care provider, on 5/19/15. (Px2). The notes indicate complaints of right arm numbness and right hand cramps, and diagnosis of questionable carpal tunnel, and while the handwritten note is unclear, it appears that an EMG/NCV was prescribed. Dr. Rawden subsequently issued a "to whom it may concern" letter on 5/22/15 noting Petitioner complained of a 6 to 10 month history of right shoulder pain that was gradually getting worse. The Petitioner associated it with pulling heavy steel doors at work, and reported repetitive activity. Dr. Rawdon stated: "This is obviously an overuse injury. He has no other past medical history of fractures. He has nothing in the past to support any previous medical condition. Based on his repetitive activity at work, it would seem fairly obvious that this is work related." (Px2). The Arbitrator notes that Dr. Rawdon issued a similarly worded letter on 3/30/07 with regard to the prior right sided symptoms. (Rx2)

The Petitioner testified that he chose to be referred to orthopedic surgeon Dr. King based on the prior good result with his previous (6 to 8 years prior) treatment for left-sided work related carpal tunnel syndrome (CTS) and ulnar nerve problems. The Respondent had referred him to Dr. King at that time. Petitioner testified he fully recovered as to the left arm and returned to full duty after his post-surgical recovery.

On 9/15/15 the Petitioner saw Dr. King. (Px3). He gave a history of right arm numbness and weakness and difficulty grasping objects. The Petitioner reported that, as a correctional officer, he would use his feet and his arm in regular duties that were repetitive in nature, and that this had created numbness and weakness in his arm. A patient intake form completed by Petitioner indicated that his problem began in January 2015 from locking and unlocking steel doors and cells. Dr. King noted the Petitioner had previously undergone a left-sided carpal tunnel and cubital tunnel releases with excellent results, and that his right-sided symptoms were the same as on

the left. He described intermittent numbness in all five fingers of the right hand. He denied having symptoms with any activities outside of work. Physical examination revealed a decreased 2-point discrimination in all five fingers of the right hand, positive Phalen's and Tinel's at the right wrist and positive compression of the ulnar nerve at the elbow with increased numbness in his small and ring fingers. He had weakness in the first dorsal interosseous testing as well as the abductor pollicis brevis. Dr. King's diagnoses were right carpal tunnel syndrome and right cubital tunnel syndrome, and he opined that Petitioner's repetitive work activities were contributing to his condition. An EMG/NCV and regular work duties were recommended.

The 10/15/15 EMG/NCV report noted Petitioner's complaints of right hand numbness and weakness, primarily in the 4th and 5th digits with a persistent cramping sensation. Test results reflected mild to moderate right cubital tunnel but no evidence of carpal tunnel, peripheral neuropathy or cervical radiculopathy. (Px4).

On 10/15/15, Dr. King noted the EMG/NCV results, and that the Petitioner had continued ulnar neuropathy symptoms. Dr. King diagnosed right cubital tunnel and recommended right ulnar nerve decompression and transposition surgery, which the Petitioner wants to undergo. He released the Petitioner to regular work duties in the meantime, and noted he "will not proceed with any treatment for his carpal tunnel at this time." (Px3).

Respondent's Section 12 examining physician, orthopedic surgeon Dr. Strecker, examined the Petitioner on 11/16/15. (Rx1). Petitioner reported working as a corrections officer for 12 years, and in January 2015 started noticing numbness and tingling in mostly the right 4th and 5th fingers, with right medial elbow pain that radiated to the forearm and fingers, as well as difficulty with gripping. The Petitioner noted he had previously undergone left carpal and cubital tunnel surgeries. Physical examination was provocative for right cubital tunnel, but not for carpal tunnel. He opined that the Petitioner had right cubital tunnel syndrome, but did not have carpal tunnel, and that treatment to date had been reasonable. He further opined that the cubital tunnel condition was not related to the Petitioner's work duties, noting he gave no history of direct trauma, prolonged elbow hyperflexion or use of vibratory or impact tools. (Rx1).

The Petitioner testified that he believes the pulling of doors and using keys at work is what caused his right arm problems. He indicated that he uses both arms to perform these activities. He testified he can have symptoms intermittently during work activities or at home, including at night, and sometimes "it just happens". He was at home when the right arm first went numb. He has no hobbies that involve use of the right arm, but he testified he is right hand dominant. The Petitioner denied any right arm problems prior to 1/6/15. He did not recall complaining of right arm/shoulder pain in 2007, testifying that this was a typo and should have indicated left arm. Dr. Rawdon apparently had sent the 3/30/07 letter to the Respondent regarding the right shoulder and arm at that time, but the Petitioner testified that this was inaccurate and he told Dr. Rawdon it should never have been sent, asking him to fix it.

The Petitioner is a Type II diabetic and takes medication, but is not insulin dependent. He denied any thyroid problems. A 6/5/15 report of his cardiologist, Dr. Jain, noted a history of coronary artery disease, dyslipidemia, carotid artery disease, hypertension and Type 2 diabetes. (Rx2).

On cross examination, the Petitioner testified he quit smoking about 14 years ago. He did not actually work on 1/6/15, the date that his right arm first became numb. He agreed that he completed multiple Form 45's with the Respondent, noting he had to do this because they kept getting lost. The initial one from 1/6/15 indicated he reported right hand/wrist and arm pain due to repetitive opening and closing of gates. He could not recall when he completed the other two. The Petitioner testified he initially determined that his condition was work related based on Dr. Rawdon's statement to him at the initial visit, but he could not recall when this was. He agreed that if the records reflected it, Dr. Rawdon told the Petitioner this at the May 2015 visit, which was subsequent to the

preparation of the 1/6/15 Form 45. As to Dr. Rawdon's 5/22/15 note indicating right shoulder pain but mentioning nothing about the right arm or elbow, the Petitioner indicated he didn't recall his exact words but that he complained of the right arm, noting that Dr. Rawdon had made the previous error in his 2007 note.

The Petitioner testified that some of the cell doors required him to kick them to move them. He testified that he has reported door issues to maintenance, sometimes in writing and sometimes verbally, noting that he could get quicker action sometimes with a phone call versus a written request. He agreed that the documentation submitted by the Respondent (Rx4) did not indicate any written maintenance requests from him, and that while he may not have made any such written maintenance requests in the last three years, he had definitely done so in the last 14 years, despite the fact there was not record of it in the exhibit. The Petitioner agreed that the intake form for Dr. Strecker, which he signed, indicates 20 doors would be gone through in 25 minutes, and that it should be 27 times every 25 minutes. The doors are unlocked, pulled open, closed and relocked. The Petitioner described how many doors he had to o through between cell block A and B, noting there are 4 cell blocks for every "John", and he has to go through all 4 cell blocks in 25 minutes. He could not say exactly how much force was required to open a steel door, but testified that a 6 or 7 year old child would likely not be able to do it.

Dr. King was deposed on 4/25/16. He acknowledged the prior left-sided surgeries and noted the Petitioner returned on 9/30/15 with complaints of numbness and weakness in his right arm and grip problems that the Petitioner believed was due to his use of his arms as a correctional officer, such as "turning locks and things and repetitive nature." Dr. King testified that examination indicated provocative tests for right carpal and cubital tunnel syndromes. He noted the EMG/NCV results were only positive for cubital tunnel, but that a person can still have carpal tunnel despite negative EMG/NCV results. Dr. King recommended right ulnar nerve decompression and transposition of the ulnar nerve. He did not recommend carpal tunnel release given the EMG/NCV results, but noted if significant symptoms continued after cubital tunnel surgery, it could be a consideration in the future. Dr. King acknowledged that Petitioner is a diabetic and that diabetes is a contributing factor in the development of cubital tunnel syndrome and carpal tunnel syndrome, but that only a small percentage of diabetics develop these conditions. Dr. King testified that his understanding of Petitioner's job duties came from the Petitioner, as he did not review any formal job description. He opined that Petitioner's job activities as a correctional officer aggravated his current condition: "turning keys and locks, pulling doors, that type of thing." He testified that the weight of the doors was not a major factor in his opinion. He assumed the Petitioner's job duties had not changed since the prior surgeries, but wasn't certain, and testified that his prior treatment of Petitioner for the left side in the same job capacity with the same activities also was the basis of his opinion. (Px5).

On cross examination, Dr. King agreed that, per his records, Petitioner's symptoms onset was in January 2015. He agreed that the only reference to the Petitioner's job duties he had in his records were in his progress note and the intake questionnaire the Petitioner completed. He was not aware of how long the Petitioner had been in his current job position. Dr. King admitted that he did not know much about the nature of the doors, including how the doors opened or how much they weighed. He assumed they required some significant force, but agreed he had no way to quantify this as he had not seen them or any data regarding them. He did not know what kind of motion was required in the arms to do the task. He did assume the Petitioner used a key to manually unlock the doors. He did not know how many hours the Petitioner worked per week. He did not testify to any specific information such as how many times a day Petitioner unlocked, locked, and opened doors. (Px5).

Dr. Strecker was deposed on 5/12/16. (Rx1). He testified that he examined the Petitioner on 11/16/15. He reviewed the medical records of Dr. King, Dr. Rawdon, and the EMG/NCV. Following a physical examination, he opined Petitioner had right cubital tunnel syndrome, but that there was no evidence of carpal tunnel

syndrome. He agreed with Dr. King's recommendation of ulnar nerve decompression with or without transposition. (Rx1).

Dr. Strecker reviewed the written job description (Px1) as well as the intake form he completed (Rx1), but testified that he gave a greater degree of deference to Petitioner's own account of his job duties versus the job description. He testified that Petitioner told him he was in charge of taking care of prisoners, would do some paperwork, and would open steels gates and turn keys. Dr. Strecker testified that Petitioner told him he would does this 15 times every 25 minutes, while the Petitioner's intake form stated that he would do this 20 times every 25 minutes. The Petitioner denied the use vibratory tools or maintaining his elbows or wrists in awkward positions. Dr. Strecker testified that he did not believe there was a causal relationship between Petitioner's job duties and the development of right cubital tunnel syndrome. He testified that occupational incidences that are associated with the development of cubital tunnel syndrome include direct trauma, activities that require leaning on or pressure to the ulnar nerve, maintaining the elbow in a hyperflexed position for prolonged periods, and the use of vibratory tools. He did not believe that Petitioner job duties fell into any of these categories. Furthermore, he testified that Petitioner's job activities of opening and closing steel doors 15-20 times per 25 minutes would not be considered repetitive activity, as "repetitive" would mean doing and activity once or twice per minute. However, Dr. Strecker also testified that, unlike with carpal tunnel, repetitive motion has not been shown to be a significant causative factor in the development of cubital tunnel. Dr. Strecker agreed that the Petitioner told him the steel doors were heavy, sometimes the locks were stiff and he had to turn the key harder to open them at times. It was Dr. Strecker's opinion that Petitioner may have had symptoms with locking, unlocking, opening, and closing steel doors, but that these activities did not make his condition worse. He acknowledged that Petitioner had several comorbid factors that could lead to the development of cubital tunnel syndrome, including his age (70 years old), his 25 year history of smoking, his peripheral vascular disease, and his diabetes. He agreed on cross examination that the Petitioner quit smoking many years prior. (Rx1).

The parties have stipulated that, as of the hearing date, no medical expenses or temporary total disability benefits were due from the Respondent.

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, and WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Initially, the Arbitrator notes that the evidence supports that the Petitioner's current condition of ill-being is right cubital tunnel syndrome. While Dr. King also diagnosed carpal tunnel syndrome, the Arbitrator believes the evidence does not support that the Petitioner has this condition at the current time. The Petitioner's main complaints to both Dr. King and Dr. Strecker are most significantly involving the 4th and 5th fingers, which relate to the ulnar nerve as opposed to the median nerve. EMG/NCV testing was positive for right cubital tunnel but was negative for carpal tunnel. Other than Dr. King's indication of positive Tinel's and Phalen's at the right wrist, there does not appear to be any significant evidence that the Petitioner actually has carpal tunnel. Given this, the Arbitrator makes no specific findings with regard to accident or causation relative to carpal tunnel syndrome. Dr. Strecker's testimony supports this determination. This decision addresses only cubital tunnel syndrome.

Is it possible that the Petitioner's work duties caused his right cubital tunnel condition? It is possible, but the preponderance of the evidence in this case indicates that the Petitioner has failed to prove it in this case.

Dr. Strecker's opinion in this case is more persuasive than that of Dr. King. Dr. King testified that he did not know very much about the Petitioner's job other than that he turned keys and locks and pulled steel doors. He did not indicate any knowledge with regard to the frequency with which the Petitioner performed these activities, or the force required for same. He testified in a conclusory fashion that the Petitioner indicated that he performed these noted duties "repetitively", but could not testify to the frequency or force required that would lead to a determination that the activity was performed "repetitively."

Dr. Strecker, on the other hand, testified that the medical literature indicates four general industrial causes for cubital tunnel: 1) direct trauma to the ulnar nerve, 2) direct sustained pressure on the ulnar nerve due to leaning on the elbow, 3) prolonged hyperflexion of the of the elbow, and 4) exposure to vibratory tools. His determination that none of these possible causes were applicable to the Petitioner is supported by the evidence in this case. The only evidence we have in this case is that the Petitioner turned keys and locks and pulled doors. No persuasive opinions were given as to how these specific activities could have contributed to cubital tunnel, nor how often they would have needed to be performed or with how much force.

There were some discrepancies brought on out cross examination regarding the frequency of certain work activities between the Petitioner's testimony and what he reported to Dr. Strecker per the surgeon's report. Nevertheless, it appears that Dr. Strecker had a more detailed, fair and complete understanding of this than Dr. King. The Petitioner testified that his symptoms could occur at work, and could occur at home, noting that the initial onset occurred on a date when he was not at work.

Based on the above, the Arbitrator finds that the Petitioner failed to prove that he sustained or aggravated right cubital tunnel syndrome which arose out of and in the course of his employment with Respondent, and failed to prove that his right cubital tunnel syndrome is causally related to his work duties with the Respondent.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's findings with regard to accident and causation, no prospective medical is awarded in this case.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☒ Reverse Causal connection	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KATHERIS ELLIS,
Petitioner,

vs. NO: 15 WC 14471

CITY OF CHICAGO – DEPT OF STREETS & SANITATION,
Respondent.

18IWCC0262

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causation connection, temporary total disability, and prospective medical treatment, and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below, but attaches the Decision of the Arbitrator, which is made a part hereof, for the statement of facts with the modifications noted below. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Commission finds the Petitioner failed to prove a causal relationship between her accident of April 21, 2015 and her current condition of ill-being and need for treatment. "[T]he Commission is not bound by the arbitrator's findings and may properly determine the credibility of witnesses, weigh their testimony and assess the weight to be given to the evidence. [citation omitted]." *R.A. Cullinan and Sons v. The Industrial Commission*, 216 Ill. App. 3d 1048, 1054, 575 N.E.2d 1240 (1991). The "interpretation of the testimony of medical witnesses is particularly within the province of the Industrial Commission. [citation omitted]." *A.O. Smith Corporation v. The Industrial Commission*, 51 Ill. 2d 533, 537, 283 N.E.2d 875 (1972).

Petitioner testified while ascending into her truck, she struck her knee on the door frame. T. 13. There is no testimony that she twisted her knee. Following her injury later in the afternoon, Petitioner sought treatment providing the following history: "she was climbing into a truck when she bumped her left knee against the door frame." PX1. A physical examination was performed and evidenced the following findings:

> Evaluation of her left knee revealed it to be 39 cm in circumference which was equivalent to that of the right knee. She had full range of motion of the bilateral knees. There was no

gross evidence of trauma to the left knee. There was no ecchymosis. There was no swelling noted. She did have a very slight area of focal tenderness to the suprapatellar of the left lateral knee region. There were no gross nerve, vessel, nor tendon deficits detected. PX1.

Petitioner was diagnosed with a contusion of the left knee and released full duty.

Thereafter, Petitioner presented to Dr. Silver on April 30, 2015 complaining of pain. Dr. Silver noted some mild effusion, but the remainder of the evaluation was essentially normal. PX2. An MRI was performed on May 7, 2014 which confirmed bone bruising and evidenced an intact collateral and cruciate ligaments as well as intact menisci. PX2. By the June 4, 2015 visit, Petitioner pain had decreased; her range of motion was full; and she no longer exhibited effusion. PX2.

On January 6, 2016, Dr. Jay Levin evaluated Petitioner pursuant to Section 12 of the Act at the request of the Respondent. Dr. Levin obtained a history from Petitioner who complained of pain with numerous activities such as walking, squatting, driving, and lifting. (Such complaints were consistent those expressed by Petitioner during physical therapy despite the therapist noting normal range of motion and strength. PX3).

Dr. Levin performed an extensive physical examination which included the Lachman test, Pivot shift test, and Apley grind test which were all negative. Dr. Levin reviewed the actual MRI films and found the lateral and medial meniscus to be normal as well as the ACL and PCL. Dr. Levin further noted a positive Hoover sign which was consistent with nonorganic etiology of Petitioner's pain complaints. Dr. Levin diagnosed a contusion and placed Petitioner at MMI and full duty four-weeks post-injury. RX4.

The Commission weighs the competing medical opinions of Dr. Levin and Dr. Silver and affords greater weight to the opinions of Dr. Levin finding such opinions more persuasive. Dr. Levin is of the opinion Petitioner suffered from a contusion. This opinion is supported by Dr. Levin's physical findings as well as the physical findings documented in Petitioner's treatment records at both U.S. Health Works and Dr. Silver. Petitioner has normal range of motion and strength and all testing was negative. Further the MRI as read by both the radiologist and Dr. Levin is grossly normal. The only finding noted is subjective complaints of pain. Such complaints of pain by Petitioner, though, are belied by her ability to return to work full duty and the non-organic pain findings noted by Dr. Levin. Dr. Levin opined Petitioner suffered from a knee contusion which resolved on or about May 20, 2015.

Unlike Dr. Levin, Dr. Silver appears to predicate his entire opinion on Petitioner's subjective complaints of pain. An expert's opinion is only as valid as the facts upon which it is based. *Gross v. Illinois Workers' Compensation Commission*, 2011 IL App (4th) 100615WC. Further Dr. Silver provides no explanation regarding his recommendation for surgery given the lack of any objective findings in the physical examination and diagnostic testing.

Section 8(a) of the Illinois Workers' Compensation Act entitles a claimant to recover medical expenses which are reasonable, necessary, and causally related to an accident. *820 ILCS 305/8(a)* (West 2010); *Zarley v. The Industrial Commission*, 84 Ill. 2d 380, 418 N.E.2d 718 (1981). The same standard applies to prospective medical care. *Homebrite Ace Hardware v. The Industrial*

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Commission, 351 Ill. App. 3d 333, 814 N.E.2d 126 (2004). Petitioner sustained a knee contusion due to her accident of April 21, 2015 with maximum medical improvement being reached by May 20, 2015. As such all treatment following May 20, 2015 is neither reasonable nor necessary nor is it causally related to Petitioner's accident.

"To show entitlement to TTD benefits, claimant must prove not only that he did not work, but that he was unable to work. [citation omitted]." *City of Granite City v. The Industrial Commission*, 279 Ill. App. 3d 1087, 1090, 666 N.E.2d 827 (1996). Further "[t]he dispositive test is whether the claimant's condition has stabilized, that is, whether the claimant has reached maximum medical improvement. [citation omitted]." *Mechanical Devices v. The Industrial Commission*, 344 Ill. App. 3d 752, 759. Petitioner reached maximum medical improvement as of May 20, 2015. As such, no temporary total disability benefits are awarded beyond May 20, 2015.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $915.08 per week for a period of 2 6/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 26 2018
CJD/dmm
O: 022818
049

Joshua D. Luskin

L. Elizabeth Coppoletti

DISSENT

I must respectfully dissent from the majority's decision that the Petitioner failed to prove causal connection. I would instead affirm the findings of Arbitrator Bocanegra, and find that Petitioner did prove her current condition of ill-being with respect to her left knee is causally related

18IWCC0262

to the April 21, 2015, accident, and is entitled to reasonable prospective medical treatment, temporary total disability, and a remand to the Arbitrator for a determination of further benefits.

The Petitioner was employed by Respondent as a laborer/garbage collector, and while working on April 21, 2015, bumped her left knee on the frame of the garbage truck as she was exiting the vehicle. Petitioner had no prior problems with her knee, nor did she seek medical treatment related to her left knee prior to the 4/21/15 accident. The PT records do note a palpable bump in her knee and her MRI showed evidence of a bone bruise. Petitioner testified as to having on-going complaints of pain that have not lessened or resolved since her work-related accident.

Petitioner sought conservative care for her left knee injury. Petitioner underwent physical therapy, but her condition actually deteriorated, rather than improve. Petitioner became pregnant and continued physical therapy through a portion of her pregnancy. By October of 2015, her physical therapy noted that progression of strengthening has been limited due to the pregnancy, and that because of that condition, Petitioner had to avoid over-strenuous activity during therapy and daily activity. Additionally, surgery had to be delayed while Petitioner was pregnant. Petitioner eventually returned to work full duty on July 7, 2016, despite the on-going problems with her left knee or need for surgery, as she testified she needed the money. Respondent's section 12 examiner incorrectly found Petitioner to only suffer from a contusion and placed her at MMI as of May 20, 2015.

Throughout Petitioner's course of treatment, her orthopedist, Dr. Silver, as well as her physical therapist, noted limitation in movement, swelling, and a palpable bump on Petitioner's knee. Dr. Silver, ultimately recommended surgery on the suspicion that Petitioner's continued complaints of pain were related to damage to her knee cartilage – an injury that would not be readily apparent on the imaging studies. Respondent's IME doctor, Dr. Levin, did not address Dr. Silver's assertion that a knee scope is necessary due to a likely cartilage issue that would not have appeared on the radiographic exams, but merely asserted that Petitioner suffered from a contusion which should have resolved after four to six sessions of Physical Therapy. Dr. Levin's exam findings and diagnosis are not as persuasive as those of Petitioner's medical treaters. Petitioner has met her burden of proof that her current condition of ill-being is causally related to her April 21, 2015, work injury.

Based on the above, I would find that Petitioner's current condition of ill-being is causally related to her work accident of April 21, 2015, and that she is entitled to temporary total disability from May 1, 2015, up to and including July 7, 2016, as well as prospective medical care including, but not limited to, the left knee arthroscopy recommended by Dr. Silver, and the matter remanded to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

ELLIS, KATHERIS
Employee/Petitioner

Case# **15WC014471**

CITY OF CHICAGO - DEPT OF STREETS & SANITATION
Employer/Respondent

18IWCC0262

On 8/31/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.48% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1067 ANKIN LAW OFFICE LLC
SCOTT GOLDSTEIN
TEN N DEARBORN ST SUITE 500
CHICAGO, IL 60602

0010 CITY OF CHICAGO LAW DEPT
STEPHANIE LIPMAN
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

18IWCC0262

Katheris Ellis
Employee/Petitioner

v.

City of Chicago- Department of Streets and Sanitation
Employer/Respondent

Case # 15 WC 14471

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 **Maria Bocanegra**, Arbitrator of the Commission, in the city of **Chicago**, on **7/19/16**. 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 **prospective medical care, medical bills, ttd, causation, Respondent credit**

18IWCC0262

FINDINGS

On the date of accident, **4/21/15**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$71,376.48**; the average weekly wage was **$1,372.62**.

On the date of accident, Petitioner was **29** years of age, ***single*** with **1** dependent children.

Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$33,075.44** for TTD, **$0** for TPD, **$0** for maintenance, and **$14,279.04** for other benefits, for a total credit of **$47,354.48**.

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 **$915.08/week** for **62 weeks**, commencing **May 1, 2015** through **July 7, 2016**, as provided in Section 8(b) of the Act. By stipulation, Respondent shall be given a credit of **$33,075.41** for temporary total disability benefits that have been paid.

Respondent shall pay for and authorize the left knee treatment and surgical recommendations of Dr. Silver, including any and all incidental care thereto.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

8-30-2016
Date

AUG 31 2016

FINDINGS OF FACT

Katheris Ellis ("Petitioner") alleged injuries arising out of and in the course of her employment with the City of Chicago ("Respondent") on April 21, 2015. On July 19, 2016, the parties proceeded to arbitration on the following disputed issues: causal connection, temporary total disability and prospective medical care for the left knee. Ax1. The parties stipulated to a credit due and owing to Respondent in the amount of $14,279.04 for ordinary disability benefits received in gross. Further, the parties stipulated that Respondent was entitled to a credit under section 8(j) for any payments that may have been made by Respondent through its Blue Cross Blue Shield PPO. On oral motion and by agreement, Petitioner's pending cases, 12 WC 25838 and 15 WC 14471 were severed in order to proceed to arbitration in 15 WC 14471 only. The following is a recitation of the facts adduced at trial as to claim 15 WC 14471.

Petitioner testified she is currently employed with Respondent's department of streets and sanitation as a laborer, whose duties include lifting, pulling, squatting, and carrying and garbage collection. As of the date of hearing, she is currently working. Petitioner testified that on April 21, 2015, she worked for Respondent as a laborer collecting garbage and that on that date, she injured her left knee when she hit it against the metal frame of the work garbage truck. She felt immediate pain, reported her injury and was sent for medical attention.

On April 21, 2015, Petitioner presented to US Health Works Medical Group a/k/a Advanced Occupational Medicine Specialist noting that she injured her left knee after hitting against the frame of a work truck. Px1. She presented with a complaint of pain to the left knee. She had a negative previous history of similar injury. On exam, she is full range of motion bilaterally, there was no gross evidence of trauma, there was no ecchymosis, swelling was negative, she was positive for focal tenderness in the suprapatellar area of the left lateral knee region. X-rays were negative. There was noted a small and testified of the quadriceps insertion on the inferior patella but it was noted to be a non-injury related incidental finding. Impression was contusion of left knee. Recommendation was regular duty, icing and ibuprofen. She was discharged from care. On April 28, 2015, Petitioner returned. Px1. Diagnosis was contusion of the left knee. She was recommended to wear a knee sleeve at all times when working and to continue ibuprofen as needed. She was released to return to work without restriction.

On April 30, 2015, Petitioner first presented to Dr. Ronald Silver. Px2. The doctor noted Petitioner's work accident whereby she struck her left knee on the metal door frame. He noted she was negative in terms of prior history. On exam, he noted parapatellar tenderness and medial joint line tenderness. There was crepitation and effusion. Ligaments were stable. X-rays were normal. The doctor was concerned with cartilage damage to the left knee. He prescribed physical therapy, bracing, anti-inflammatories and an MRI. Petitioner was temporarily disabled.

18IWCC0262

On May 6, 2015, Petitioner began therapy Athletico Physical Therapy pursuant to Dr. Silver's recommendation and referral. Px3. Intake documentation noted that Petitioner had her left knee on the door frame of a city garbage truck on April 21. She reported problems of popping, aching, and bruising. She continued physical therapy to the left knee per Dr. Silver's orders through December 23, 2015, at which time it was noted by her therapist that Petitioner presented with gait abnormality, left leg weakness, swelling of the left knee joint and internal derangement of the left knee. Subjectively, Petitioner continued to report ongoing left lateral knee pain with limiting walking and standing overall. She related that surgery was on hold due to pregnancy. Although additional physical therapy was recommended the plan was to hold therapy.

On May 7, 2015 MRI of the left knee showed mild bone marrow edema involving the distal femur presumably post dramatic bone bruising, intact ligaments and intact menisci. Px2. On May 14, 2015, Dr. Silver opined that Petitioner's MRI scan demonstrated a bone contusion of the distal femur. He noted that at times, this may be associated with overlying articular cartilage damage but recommended Petitioner be treated conservatively in the hopes that it would resolve. She remained temporarily disabled.

On June 4, 2015, Dr. Silver noted Petitioner had made progress with regards to the left knee and conservative care by way of therapy, anti-inflammatories and pain medication. Tenderness was less and she no longer had a fusion. She remains limited to sedentary work only it was to continue physical therapy. He prescribed medication as a matter of medical necessity due to the work injury.

On July 9, 2015, Petitioner returned to Dr. Silver with continued complaints. She remained limited to sedentary work and was to continue therapy. She cannot get medications because she was pregnant.

On August 13, 2015, Dr. Silver noted Petitioner continued with left knee pain. He was concerned with overlying articular cartilage damage. She was restricted to sedentary work it was to continue therapy.

On September 22, 2015, Petitioner followed up with Dr. Silver. Dr. noted Petitioner was symptomatic with persistent pain in the medial and lateral joint line tenderness and parapatellar tenderness. He was concerned with overlying articular cartilage damage in the region of the bone contusions of the MRI. She remained sedentary work in therapy. He was unable to prescribe medications due to pregnancy.

On November 17, 2015, Dr. Silver noted Petitioner continued with left knee pain and medial and lateral joint line tenderness as well as peer patellar tenderness with mild effusion present. He continued to be concerned with overlying articular cartilage damage in the region of the bone

contusion on MRI as her symptoms have persisted for many months. She remained limited to sedentary work it was to continue therapy. He was unable to prescribe medication due to pregnancy.

On January 6, 2016, Petitioner presented for Section 12 examination with Dr. Jay Levin. Rx4. Petitioner related she worked as a laborer for the City of Chicago working on a garbage truck. Her duties include included pushing, pulling, bending, squatting and getting in and out of the truck several times and looking up to 100 pounds. Patricia related that prior to her injury of April 2015, she had no left knee complaints or injuries. She stated that on April 21, 2015, she was stepping up into her work truck when she struck her left kneecap on the frame of the truck and had immediate pain. She attempted to continue to work, reported her injury and was sent for treatment. She was eventually referred to Dr. Ronald Silver. Dr. Levin noted that she underwent therapy with no improvement and was recommended for an MRI at the end of 2015. Petitioner was also pregnant at the time of the examination. The doctor noted that Dr. Silver was recommending surgery. Petitioner related that she currently then had left knee pain 7/10 up to 10 out of 10. She reported giving out, popping, cracking when changing positions and some increased pain during therapy. On exam, Petitioner reported pain with squatting past 100° anteriorly, Lockman's testing was negative bilaterally, Pivot shift test was negative bilaterally, Apley grind test was negative bilaterally and there was no restriction to the medial lateral excursion of the patella bilaterally. There was superolateral patellar tenderness. The doctor noted no medial or lateral joint line tenderness. There was tenderness over the left superior aspect of the patella on AP exam. Strength, reflexes and sensation were normal. The doctor reviewed the MRI the left knee and concluded there was normal menisci, normal ACL and normal PCL. Dr. Levin diagnosed contusion of the left anterior knee/patella. The doctor recommended some additional therapy despite ODG recommendations. The doctor felt that Petitioner had completed more than enough physical therapy and that her left knee condition should have resolved within four weeks post injury. The doctor opined that Petitioner's continued subjective complaints were not related to the work accident to the left knee. The doctor noted that Petitioner, on exam, had non-organic findings including a positive Hoover's sign consistent with non-organic etiology. Dr. Levin stated Petitioner could return to work full duty 14 days after her accident and was currently at maximum medical improvement.

On January 12, 2016, Dr. Silver opined Petitioner was a candidate for arthroscopic surgery as he suspected overlying articular cartilage damage in the region the bone contusions based on MRI of the left knee. She remained on sedentary work. Px2.

On March 8, 2016, Dr. Silver noted Petitioner was post-partum one month and remained limited to sedentary work. Impression was unchanged. Px2.

On April 19, 2016, Dr. Silver noted Petitioner continued to do poorly. Px2. She continued with medial and lateral joint line tenderness and parapatellar tenderness remained. Petitioner had positive McMurray testing and he noted her symptoms were persistent for the past year ever since the work injury. The doctor continued to suspect overlying articular cartilage damage in the region of bone contusions on based on MRI. The doctor continued to recommend arthroscopic repair of the left knee and that Petitioner be limited to sedentary work only.

Currently, Petitioner states she awaits surgery and wishes to undergo Dr. Silver's recommended left knee surgical procedure. Petitioner stated she wants to feel better. Petitioner said she discontinued therapy because it was not helping and because she was pregnant. She stated she was not allowed to continue therapy during later stages of pregnancy.

Currently, Petitioner reported feeling pain on a consistent basis. She states she feels knee pain while working. On cross, she stated she is back at her usual and customary position due to financial reasons. She confirmed she did not attempt to return to work full duty following Dr. Levin's exam. Petitioner confirmed that after Dr. Levin's exam, benefits were terminated and that is when she applied for and began receiving ordinary duty disability benefits. Rx1. On July 15, 2016, Respondent's committee on finance via correspondence indicated that Petitioner would be paid ordinary disability benefits from January 9, 2016 through May 31, 2016 at a rate of $99.16 per day. The total amount paid to date was $14,279.04. Rx2.

CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment

The Arbitrator finds that Petitioner's testimony was credible in unrebutted at trial. Petitioner was consistent through-out her testimony regarding the mechanism of injury, the course of treatment and ongoing complaints to the left knee and any interruptions in medical treatment.

ISSUE (F),(O) Is Petitioner's current condition of ill-being causally related to the injury?

The Arbitrator incorporates the findings of fact as though fully set forth herein. The Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that her current condition of the building as it relates to the left knee is causally related to her undisputed work accident. Petitioner's mechanism of injury was that she struck the left kneecap against the metal frame of the work truck. This mechanism was repeated at trial and consistently through-out Petitioner's treatment records. Petitioner sought timely treatment and was noted to have no prior history of lucky complaints, injuries or symptoms. Petitioner was initially diagnosed with a left knee contusion and released from care. Upon treating with Dr. Silver, Dr. Silver suspected

cartilage damage. On his initial exam he noted parapatellar tenderness as well as medial joint line tenderness. MRI ruled out meniscal and ligament injury but according to Dr. Silver the MRI was suspicious for a bone contusion of the distal femur. He noted that this could be associated with overlying articular cartilage damage and recommended a reasonable course of conservative treatment. Throughout the remainder of Dr. Silver's treatment of the Petitioner, Dr. Silver continue to suspect overlying articular cartilage damage and has most recently opined that she is a surgical candidate due to her failure, in part, to resolve with conservative care. The Arbitrator finds Dr. Silver's opinions consistent and credible.

In rejecting the medical opinions of Dr. Levin, the Arbitrator notes that while Dr. Levin was correct that the MRI was negative for meniscal and/or ligament injury, the doctor did not address Dr. Silver's suspicion for overlying articular cartilage damage and or bone contusion. The doctor found that on exam, Petitioner was non-tender and that her exam was otherwise normal. The Arbitrator notes that this exam is at odds with every other treatment record as noted by Dr. Silver, which extended over a lengthy period of time. In short, the Arbitrator is not persuaded that Petitioner only needed, according to Dr. Levin, was a few weeks of physical therapy. Further, Dr. Levin's diagnosis is at odds with Petitioner's exam and clinical findings as noted in her records. To the extent treatment was delayed, the Arbitrator finds that Petitioner's pregnancy was not an unreasonable basis to interrupt treatment. The Arbitrator declines to adopt Dr. Levin's opinions on this matter. Based on the foregoing, the Arbitrator concludes that Petitioner's current condition of ill-being as it relates to the left knee is causally related to her undisputed work accident.

ISSUE (L),(O) ***What temporary benefits are in dispute?***

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. The Arbitrator concludes, having found in favor of Petitioner on the issue of causal connection, Petitioner has proven by a preponderance of the evidence that she is entitled to temporary total disability benefits as a result of her work-related injuries. At trial, Petitioner claimed entitlement to temporary total disability benefits from May 1, 2015 through July 7, 2016. Ax1. Respondent claims Petitioner is only entitled to temporary total disability benefits from May 1, 2015 through May 20, 2015. Ax1.

The credible record demonstrates that beginning April 30, 2015, Dr. Silver either placed Petitioner on sedentary duty or removed her from work. Px2. On April 19, 2016, Dr. Silver continued to recommend that Petitioner be limited to sedentary work only as a result of her ongoing left knee complaints. As of the date of trial, there is no evidence that Dr. Silver has discontinued these limitations. However, Petitioner did testify that she returned to Respondent in a full duty capacity, as she was no longer receiving any disability benefit or payment. The Arbitrator is not persuaded that Petitioner's condition stabilized or otherwise reached maximum

medical improvement on May 20, 2015 as there is no evidence in support thereof or that it has stabilized by virtue of Dr. Silver's full duty release in July 2016. The Arbitrator also rejects Dr. Levin's contention that Petitioner stabilized shortly after her work accident. The record demonstrates Petitioner was inhibited from fully treating due to pregnancy and when she did treat, the record shows ongoing symptoms not fully resolved with conservative care. The Arbitrator concludes that Petitioner has proven her condition has not yet resolved. Therefore, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits beginning May 1, 2015 up to and including July 7, 2016. Respondent shall pay Petitioner temporary total disability benefits of **$915.08/week** for **62 weeks**, commencing **May 1, 2015** through **July 7, 2016**, as provided in Section 8(b) of the Act. By stipulation, Respondent shall be given a credit of **$33,075.41** for temporary total disability benefits that have been paid.

ISSUE (K), (O) ***Is Petitioner entitled to any prospective medical care?***

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. The Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that she is entitled to prospective medical care as recommended by Dr. Silver, including but not limited to a left knee arthroscopy. In so concluding, the Arbitrator adopts and relies on the opinions of Dr. Silver, which are entitled to greater weight than the opinions of Dr. Levin's. Respondent shall pay for and authorize the left knee treatment and surgical recommendations of Dr. Silver, including any and all incidental care thereto.

ISSUE (O) ***Other: Prospective medical care, medical bills, ttd, causation, Respondent credit***

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. The Arbitrator has already addressed the other issues of causation, credit, prospective medical care and temporary total disability listed in Ax1 as noted above. The Arbitrator directs this portion of the decision to medical bills, which was also listed as an "other" disputed issue in Ax1. The Arbitrator finds that no evidence or testimony was presented on the issue of medical bills therefore the Arbitrator makes no findings or conclusions of law as to same.

Signature of Arbitrator

8-30-2016
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Hector Beltran,

Petitioner,

vs. NO: 14WC 30689

Morton's of Chicago,

Respondent,

18IWCC0263

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causation, temporary total disability, medical, prospective medical, partial permanent disability, "Section 8A Lumbar Surgery", and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 13, 2016 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

18IWCC0263

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 26 2018

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CJD/rlc
049

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

BELTAN, HECTOR
Employee/Petitioner

Case# **14WC030689**

MORTON'S OF CHICAGO
Employer/Respondent

18IWCC0263

On 9/13/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.54% 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:

5006 ROMAKER LAW FIRM
CHARLES P ROMAKER
211 W WACKER DR SUITE 1450
CHICAGO, IL 60606

0507 RUSIN & MACIOROWSKI LTD
JEFFREY T RUSIN
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Hector Beltan
Employee/Petitioner

v.

Morton's of Chicago
Employer/Respondent

Case # 14 WC 30689

Consolidated cases: ___

18IWCC0263

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **Geneva**, on **August 17, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other ___

FINDINGS

18IWCC0263

On the date of accident, **9/5/14**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$24,031.28**; the average weekly wage was **$462.14**.

On the date of accident, Petitioner was years of age, ***single*** with dependent children.

Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$16,481.19** for TTD, $ for TPD, $ for maintenance, and **$2,500.00** for a PPD advance, for a total credit of **$18,981.19**.

Respondent is entitled to a credit of $ under Section 8(j) of the Act.

ORDER

Petitioner failed to meet his burden of proof with respect to the issue of accident. Therefore the claim for benefits is denied.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

9/12/16
Date

SEP 13 2016

18IWCC0263

FINDINGS OF FACT

This claim involves a Petitioner alleging injuries sustained while working for the Respondent on September 5, 2014. On that day, Petitioner claims he injured his low back, right leg and left leg when he fell off a ladder at work. (Arb. Exh. 2) Respondent disputes Petitioner's claims and disputes the following issues: 1) accident, 2) causation, 3) TTD, 4) medical expenses and 5) prospective medical care. (Arb. Exh. 1)

Prior Claim

Hector Beltran (hereinafter "Petitioner") testified that he began working for Morton's Steak House (hereinafter "Respondent") in August 2013. Prior to his employment with Respondent, Petitioner experienced injuries to his left knee and low back in October, 2011 for which he filed workers compensation claims against another employer. For this prior claim, he received treatment from Dreyer Medical Clinic, Nuestra Clinica, Dr. Freedberg, Dr. Chami and Dr. Salehi. His prior medical treatment included an MRI to his low back and left leg, followed by injections and then surgery to his left leg in January, 2012. Dr. Salehi had recommended an L5-S1 fusion for his back injury, which was scheduled in December, 2012. Petitioner ultimately opted against undergoing back surgery at that time and subsequently settled that case. Petitioner testified that he did not recall whether he was ever released from care from his prior treating physicians, or whether he was authorized to return to work relating to his low back condition. He also testified that his problems with his left leg and back had resolved and that he did not receive any further medical treatment for those conditions from 2012 through the date of his most recent accident on September 5, 2014.

Present claim

On September 5, 2014, Petitioner was employed by Respondent as a cook/prepper, whose job duties required that he stand all day without any breaks and also lift various heavy boxes weighing up to 50 pounds. Petitioner denied performing any cleaning type of activities, and indicated that he had never been asked to perform any type of cleaning job activities prior to September 5, 2014. He also denied any problems in terms of performing his job duties in relation to his left knee or low back condition. Petitioner testified that on that date he was working in a different capacity as a porter, which is essentially a cleaning position. He testified that he came in on his day off because the manager requested that he do so due to lack of other employee availability. Petitioner testified that he got in to work at around 8:00 am that day and that his alleged accident occurred around Noon.

Petitioner testified that on the date in question, he was on a step ladder and was trying to replace the filters in the fan above the stove that he had just cleaned. He testified that he was standing on the step ladder with his left leg and had his right foot on the stove, near a big pot full of water that is used to make soups. He described the ladder was about chest high and about 3-4 feet tall. Petitioner testified that he was on the third step when he fell. He testified that the third step was not the top step, and was uncertain as to how many more steps there were beyond the third step. Petitioner testified that he then slipped while standing on the ladder and landed backwards, directly striking his low back and buttocks on the ground. He testified that his left foot got caught in the step ladder. He testified that a large amount of water spilled onto the ground and he fell into the water. He denied having to change his clothes, but did

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indicate that he was wet from the water. He testified that when he fell to the floor, he felt that his back cracked and he had immediate pain in the lumbar spine and left knee following this incident.

Petitioner testified that he provided the same exact history of his slip and fall, and subsequent injuries and complaints to all of his treating physicians.

After the accident, Petitioner testified that he continued to work and finished his shift. He indicated that he mopped up the water on the floor. At the end of his shift, he told his supervisor about his alleged injury.

Petitioner then sought medical treatment after his shift at Nuestra Clinica, with Dr. Gattas (Px . 1). Petitioner chose to treat at Nuestra Clinica, a location where he had previously treated at, because they speak Spanish. The September 5, 2014 Initial Evaluation Report indicates:

> He states that he had his foot on the stove and was trying to get his footing on a "salad maker", which was not too stable when he completely lost his balance. The patient states that he was trying not to fall completely and that in the process he twisted his back and felt a "crack", along with immediate pain. He states that when he landed, he landed in such a way that his knees also were in an awkward position, and he felt pain in both of them as well. (PX 1)

Petitioner went to therapy at Nuestra Clinica three days a week and continued to treat at Nuestra Clinica on a regular basis from September 2014 through February 2016. Petitioner testified that Dr. Gattas authorized Petitioner to remain off work (Px. 1).

Petitioner testified that he initially underwent an MRI for the lumbar spine and the right knee. No MRI of the left knee was done initially (Px. 2).

Petitioner testified he was referred to Dr. Dasgupta and he underwent an injection into the lumbar spine in October 2014 (Px. 3). Dr. Dasgupta's consultation note from October 1, 2014 indicates in its history section:

> He was attempting to put a new filter in an extractor. He states he had his foot on the stove and was trying to get his footing on the salad maker which was not too stable when he lost his balance. He states that he fell backwards catching his leg on the ladder that he had been using. He also twisted his back in the process and felt a pop along with immediate pain. He is having a somewhat difficult time recalling exactly where he landed but it sounds as though he did land in the buttock area after endorsing significant trauma to the knees as both his knees apparently got caught on the ladder as he was falling. (Px. 3)

On October 8, 2014, Petitioner saw Dr. Freedberg. (Px. 6). Dr. Freedberg's records provide the following history:

> Patient states he was placing some filters on shelves and he was on a ladder so he was able to reach. Patient is a cook and states in front of him…was a big pot with hot water to make soups and such for the day. Patient then slipped and one knee R landed on the floor while the other one was stuck on the ladder and twisted, L. Patient s[t]ates he fell into the floor the pot with hot water landed on him as well. Patient was able to get his other leg out of the ladder he was able to get up.

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Patient state he felt dizzy and he was picking everything up and cleaning up the water. Patient was asked if he was okay and he said he was fine and continued into his day. Patient states till later his supervisor came in and he told him what happened and he was having knee and back pain at the time. (PX 6)

Petitioner testified that he treated with Dr. Freedberg relating to his left knee condition and that he advised Dr. Freedberg as to his complaints relating to the lumbar spine as well. Per Dr. Freedberg's recommendation, Petitioner underwent an MRI of the left knee in October of 2014. Dr. Freedberg authorized petitioner to remain off work relating to the left knee condition from October 8, 2014 through December 2, 2015 (Px. 6). Petitioner testified that he eventually underwent left knee surgery with Dr. Freedberg on February 8, 2015 involving a left knee arthroscopy, medial meniscectomy and chondroplasty. (Px. 6). Petitioner testified that he continued to follow up and treat with Dr. Freedberg after his surgery, as well as with Dr. Gattas. Petitioner testified that he saw Dr. Freedberg approximately once a month following his surgery and was eventually released to return to work relating to his left knee condition by Dr. Freedberg as of December 2, 2015 (Px. 1; Px. 6).

Petitioner testified as to his referral to treat with a pain management physician, Dr. Visotsky, as well as Dr. Novoseletsky (Px. 3). Petitioner testified that he treated with them in June and August 2015 and underwent lumbar injections.

Petitioner testified that he was eventually referred to treat with a spinal specialist, Dr. McNally (Px. 6). Petitioner testified that he treated with Dr. McNally in September 2015. He underwent an updated MRI as well as an EMG study. On November 24, 2015, Dr. McNally recommended that Petitioner undergo surgery for his back (Px. 6). Petitioner testified that he wants to proceed with that surgery. Petitioner did testify that the surgery was not authorized.

Petitioner testified that he did undergo an IME with Dr. Walsh as of August 23, 2015 (Rx. 6). Dr. Walsh attributed Petitioner's condition of ill-being to pre-existing conditions that were not aggravated by Petitioner's alleged accident.

Petitioner complained that he continues to have pain in the low back, radiating pain down the buttock. He testified that due to this ongoing pain, he still wishes to pursue the surgical recommendation. He admitted that he has not treated with Dr. McNally since November 24, 2015. Petitioner testified that his last medical visit was with Nuestra Clinica in February 2016. He testified that he stopped treating there due to insurance coverage issues.

Testimony of Charles Johnson

Mr. Charles Johnson testified on behalf of the Respondent. He is employed at Morton's as the food and beverage manager and has been in that position for the last 30 years. Mr. Johnson testified that he does have some interaction with the Petitioner and acted in a manager/supervisory role. Mr. Johnson was aware of Petitioner's job duties and what Petitioner was required to do on a daily basis. Mr. Johnson was not Petitioner's direct supervisor, but on the alleged date of accident, Mr. Johnson was the manager in charge.

Mr. Johnson testified as to the events that occurred on September 5, 2014. On that day, Mr. Johnson was working in a different room preparing the food and beverage menu for the weekend. Mr. Johnson heard

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have fallen from. But even putting Mr. Johnson's testimony aside, the initial medical records provide a history that is quite different from Petitioner's description of falling from a ladder.

As indicated above, Petitioner went to Nuestra Clinica on the day of the alleged accident. The history in the records from that same day indicate Petitioner lost his balance while stepping on a stove and a salad maker, and that Petitioner injured himself from twisting his back. And although Petitioner speaks Spanish, he testified that he went to Nuestra Clinica because they speak Spanish there – so presumably, the different accounts of what happened should not have been due to any language difference. The Arbitrator notes that in the initial medical record from Nuestra Clinica, there is no mention of the Petitioner falling from a ladder and that the account of events indicated in those records are clearly different from Petitioner's testimony. The mechanism of Petitioner's accident seems to change when he sees his next medical provider.

By the time Petitioner gets to see Dr. Dasgupta on October 1, 2014, the description of the accident has morphed to a fall from stepping onto a salad maker and stove and then falling onto a ladder where he got his leg caught. The record later indicates that both knees got caught in the ladder as Petitioner apparently landed on his buttocks when he fell. This third account of what allegedly happened to Petitioner on September 5, 2014 appears to be a variation of Petitioner's initial history at Nuestra Clinica and his testimony at trial. However, this third depiction is still at odds with Petitioner's testimony that he fell from a ladder.

And then there is another version of event contained in Dr. Freedberg's records. (PX 6) According to the history provided to Dr. Freedberg at Suburban Orthopedics on October 8, 2014, Petitioner claimed he was on a ladder when he slipped and his right knee landed on the floor while the left was stuck in the ladder and twisted. In this history, Petitioner claims that this right knee directly struck the ground and there is no mention of Petitioner directly striking his low back on the ground. Petitioner also claimed that a pot of hot water landed on him as well. This version of events does not mention the stove or salad maker.

The medical records all support the fact that the Petitioner had a pre-existing knee and back condition for which surgery had been recommended prior to the alleged date of accident in the present case.

Given these conflicting facts with regard to how the Petitioner allegedly injured himself, the Arbitrator concludes that the Petitioner failed to prove that he sustained an accident on September 5, 2014. Specifically, the Arbitrator finds that the Petitioner's testimony lacks credibility when weighed against the preponderance of the evidence. There are simply too many conflicts between the Petitioner's testimony and a bulk of the evidence for the Arbitrator to ignore. Accordingly, Petitioner's claim for benefits is denied.

2. Based on the Arbitrator's findings with regard to the issue of accident, all other issues are rendered moot.

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a loud noise and thought it was sheet pans falling to the ground. Within about 15 seconds, Mr. Johnson testified that he looked to see where the sounds came from and saw the Petitioner standing up with a water on the ground. Mr. Johnson could not recall as to whether or not petitioner was wet, but acknowledged the large amount of water on the floor. Mr. Johnson testified that he did not observe the Petitioner in any pain and/or problems. He testified that the Petitioner did not provide any indication to him that he was injured and/or hurt. Mr. Johnson does not speak Spanish and did not have an in-depth conversation with the Petitioner due to the language barrier, but it was Mr. Johnson's testimony that the Petitioner did not allege any complaints of pain and in fact proceeded to mop up the floor due to all the water on the floor. Lastly, Mr. Johnson testified that there was no step ladder present in or around the area where Petitioner allegedly fell.

On cross examination, Mr. Johnson clarified that he was not a direct witness to the accident. Mr. Johnson again testified that it took him only 15 seconds following the alleged sounds that he heard to get to see where Petitioner was standing. Again, Mr. Johnson firmly concluded that there was no ladder present in and/or around the area where petitioner allegedly fell. Mr. Johnson did confirm that he does not speak Spanish and it was possible that any conversation and/or questions asked by Mr. Johnson to the Petitioner would be difficult for the Petitioner to interpret, given his lack of English ability. However, Mr. Johnson did testify that the Petitioner told him in "broken English" that he was going to mop the floor. Mr. Johnson did confirm that Petitioner mopped the floor.

Hector Beltran Rebuttal Testimony

After Mr. Johnson testified, the Petitioner was brought back to the witness stand to provide some testimony in response to Mr. Johnson's testimony. The Petitioner denied that Mr. Johnson responded to the sounds of the accident within 15 seconds. Petitioner indicated that it took him approximately 15 seconds to unhook his foot from the step ladder and then stand up. Petitioner testified that Mr. Johnson only saw him for about 2 or 3 seconds. Petitioner did admit that he was standing and was able to mop the floor after his alleged accident, even though he claimed that he had significant pain in his low back and left knee at that time. Petitioner also testified that he did not report any accident to Mr. Johnson as he did not know who Mr. Johnson was, even though testimony from Mr. Johnson clarified that he did have prior interactions with the Petitioner and did oversee his job activities and duties at times.

CONCLUSIONS OF LAW

1. With regard to the issue of accident, the Arbitrator finds that the Petitioner has failed to meet his burden of proof. Specifically, the Arbitrator finds the Petitioner's testimony lacks credibility in his claim of what allegedly happened on the date in question. This finding is supported by the testimony and the medical evidence. Petitioner testified with no uncertainty at the hearing that he fell while standing on a step ladder and that his left leg got caught in the ladder. He apparently fell approximately 3 to 4 feet and he landed on his back and experienced immediate pain to his knee and back. However, this account of events is questionable when taking into consideration the testimony of Mr. Johnson, who went out to the scene approximately 15 seconds after he head a loud sound and saw Petitioner standing near a puddle of water. Mr. Johnson did not see any step ladder and Petitioner made no complaints of pain or falling. The Arbitrator also notes that Mr. Johnson's testimony was confirmed by the February 4, 2015 medical record from Suburban Orthopedics, wherein Petitioner clarifies in that record that after his alleged fall, a manager came and asked him if he was fine and petitioner told him that he was (Px. 6). Although Mr. Johnson did not actually see the accident occur, he would have noticed the ladder Petitioner claims to

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

Mark Szymanski,

Petitioner,

vs. NO: 15 WC 13810

18IWCC0266

Village of Sauget,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue(s) of causal connection, medical expenses, and prospective medical care, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 16, 2017 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

No bond is required for the removal of this cause to the Circuit Court. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 27 2018
SJM/sj
o-4/5/2018
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

SZYMANSKI, MARK
Employee/Petitioner

Case# **15WC013810**

VILLAGE OF SAUGET
Employer/Respondent

18IWCC0266

On 10/16/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.22% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0969 RICH RICH & COOKSEY PC
THOMAS C RICH
6 EXECUTIVE DR SUITE 3
FAIRVIEW HTS, IL 62208

0299 KEEFE & DePAULI PC
PATRICK M KEEFE
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

18IWCC0266

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)

Mark Szymanski
Employee/Petitioner

v.

Village of Sauget
Employer/Respondent

Case # **15** WC **13810**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Collinsville**, on **September 21, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **August 9, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

Per the stipulation of the parties, in the year preceding the injury, Petitioner earned **$53,518.40**; the average weekly wage was **$1,029.20**.

On the date of accident, Petitioner was **56** years of age, ***married*** with **2** dependent children.

Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$ALL TTD PAID** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$ALL TTD PAID.**

ORDER

Respondent shall authorize the treatment recommended by Dr. Hagan, including, but not limited to, the recommended surgery.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Melinda M. Rose Gillman

Signature of Arbitrator

10/11/17

Date

ICArbDec19(b)

OCT 16 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

Mark Szymanski
Employee/Petitioner

Case # 15 WC 13810

v.

Consolidated cases: N/A

Village of Sauget
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The parties stipulated at the time of arbitration that Petitioner sustained accidental injuries in the course of his employment as a Police Officer for the Respondent Village of Sauget on August 9, 2014, when he rushed to a call to break up a club fight at the Oz Night Club, exited his vehicle and twisted his ankle while running towards the south exit door of the premises. (AX1). Petitioner testified that the parking lot was in very poor condition. He testified that he suffered no prior injuries to his right foot or ankle and required no treatment to the injured extremity prior to this accident. The Arbitrator notes that the only issues in dispute at the time of arbitration were that of causal connection and prospective medical treatment. (AX1).

Petitioner testified that he has had two surgeries to his right foot to date. He testified that he continues to have pain down the right side of his calf that travels across his foot under his ankle bone, along with numbness in the ball of his foot and three of his toes. He testified that he wishes to receive the surgery recommended by Dr. Hagan.

On cross-examination, Petitioner testified that he is no longer working as a police officer and that he has had difficulty obtaining employment in the security sector because of his injury. He testified that he was terminated from a security subcontractor position because they did not want an injured person working in that position. He testified that he takes 300mg of Gabapentin three times a day for his foot symptoms in addition to several over-the-counter anti-inflammatory pain medications.

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The Medical Records List was entered into evidence at the time of arbitration as Petitioner's Exhibit 2.

The medical records of Dr. C. James Anderson were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on September 18, 2014, at which time it was noted that his right ankle "turned a wrong way" while getting out of a police car on August 9, 2014. It was noted that Petitioner had a bruised medial ankle initially and now had pain over the entire circumference of the right ankle that radiated proximally to the medial leg and posterior calf. The assessment was noted to be that of DM II without complication, tibial tendinitis, ankle sprain, difficulty or pain with ambulation and pain in limb. Petitioner was ordered to undergo x-rays and dispensed DME, and it was noted that Petitioner had a probable injury to the PT tendon and medial ankle ligaments and was recommended immobilization with a fracture boot. At the time of the October 2, 2014 visit, it was noted that Petitioner was still very tender to the medial ankle and that it radiated pain upwards to the medial calf.

It was noted that Petitioner's ankle clicked in the back of the heel emitting mild pain and that the pain also continued to the lateral foot radiating to the fifth digit. It was noted that imaging studies were ordered and that Petitioner was recommended to remain off work until the follow-up appointment to discuss the MRI results. (PX3).

The records of Dr. Anderson reflect that Petitioner's MRI was reviewed on October 14, 2014, at which time it was noted that there was prominent tendinosis and/or grade 1 injury of the musculotendinous junction of the posterior tibial tendon; tendinosis extends just distal to this level; there is tenosynovitis extending from this level distally over the course of the tendon to the insertion. At the time of the October 16, 2014 visit, it was noted that Petitioner felt "quite a bit" better and had been wearing the boot as much as possible but admitted to "not all the time." It was noted that Petitioner continued to hear and feel clicking to the ankle and that he had sharp pain to the lateral and medial ankle emitted with weightbearing but could "shake it out." It was noted that Petitioner also noted pain to the lateral ankle and foot radiating to the fifth digit. Petitioner was recommended to continue in the CAM walker more often with all weightbearing activity for approximately two more weeks along with the use of an ankle compression brace. Petitioner was also recommended to begin physical therapy. (PX3).

The records of Dr. Anderson reflect that Petitioner was seen on October 30, 2014, at which time it was noted that he had gone to therapy about three times and was taking Ibuprofen about twice a day for the pain. It was noted that Petitioner had been wearing the CAM walker as directed and felt that he was improving and may be ready to return to work within 1-2 more weeks. Petitioner was recommended to transition to an ankle brace and to continue physical therapy. At the time of the November 6, 2014 visit, it was noted that Petitioner just left his last physical therapy visit and was still taking Ibuprofen about twice a day for the pain. It was noted that Petitioner had been wearing the CAM walker and weaning to the AFO, that he was wearing the AFO 2-3 hours per day and that then the foot started aggravating him. It was noted that Petitioner stated that the brace was irritating the ankle a little after wearing it awhile and that he had not been wearing the ankle compression sleeve under the brace. Petitioner was recommended to transition to ankle brace only over the next few days and was also recommended prefab inserts for additional arch support. (PX3).

The records of Dr. Anderson reflect that Petitioner was seen on November 13, 2014, at which time it was noted that he was no longer in physical therapy and that the foot was better with stretching. It was noted that Petitioner was still taking Ibuprofen about twice a day for the pain, that he was wearing the ankle compression sleeve under the brace and that he was weaning off the brace. Orthoses were dispensed. At the time of the February 3, 2015 visit, it was noted that Petitioner's right ankle was still a little sensitive with the medial aspect being weaker and a little more painful than the left. It was noted that Petitioner took Celebrex or Ibuprofen for pain. Petitioner was ordered to undergo an MRI to evaluate for a tear of the right PT tendon. Petitioner's MRI of the right ankle was reviewed on March 5, 2015, at which time it was noted that there was marked abnormality of the PT tendon compared to the prior MRI with findings suspicious for a complete tear of the PT tendon and associated tendinosis and tendinopathy. At the time of the March 18, 2015 visit, it was noted that Petitioner reported that his right foot still bothered him with any weightbearing activity and that there was pain on the malleolus sides bilaterally and across the top of the foot. Petitioner was recommended to undergo surgery to repair the tear of the tendon and to augment the repair of the tendon as well as possible fusion of the medial column versus use of HyproCure STJ implant to reduce STJ pronation. (PX3).

The medical records of Belleville Memorial Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner underwent an MRI of the right ankle on October 9, 2014, which was interpreted as revealing (1) there is prominent tendinosis and/or grade 1 injury of the musculotendinous junction of the posterior tibial tendon; tendinosis extends just distal to this level; there is tenosynovitis extending from this level distally over the course of the tendon to the insertion; (2) there is mild tenosynovitis of the peroneus longus and brevis tendon at the level of the ankle joint

extending just distally; (3) there is a tiny osteochondral lesion of the lateral talar dome of only 1 mm; (4) there is subchondral cyst formation seen of the posterolateral aspect of the talus along the superior aspect of the posterior subtalar joint subjacent to the attachment of the posterior talofibular ligament; (5) there is minimal subcutaneous edema along the medial aspect of the ankle joint. (PX4).

The medical records of Mid America Imaging were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner underwent an MRI of the right ankle on March 2, 2015, which was interpreted as revealing (1) marked abnormality in the posterior tibialis tendon; present findings appear more severe than what is described in the prior report; progression of the disease in this area is suspected with tendinosis, tendinopathy and likely full thickness tear; peritenonintis is also seen; (2) multiple areas of other peritenonitis including the peroneus brevis and longus tendons and flexor digitorum tendon; (3) small osteochondral defect laterally in the talar dome; (4) abnormal edema in the sinus tarsi. The Addendum issued shortly thereafter referenced comparison with the prior study dated October 9, 2014 and noted that interval change in the posterior tibialis tendon was seen with discontinuity now demonstrated; examination of the posterior talus shows cystic changes; subtle edema in this region is seen; correlation with prior study shows similar findings; no definite interval change is noted; edematous change in the sinus tarsi is also similar to prior exam. (PX5).

The medical records of Belleville Memorial – Occupational Therapy were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Petitioner underwent physical therapy for the timeframe of October 23, 2014 through November 6, 2014. (PX6).

The medical records of Dr. Matthew Bradley were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The records reflect that Petitioner was seen on April 27, 2015, at which time it was noted that he was sent to Dr. Bradley after the MRI scan came back positive for full thickness tear to his posterior tibial tendon in combination with an OCD lesion of his lateral talar dome. It was noted that Petitioner's MRI scan clearly showed some acute injury with edema noted medially as well as a small tear to his posterior tibial tendon and that he was treated appropriately with some activity modification, some bracing, anti-inflammatories, physical therapy and rehabilitation. It was noted that Petitioner had failed non-operative treatment and that Dr. Bradley felt that surgical intervention was the only thing that could provide him with pain relief and function to his foot. It was noted that a discussion was had regarding repair of the posterior tibial tendon with augmentation, a calcaneal osteotomy and a potential lateral column lengthening-type procedure for restoration of the arch and treatment of his posterior tibial dysfunction. It was noted that Petitioner wished to discuss it with his family and would call to schedule his appointment appropriately and in the interim, would continue to wear his boot as needed for pain control and stability. (PX7).

The records of Dr. Bradley reflect that Petitioner was seen on June 4, 2015, at which time it was noted that his pain was adequately controlled and that he had been non-weightbearing in the posterior splint and that he had been using a knee scooter. It was noted that Petitioner was pleased with his progress. Petitioner was placed in a post-operative shoe and was instructed to remain non-weightbearing in the right lower extremity. Petitioner was also instructed to work on range of motion of the ankle and to continue to use a knee scooter. At the time of the July 9, 2015 visit, it was noted that overall Petitioner was doing quite well and that he had been compliant with his non-weightbearing. It was noted that Petitioner stated that when his foot was down, it swelled and that he had been utilizing a knee scooter. It was noted that overall Petitioner was healing appropriately and had no complications appreciated. Petitioner was instructed to initiate some light weightbearing and to increase each week to full unrestricted weightbearing in the stiff sole rocker bottom shoe over the next month's timeframe. It was noted that if Petitioner continued to show good bone healing, consideration could be given towards removal of the shoe and fabrication of some custom orthotics. (PX7).

The records of Dr. Bradley reflect that Petitioner was seen on August 13, 2015, at which time it was noted that overall he was doing exceptionally well. It was noted that Petitioner reported pain to palpation along his dorsolateral incision and had some ongoing swelling issues, but otherwise was doing quite well and was quite happy. It was noted that Petitioner could continue to be full weightbearing in his post-operative shoe. It was noted that Petitioner's foot continued to be a little too swollen for regular shoe wear but once he could get into regular shoe wear, he could get the recommended compression stockings to help with some of the swelling. It was also noted that a prescription for compounding pharmacy medications was written to help with some of the neuropathic pain he was having about his incision and to help with some of the subcutaneous scarring. At the time of the September 24, 2015 visit, it was noted that Petitioner was doing well and was weightbearing in a normal shoe. It was noted that he still reported some discomfort laterally as well as posterior inferior along his calcaneus and that he stated he did notice improvement with the compounding cream. The assessment was noted to be that of status post right flat foot reconstruction. It was noted that Petitioner would be weightbearing in his normal shoe and that he was to go to physical therapy. (PX7).

The records of Dr. Bradley reflect that Petitioner was seen on November 5, 2015, at which time it was noted that he had been to physician's assistant and was weightbearing as tolerated in a regular shoe at that time. It was noted that Petitioner was still using a topical compound cream for some nerve pain involving the lateral foot after surgery and that he still reported pain involving his heel. It was noted that Petitioner stated that he felt as though he was walking on the calcaneal screws and hardware prominence and that he also mentioned some lateral foot pain over the opposite surgical site. Petitioner was recommended to undergo a CT to evaluate for fusion and it was noted that they would plan to schedule for hardware removal of the calcaneus screws. It was noted that if there did happen to be any need for revision surgery involving the lateral column lengthening site for lack of fusion, it would be planned to be performed at the same time as the hardware removal. At the time of the December 7, 2015 visit, it was noted that Petitioner's pain was unchanged from his examination previously on November 5, 2015. It was noted that the CT done at Excel Imaging dated November 11, 2015 showed that all his osteotomies and fusion sites had healed and that there was a single broken screw within his plate noted. It was noted that Petitioner had excellent healing of his arthrodesis sites and that Dr. Bradley thought it was safe to remove the hardware. It was noted that surgery was planned to include removal of hardware from the calcaneus as well as lateral dorsal foot with in situ neurolysis of any superficial nerves encountered over the plate. (PX7).

The records of Dr. Bradley reflect that Petitioner was seen on March 31, 2016 visit, at which time it was noted that he presented for his first post-operative evaluation two weeks after undergoing removal of hardware and neurolysis of the sural nerve of the right foot. It was noted that Petitioner reported intermittent pain and reported some drainage from the incision over the posterior calcaneus. Petitioner was placed on a 10-day course of Bactrim for the drainage from his calcaneal wound and was placed back into a post-operative shoe. At the time of the April 14, 2016 visit, it was noted that overall Petitioner was doing well and had been maintained on his antibiotics. It was noted that Petitioner stated that the drainage was almost completely resolved and that he did have some para-incisional pain to the touch but had been able to get himself over into regular shoe wear. It was noted that overall Petitioner's pain was improving but that he did have some pain on the ball of his foot, but he thought it was because he was walking primarily on the ball and not onto his heel. It was noted that Petitioner had no current signs of infection and would complete his course of antibiotics. Petitioner was given some silicone heel cups to help unload or offload some of the pressure around the calcaneal incision. (PX7).

The records of Dr. Bradley reflect that Petitioner was seen on May 12, 2016, at which time it was noted that much of his pre-operative pain had resolved but that he continued to have a burning, radiating pain over his posterior lateral and slightly medial ankle. It was noted that no new trauma was noted and no symptoms of infection were reported. Petitioner was instructed to continue his home exercise program for range of motion and was referred to Dr. Hagan for peripheral nerve pain evaluation and treatment. It was

noted that Petitioner may be a candidate for rocker bottom shoes or stiff soles but that they would hold off on changing foot wear until the peripheral nerve evaluation. At the time of the June 23, 2016 visit, it was noted that Petitioner reported that Dr. Hagan injected his nerve and that he had complete 100% pain relief. It was noted that Petitioner was feeling great until the injection wore off and that Dr. Hagan wanted to perform surgery. Petitioner was recommended to continue following up with Dr. Hagan. At the time of the September 1, 2016 visit, it was noted that Petitioner's symptoms of burning and "pins and needles" was in the same location as before and that no new injury or trauma was noted. Petitioner was recommended to return one month after his surgery with Dr. Hagan to go over the outcomes and to see how he was doing. (PX7).

The medical records of Chesterfield Surgery Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The records reflect that on May 22, 2015, Petitioner underwent (1) medial translating Dwyer-type calcaneal osteotomy; (2) lateral column lengthening; (3) arthrodesis of the calcaneocuboid joint; (4) debridement and synovectomy, posterior tibialis tendon; (5) fabrication of posterior splint with stirrups for a pre- and post-operative diagnosis of semi-rigid, un-completely correctable flatfoot deformity secondary to posterior tibialis rupture. (PX8).

The medical records of St. Joseph's Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The records reflect that Petitioner underwent pre-operative testing on March 1, 2016. (PX9).

The medical records of St. Elizabeth's Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The records reflect that Petitioner underwent physical therapy for the timeframe of October 20, 2015 through November 4, 2015. (PX10).

The medical records of Excel Imaging were entered into evidence at the time of arbitration as Petitioner's Exhibit 11. The records reflect that Petitioner underwent a CT of the right foot on November 11, 2015, which was interpreted as revealing (1) status post posterior calcaneal osteotomy two screw fixation; no evidence of hardware failure; (2) status post calcaneocuboid arthrodesis with a device within the calcaneocuboid articulation as well as lateral plate and screw fixation of the calcaneus and cuboid; there is incomplete fusion; there is no evidence of hardware failure; (3) mild 1st MTP osteoarthritis; (4) there is diffuse dorsal foot and ankle subcutaneous edema. (PX11).

The medical records of SSM Health St. Clare Fenton were entered into evidence at the time of arbitration as Petitioner's Exhibit 12. The records reflect that on March 18, 2016, Petitioner underwent (1) hardware removal, right lateral column of the foot; (2) hardware removal, right calcaneus; (3) sural nerve neurolysis, right foot for pre- and post-operative diagnoses of (1) painful retained hardware, right foot; (2) sural nerve adhesions, right foot. (PX12).

The medical records of Dr. Robert Hagan were entered into evidence at the time of arbitration as Petitioner's Exhibit 13. The records reflect that Petitioner was seen on June 13, 2016, at which time it was noted that he was a retired police officer for the Village of Sauget that originally was injured on August 9, 2014 when in an altercation with a suspect. It was noted that Petitioner originally had an inversion injury of his right ankle and that he eventually underwent right ankle surgery with Dr. Bradley in May of 2015. It was noted that with continued pain post-operatively, Petitioner underwent hardware removal in March of 2016 and that he had continued to have pain and discomfort throughout his foot since his initial surgery and that he related it to his initial injury. It was noted that Petitioner complained of an electrical-type stimulation that shot from his ankle up to his knee along with numbness in the first and second toes, and that he had pain deep within the ankle with any type of movement and had difficulty walking because of the pain. It was noted that Petitioner was a non-diabetic and complained of burning in his feet, that he had feelings of numbness and occasional muscle spasms in his feet, that he had difficulty with sleeping, that he had tried heel cushions and orthotics with very little relief and that he had no complaints of left lower extremity

symptoms. The impression was noted to be that of right lower extremity common peroneal nerve neuropathy, deep peroneal neuropathy, superficial peroneal neuropathy and sural neuropathy. A diagnostic injection of the deep peroneal nerve was recommended and performed. It was noted that surgical intervention consisting of a right lower extremity common peroneal nerve decompression, superficial peroneal nerve decompression, deep peroneal nerve resection and burial and medial and lateral sural nerve resection and burial was recommended and that it was felt that Petitioner's current symptoms were related to his work injury of August 8, 2014. (PX13).

The transcript of the deposition of Dr. Hagan was entered into evidence at the time of arbitration as Petitioner's Exhibit 14. Dr. Hagan testified that he is a board-certified plastic surgeon specializing in peripheral nerve and hand surgery. He testified that he saw Petitioner on June 13, 2016 and that at the conclusion of the history and physical examination, he felt that Petitioner had a combination of peripheral nerve issues residual to his work injury of August 9, 2014 and that he was diagnosed with having a sural nerve neuroma as well as persistent chronic anterior lateral ankle pain or sinus tarsi pain as outlined by having common peroneal nerve, deep peroneal nerve and superficial peroneal nerve neuropathy as well as sural nerve neuroma. (PX14).

Dr. Hagan testified that in patients who had predominantly an inversion or eversion ankle injury where there was a fracture or a bad sprain, there could be a traction-type injury on the nerves in the lower extremity and that most commonly it was the common peroneal nerve. He testified that as the other components of the injury were getting better, the nerve-related injuries were either staying the same or progressing because of residual scar tissue that was developing. He testified that as part of the composite of the injuries that he thought Petitioner had, he did an additional diagnostic block of the deep peroneal nerve which was done to increase the level of confidence as to whether it was the nerve that was involved. He testified that he blocked the deep peroneal nerve above the level of the ankle, which relieved Petitioner's sinus tarsi pain and some of his anterior lateral capsular pain. He testified that it was common for an individual to have a traction injury to the deep peroneal nerve and have persistent sinus tarsi pain. He testified that the injection was diagnostic only. (PX14).

Dr. Hagan testified that assuming Petitioner's exam was the same and that he was still in pain, he would recommend surgery. He testified that generally people were back to work to full duty within 12 weeks and that the issue for Petitioner would be post-operative swelling and/or just the overall disuse of his leg may extend that. He agreed that he would need to see Petitioner again before he made the decision to move forward with surgery. He testified that his treatment, diagnosis and recommended treatment plan was related within a reasonable degree of medical certainty as to the work accident. (PX14).

On cross examination, Dr. Hagan agreed that he saw Petitioner on just one occasion. He testified that Dr. Bradley referred Petitioner to him. He testified that the diagnostic injection was performed a little more than an inch above the ankle in the anterior compartment of the leg. He testified that Petitioner's relief was in the ankle and the sinus tarsi. He agreed that Petitioner had symptoms and clinical findings that led him to believe that he had had some abnormality of the sural nerve but that he did not think it was necessary to do any further diagnostics because he was confident in that finding. He agreed that Petitioner had complaints and clinical findings representative of a peroneal nerve abnormality. He testified that they would often use a diagnostic block for the deep peroneal nerve because it was harder to get a focal examination of it. (PX14).

On cross examination, Dr. Hagan testified that imaging would not reveal the type of pathology that Petitioner has. He testified that they utilized ultrasound to look at the deep peroneal nerve, but that they would not routinely order additional MRIs or x-rays to evaluate the nerve pathology. He testified that Petitioner's body habitus and weight would affect his recovery, but certainly did not cause him to have potentiated pathology. He testified that Petitioner's weight did not contribute to ongoing compressions or the development of other neurolytic abnormality. (PX14).

On cross examination, Dr. Hagan testified that Petitioner was noted to have pain and numbness in the anterior lateral leg, lateral ankle and calcaneal and anterior lateral ankle and dorsum of the foot, which was consistent with the peroneal nerve and sural nerve distributions. He testified that the muscle spasms or cramping in the foot and calf would routinely have been seen with an extremity that had pain and not walking on it correctly. (PX14).

On cross examination, Dr. Hagan testified that 25-30% of his practice focused on the lower extremity and that it was hard to estimate how much of his practice would be just directed to the foot and ankle. He testified that he routinely performed nerve surgery in the foot and ankle region, whether it was tarsal tunnel, a neuroma, deep peroneal nerve compression or soft tissue-type reconstruction. (PX14).

The transcript of the deposition of Dr. Schmidt was entered into evidence at the time of arbitration as Respondent's Exhibit 1. Dr. Schmidt testified that he is a board-certified orthopedic surgeon and subspecializes in the foot and ankle. He testified that 100% of his treatment practice deals with conditions involving the foot and ankle. (RX1).

Dr. Schmidt testified that he examined Petitioner on three occasions for an Independent Medical Examination and that he prepared three reports associated with those three visits, specifically July 16, 2015, February 1, 2016 and September 12, 2016. He testified that he also issued a supplemental statement on October 26, 2016 after reviewing additional medical records. (RX1).

Dr. Schmidt testified that based on his initial visit with Petitioner, his understanding of the nature of the injury that he sustained was that of an injury to the right ankle whereby he twisted it and subsequently ruptured his posterior tibial tendon. He testified that as of the time that he first examined Petitioner, the diagnosis was that of status repair of the posterior tibial tendon with accompanying bony reconstruction. He testified that he agreed that the original surgery that was done was reasonable and necessary to cure or relieve the effects of the injury that Petitioner sustained. He testified that when he next saw Petitioner on February 1, 2016, his condition was that he had ongoing right foot pain and was told that his screws were working out and that he needed further surgical intervention. He testified that he believed that the additional surgery was reasonable and necessary at that time as it related to his injuries. He testified that the surgery that was being proposed was to remove the hardware and decompress the sural nerve. He testified that Petitioner's pain at the time of that examination was in the area of his surgical intervention and that clinically Petitioner clearly showed irritation of his sural nerve. (RX1).

Dr. Schmidt testified that when he saw Petitioner on September 12, 2015, he still complained of right foot pain and had had the surgery with the hardware removal and a neurolysis, which was a decompression of the sural nerve. He testified that he found Petitioner's pain to be in the lateral border of the foot and in the distribution of the sural nerve. He testified that he felt that Petitioner had ongoing sural nerve irritation, that he preferred resection of the nerve over decompression and that this may be something that needed to be considered. He testified that at that time, his opinion was that Petitioner was not in need of any additional treatment that would have been related to the work injury he sustained. He testified that he believed that Petitioner had reached maximum medical improvement from the effects of the work injury and that he felt that Petitioner was capable of working at that time without restrictions. (RX1).

Dr. Schmidt testified that it was his impression that Petitioner's sural nerve was driving his pain but that the sural nerve was not connected to the deep peroneal nerve. He testified that if Petitioner's peroneal nerve was driving 100% of his pain, that would not be related to his injury or his previous surgeries so therefore he did not think any further sural nerve surgery would be indicated based on the results of the injection. He testified that Petitioner indicated to him that the injection had been done on the outside of his leg just below his knee. When asked to assume that Dr. Hagan testified that the block was administered approximately 8-10 cm above the outside of the ankle and whether that altered his opinion, Dr. Schmidt responded that if it was indeed the deep peroneal nerve, then it did not because it still indicated that the

deep peroneal nerve was driving Petitioner's pain. He testified that there were no branches to the sural nerve from the deep peroneal nerve, so it was Petitioner's deep peroneal nerve that was driving his pain. (RX1).

Dr. Schmidt testified that he agreed that Petitioner had some sort of injury or compression of the deep peroneal nerve at some point and that it could be compressed at the fibular head or at the anterior tarsal tunnel just at the level of the ankle. He testified that during the time of his first two examinations of Petitioner, there were no clinical findings related to injury of the peroneal nerve at that time. He testified that when he examined Petitioner on September 12, 2016, Petitioner had a Tinel's sign up by the fibular head, which was an indication of compression of the nerve at that site. He testified that Petitioner did not have any clinical findings of peroneal nerve abnormality anywhere else along its course. He testified that based on his understanding of the mechanism of injury Petitioner sustained, this was not the type of injury that could cause damage to the peroneal nerve. He testified that to rupture the posterior tibial tendon, one would have to have an eversion external rotation-type injury and that this would not be in the area of the peroneal nerve, either at the anterior ankle or at the fibular head. He testified that the surgery was not in the area of the nerve in either of these locations and that he would not be able to link it either traumatically or surgically to that nerve in any way. He testified that neither of the surgeries that Petitioner underwent following the injury could have caused damage or injury to the peroneal nerve anywhere along its course. He testified that there may be sufficient evidence of injury to the peroneal nerve at the fibular head to justify decompression at that site, that Petitioner demonstrated a Tinel's sign and that he might need an EMG nerve conduction study. (RX1).

Dr. Schmidt testified that he felt that Petitioner did not sustain any type of injury to the peroneal nerve as a result of the work injury or any of the treatment administered to him for that work injury and that he did not feel that the surgery being proposed to decompress the peroneal nerve and to excise the sural nerve would be causally related to the work injury or any treatment that Petitioner had received for the work injury. He testified that it may well be reasonable to do the surgeries, certainly the decompression of the peroneal nerve given the compression of the injection. He testified that given the results of the injection, he did not believe that any further treatment to the sural nerve would be reasonable and necessary. (RX1).

On cross examination, Dr. Schmidt testified that he did not read the deposition of Dr. Hagan as it was not provided to him. When asked if he agreed with Dr. Hagan that Petitioner had a combination of peripheral nerve issues residual to his injury and a sural nerve neuroma as well as persistent chronic anterolateral ankle or sinus tarsi pain, Dr. Schmidt responded that Petitioner may have some entrapment of his peroneal nerve and that he would not be able to explain a sural nerve neuroma given the results of Petitioner's injection. He testified that chronic anterolateral ankle pain was a symptom, not a diagnosis. (RX1).

On cross examination, Dr. Schmidt testified that in the first exam he felt that Petitioner was magnifying his symptoms somewhat, but that he did not think he was a malingerer or faking his injuries. He testified that this was not a traction injury and that it would be more of a twisting injury, and that for one to tear the posterior tibial tendon with a twist they would have to evert or twist out. He testified that the peroneal nerve was on the outside part of the leg, so that would not place traction on the peroneal nerve. He testified that a twisting injury was not going to cause the peroneal nerve neuropathy. (RX1).

On cross examination, Dr. Schmidt testified that he had no medical records indicating that Petitioner had any right ankle problems before this injury. He agreed that it was his opinion that Petitioner's current symptoms had nothing whatsoever to do with the accident. When asked what was causing the symptoms, Dr. Schmidt responded that it was not uncommon for people to get entrapment of their nerve insidiously both in the anterior ankle and around the fibular head and that it happened just like carpal tunnel or tarsal tunnel. He testified that certainly someone could have another condition after the trauma and that not everything was related to the trauma. He testified that there were no indications in the early record of

Petitioner having any difficulty with his peroneal nerve whatsoever and that the nerve itself was not in the field of surgery, so therefore he thought Petitioner had developed entrapment of the nerve. He testified that he did not disagree that Petitioner needed to have his peroneal nerve decompressed at the fibular head and at the anterior ankle, but that he did not think it was related to the injury or the surgery. (RX1).

On cross examination, Dr. Schmidt testified that Petitioner's left ankle was giving him no complaints. He testified that he did not have any records indicating that Petitioner had any treatment to his left ankle before this incident. He testified that Petitioner did not report to him any intervening or other trauma at the time he last saw him nor did he see anything in the records. (RX1).

CONCLUSIONS OF LAW

With respect to disputed issue (F) pertaining to causal connection, the Arbitrator finds that Petitioner has met his burden of proving that his current condition of ill-being is causally related to the accident of August 9, 2014.

The Arbitrator notes that the causation dispute in this matter arises out of a difference in medical opinion between Dr. Hagan, Petitioner's current treating physician, and Dr. Schmidt, Respondent's Section 12 examiner. The testimony reflects that Dr. Schmidt does not believe that Petitioner sustained a peroneal nerve injury in addition to his sural nerve injury, while Dr. Hagan believes that Petitioner's history and clinical examination findings support that such an injury occurred. (PX13; PX14; RX1). Turning to the circumstantial evidence in this case, the Arbitrator notes that the evidence reflects that Petitioner was working full duty before his accident, and further notes that both physicians acknowledged that Petitioner had no history of right ankle pain or injury prior to the accident. Furthermore, the Arbitrator notes that the record is not only void of prior right ankle symptomatology, but is also void of any evidence of an intervening accident.

The Arbitrator notes that the medical evidence in this case reflects that Dr. Hagan has recommended a third surgical intervention which is to consist of a right lower extremity common peroneal nerve decompression, superficial peroneal nerve decompression, deep peroneal nerve resection and burial and medial and lateral sural nerve resection and burial. (PX13). Despite acknowledging that Petitioner continued to complain of the same sural nerve pain, and even acknowledging preference for the currently recommended resection surgery over the sural nerve decompression as performed in the second surgery, Dr. Schmidt opined that Petitioner was at maximum medical improvement and that Petitioner's need for a third surgery was not related to the work injury because the injection into the deep peroneal nerve relieved his symptoms. (RX1). Dr. Schmidt testified that he believed the sural nerve to be the source of Petitioner's pain, but stated that the two nerves were not connected. (*Id.*). Dr. Schmidt agreed that Petitioner likely suffers from injury or compression to the deep peroneal nerve, possibly at the tarsal tunnel just at the level of the ankle, but did not believe it to be related to the work accident. (*Id.*).

The Arbitrator finds to be highly persuasive, however, the testimony of Dr. Hagan as to how Petitioner's sural neuroma progressed and affected the peroneal nerve because of developing scar tissue. (PX14). The Arbitrator infers, then, that Dr. Hagan believed Petitioner's peroneal nerve injury is a natural consequence of the injury as a result of progression of scar tissue pathology, rather than an immediate traumatic consequence of the mechanism of injury.

In the case at hand, the Arbitrator gives significant weight to the fact that Petitioner's symptoms and complaints have largely been consistent since the date of his injury and finds that the evidence supports Dr. Hagan's position as Petitioner's injury progressed from a defect into the full-thickness tear which required his first two surgeries to fuse his injury, remove his hardware and decompress his nerves. (PX5;

PX7). The medical records reflect that Petitioner had a persistent problem with swelling, and the Arbitrator finds that it logically follows that Petitioner's multiple surgical procedures likely produced significant scar tissue. As the evidence reflects that Petitioner sustained no intervening accidents, the Arbitrator finds the opinions of Dr. Hagan to be more persuasive than those proffered by Dr. Schmidt. As a result thereof, the Arbitrator finds that Petitioner has met his burden of proving that his current condition of ill-being is casually connected to his accidental injury of August 9, 2014.

With respect to disputed issue (K) pertaining to prospective medical treatment, in light of the Arbitrator's finding as to the issue of causation, the Arbitrator finds that Respondent shall authorize the treatment recommended by Dr. Hagan, including, but not limited to, the recommended surgery.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jodie Dawe,

Petitioner,

vs. NO: 15WC 33668

Christopher Elementary School,

18IWCC0267

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue(s) of accident, medical expenses, causal connection, prospective medical care, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 13, 2017 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

18IWCC0267

No bond is required for the removal of this cause to the Circuit Court. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 27 2018
SJM/sj
o-4/5/2018
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

DAWE, JODIE
Employee/Petitioner

Case# **15WC033668**

CHRISTOPHER ELEMENTARY SCHOOL
Employer/Respondent

18IWCC0267

On 9/13/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.14% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0299 KEEFE & DePAULI PC
JAMES K KEEFE JR
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

2795 HENNESSY & ROACH PC
YATES WELLER
415 N 10TH ST SUITE 200
ST LOUIS, MO 63101

18IWCC0267

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

- ☐ Injured Workers' Benefit Fund (§4(d))
- ☐ Rate Adjustment Fund (§8(g))
- ☐ Second Injury Fund (§8(e)18)
- ☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

JODIE DAWE
Employee/Petitioner

v.

CHRISTOPHER ELEMENTARY SCHOOL
Employer/Respondent

Case # **15** WC **33668**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Herrin**, on **April 13, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. ☐ Was there an employee-employer relationship?

C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

D. ☐ What was the date of the accident?

E. ☐ Was timely notice of the accident given to Respondent?

F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?

G. ☐ What were Petitioner's earnings?

H. ☐ What was Petitioner's age at the time of the accident?

I. ☐ What was Petitioner's marital status at the time of the accident?

J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

K. ☒ Is Petitioner entitled to any prospective medical care?

L. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD

M. ☐ Should penalties or fees be imposed upon Respondent?

N. ☐ Is Respondent due any credit?

O. ☐ Other _____

FINDINGS

On the date of accident, **August 25, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did not* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is not* causally related to the accident.

In the year preceding the injury, Petitioner earned $**41,600.00**; the average weekly wage was $**800.00**.

On the date of accident, Petitioner was **38** years of age, *married* with **2** dependent children.

Respondent *has not* paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0**.

Respondent is entitled to a credit of $**0** under Section 8(j) of the Act.

ORDER

As explained in the Arbitration Decision, Petitioner failed to prove by a preponderance of the evidence that she sustained an accident that arose out of and in the course of her employment on August 25, 2015, and that her current condition of ill-being is causally related thereto. All benefits are hereby denied. All other issues are moot and the Arbitrator makes no conclusions as to those issues.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

September 5, 2017
Date

ICArbDec19(b)

SEP 13 2017

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

18IWCC0267

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

JODIE DAWE
Employee/Petitioner

v.

Case #: 15 WC 33668

CHRISTOPHER ELEMENTARY SCHOOL
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The Arbitrator notes at the outset that at the time of hearing Petitioner moved to amend the Application for Adjustment, to change the date of accident from August 24, 2015, to August 25, 2015. Respondent had no objection and the Application was so amended instanter. Petitioner alleged bilateral repetitive carpal tunnel syndrome as a result of working as an elementary school teacher for Respondent. In dispute was accident, causation, medical bills, and proposed bilateral surgeries.

On August 25, 2015, Petitioner was 38 years old, married, and had two dependent children. She was employed by Respondent as a teacher and had been so employed for 17 years. She had been teaching third grade for 12 years and before that had taught fourth grade. She works nine months out of the year and has the summer off. She receives a two week vacation at Christmas, one week in the Fall and one week in the Spring. She does not perform work activities during vacations. She testified she starts setting up her classroom in July, which consists of moving desks and shelves, and preparing lesson plans and quizzes. She denied suffering from diabetes, hypertension, or hypothyroidism and is not a smoker. She had her gall bladder removed in 2013 and fractured her right wrist 20 years ago, which was casted. She currently takes birth control. She denied any other injuries to her right or left wrist prior to being diagnosed with carpal tunnel syndrome. She is right-hand dominant.

Petitioner saw Dr. Mirly in May 2016, who diagnosed bilateral carpal tunnel syndrome. He initially recommended conservative treatment with night braces, which did not provide relief. He ultimately recommended surgery, which Petitioner would like to have. Her current complaints are numbness in the fingertips and fingers and tightness in her hands and wrists bilaterally.

Petitioner testified that she developed numbness, tingling, and tightness in her hands in early 2014. She saw her primary care physician, Dr. Ralph Latta, on February 14, 2014, primarily for a urinary tract infection. At that time she also mentioned that she experienced intermittent numbness and tingling in the right hand when her right arm was extended above her head while fixing her hair. She explained that this was the example she gave to the doctor as to when she experienced the hand symptoms. Dr. Latta did not recommend testing or treatment for the right hand at that time.

Petitioner returned to Dr. Latta on August 17, 2015, primarily for a headache but also discussed her hand complaints. At that time she had been back to school for about a week, but had also been setting up her classroom during the previous month. Dr. Latta referred her for a right nerve conduction study, which was completed on August 25, 2015. Petitioner followed up with Dr. Latta in October 2015, who then ordered a left nerve conduction study. At that point, Dr. Latta referred Petitioner to a surgeon, Dr. Ahn. However, she did not see Dr. Ahn as she was unable to obtain approval. It was Petitioner's understanding from her physician at that time that her complaints were work related.

Petitioner testified that she notified Respondent via email to the secretary that she had a work related injury. Respondent sent a denial letter dated September 23, 2015. PX8.

Petitioner previously prepared a description of her daily duties, which was admitted as Petitioner's Exhibit 3. She described her work day as being about seven hours long.

1. 8:10-8:30. While the children are doing daily language, Petitioner performs attendance, lunch count, sort through homework, and responds to notes in their planners. She then checks the daily language sentence and it is changed on the board.
2. 8:30-9:00. Petitioner does Language Arts which involve skills sheets that are projected on the whiteboard. She writes on the whiteboard using a stylus. Her hands are above head level.
3. 9:00-10:00. During math she spends approximately 45 minutes at the whiteboard. Petitioner described math as being spent mostly at the board writing with either the digital stylus or the dry erase marker modeling math problems. She writes problems on the board and the students come up and solve them. She uses the computer by clicking through PowerPoint presentations. She also grades papers and corrects students' work by written hand.
4. 10:45-11:00. Spelling is spent at the whiteboard writing and modeling for students. The students complete skill sheets throughout the week. She checks the students' work and makes corrections by handwriting.
5. 11:45-12:20. During Science and Social Studies, a lot of the time is spent reading. They do perform some skill sheets that are also projected on the board and Petitioner writes on the whiteboard. She creates study guides for them that might also be put on the board and the children copy it on to their study guide to take home. She has also created various games on the computer that she uses a mouse to navigate through.
6. 12:25-1:10. Prep time requires sorting papers, grading papers, creating and typing lesson plans and test worksheets, recording behaviors in student planners, writing notes to parents, and recording grades into the computer.

7. 1:15-1-30. During Reading, Petitioner reads a story to the students and they complete skills sheets throughout the week. She compares and contrasts parts of the story with diagrams and draws them on the board.
8. 1:30-1:45. Petitioner checks students' planners, which requires marking each one by hand to show that they have written the assignments correctly.
9. 1:45-2:10. Petitioner teaches Writing, which requires modeling on the whiteboard. She checks and edits cursive handwriting by hand.
10. 2:10-2:40. She reads with students and monitors group centers.
11. 2:40-2:50. Prepares for dismissal.
12. 2:50. Student dismissal.
13. 3:00-3:15. Prepares papers and plans for the following day.
14. Petitioner occasionally grades papers at home.

Petitioner described the whiteboard as a digital board that is connected to a computer that can be written on with a digital stylus or a whiteboard marker, a dry erase marker. Christopher Elementary has had whiteboards in the classrooms for 8-10 years. Prior to using a whiteboard, she would write on a chalkboard.

Petitioner described that her hands become numb performing the work activities and more quickly when she is working on the whiteboard and her hands are raised. She tries to rest her hands by having them fall to her sides and wiggling her fingers. She testified that the symptoms have gradually worsened. Her routine rarely changes, other when she spends more time grading papers. Recently she has used her hands more frequently to assist a student who has two broken wrists. Petitioner testified that she averages 200 minutes per day writing, although some days are less and some are more. She indicated she spends approximately 85 to 90 minutes on the computer typing, which includes her time using the mouse. She testified that she uses the mouse with her right hand but will switch to her left hand if her fingers go numb. When she is not doing certain activities as often, her complaints resolve.

Petitioner testified that she does have symptoms in both of her hands outside of work. In the summer she does not write as much and thus it is much more relaxed. She does sometimes wake at night with a numb hand. She also notices symptoms while driving. Her hobbies include planting flowers in the summer and swimming.

On cross-examination, Petitioner testified that in 2014 or 2015 her class size went from 19 to 26 students. Prior to that she had 22 students, and the range is 20 to 26. She testified that when she writes on the whiteboard her hand is raised maybe four to six inches above her head. She mostly writes a series of a few words on the board, but once a day is paragraph writing. During the time she spends at the whiteboard she is also interacting with students, so she may write a few words or sentences or a math equation, and then will interact with the students.

Petitioner testified that some of the skill sheets she referenced, which are projected onto the whiteboard, are pre-prepared. While she is grading papers, most of the corrections involve checkmarks or x's or crossing out an incorrect answer, though some tests do have short answer questions also. Petitioner indicated that while taking attendance and doing the lunch counts, she is simply clicking a computer mouse. She also testified that from 2:10 p.m. until the students are

dismissed, she is reading with the students or monitoring their individual group centers and getting prepared for dismissal. She also has a lunch break every day.

Continuing on cross-examination, Petitioner testified she has symptoms in both her right and left hand. Before her symptoms began she predominantly used her right hand to perform the described activities. She started using her left hand as a "helper" after the symptoms began. She testified she never went to the doctor specifically because she was having complaints in her upper extremities.

With regard to her summer break, Petitioner confirmed that she has two and a half to three months off during the summer. The time she spends in the classroom to set up her room is voluntary and she does not have a specific number of hours to work each day. She also acknowledged that she does not perform any work on the whiteboard or grade papers during the summer months.

Petitioner acknowledged that she has a computer at home but denied using it very often. She admitted that she does have a Facebook account. She agreed that in February 2014 she first provided a history of numbness and tingling in her right hand while fixing her hair. She noticed the complaints when her hand was above her head and she still notices these symptoms while fixing her hair. She confirmed that in May 2016 she told Dr. Mirly that she had symptoms not only while typing but also while driving. She acknowledged that driving was not part of her job description. She confirmed that she has not missed any time from work since August 2015 as a result of her complaints to her right or left hand.

Respondent called Roy Kirkpatrick as a witness. He has been the principal at Christopher Elementary School for six years. Petitioner is under his supervision and believes she was hired in August 2000. He testified that he performed formal observation of Petitioner every two years, with the most recent being in November 2016, and also had informal visits to her classroom. He did not recall any specific observation of her having difficulty performing any of her job duties. Mr. Kirkpatrick only recently became aware of Petitioner's claim, and testified that she never reported complaints in her upper extremities to him, nor did she make any formal report of a work injury to him. She never made him aware of any difficulties she had in performing her job duties.

Mr. Kirkpatrick testified regarding Respondent's Exhibit 4, which he prepared as a response to the daily duties as written by Petitioner (Petitioner's Exhibit 3). He believed that his responses and descriptions more accurately represent Petitioner's work activities. He also took a photograph of the whiteboard in Petitioner's classroom and described her writing sentences or word problems or math problems on the whiteboard for students to see. He described this as an interactive process between Petitioner and the students during her time at the whiteboard. During reading time, less time would be spent at the whiteboard. He testified that his understanding of her grading papers included collecting papers, checking for correct answers, and making notations of incorrect answers or clarifications. He testified that percentage grades are input into the computer. Mr. Kirkpatrick's responses to Petitoner's self-prepared job duties are based on his years of experience as a teacher, supervising other elementary teachers, and his direct observation of Petitioner.

Mr. Kirkpatrick testified that Petitioner works 180 days per year, including four institute days where there is no student contact. There are approximately four weeks off for breaks during the school year and two and a half months off during the summer. He was not aware of any missed time by Petitioner for complaints to her upper extremities.

On cross-examination, Mr. Kirkpatrick acknowledged that he had never taught third or fourth grade and that he last taught 14 years ago as an art teacher. He testified that he formally observed Petitioner for approximately 45 minutes, and did not spend a full day of observation in her classroom. He acknowledged that he did not speak with any other grade school teachers at Christopher Elementary before he completed his responses on Respondent's Exhibit 4.

Mr. Kirkpatrick described the stylus used to write on the whiteboard as comparable to a large Expo marker. He testified that it does not require a lot of pressure or force, but simply requires contact with the board.

Medical records from Dr. Ralph Latta show that Petitioner was seen on February 14, 2014, with the primary complaint of a urinary tract infection. The record also states, "...she has intermittent numbness and tingling sensation in the fingers of her right hand when she has her right arm extended above her head while fixing her hair. She states the symptoms resolve when she lowers her arm. She states she does have history of intermittent neck pain/discomfort over the years." Dr. Latta's assessment was that the numbness and tingling were likely positional and that further workup was not warranted. He noted if the symptoms worsened Petitioner should return for further evaluation and that it may be related to neck problems or shoulder impingement. PX5.

The next record from Dr. Latta is August 17, 2015, with two complaints. The first was right hand numbness and tingling on and off for at least a year, which frequently woke her. It was noted there was no trauma and that it happened during the day with repetitive use of the hand. There was no elbow or shoulder pain. She also complained of persistent daily headaches at that time, with no neck injuries or neck pain. Dr. Latta's assessment was progressive carpal tunnel syndrome and he ordered a nerve conduction study at that time. PX5.

On August 25, 2015, Petitioner underwent a right EMG/NCS by Dr. Nemani, upon referral by Dr. Latta. The study revealed mild right carpal tunnel syndrome, with no evidence of ulnar neuropathy or cervical radiculopathy. PX4.

On October 5, 2015, Petitioner returned to Dr. Latta with complaints of left hand and wrist numbness and tingling, present off and on for at least a year. She reported the left was not quite as severe as the right, but similar symptoms. It was noted, "States that 75% of the day involves grading, computer work, writing in the planners, writing at the whiteboard which is repetitious. When her hands are overhead it seems to aggravate it more like when she writes on the board at work. She wakes at night with it asleep. It happens during the day with repetitive use of the hand." On examination, Tinel's and Phalen's tests were negative and she had full range of motion of the left wrist. Dr. Latta's assessment was progressive carpal tunnel syndrome

and he ordered a left nerve conduction study. PX5. The Arbitrator notes this is the final record submitted from Dr. Latta.

On October 20, 2015, Petitioner underwent a left EMG/NCS by Dr. Nemani, upon referral by Dr. Latta. The study revealed mild left carpal tunnel syndrome. There was a handwritten notation on the reported that Petitioner "needs to see Dr. Ahn". PX4.

Petitioner submitted three letters from her attorney to Respondent's insurance carrier requesting approval for Petitioner to be examined by Dr. Ahn, as requested by Dr. Nemani. The letters are dated December 4, 2015, December 31, 2015, and January 26, 2016. PX6.

The next medical record is May 6, 2016, when Petitioner presented to Dr. Harvey Mirly at Memorial Medical Group, upon referral by Dr. Latta. She reported having bilateral carpal tunnel syndrome for a couple of years, with a "significant increase in the severity of her symptoms over the past year". It was noted she had been employed as a teacher for 16 years. Dr. Mirly reviewed the EMG/NCS for the left hand but not the right hand. He noted Petitioner had symptoms consistent with carpal tunnel syndrome. Petitioner reported nocturnal numbness, shaking her hands when they were numb, and symptoms with activities such as typing and driving. On examination, there was no thenar atrophy or weakness, full range of motion, mild numbness with Phalen's test, and positive Tinel's. His assessment was bilateral carpal tunnel syndrome, right greater than left. He gave no causation opinion at that time. He prescribed night splints with possible injections or surgeries. She was instructed to report her response to the splints by a postcard follow up. On May 6, 2015, Dr. Mirly's record shows that Petitioner advised had a little improvement with the braces at night, but continued with numbness throughout the day. She also reported slight pain in the right wrist throughout the day. PX1.

On October 4, 2016, Petitioner was evaluated by Dr. David Brown of The Orthopedic Center of St. Louis, Respondent's Section 12 examiner. Dr. Brown reviewed records from Benton Family Center (Dr. Latta) and Dr. Mirly, as well as the EMG/NCS studies. Petitioner reported she had been a teacher for 17 years and was currently a third grade teacher. She described her job duties as working on a computer, using a mouse, typing, using a smartboard which involved using a mouse, writing on a board, and grading papers. Petitioner provided a detailed, typewritten summary of her duties (Petitioner's Exhibit 3) and reported that about 70% of her work day involved some type of working using a mouse, working on a computer, or using a smartboard where she used a mouse. Petitioner reported that two years prior she developed a gradual onset of numbness and tingling in both hands, right greater than left, and had nocturnal paresthesias. She had recently worn wrist splints at night for a couple of months, with minimal improvement in her symptoms. Petitioner denied being involved in any hobbies or sports activities outside of work. RX1.

On examination, Petitioner had good range of motion of both elbows, wrists, and digits. She had positive Tinel's sign and Phalen's sign bilaterally. Dr. Brown opined that Petitioner had symptoms and findings consistent with bilateral carpal tunnel syndrome, which had been confirmed electrodiagnostically. He noted she had failed to improve with conservative care and believed it was reasonable to proceed with staged bilateral carpal tunnel releases. He believed Petitioner could continue to work without restrictions. RX1.

With regard to causation, Dr. Brown noted that Petitioner had no medical problems such as diabetes, hypothyroidism, arthritis, or obesity that would put her at an increased risk for carpal tunnel syndrome. He noted Petitioner had two non-occupational factors that put her at increased risk for carpal tunnel syndrome, which were her age of forty years old and her gender as a female. He noted that the only job description he had was the one provided by Petitioner, and further noted that she had indicated that 70% of her job involved some type of work on a computer or using a mouse. Based on that, combined with the duration of her 17 years as a teacher, Dr. Brown opined that Petitoner's work activities "as she described them" may have possibly aggravated her bilateral carpal tunnel syndrome. He noted that if additional information regarding her job duties was provided, he would review same and provide an addendum. RX1.

On February 6, 2017, Dr. Brown authored an Addendum report after reviewing Respondent's responses to Petitoner's description of her job activities (Respondent's Exhibit 4). Based upon this additional information, Dr. Brown opined, "If I'm to rely on that information solely to base my medical causation opinion regarding the diagnosis of carpal tunnel syndrome, I would not consider the job duties as described by the employer as being a factor in the need for further evaluation and treatment for a diagnosis of carpal tunnel syndrome." RX2.

On March 22, 2017, Dr. Mirly authored a reported at Petitioner's request, after reviewing the daily job activities provided (Petitioner's Exhibit 3). Dr. Mirly opined that based upon the job description provided and a lack of non-occupational risk factors, the cumulative effect of her work duties over 16 years would be a contributory factor to the development of symptomatic carpal tunnel syndrome.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the above Findings of Fact, and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After review of the evidence and due deliberations, the Arbitrator finds on the issues presented at trial as follows.

In support of the Arbitrator's decision relating to issue (C), whether an accident occurred which arose out of and in the course of Petitioner's employment by Respondent, and issue (F), whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

To obtain compensation under the Illinois Worker's Compensation Act, a claimant must show by a preponderance of the evidence that he suffered a disabling injury arising out of and in the course of his employment. 805 ILCS 305/2; *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill.App.3d 1010, 1013 (1st Dist. 2011) The Arbitrator notes that Petitioner put forth a theory of repetitive trauma in support of her claim that she sustained an accident that arose out of and in the course of employment. Illinois recognizes that a claimant's condition may not always arise out of a single incident of trauma and thus benefits may be awarded for repetitive trauma. However, even when repetitive trauma is asserted as a theory of accident, the employee must still show that the job duties were, in fact, repetitive. *Williams v. Industrial Commission*, 244 Ill.App.3d 204 (1st Dist. 1993).

Based upon the evidence as a whole, the Arbitrator finds that Petitioner did not prove that she had repetitive job duties that caused, aggravated, or accelerated her bilateral carpal tunnel syndrome. As such, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that she sustained an accident which arose out of and in the course of her employment.

Petitioner testified as to her job duties, as detailed above in the Findings of Fact. She testified that her work on the whiteboard, on the computer, and in grading papers caused her complaints. Specifically, she testified that she spends approximately 200 minutes per day writing and 85 to 90 minutes on the computer with typing and using the mouse.

Petitioner's day begins at 8:10 a.m. and ends at 3:15 p.m. However, Petitioner testified that at 2:10 p.m. she spends her time reading to the students, monitoring their individual or group centers and getting prepared for dismissal. During the day, Petitioner testified that from 8:10 to 8:30 a.m. (20 minutes) she does lunch count and takes attendance. She may also respond to notes in the student's planners, and record homework in the grade book. According the testimony of Roy Kirkpatrick, these activities involve the clicking of the mouse and some minimal written notations. Per Petitioner's testimony, these activities were performed with her right hand only prior to when her complaints began.

Between 8:30 and 9:00 a.m. (30 minutes) Petitioner testified she teaches Language which involves time spent at the whiteboard using a stylus with hands above head level. She uses skill sheets that are pre-prepared. According to Mr. Kirkpatrick while some writing can occur above head level, it can also be performed at eye or chest level. He also testified that the stylus does not require firm pressure to use, only contact with the board.

From 10:00 to 10:45 a.m. (45 minutes) Petitioner teaches Reading. During this time, she reads to the students but may also use the whiteboard (writing or modeling for the students), use the computer clicking through a power point presentation, and/or grading papers, checking and correcting students' work.

From 10:45 to 11:10 a.m. (25 minutes), Petitioner teaches Spelling. She does use the whiteboard and pre-prepared skill sheets, writing and modeling for students. She will also spend this time checking students' work and correctly writing words.

From 11:45 a.m. to 12:20 p.m. (35 minutes) Petitioner testified she is teaching Science and Social Studies. During this time, she reads to the students but also will spend some time at the white board. She will write things on the board for the students to copy. She also spends this time grading papers, checking and correcting students' work. According to Mr. Kirkpatrick, any writing associated with checking the students' work would be check marks and short phrases/sentences.

From 12:25 to 1:10 p.m. (45 minutes) is Petitioner's personal prep time which she testified she spends sorting papers, grading papers, creating and typing lesson plans, creating and typing tests and worksheets, records behaviors in students planners, writing notes to parents, and

recording grades into the computer. Petitioner also testified she does take a lunch but did not specifically indicate during what time she takes lunch.

From 1:15 to 1:30 p.m. (15 minutes) Petitioner reads aloud to the students. For another 15 minutes from 1:30 to 1:45 p.m. Petitioner checks students' individual planners, marking each one to show they have completed their assignments. From 1:45 to 2:10 (25 minutes) Petitioner teaches Writing which involves time at the whiteboard modeling for students. She also checks and edits the students' writing.

From 2:10 until the end of the day at 3:15 p.m. Petitioner reads to the students, monitors individual/group centers, prepares for dismissal, dismisses students, and prepares and plans for the following day.

Even if we were to assume Petitioner spent every minute of the noted time above writing on the whiteboard, using the computer and mouse and writing by hand, the total time maximum time allotted for these activities is 220 minutes—again this does not account for Petitioner's lunch time and by her own admission the fact that not every minute is spent on these activities, as there is constant interaction with the students during this time. Petitioner testified that she spends a total of approximately 285 to 290 minute a day performing activities with her hands which is inconsistent with the breakdown of her activities. When the evidence is considered as a whole, Petitioner's testimony regarding the extent of the activities involving her upper extremities is not credible and she has not met her burden of proof that her job activities put her at an increased risk for development of bilateral carpal tunnel syndrome.

On the issue of medical causation, Petitioner offered treatment records from Dr. Ralph Latta and Dr. Harvey Mirly. Petitioner testified that she never sought out evaluation or treatment solely for her upper extremity complaints. She first made mention of her complaints to Dr. Latta on February 14, 2014, when she complained of intermittent numbness and tingling in the fingers of her right hand when she has her right arm extended above her head while fixing her hair. She stated the symptoms resolved when she lowered her arm. She also noted a history of intermittent neck pain/discomfort over the years. During this visit, Petitioner also had complaints of intermittent "tickling" sensation in her right foot. At no time during this visit did she mention her job duties or any other activities as causing her complaints. Dr. Latta felt her right hand complaints were positional in nature and noted if her symptoms worsened, he recommended further evaluation for possible relation to neck problems or shoulder impingement.

Petitioner was not seen again until August 17, 2015, when she was diagnosed with right carpal tunnel syndrome and referred for an EMG/NCV. During this visit she mentioned increased symptoms with activities but did not identify those activities as work-related. Petitioner had an EMG/NCV of her right arm on August 25, 2015, and of her left arm on October 20, 2015, both confirming mild carpal tunnel syndrome.

Petitioner was referred to Dr. Harvey Mirly and seen on May 6, 2015. Dr. Mirly diagnosed bilateral CTS with initial recommendation for splinting with possible injection or surgery. He noted she had symptoms with activities such as typing and driving. Dr. Mirly did not give an opinion with regard to causation at that time. The records reflect that Petitioner was

seen on only this one occasion by Dr. Mirly. On March 22, 2017, however, Dr. Mirly issued a report in response to a request by Petitioner's counsel. At that time, he reviewed only the job description provided by Petitioner, and not the information provided by Respondent. He opined that Petitioner's work activities would be a contributing factor to the development of carpal tunnel syndrome but not solely causative. He also opined that outside activities would also be contributory to the condition. Despite the lack of further follow up, he recommended surgery.

Petitioner was seen at the request of Respondent by Dr. David Brown on October 4, 2016. At the time of this evaluation, Dr. Brown only had the benefit of the job description provided by Petitioner. Petitioner reported to Dr. Brown that 70% of her work involved some type of work on the computer or using a mouse. He diagnosed bilateral carpal tunnel syndrome and recommended surgery. On the issue of causation, based on the information provided by Petitioner at that time, Dr. Brown opined that her work activities may have possibly aggravated her bilateral carpal tunnel syndrome.

Subsequent to that examination, however, Dr. Brown was provided Respondent's detailed responses to the job description provided by Petitioner. Dr. Brown reviewed same and issued a supplemental report on February 6, 2017. He opined that if he relied solely on the information provided by Respondent about Petitioner's job duties, he would ***not*** consider those duties to be a factor in the need for further evaluation and treatment for a diagnosis of bilateral carpal tunnel syndrome.

The evidence presented at trial, and specifically Petitioner's own testimony about her job duties, is not consistent with her representation to Dr. Brown that 70% of her job duties involved work on a computer or using a mouse. As such, Dr. Brown's initial opinion that Petitioner's job duties may have aggravated her condition was based on her representations to him as to what those job duties entailed. When he was provided additional detailed information from Respondent, his opinion on medical causation changed. The Arbitrator finds this to be significant and persuasive. The Arbitrator further finds it significant that Dr. Mirly examined Petitioner on only one occasion and did not provide a medical causation opinion at that time. Rather, he provided an opinion nearly a year later at the request of Petitioner's attorney, who provided the job description written by Petitioner. Dr. Mirly was not provided with Respondent's detailed response to that job description. As such, the Arbitrator finds his opinion to be based on incomplete information and thus lacking in credibility.

Based upon the foregoing and the record in its entirety, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that she sustained an accident on August 25, 2015, that arose out of and in the course of her employment. All other issues are rendered moot and the Arbitrator makes no findings regarding same.

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

David E. Horwath, Jr.,

Petitioner,

vs. NO: 15WC 15443

F H Paschen Construction,

18IWCC0268

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, causal connection, prospective medical care, notice, temporary total disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 9, 2017 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

18IWCC0268

No bond is required for the removal of this cause to the Circuit Court. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 27 2018
SJM/sj
o-4/5/2018
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

HORWATH, DAVID
Employee/Petitioner

Case# 15WC015443

F H PASCHEN
Employer/Respondent

18IWCC0268

On 8/9/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.14% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1167 WOMICK LAW FIRM CHTD
CASEY VANWINKLE
501 RUSHING DR
HERRIN, IL 62959

2674 BRADY CONNOLLY & MASUDA PC
JULIA B McCARTHY
211 LANDMARK DR SUITE 2
NORMAL, IL 61761

18IWCC0268

STATE OF ILLINOIS)
)SS.
COUNTY OF JEFFERSON)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)/8(a)

DAVID HORWATH
Employee/Petitioner

v.

F.H. PASCHEN
Employer/Respondent

Case # **15** WC **15443**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **November 2, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **September 8, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did not* sustain an accident that arose out of and in the course of employment.

Petitioner's current condition of ill-being *is not* causally related to the alleged accident.

In the year preceding the injury, Petitioner earned **$99,317.00**; the average weekly wage was **$1,910.00**.

On the date of accident, Petitioner was **33** years of age, ***single*** with **1** dependent child.

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$0** for TTD, **$N/A** for TPD, **$N/A** for maintenance, and **$N/A** for other benefits, for a total credit of **$0**.

ORDER

The Arbitrator finds that the Petitioner failed to prove that he sustained accidental injuries arising out of and in the course of his employment on September 8, 2014. No benefits are awarded.

RULES REGARDING APPEALS: Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE: If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

August 3, 2017
Date

AUG 9 – 2017

STATEMENT OF FACTS

The Petitioner testified that on 9/8/14, while working at a bridge site assembling a pile driver, he was using a pry bar and felt a pop in his low back. He had immediate problems but continued to work and didn't seek treatment, though he testified he notified his foreman, Richard Patrick, and the superintendent, Dustin Vibbert of the incident that same day. He testified he continued to work full duty until being terminated in November 2014. Petitioner testified he had a conversation with the employer, without specifying whom, that: "He told me that he was going to put me on light duty, and it was never really light duty." As to whether Petitioner was able to work full duty at the time of his termination, he testified: "Not completely, no." Petitioner testified that he

was not asked by either Mr. Patrick or Mr. Vibbert to complete injury paperwork until a couple of months after the accident.

Petitioner testified his symptoms were across the "back part of my back" with a continuous burn, as well as symptoms in his legs. He initially sought treatment at the company facility, WorkCare, and testified he was put into physical therapy, which only provided temporary relief.

The initial 10/10/14 report from WorkCare notes Petitioner reported he was assembling equipment on 9/8/14 and pulling a pry bar when he felt sharp low back pain with progressive worsening since. He also complained of coccyx area pain. The pain was worse with bending, sneezing and sitting up. Examination was normal. The diagnosis was coccygodynia, lumbar spine, and Petitioner was allowed to continue working regular duty with over-the-counter medication. On 10/17/14, WorkCare noted primarily coccyx/sacral pain, and Petitioner was prescribed physical therapy, Medrol dosepak and continued regular duty, and he was to follow up in 3 weeks. The record reflects the Petitioner did undergo therapy. (Px3).

On 1/27/15, WorkCare noted Petitioner's pain remained the same, slightly improved with therapy. Continued therapy was prescribed, as well as continued light duty. The Arbitrator located no evidence of light duty restrictions prior to this date in the record, so it is unclear what was "continued". On 2/19/15, Petitioner reported he had the same pain, which he indicated was at a 7 out of 10 level. He was referred to Dr. Newell for pain management, and he was to continue working with restrictions "per employer's discretion". (Px3).

Petitioner visited physiatrist Dr. Newell on 2/25/15. Petitioner reported persistent but fluctuating low back pain without radiation. It was burning, stabbing and pulling in nature. Dr. Newell indicated Petitioner did not recall a specific injury, but indicated he was putting together a pile driver and "using a lot of to work ranges (sic)" and began to have pain in the low back and tail bone area. X-ray was essentially normal, and Petitioner denied any prior back injuries. Examination reflected some pain with forward flexion. Dr. Newell noted: "He is very difficult to activate his pain", as most provocative maneuvers were negative. He performed bilateral trigger point injections at the coccyx/sacral region, and indicated if they didn't help he likely would not have anything else to offer Petitioner as far as treatment. Dr. Newell saw no reason to continue to restrict Petitioner's work duties, as he believed the problem was mainly a pain issue. As to symptom onset, Dr. Newell stated Petitioner "is not the best historian" and that he did not have any focal injury, "but given the type of work he does, it is more likely than not related to his work." (Px5).

At a 3/11/15 follow up, Dr. Newell noted Petitioner was improving, but his symptoms were aggravated by daily activities. Petitioner was frustrated with a lack of improvement, but was continuing to perform his regular work duties. He had relief with the injections, "but not enough". A pelvic MRI was prescribed to evaluate or exclude possible bony causes such as a stress reaction. (Px5).

The last visit with WorkCare was on 3/13/15, and Petitioner reported only temporary relief with the injections performed by Dr. Newell. He testified the improvement lasted for a couple of weeks. Examination remained normal except for coccyx pain with range of motion. He was discharged, it appears to Dr. Newell's care, and advised to return to regular duty work. (Px3).

The 4/12/15 pelvic MRI report (Px2) notes an impression of no acute osseous injury involving the sacrum/coccyx, mild degenerative lower lumbar and SI joint changes with no evidence of active sacroiliitis or ankyloses. On 4/15/15, Dr. Newell indicated Petitioner had been resting for the past month without much change in his condition, noting injections only helped for a couple of weeks. The MRI showed no coccyx abnormalities, and only mild degenerative low back changes. Etiology of the symptoms was unclear – Dr.

Newell noted a possible ligamentous instability, "but I don't know how to improve that." He opined the problem was likely going to be chronic and Petitioner would have to learn to deal with it. He was discharged from Dr. Newell's care and advised to follow up with his primary care provider, Dr. Watters, to verify there were no internal problems. Dr. Newell also opined Petitioner could perform regular duty. (Px5).

Petitioner then testified he was continuing to work during this time and while he was doing his job, he was at a slower pace and wasn't doing it "the way I was supposed to" due to pain. He stopped working on 4/23/15, after which he filed for and drew unemployment, which required him to indicate he was able to work. He testified he was able to work, but not doing heavy road construction. He has not received any TTD since leaving Respondent's employ as of 4/23/15.

On 4/29/15, Petitioner saw Dr. Watters, reporting he hurt his back pulling on a pry bar 6 months ago, and felt a pop in the low back with immediate pain that was ongoing. Symptoms included back pain and stiffness, left greater than right, with no radiation. Dr. Watters prescribed cyclobenzaprine and advised Petitioner to follow up as needed. Petitioner returned on 5/13/15, noting he had been to therapy and a chiropractor "and is not interested in pursuing either any more." Dr. Watters prescribed Diclofenac. (Px1).

Petitioner was ultimately referred by his attorney for an examination with Dr. Gornet on 10/22/15. His report stated "Independent Medical Examination." Petitioner reported central and left low back pain which began on or about 10/10/14 "approximately a year ago", while pulling a pry bar while assembling a pile driver. He reported a pop in the back and increasing pain, along with an inability to get back to work full duty since that time. Petitioner denied any significant radicular pain, numbness or weakness. X-rays reflected no abnormalities or instability. Lumbar MRI was for the most part normal at all levels, with a "suggestion of maybe a left-sided disc protrusion out in the foramen at L4/5 as well as an annular tear at L5/S1 left." The Arbitrator notes the MRI radiology report was not submitted into evidence. Dr. Gornet's working diagnosis was an L5/S1 disc injury with annular tear, stating "this injury is subtle, but can produce symptoms consistent with (Petitioner's) current complaints, essentially a normal neurologic exam, but refractory low back pain to most conservative care." He indicated that Petitioner's options were permanent restrictions and vocational rehabilitation, or discogram/CT and MRI spectroscopy, noting if he has a simple symptomatic L5/S1 annular tear, L5/S1 fusion could be considered on an elective basis: "Obviously, this is a quality of life issue. There is no impending neurologic issue or deficit that plays an overwhelming role here." Based on history he opined that Petitioner's condition is causally related to the work injury, and he restricted Petitioner to 25 pound lifting with no repetitive bending or lifting, and alternating sit/stand as needed. Petitioner testified that he wants to undergo the surgery so he can return to his regular work duties.

On cross examination, Petitioner could not pinpoint his date of accident other than that it occurred sometime in September 2014. He agreed he continued to perform heavy work from that point until 4/23/15, sometimes working 10 hour days.

Petitioner agreed Respondent had daily Job hazard analysis forms, which employees are supposed to sign off on if they sustain an injury, including a description of what happened and how they were injured. He was shown the Respondent's Job Hazard Analysis forms for September and October 2014 (Rx6), and agreed on 9/9/14 he indicated he was injured getting rust in his eye and signed the document, and that on 9/19/14 he also signed and indicated that he hurt his wrist, and this was signed off on by Mr. Patrick as well. He was asked to review the forms from 9/8 to 10/7/14 and declined to do so, but agreed none of them indicated his reporting of a low back injury. The Petitioner's testimony was not tremendously clear, but it appeared to the Arbitrator that he testified that a number of these job hazard sheets are held by different people, so "that don't mean anything." (Rx6, 7 & 8).

Petitioner again agreed on cross exam that he continued to work full duty through 4/23/15, and then sought an attorney and signed an Application for Adjustment (Arbx2) for the claimed injury on 5/1/15, shortly after he was terminated. Petitioner denied that he was laid off at that time due to his industry's portion of the job being completed, and testified he was fired at that time.

Petitioner agreed that after seeing his own doctor a few times in May 2015, he sought no medical attention other than one visit with Dr. Gornet on 10/22/15 at his attorney's request. He did then have a Section 12 examination at Respondent's request with Dr. Mirkin in February 2016. He hasn't seen any other physicians since that time. He hasn't had any actual treatment since May 2015.

Petitioner agreed he received unemployment benefits after his termination, and agreed he has had prior workers' compensation settlements, including one in February 2016. Records submitted by Respondent (Rx3) indicate prior workers' compensation settlements regarding 7/20/10 and 2/16/12 accidents while working for employers other than Respondent. Petitioner testified these claims involved head and shoulder traumas. 2015 tax records of the Petitioner reflect that he was employed by both Respondent and Stallworth Underground in 2015, earning $5,667 with the former and $6,885.48 with the latter. (Rx4). There was no testimony from Petitioner with regard to employment with Stallworth.

In redirect testimony, Petitioner testified that, had he been physically capable, he could have obtained work at other jobsites. He testified he hasn't sought such work because he is unable to return to heavy construction work consistently. He testified that he has had no outside income other than unemployment benefits.

As to the job hazard analysis sheets, he testified that he did not complete one for his back injury because "I was told not to, to wait and see if I started feeling better before", but he could not say who told him this.

Surveillance investigator Chris Chlarson testified on behalf of the Respondent. He investigated the Petitioner, determined what vehicles he owned, and located his residence as 1306 S. Holland in Harrisburg, Illinois, which matches the address listed on Petitioner's Application for Adjustment. He went to the location for surveillance on 4/27/16 at 6 a.m. At approximately 1:21 p.m. that day, he testified the film depicts the Petitioner carrying a ladder while wearing a carpentry tool belt. Following an off the record discussion, the Petitioner agreed that he is the party depicted in the video wearing the dark shirt, carrying the ladder and wearing the tool belt.

The Arbitrator reviewed the surveillance video from 4/27/16 (Rx5). After a rainy morning, the Petitioner was seen exiting a pickup truck at approximately 1:12 p.m. with a large clipboard and paperwork. The Arbitrator notes that these appear to be the types of materials that a contractor would have. From approximately 1:18 p.m through 2:45 p.m., the Petitioner performs carpentry work which involves climbing a ladder, reaching overhead, carrying a ladder, bending and using various tools. He is seen at one point climbing in and out of a car through what appears to be a window with a small opening, resulting in a very awkward entry and exit. He did not exhibit any obvious physical limitations. The Arbitrator notes that the Petitioner did not testify with regard to an explanation of what he was doing in the video on 4/27/16.

Dustin Vibbert, Respondent's project superintendent, testified on behalf of Respondent. Petitioner was one of his workers on the Big Muddy project. Mr. Vibbert testified that the Respondent's standard procedure regarding the reporting of work related injuries starts with the job hazard analysis form, which employees can sign to indicate either an injury to themselves or one that they witnessed. Mr. Vibbert testified that Petitioner never reported a work related back injury to him in September 2014. He testified he observed the Petitioner working on a daily basis, and saw no evidence that Petitioner was having difficulty performing his job. Sometime in

October 2014 he became aware the Petitioner was claiming a work injury. Initially when an injury is reported, they start the process and then determine if a medical visit is needed. In this case, they checked the job hazard analysis forms, and, while Petitioner had reported other injuries, there was no indication that Petitioner reported an injury to his back.

Petitioner continued to work for Respondent through 4/23/15, working standard hours from 7 a.m. to 3:30 p.m. Mr. Vibbert testified that the Petitioner was working within his light duty restrictions, which Respondent accommodated. At some point, Vibbert testified that Petitioner was released to full duty. Petitioner continued to carry out his work duties, but did observe Petitioner having problems doing so "when it was convenient." When the Petitioner's part of the project ended, he was laid off as part of a general work force reduction, which Mr. Vibbert testified was standard practice in the industry.

On cross examination, Mr. Vibbert agreed he wasn't certain exactly when in October 2014 he became aware of Petitioner claiming a work injury. When he did, he went straight to the office to complete the paperwork. Following this, again, he agreed WorkCare restricted the Petitioner's duties, and he testified that the Respondent honored those restrictions. Vibbert knew Petitioner was later released to full duty, but wasn't sure of the date.

On further cross exam, Mr. Vibbert testified that when Petitioner was laid off, not all of the workers for his type of job were laid off. He testified that he determines who gets picked for layoff, and that it is based on a number of factors – seniority, specific skills, union factors, minorities, etc. Vibbert agreed that Petitioner was laid off just over a week after he had a full duty release. The foreman, Mr. Patrick, would have notified him if Petitioner had reported an injury to him, testifying that there was zero chance that Patrick would not have told him if Petitioner had done so.

Petitioner attended therapy at SIU/RIC in late 2014 and early 2015. (Px3). He did provide a consistent history of accident on 10/10/14. The last visit notes Petitioner stated his doctor was going to refer him to another doctor to look at other treatment options to include possible injections. Treatment appears directed to the coccyx area, and biofeedback was part of the treatment. The diagnoses were low back pain, sacroiliitis and coccyx pain. The records reflect essentially temporary relief with treatment, and that the pain would return with activity, especially work. There were tightness and trigger points noted. (Px3).

Dr. Mirkin testified via deposition. (Rx2). A pain diagram was completed which reflected low back pain down the back of the left leg. Dr. Mirkin noted his February 2016 examination reflected markedly positive Waddell signs, and the Petitioner reported that he was not able top perform range of motion movements. Neurological examination was normal. Dr. Mirkin opines that the Petitioner displayed symptom magnification, and that there was no indication for any type of surgery. (Rx2).

Dr. Mirkin later reviewed the 10/22/15 lumbar MRI, finding a very minimal L5/S1 bulge, no nerve compression and a very small annular lesion. He testified that these findings were minimal without any pressure on the nerves, and so the MRI was essentially normal. The radiologist noted the annular tear was right sided, while the Petitioner complained of left sided symptoms. Dr. Mirkin also opined that the annular tear and disc bulge were not particularly pathologic, and that no responsible spine surgeon would look at his examination and MRI and perform surgery. He found no need for a functional capacity evaluation or work restrictions. He also opined that there is no sufficient evidence to find that a discogram is valid, as the test itself can hurt the disc, and no solid scientific evidence exists to show the test is a valid predictor of how one will do with surgery. Dr. Mirkin opined that the Petitioner was at MMI after his treatment with Dr. Newell ended. (Rx2).

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that, based on the greater weight of the evidence, the Petitioner has failed to prove that he sustained a 9/8/14 accident pursuant to the Act.

The Arbitrator does not find the Petitioner's testimony in this case to be credible. First, he testified that he notified both Mr. Patrick and Mr. Vibbert of his injury on the alleged date of accident, but that no paperwork was completed for at least a couple months after this. Mr. Vibbert testified that the Petitioner never reported this alleged injury to him on 9/8/14.

Petitioner then sought no treatment for a month. He testified initially that he had been "let go" by Respondent in November 2014, but then testified he continued to work full duty for Respondent until being laid off in April 2015. His initial visit with WorkCare did contain a history of the incident that is consistent with his testimony, but his initial 2/25/15 visit with Dr. Newell indicated he reported no specific trauma.

The job hazard analysis forms indicate no evidence or reference to the Petitioner's claimed injury. While the Petitioner claims that multiple versions of these documents are used by the employer, he also agreed that he did not indicate the claimed 9/8/14 injury, while copies of the forms from other dates reflect that the Petitioner had reported injuries and thus clearly was aware that he was to indicate work injuries within these documents. It doesn't make sense to the Arbitrator that the Petitioner would have reported what appear to have been more minor injuries of rust in the eye and a wrist injury on the forms, but then did not do so with what he claims to be a more significant injury. He testified that someone, apparently with Respondent, advised him not to report the injury on the form and to wait to see how it went, but Petitioner could not identify who this alleged person was.

The Petitioner continued to work for a month after the alleged accident before seeking any treatment. He then continued to work thereafter, based on the evidence presented, until being laid off in April 2015, in what appears to be a fairly heavy job. He testified that he was not allowed to work light duty by the Respondent, but the Arbitrator notes that the only restriction that was located in the record prior to Dr. Gornet in October 2015 was that issued by Dr. Newell indicating he could work light duty "at employer's discretion". He filed for and received unemployment benefits, testifying he understood that this required him to verify he was ready, willing and able to work. There is evidence in the form of tax returns which show the Petitioner worked for an outfit called Stallworth Underground in 2015, which the Petitioner did not testify about. There is surveillance video that clearly depicts the Petitioner performing carpentry work in April 2016, including climbing, reaching, lifting and carrying materials, all while wearing what appeared to be a fairly heavy tool belt. He then climbs into a car through the window in a very awkward way, a way that leaves the Arbitrator with significant questions as to the Petitioner's claimed pain level. At no time in the video does the Petitioner appear to be limited in his activities or showing any obvious evidence of pain.

While Dr. Gornet issued restrictions and offered more significant treatment, he acknowledged that this a "quality of life' issue and not an emergent situation, and it is also clear he did not review any of the noted information regarding Petitioner's activities after the alleged accident or the surveillance video. Dr. Mirkin noted significant evidence of Waddell signs and symptom magnification, with the Petitioner indicating he was not even able to perform 10% of his range of motion. This is clearly belied by his ongoing activities.

There is certainly evidence which exists in the record which supports that the Petitioner was injured as he says he was on 9/8/14, however the greater weight of the evidence does not support that his version of what occurred is credible, for the reasons noted above. As such, the Arbitrator finds that the preponderance of the evidence indicates the Petitioner failed to prove he sustained an accident arising out of and in the course of his employment on 9/8/14.

WITH RESPECT TO ISSUE (E), WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's finding that the Petitioner failed to prove a 9/8/14 accident, this issue is moot.

WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's finding that the Petitioner failed to prove a 9/8/14 accident, this issue is moot.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's finding that the Petitioner failed to prove a 9/8/14 accident, this issue is moot.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's finding that the Petitioner failed to prove a 9/8/14 accident, this issue is moot.

WITH RESPECT TO ISSUE (L), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's finding that the Petitioner failed to prove a 9/8/14 accident, this issue is moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jeff Gifford,

Petitioner,

vs. NO: 15WC 39028

Romeoville Police Department,

18IWCC0269

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by both parties herein and proper notice given, the Commission, after considering the issue(s) of accident, casual connection, permanent disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 14, 2017 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

18IWCC0269

No bond is required for the removal of this cause to the Circuit Court. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 27 2018
SJM/sj
o-4/19/2018
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GIFFORD, JEFF
Employee/Petitioner

Case# 15WC039028

18IWCC0269

ROMEOVILLE POLICE DEPARTMENT
Employer/Respondent

On 9/14/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.14% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0154 KROL BONGIORNO & GIVEN LTD
RANDALL W SLADEK
120 N LASALLE ST SUITE 1150
CHICAGO, IL 60602

1505 SLAVIN & SLAVIN LLC
BRIAN DRISCOLL
120 N LASALLE ST SUITE 2500
CHICAGO, IL 60602

18IWCC0269

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jeff Gifford
Employee/Petitioner

v.

Romeoville Police Department
Employer/Respondent

Case # 15 WC 39028

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christine M. Ory**, Arbitrator of the Commission, in the city of **New Lenox**, on **February 7, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. X Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. X Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. X Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. X What temporary benefits are in dispute?
☐ TPD ☐ Maintenance X TTD
L. X What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **October 30, 2015,** Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to a work accident.

In the year preceding the injury, Petitioner earned **$91,520.00**; the average weekly wage was **$1,760.00**.

On the date of accident, Petitioner was **43** 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.

To date, Respondent has paid $ **0** in TTD and/or for maintenance benefits, and is entitled to a credit for any and all amounts paid.

Respondent shall be given a credit of $ **0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of $ **0.**

Respondent is entitled to a credit of **$21,820.96** under Section 8(j) of the Act.

ORDER

Medical Benefits

Respondent shall pay the $21,810.96 subject to the fee schedule, pursuant to §8 and §8.2 of the Act and subject to any credit for any portion of the bill paid pursuant to §8 j .

Temporary Total Disability

Respondent shall pay temporary total disability from November 3, 2015 through January 12, 2016 which is 10-1/7 weeks @ $1,173.33 per week.

Permanent Disability

Respondent shall pay $755.22 for 17.2 weeks, as provided in §8 (e) 12 of the Act, as petitioner's injuries sustained caused 8% loss of use of the right leg.

RULES REGARDING APPEALS Unless a Petition for Review is filed within 30 days after receipt of this decision, and a review is perfected in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Christine M Ory

Signature of Arbitrator

ICArbDec p. 2

09/13/2017

Date

SEP 14 2017

19IWCC0269

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jeff Gifford	)	
Petitioner,	)	
vs.	)	**No. 15 WC 39028**
Romeoville Police Department	)	
Respondent.	)	
	)	

ADDENDUM TO ARBITRATOR'S DECISION
FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter proceeded to hearing in New Lenox on February 10, 2017. The parties agree that on October 30, 2015, petitioner and the respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer and that petitioner gave timely notice of the claimed accident. The parties agree petitioner earned $91,520.00 in the year predating the accident and that his average weekly wage, calculated pursuant to §10, was $1,760.00.

At issue in this hearing is as follows:

1. Whether the petitioner sustained accidental injuries that arose out of and in the course of his employment.
2. Whether petitioner's current condition of ill-being is causally connected to the claimed injury.
3. Whether respondent is liable for medical bills.
4. Whether petitioner is entitled to temporary total disability.
5. The nature and extent of petitioner's injury.

STATEMENT OF FACTS

Petitioner, Jeff Gifford, Testimony

Petitioner testified he was employed by respondent as a police officer for more than 20 years. In October/November 2015 he was to undergo a physical fitness exam. Police officers are required to undergo the physical fitness exam twice a year. The physical fitness exam includes a mile and a half run.

On October 30, 2015, as petitioner was running the one and a half miles he heard a pop in his right knee and felt a sharp pain. He completed the run and reported the incident to Sargent Bulmann. During the weekend before, he called in as he had tweaked his knee. He called in sick on Monday due to pain in his back and knee. He worked on Wednesday, Thursday and took the fitness test on Friday (October 30, 2015).

On November 1, 2015 he started at 6 A.M. He was not able to finish the shift. He reported to Sargent McKenzie. He was off work Tuesday and Wednesday. He went to see Dr. Burra on November 3, 2015. Dr. Burra had provided treatment to petitioner in 1998 when he had been struck by a car while directing traffic. Dr. Burra ordered an MRI. He was taken off work by Dr. Burra.

On November 24, 2015, Dr. Burra advised he had a tear of the medial meniscus horn. He was kept off work. Dr. Burra performed surgery on December 10, 2105. He received physical therapy at ATI. He saw Dr. Burra on December 21, 2015. He was doing okay. On January 12, 2016, petitioner was released to return to work without restrictions. He has not seen Dr. Burra since then and has had no further treatment. He is not on any medication. His right leg aches.

On cross-examination, petitioner confirmed that the Saturday before October 30, 2015, petitioner tweaked his back and knee. He called off work on October 26, 2015 as a result. He did not recall that the fitness test was originally set for October 26, 2015, but confirmed he was scheduled to take it on October 30, 2015.

Robert Fetzer Testimony

Robert Fetzer respondent's commander, was called to testify in behalf of respondent. He had been employed by respondent or 26 years; two years as commander. Before that he was sergeant.

Fetzer confirmed the proctor was to insure the test was done correctly. Some proctors will ask if anyone was hurt; some don't.

Fetzer was asked by the Chief of Police to investigate whether petitioner was hurt before the fitness test. Fetzer completed his report on December 18, 2015 (RX.1). Lucchesi reported petitioner may have injured his knee on October 24, 2015 at home. Petitioner was to have the fitness test on October 26, 2015 and was rescheduled to October 30, 2015.

Petitioner did not report the injury to the Kramer, the proctor. He did not email Kramer of the injury.

On cross-examination, Fetzer confirmed he was responsible to determine if someone was abusing sick time, workers' compensation cases or if violating policy concerning reporting of workers' compensation cases.

Fetzer confirmed petitioner reported the incident to Sgt. Bulmann on October 30, 2015 at 14:00 hours. Petitioner violated policy as he did not first go to Edward Hospital Occupational Health for treatment before seeing Dr. Burro.

Fetzer concluded his investigation revealed petitioner injured his right knee and back on Saturday, October 24, 2015 and also injured it on October 30, 2015. Fetzer did not believe petitioner could have completed the agility test if his knee was already hurt.

On re-direct he was not sure if petitioner reported he was actually hurt. There was no evidence he was faking or not faking.

Fetzer confirmed petitioner had not hid the fact that he hurt his knee and back the weekend before.

Hinsdale Orthopaedics Records (PX.1)

The records include a bill for services rendered totaling $17,672.00

Petitioner was first seen by Dr. Burra, after the claimed October 30, 2015 accident, on November 3, 2015. He recites a history of participating in a mile and a half run and noticing sharp pain in his right knee during and immediately after the run. Dr. Burra's exam revealed patellofemoral pain as well as meniscal pathology. Dr. Burra surmised the patellofemoral pain was the result of running and that the probable meniscal tear may have resulted from twisting or fall stepping or stepwise resulted in some buckling. An MRI was ordered.

Petitioner was seen by Dr. Burra on November 24, 2015, after obtaining an MRI of his right knee on November 20, 2015. Dr. Burra reported the MRI showed a posterior horn meniscal tear. Dr. Burra proposed arthroscopic surgery.

Petitioner had a pre-operative visit with Dr. Burra on December 8, 2015 and underwent the arthroscopic medial meniscectomy on December 10, 2015.

At the December 21, 2015 post-operative visit, he was doing well and in physical therapy.

At the January 12, 2016 visit, Dr. Burra noted petitioner had made good progress in physical therapy and demonstrated excellent range of motion and strength. Dr. Burra released petitioner to return to work full duty and released from his care.

(The balance of these records were treatment of petitioner's shoulder and unrelated to this claimed work injury.)

ATI Physical Therapy Records (PX.2)

Petitioner received physical therapy from December 11, 2015 through January 12, 2016. The records include the bill for services rendered totaling $4,148.96.

Commander Fetzer's December 18, 2015 Internal Investigation Report (RX.1)

[This report also included investigation of another officer that is not relative to petitioner's case.]

According to Fetzer's report, on December 4, 2015 he was asked by Deputy Chief Lucchesi to investigate how petitioner was injured. In the report, Fetzer references an email from Sargent Truhlar to Lucchesi regarding petitioner calling in sick on October 25, 2015. Fetzer also referenced an email from Sergeant Bulmann to Lucchesi dated October 31, 2015 informing Lucchesi of petitioner's injury.

There was reference to petitioner being seen on December 4, 2015 at a pub leaning against a railing.

Fetzer spoke with Bulmann who confirmed petitioner took the fitness test on the morning of October 30, 2015. Bulmann reported that petitioner continued to work after completing the test. However, petitioner reported knee pain at approximately 1600 hours. Bulmann advised petitioner to file the appropriate WC forms.

Fetzer spoke with petitioner on December 14, 2015. Petitioner confirmed he notified Sergeant Truhlar via text on October 26, 2015 that he tweaked his back and knee. Petitioner advised Fetzer that he awoke on Sunday with pain in his back and knee and was unsure how it occurred. By Tuesday's shift his knee was no longer bothering him and he was able to come to work. He felt fine the remainder of the week.

On October 30th, he was able to complete all events of the physical agility test. Petitioner indicated that after he passed the run he felt pain in his right knee, but he thought it would subside. He did not remember Officer Kramer, who was proctoring the test, asking if anyone was hurt or asking to then email Commander Ferdinardo if they were.

Petitioner returned to his regular duties that day, but as the pain did not subside he reported the injury to Bulmann and filed the appropriate paperwork. He was scheduled to be off work on October 31, 2015. He returned to work on November 1, 2015 but his knee was bothering him so much he asked to leave. He was off on November 2nd and then saw Dr. Burra on November 3rd.

19IWCC0269

Fetzer brought to petitioner's attention he did not follow department protocol in going directly to Dr. Burra rather than first going Edward Occupational Health. Petitioner acknowledged he was aware of the memo requiring him to go to Edward Occupational Health, but added that Occupational Health would have referred him to a specialist anyway.

Petitioner agreed he had jokingly made the statement that he doesn't work light duty. Petitioner agreed he was Stout's Bar and Parliament club on November 7th, but did not dance. He also confirmed he was at a masquerade party on November 21st, but did not dance. He agreed he was at Basecamp Pub in Lisle on December 4th, but did not dance.

Fetzer confirmed with Officer Kramer, the fitness test proctor. Kramer confirmed he asked all participants if they were hurt. Kramer confirmed petitioner passed all the events, but he did walk the last lap of the run.

Fetzer spoke with Commander Ferdinardo. Ferdinardo confirmed petitioner passed all events. Ferdinardo did not receive an email reporting the injury. However, Ferdinardo believed he received a text from petitioner on November 2nd or 3rd advising he was injured during the fitness test. Ferdinardo texted back to tell petitioner to report the injury to Lucchesi as he (Ferdinardo) was on vacation.

Fetzer spoke with other participants of the fitness test on October 30th with petitioner. None of the other participants were aware of petitioner sustaining an injury. All confirmed Officer Kramer had asked all the participants if they had been injured.

Based upon his investigation, Fetzer concluded petitioner possibly injured his right knee on October 24th or October 25th, but recovered during the week and injured it again during the fitness test. Fetzer found it unlikely that petitioner could have satisfactorily completed the fitness test with a knee that was already injured.

Fetzer did find petitioner violated department policy by not first seeing a doctor at Edward Occupational Health.

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

C. With respect to the issue of whether an accident occurred that arose out of and in the course of Petitioner's employment by respondent, the Arbitrator makes the following conclusions of law:

By his own admission, petitioner's back and right knee were hurting so bad that he had to call in sick on October 25, 2015. However, he returned to work, and worked the rest of the week in his usual capacity as a police officer. On Friday, October 30, 2015, while running a mile and a half, as part of a mandatory fitness test, he felt a sharp pain in his right knee. He did not report the problem immediately to the proctor, as he thought the pain would subside. He tried working his shift that day and could not finish it as the pain continued. He reported the injury to Sgt. Michienzi and went home.

Commander Fetzer, who completed an investigation of the claimed accident, concluded petitioner injured his right knee while performing the fitness test on October 30, 2015.

The evidence, taken as a whole, supports the Arbitrator's findings that petitioner injured his right knee in an accident that arose out of and in the course of his employment with respondent on October 30, 2015, while participating in a mandatory fitness test.

18IWCC0269

F. With respect to the issue of whether the petitioner's condition of ill-being is related to the injury, the Arbitrator makes the following conclusions of law:

Dr. Burra believed petitioner's running action caused the meniscal tear. Although petitioner may have "tweaked his knee" the weekend before, he was able to work his regular shift and participate in the one and a half mile run during the agility test. As rationalized by Commander Fetzer, if the injury had occurred to his right knee the weekend before, he would not have been capable of doing a mile and a half run on an injured knee. Respondent offered no medical evidence to refute causation.

Therefore, the Arbitrator finds petitioner's accident while running during the mandatory agility test, caused the posterior horn meniscal tear in petitioner's right knee that necessitating the medial meniscectomy performed by Dr. Burra on December 10,2 015.

J. With respect to the issue regarding medical bills, the Arbitrator makes the following conclusions of law:

The Arbitrator finds petitioner's right knee injury, for which he received treatment from Dr. Burra of Hinsdale Orthopaedics and ATI Physical Therapy, was the result of the work accident of October 30, 2015, and awards the bills of $17,662.00 (excludes $10 for disability forms) to Hinsdale Orthopaedics and $4,148.00 to ATI Physical Therapy, with credit to be given for payments made by Blue Cross and Blue Shield, pursuant to 8 j, and in accordance with the fee schedule, and §8 and §8.2 of the Act.

K. With respect to the Arbitrator's decision with regard to TTD, the Arbitrator makes the following conclusions of law:

The medical records support petitioner's claim for temporary total disability from November 3, 2015 through January 12, 2106, which is 10-1/7 weeks at $1,173.33 per week.

L. In support of the Arbitrator's decision with regard to the nature and extent of petitioner's injury, the Arbitrator makes the following conclusions of law:

Petitioner sustained a tear of the horn of the medial meniscus of the right leg that was surgically repaired arthroscopically. Petitioner was temporarily total disabled for a little over ten weeks. He reports only achiness in his knee.

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:

With regard to subsection (i) of §8.1b (b) the Arbitrator notes that there was no permanent partial disability impairment rating provided. The Arbitrator, therefore, cannot give any weight to this factor.

With regard to (ii) of §8.1b (b) the occupation of the injured employee, the Arbitrator notes petitioner is employed as a police officer. As such, he is required to perform various physical activities. Therefore, the Arbitrator gives some weight to this factor.

With regard to (iii) of §8.1b (b) the age of the employee at the time of the injury was 43 years of age. Therefore, the Arbitrator gives some weight to this factor.

With regard to (iv) of §8.1b (b) the employee's future earning capacity, the Arbitrator notes petitioner was able to return to work in his usual capacity of a police officer at his regular salary. The Arbitrator, therefore, gives little weight to this factor.

18IWCC0269

With regard to (v) of §8.1b (b) evidence of disability corroborated by the treating medical records, the Arbitrator notes after petitioner underwent an arthroscopic medial meniscectomy and physical therapy, he was released from Dr. Burra's care with no work restrictions, excellent range of motion and strength on January 12, 2016. Petitioner has not needed to return to the doctor since that time. Therefore, the Arbitrator gives little weigh to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 8% loss of use of the right leg pursuant to § 8 (e) 12 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Crystal Quandt,

Petitioner,

vs. NO: 14WC 33491

State of Illinois/Murray Center

Respondent.

18IWCC0264

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of permanent disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 13, 2017 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

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: APR 27 2018
SJM/sj
o-4/19/2017
44

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

QUANDT, CRYSTAL
Employee/Petitioner

Case# **14WC033491**

11WC008596

SOI/MURRAY CENTER
Employer/Respondent

18IWCC0264

On 10/13/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.22% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0969 RICH RICH & COOKSEY PC
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SPRINGFIELD, IL 62794-9208

CERTIFIED as a true and correct copy
pursuant to 820 ILCS 305/14

OCT 13 2017

RONALD A. RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

18IWCC0264

STATE OF ILLINOIS)
)SS.
COUNTY OF JEFFERSON)

- ☐ Injured Workers' Benefit Fund (§4(d))
- ☐ Rate Adjustment Fund (§8(g))
- ☐ Second Injury Fund (§8(e)18)
- ☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

CRYSTAL QUANDT
Employee/Petitioner

v.

STATE OF ILLINOIS / MURRAY CENTER
Employer/Respondent

Case # 14 WC 33491

Consolidated cases: 11 WC 08596

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **May 5, 2017**. By stipulation, the parties agree:

On the date of accident, **August 11, 2014**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

On this date, Petitioner sustained an accident that arose out of and in the course of employment.

Timely notice of this accident was given to Respondent.

Petitioner's current condition of ill-being is causally related to the accident.

In the year preceding the injury, Petitioner earned **$41,773.93**, and the average weekly wage was **$803.34**.

At the time of injury, Petitioner was **47** years of age, ***single*** with **0** dependent children.

Necessary medical services and temporary compensation benefits have been provided by Respondent.

Respondent shall be given a credit of **$N/A** for TTD, **$N/A** for TPD, **$N/A** for maintenance, and **$N/A** for other benefits, for a total credit of **$N/A**.

18IWCC0264

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury, and attaches the findings to this document.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of **$482.00 per week** for **5.375 weeks**, because the injuries sustained caused the **2.5% loss of use of the right leg**, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner compensation that has accrued from **December 1, 2014** through **May 5, 2017**, and shall pay the remainder of the award, if any, in weekly payments.

RULES REGARDING APPEALS: Unless a Petition for Review is filed within 30 days after receipt of this decision, and a review is perfected in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE: If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

September 29, 2017
Date

OCT 13 2017

STATEMENT OF FACTS

These matters were previously heard on Section 19(b) Petitions, where the issue of whether Petitioner's knee condition was related to one of the accidents involved was the only issue litigated, and the Arbitrator determined the knee was not causally related to the 2/4/11 accident, and was initially related to the 811/14 accident, but that causation ended as of 11/6/14 (see Px17 & 18). Both of these decisions were affirmed and adopted by the Commission. (Px18; Rx6 & 7). The only current issue is the nature and extent of Petitioner's neck and low back injuries.

According to the prior decision, Petitioner worked for Respondent as a Mental Health Technician. On 2/4/11, the Petitioner was struck in the face while seated and pushed into a railing and wall, reporting neck and upper back injuries. She went to the ER at St. Mary's Good Samaritan Hospital on 2/8/11, reporting head and neck pain. X-ray noted a prior cervical fusion at C4/5 and C6/7 with Dr. Gornet. (Px3 & 5). While initially undergoing chiropractic treatment from February to June 2011 (Px4), Petitioner saw orthopedic surgeon Dr. Gornet on 2/24/11, and his report notes the prior surgery involved disc replacements at C4/5, C5/6 and C6/7 (on 4/16/08). The report notes Petitioner reported being punched in the head by a combative patient, her head struck

the wall and she twisted it rapidly to the left, with pain in the neck, head, right shoulder, upper back and lower back into the right buttocks. X-rays showed the prostheses remained in place. (Px6). Dr. Gornet noted that Petitioner was experiencing neck pain, headaches, and low back pain radiating into her right buttock. He recommended conservative treatment with chiropractor Dr. Bowman and time off work. When Petitioner returned on 4/21/11, Dr. Gornet noted that Petitioner's condition was slowly improving, but she continued to have upper and lower back complaints. On 6/16/11, Petitioner reported her neck was improved but she had right scapular and flank pain, and low back pain into the right buttock and leg. Dr. Gornet advised that if Petitioner's back symptoms did not improve, he would obtain a lumbar MRI. (Px6).

The 7/11/11 MRI showed annular tears at L3/4 and L4/5. (Px7). When a recommended 7/20 and 8/10/11 right L4/5 injections (Px8) did not improve Petitioner's condition, Dr. Gornet recommended a CT discogram and continued Petitioner off work. (Px6). The 9/21/11 discogram showed a provocative disc and concordant pain at L4/5, and a non-provocative disc at L3/4. (Px9). Thus, on 10/3/11 he recommended surgery. (Px6). Surgery was performed on 10/25/11, involving a right L4/5 laminotomy with placement of a spinous process distractor. (Px9). Following surgery, on 12/8/11, Petitioner was given therapy exercises. On 1/19/12, Petitioner reported feeling much improved with some intermittent low back and buttock pains and normal neurological exam. She was released to return to full duty as of 3/1/12. On 11/26/12, Petitioner reported a slow increase in low back pain radiating into the right leg. Lumbar MRI on that date showed satisfactory positioning of the distractor, an annular bulge at L4/5 with central herniation and moderate central canal stenosis and moderate left greater than right foraminal stenosis. Also on 11/26/12, Petitioner noted she continued to work full duty but reported increased pain with being forced to work double shifts with repetitive bending and lifting. On 6/6/13, Petitioner indicated her neck was doing well, but she complained of low back pain into the bilateral buttocks and hips. Full duty was continued, but Dr. Gornet indicated he would consider L4/5 fusion if she got worse. On 11/4/13, Dr. Gornet indicated the L4/5 level continued to deteriorate. An 11/4/13 updated lumbar MRI showed post-operative L4/5 changes with advanced degenerative disc disease resulting in mild canal stenosis but with more advanced foraminal stenosis and residual broad-based disc protrusion with small midline annular tear. Neurologic examinations remained normal. (Px6 & 7).

At hearing, the Petitioner testified that the surgery did improve her condition, but she continued to have waxing and waning difficulty with her low back according to annual post-surgical follow-up visits with Dr. Gornet on 11/3/14, 9/14/15 and 9/15/16. (Px6).

According to the prior decision in case number 14 WC 33491, the Petitioner sustained an injury to the right knee on 8/11/14, when a patient kicked an end table into her leg while she was trying to keep him seated. An ER report from St. Mary's n 8/13/14 indicated complaints of right knee pain, with significant swelling, pain and difficulty with weightbearing. (Px3 & 18).

Petitioner testified that her symptoms increase with most activities of daily living. This includes doing laundry, mowing the yard, driving long distances, and shopping. She testified that someone else does her yard work, but then testified on cross that she last mowed her lawn 2 weeks prior, but that she has help when doing so. Petitioner takes over-the-counter medication and occasionally Vicodin for her symptoms. The Arbitrator notes that Petitioner testified she last saw Dr. Gornet in September 2016, that she obtained Vicodin from her primary care provider Dr. Jha, and then that she obtained them from a different primary provider, Dr. Baumgart. Dr. Jha's records note only an 8/13/14 note, indicating right knee complaints, and there is no indication he prescribed any medication, though he noted Petitioner was on numerous prescriptions. Her hobbies of animal rescuing and yard work have been adversely affected by her injury. She testified that she has been working for the past two weeks taking care of an elderly woman with dementia, but that while she does help her to the bathroom and such, she does not lift.

WITH RESPECT TO THE ISSUE OF THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Pursuant to §8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability for accidental injuries occurring on or after September 1, 2011:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's (AMA) "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors;

(i) the reported level of impairment pursuant to subsection (a);
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

In this case, the Arbitrator notes that the previous 19(b) decision of the Arbitrator found that the Petitioner's right knee condition was causally related to the 8/11/14 accident, but was no longer related to the accident following 11/3 and 11/6/14 visits with Dr. Paletta and the right knee MRI obtained in November 2014. Thus, the determination of permanency, pursuant to the law of the case, involves the condition of the Petitioner's knee as of the determined end of the causal relationship.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no AMA impairment report and/or opinion was submitted into evidence. As such, this factor carries no weight in the permanency determination.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a mental health technician at the time of the accident and that she continued to work in that capacity following the prior Arbitrator's determination that causation of the right knee condition ended. Thus, the evidence does not support that the Petitioner was unable to continue to work in her occupation as a result of the 8/11/14 accident, and this factor tends to show a lesser degree of permanency.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 47 years old at the time of the accident. Neither party submitted evidence specifying the impact of the Petitioner's age on her permanent condition. As such, this factor carries no weight in the permanency determination.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator, as noted above, finds that the evidence does not support the 8/11/14 injury resulted in a loss of earning capacity. This factor therefore tends to show a lesser degree of permanency.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that the prior decision in this case specifically determined that the causal relationship of the Petitioner's right knee condition to the 8/11/14 accident ended following 11/3 and 11/6/14 visits with Dr. Paletta and the right knee MRI performed that same month. The Arbitrator stated: "Petitioner sustained an accident involving her right knee and her initial visit with Dr. Paletta was reasonable. However, she failed to prove that any subsequent care and treatment with him, or his recommendation for prospective medical care, is causally related to her 8/11/14 accident." The Arbitrator further indicated: "The condition for which Dr. Paletta wishes to perform surgery at the present time is the same one the Petitioner had in 2012." As noted above, the decision was affirmed and adopted by the Commission. Essentially, this case arguably involves a minor aggravation of a preexisting condition, one that did not result in an ongoing causal relationship to the accident.

Based on the above factors, the record taken as a whole and a review of prior Commission awards involving similar injuries and outcomes, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 2.5% loss of use of the right leg pursuant to §8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Crystal Quandt,

Petitioner,

vs. NO: 11WC 08596

State of Illinois/Murray Center

Respondent.

18IWCC0265

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of permanent disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 13, 2017 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

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: APR 27 2018
SJM/sj
o-4/19/2017
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

QUANDT, CRYSTAL
Employee/Petitioner

Case# **11WC008596**
14WC033491

SOI/MURRAY CENTER
Employer/Respondent

18IWCC0265

On 10/13/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.22% 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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BUREAU OF RISK MANAGEMENT
PO BOX 19208
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CERTIFIED as a true and correct copy
pursuant to 820 ILCS 305/14

OCT 13 2017

RONALD A. RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF JEFFERSON)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

CRYSTAL QUANDT
Employee/Petitioner

v.

STATE OF ILLINOIS / MURRAY CENTER
Employer/Respondent

Case # **11** WC **08596**

Consolidated cases: **14 WC 33491**

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **May 4, 2017**. By stipulation, the parties agree:

On the date of accident, **February 4, 2011**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

On this date, Petitioner sustained an accident that arose out of and in the course of employment.

Timely notice of this accident was given to Respondent.

Petitioner's current condition of ill-being is causally related to the accident.

In the year preceding the injury, Petitioner earned **$36,145.72**, and the average weekly wage was **$695.11**.

At the time of injury, Petitioner was **44** years of age, ***single*** with **0** dependent children.

Necessary medical services and temporary compensation benefits have been provided by Respondent.

Respondent shall be given a credit of **$N/A** for TTD, **$N/A** for TPD, **$N/A** for maintenance, and **$N/A** for other benefits, for a total credit of **$N/A**.

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury, and attaches the findings to this document.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of **$417.07 per week** for **62.5 weeks**, because the injuries sustained caused the **12.5% loss of the person as a whole**, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner compensation that has accrued from **September 15, 2016** through **May 4, 2017**, and shall pay the remainder of the award, if any, in weekly payments.

RULES REGARDING APPEALS: Unless a Petition for Review is filed within 30 days after receipt of this decision, and a review is perfected in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE: If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

September 29, 2017
Date

OCT 13 2017

STATEMENT OF FACTS

These matters were previously heard on Section 19(b) Petitions, where the issue of whether Petitioner's knee condition was related to one of the accidents involved was the only issue litigated, and the Arbitrator determined the knee was not causally related to the 2/4/11 accident, and was initially related to the 811/14 accident, but that causation ended as of 11/6/14 (see Px17 & 18). The only current issue is the nature and extent of Petitioner's neck and low back injuries.

According to the prior decision, Petitioner worked for Respondent as a Mental Health Technician. On 2/4/11, the Petitioner was struck in the face while seated and pushed into a railing and wall, reporting neck and upper back injuries. She went to the ER at St. Mary's Good Samaritan Hospital on 2/8/11, reporting head and neck pain. X-ray noted a prior cervical fusion at C4/5 and C6/7 with Dr. Gornet. (Px3 & 5). While initially undergoing chiropractic treatment from February to June 2011 (Px4), Petitioner saw orthopedic surgeon Dr. Gornet on 2/24/11, and his report notes the prior surgery involved disc replacements at C4/5, C5/6 and C6/7 (on 4/16/08). The report notes Petitioner reported being punched in the head by a combative patient, her head struck

the wall and she twisted it rapidly to the left, with pain in the neck, head, right shoulder, upper back and lower back into the right buttocks. X-rays showed the prostheses remained in place. (Px6). Dr. Gornet noted that Petitioner was experiencing neck pain, headaches, and low back pain radiating into her right buttock. He recommended conservative treatment with chiropractor Dr. Bowman and time off work. When Petitioner returned on 4/21/11, Dr. Gornet noted that Petitioner's condition was slowly improving, but she continued to have upper and lower back complaints. On 6/16/11, Petitioner reported her neck was improved but she had right scapular and flank pain, and low back pain into the right buttock and leg. Dr. Gornet advised that if Petitioner's back symptoms did not improve, he would obtain a lumbar MRI. (Px6).

The 7/11/11 MRI showed annular tears at L3/4 and L4/5. (Px7). When a recommended 7/20 and 8/10/11 right L4/5 injections (Px8) did not improve Petitioner's condition, Dr. Gornet recommended a CT discogram and continued Petitioner off work. (Px6). The 9/21/11 discogram showed a provocative disc and concordant pain at L4/5, and a non-provocative disc at L3/4. (Px9). Thus, on 10/3/11 he recommended surgery. (Px6). Surgery was performed on 10/25/11, involving a right L4/5 laminotomy with placement of a spinous process distractor. (Px9). Following surgery, on 12/8/11, Petitioner was given therapy exercises. On 1/19/12, Petitioner reported feeling much improved with some intermittent low back and buttock pains and normal neurological exam. She was released to return to full duty as of 3/1/12. On 11/26/12, Petitioner reported a slow increase in low back pain radiating into the right leg. Lumbar MRI on that date showed satisfactory positioning of the distractor, an annular bulge at L4/5 with central herniation and moderate central canal stenosis and moderate left greater than right foraminal stenosis. Also on 11/26/12, Petitioner noted she continued to work full duty but reported increased pain with being forced to work double shifts with repetitive bending and lifting. On 6/6/13, Petitioner indicated her neck was doing well, but she complained of low back pain into the bilateral buttocks and hips. Full duty was continued, but Dr. Gornet indicated he would consider L4/5 fusion if she got worse. On 11/4/13, Dr. Gornet indicated the L4/5 level continued to deteriorate. An 11/4/13 updated lumbar MRI showed post-operative L4/5 changes with advanced degenerative disc disease resulting in mild canal stenosis but with more advanced foraminal stenosis and residual broad-based disc protrusion with small midline annular tear. Neurologic examinations remained normal. (Px6 & 7).

At hearing, the Petitioner testified that the surgery did improve her condition, but she continued to have waxing and waning difficulty with her low back according to annual post-surgical follow-up visits with Dr. Gornet on 11/3/14, 9/14/15 and 9/15/16. (Px6).

According to the prior decision in case number 14 WC 33491, the Petitioner sustained an injury to the right knee on 8/11/14, when a patient kicked an end table into her leg while she was trying to keep him seated. An ER report from St. Mary's n 8/13/14 indicated complaints of right knee pain, with significant swelling, pain and difficulty with weightbearing. (Px3 & 18).

Petitioner testified that her symptoms increase with most activities of daily living. This includes doing laundry, mowing the yard, driving long distances, and shopping. She testified that someone else does her yard work, but then testified on cross that she last mowed her lawn 2 weeks prior, but that she has help when doing so. Petitioner takes over-the-counter medication and occasionally Vicodin for her symptoms. The Arbitrator notes that Petitioner testified she last saw Dr. Gornet in September 2016, that she obtained Vicodin from her primary care provider Dr. Jha, and then that she obtained them from a different primary provider, Dr. Baumgart. Dr. Jha's records note only an 8/13/14 note, indicating right knee complaints, and there is no indication he prescribed any medication, though he noted Petitioner was on numerous prescriptions. Her hobbies of animal rescuing and yard work have been adversely affected by her injury. She testified that she has been working for the past two weeks taking care of an elderly woman with dementia, but that while she does help her to the bathroom and such, she does not lift.

WITH RESPECT TO THE ISSUE OF THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

As this accident predates 9/1/11, this case predates the effective date of Section 8.1(b) of the Act.

The Arbitrator notes that the Respondent did not dispute the causal relationship of the Petitioner's neck and low back to the 2/4/11 accident, according to the prior Arbitrator's decision in this case. The records indicate that the Petitioner had a prior neck surgery, and that there does not appear to be any significant residuals from the aggravation of this condition on 2/4/11.

As to the low back, Dr. Gornet performed surgery at L4/5, including a spinous distractor, and the Petitioner continues to complain of symptoms. Dr. Gornet indicated that Petitioner was doing well, that she could continue to work full duty from a lumbar standpoint, but that if she continued to worsen she could ultimately be a fusion candidate at that level.

The Arbitrator in the prior case noted some level of questioning of the Petitioner's credibility in this case, and the Arbitrator here notes there is some questionability with regard to the Petitioner's testimony as to her obtaining of Vicodin. While the Petitioner testified that she at least in part is no longer working for Respondent due to her condition, she also agreed on cross exam that she no longer works for Respondent for unrelated disciplinary reasons. The Arbitrator does note the records of Dr. Gornet note her complaints of having to work double shifts for Respondent and having to bend and lift. There also is an indication, however, that she was off work for at least some period or periods of time due to her knee condition, which the Arbitrator previously found to be unrelated.

Based on the above factors, the record taken as a whole and a review of prior Commission awards involving similar injuries and outcomes, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 12.5% loss of use of the person as a whole pursuant to §8(d)2 of the Act.