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

Shannon Anderson,

Petitioner,

vs. NO: 16WC003731

Olin,

Respondent.

18IWCC0001

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 penalties and fees and permanent disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 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.

18IWCC0001

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: JAN 2 - 2018

Stephen J. Mathis

SJM/sj
o-12/7/17
44

Deborah L. Simpson

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ANDERSON, SHANNON
Employee/Petitioner

Case# **16WC003731**

OLIN
Employer/Respondent

18IWCC0001

On 2/6/2017, 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 0.62% 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:

4463 GALANTI LAW OFFICE
DAVID M GALANTI
PO BOX 99
E ALTON, IL 62024

0299 KEEFE & DePAULI PC
MICHAEL KEEFE
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

18IWCC0001

STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Shannon Anderson
Employee/Petitioner

v.

Olin
Employer/Respondent

Case # **16** WC **3731**

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 **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. [ ] What temporary benefits are in dispute?
   [ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On **January 19, 2016**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, per the stipulation of the parties, Petitioner earned **$50,612.64** and the average weekly wage was that of **$973.32**.

On the date of accident, Petitioner was **39** years of age, ***married*** with **2** dependent children.

Respondent shall be given a credit of **$926.95** for TTD, **$0** for TPD, **$0** for maintenance, **$0** in non-occupational indemnity disability benefits and **$0** in other benefits, for a total credit of **$$926.95.**

ORDER

Respondent shall pay Petitioner the sum of **$583.99/week** for a further period of **9.5 weeks**, as provided in **Section 8(e)** of the Act, because the injuries sustained caused **25% loss of use of the right middle finger.**

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. Bruce-Gallivan

Signature of Arbitrator

2/2/17

Date

ICArbDec p 2

FEB 6 - 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Shannon Anderson
Employee/Petitioner

Case # **16** WC **3731**

v.

Consolidated cases: **N/A**

Olin
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that she is currently 40 years old and works for Respondent, where she has worked for 10 ½ years. She testified that she was undergoing training on the date of accident, and that her glove was pulled into a machine by a gear. She testified that her right middle finger was injured in the accident, and that she is right-hand dominant. She denied having had any prior injuries to this finger.

Petitioner testified that she first sought medical treatment at work, and that the security guard drove her to Alton Memorial Hospital. She testified that she was referred to Dr. Vest, who performed surgery on January 19, 2016. She testified that while she was off work, all of her temporary total disability benefits were paid. She denied having had any subsequent injuries to her right middle finger.

Petitioner testified that half of the finger is numb, but that the other side has feeling. She testified that she is numb on the tip as well as the little finger side on the right middle finger. The Arbitrator notes that the right middle finger is slightly longer and, as stipulated by the parties at the time of arbitration, the right middle finger is approximately 1/8" longer as compared to the left middle finger.

Petitioner denied having received any additional monies from Respondent following her return to work. She further denied having received any monies in settlement for the loss of use of her finger.

The medical records of Alton Memorial Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The records reflect that Petitioner underwent a History and Physical Examination on January 19, 2016 for an admission related to an open fracture of the distal phalanx of the right third finger. It was noted that Petitioner had been seen in the Emergency Room that evening for an acute crush injury to her right third finger. It was noted that Petitioner's right third finger was caught in a gear on a machine, that she was wearing a work glove, that the tip of her finger was crushed and that she pulled forcibly to jerk it out of the gears and felt the gears grinding on her finger. It was noted that Petitioner developed immediate pain and swelling. It was noted that diagnostic studies showed the comminuted fracture of the distal 50% of the distal phalanx of the third finger with mild to moderate displacement of the tuft of the distal phalanx, and that the middle phalanx and proximal phalanx were intact. It was noted that Petitioner would be taken to surgery for irrigation and debridement of the open fracture with open treatment of the fracture, and it was also noted that there may be a possible need for internal fixation with K-wire. The records further reflect that Petitioner underwent x-rays of the right long finger on the same date, which were interpreted as revealing a comminuted distal tuft fracture of the right long finger with associated soft tissue defect which may represent an open fracture. (PX1).

The medical records of Dr. Vest were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect that Petitioner was issued a work slip on June 24, 2016 allowing her to return to work without restrictions. The records reflect that x-rays of the right hand were performed on June 24, 2016, which were interpreted as revealing a healing fracture of the distal phalanx of the right third finger. At the time of the June 24, 2016 visit, it was noted that Petitioner reported good range of motion in the finger and denied pain, and that she had an area of diminished sensation over the tip of the right middle finger but stated that it did not bother her. It was noted that Petitioner had been working full duty without restrictions since May 5, 2016 and was right-handed. Petitioner was encouraged to continue daily home exercises as directed by prior physical therapy. It was noted that the area of diminished sensation over the tip of the right third finger may improve over time and that Petitioner was at maximum medical improvement. (PX2).

The records of Dr. Vest reflect that Petitioner was seen on May 13, 2016, at which time it was noted that she continued to experience numbness over the laceration but stated that the swelling had improved. It was noted that Petitioner had been working regular duty 8-hour shifts, no more than 6 days per week, and was doing well, and that she was not taking any pain medication. It was noted that Petitioner was improving and her x-rays showed signs of healing, and she was encouraged to continue soft tissue massage and range of motion stretches of the fingers as directed by prior physical therapy. Petitioner was also instructed to take Tylenol as needed. At the time of the April 18, 2016 visit, it was noted that Petitioner had been working regular duty, 8-hour shifts no more than 6 days per week, for the past few weeks. It was noted that Petitioner stated that the distal tip of the right third finger was still swollen, but her range of motion was doing well. It was noted that Petitioner was not taking any pain medications and was right-handed. Petitioner was recommended to perform soft tissue massage over the incision as needed, and to ice the finger daily to decrease swelling. Petitioner was also encouraged to continue daily home exercises as directed by prior physical therapy. (PX2).

The records of Dr. Vest reflect that Petitioner was seen on March 18, 2016, at which time it was noted that she was doing well and denied much pain. It was noted that Petitioner reported persistent mild swelling in the distal tip of the finger with occasional numbness, and that she had completed physical therapy. It was noted that Petitioner was not taking any pain medications. Petitioner was encouraged to continue daily home exercises as directed by prior physical therapy and was allowed to return to regular duty work on March 21, 2016 with the restriction of no working more than 8 hours per day, no more than 6 days per week. At the time of the February 29, 2016 visit, it was noted that Petitioner stated that the incision had completely healed, but she continued to use a Band-Aid over the end of the finger. It was noted that Petitioner mentioned that the finger was sensitive when it bumped objects. It was noted that Petitioner was not taking any pain medications and had been working light duty at Olin. Petitioner was instructed to continue physical therapy as ordered and was encouraged to perform a home exercise program as directed. It was noted that Petitioner could return to light duty work on February 20, 2016 with the restrictions of no lifting more than 1-2 pounds with the right hand. (PX2).

The records of Dr. Vest reflect that Petitioner was seen on February 15, 2016, at which time it was noted that she had been performing daily dressing changes and stated that the false nail fell off over the weekend. It was noted that physical therapy had been approved but Petitioner had not yet scheduled her first session. It was noted that Petitioner was instructed to continue to ice and elevate the right hand to decrease pain and swelling, that she could wiggle the fingers of the right hand as tolerated but she was to be non-weight bearing on the right arm. At the time of the February 8, 2016 visit, it was noted that Petitioner had been performing daily dressing changes and had not noticed fever or chills. It was noted that Petitioner reported intermittent soreness, especially if she bumped the finger. It was noted that Petitioner had not been taking any pain medication and had been working light duty for the last week. Petitioner was recommended to undergo physical therapy and was encouraged to perform passive range of motion of the joints of the fingers of the right hand. (PX2).

The records of Dr. Vest reflect that Petitioner was seen on February 1, 2016, at which time it was noted that she had been performing daily dressing changes over the finger. It was noted that Petitioner had not noticed any drainage and denied fever or chills. It was noted that Petitioner was no longer taking Norco and had been off work since the injury. It was noted that Petitioner was to alert the office if she developed any concerning symptoms, such as fever, chills or streaking erythema from the third finger. It was noted that Petitioner could return to light duty work on February 2, 2016 with the restrictions of no use of the right hand. At the time of the January 22, 2016 visit, it was noted that Petitioner was doing well but reported a throbbing feeling in the end of her finger. It was noted that Petitioner had kept the surgical dressing clean, dry and intact, and denied numbness or tingling in her hand. Petitioner was instructed to keep the dressing clean, dry and intact until seen in the office for another dressing change. It was noted that Petitioner was to be off work until further notice. (PX2).

The Operative Report was entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The report reflects that on January 19, 2016, Petitioner underwent (1) irrigation and debridement of open fracture of distal phalanx of right third finger with excision of devitalized bone; (2) open reduction of fracture of distal phalanx of right third finger with repair of complex laceration for a pre- and post-operative diagnosis of comminuted displaced open fracture of the distal phalanx of the right third finger. As to the operative description, it was noted that Dr. Vest "began by debriding the wound sharply with the scalpel, performing excisional debridement of nonviable skin edges, subcutaneous tissues, periosteal tissues and small bone fragments from the distal phalanx, preserving as much of the bone as possible." (PX3).

The Medical Bills Checklist was entered into evidence at the time of arbitration as Petitioner's Exhibit 4.

The Motion for Penalties and Attorney's Fees was entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The Motion alleged that Respondent had refused to pay 50% statutory loss on the matter and that the Operative Note clearly indicated that bone was excised during the procedure. Attached as an exhibit to the Motion for Penalties and Attorney's Fees was a letter dated July 11, 2016 which memorialized a telephone conversation on July 6, 2016 at which time it was discussed that Petitioner had bone removed and it was her attorney's position that it automatically entitled her to 50% statutory loss of use of the finger. (PX5).

The Response to Penalties was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The Response noted that Petitioner was evaluated by Dr. Vest, who noted a comminuted fracture to the right third finger and recommended surgery. It was noted that the Operative Report stated that there was debridement of "small bone fragments" from the distal phalanx. It was noted that the Operative Report dated January 19, 2016 did not reference loss of the first or distal phalanx, and that the word "amputation" did not appear in Dr. Vest's History and Physical, Operative Report, radiographs or any post-operative office note. Respondent alleged that Petitioner's Motion cited no authority that excision of bone constituted statutory loss triggering 50% loss. (RX1).

CONCLUSIONS OF LAW

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injury, and consistent with 820 ILCS 305/8.1b, permanent partial disability shall be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of Section 8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. No single enumerated factor shall be the sole determinant of disability. *Id.*

With respect to Subsection (i) of Section 8.1b(b), the Arbitrator notes that no AMA rating was offered by either party. The Arbitrator places no weight on this factor when making the permanency determination.

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that she continues to work for Respondent. The Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 39 years old on her date of accident. Given the younger age of Petitioner and the fact that her treating physicians have placed her under no restrictions, the Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (iv) of Section 8.1b(b), the Arbitrator notes that, following her work injury, Petitioner returned to her pre-accident employment with Respondent. As there was no direct evidence of reduced earning capacity contained in the record, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (v) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that half of the finger is numb, but that the other side has feeling. She testified that she is numb on the tip as well as the little finger side on the right middle finger. At the time of the June 24, 2016 visit with Dr. Vest, it was noted that Petitioner reported good range of motion in the finger and denied pain, and that she had an area of diminished sensation over the tip of the right middle finger but stated that it did not bother her. (PX2). The Arbitrator concludes that Petitioner's evidence of disability at the time of arbitration, namely her continued complaints and limitations, was somewhat corroborated by her treating records at the conclusion of her treatment with Dr. Vest. The Arbitrator accordingly places lesser weight on this factor in determining permanency.

Having reviewed the evidence as a whole, the Arbitrator finds that Petitioner's undisputed accident did not result in an amputation as defined by the Act, as the record as a whole lacked reference to an amputation and the Operative Report referenced the debridement of small bone fragments. (PX3). The Arbitrator notes that the determination of permanent partial disability benefits is not simply a calculation, but an evaluation of all of the factors as stated in the Act in which consideration is not given to any single factor as the sole determinant. Based on the above factors and the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of **25% loss of use of the right middle finger** as provided in Section 8(e) of the Act.

With respect to disputed issue (M) pertaining to penalties and fees, the Arbitrator denies Petitioner's claim for penalties and fees under Sections 19(k) or 16 of the Act.

Section 19(k) of the Act provides in pertinent part:

> In case where there has been any unreasonable or vexatious delay of payment or intentional underpayment of compensation, or proceedings have been instituted or carried on by the one liable to pay the compensation, which do not present a real controversy, but are merely frivolous or for delay, then the Commission may award compensation additional to that otherwise payable under the Act equal to 50% of the amount payable at the time of such award. Failure to pay compensation in accordance with the provisions of Section 8, paragraph (b) of this Act, shall be considered unreasonable delay. 820 ILCS 305/19(k).

Section 16 of the Act provides for an award of attorney's fees where an employer, its agent, or insurance carrier "has been guilty of delay or unfairness towards an employee in the adjustment, settlement or payment of benefits due such employee ... or has been guilty of unreasonable or vexatious delay, intentional under-payment of compensation benefits, or has engaged in frivolous defenses which do not present a real controversy, within the purview of the provisions of paragraph (k) of Section 19 of this Act, the Commission may assess all or any part of the attorney's fees and costs against such employer and his or her insurance carrier." 820 ILCS 305/16.

In the case at hand, the evidence reflects that Respondent was aware that Petitioner sustained bone loss to some extent given that the Operative Report referenced the debridement of small bone fragments. (PX3). However, the specific amount of bone loss sustained by Petitioner in the distal phalange of the right third finger is not specified in the medical records, and the appearance of the right middle finger at the time of arbitration was that of being elongated and thinner as compared to the third finger of Petitioner's left hand. As such, the Arbitrator finds that Petitioner did not sustain an amputation pursuant to the Act requiring immediate payment as defined by the Act.

Penalties and fees may be awarded where the delay of payment is deliberate, resulted from bad faith or improper purpose. *McMahan* v. *Indus. Comm.*, 183 Ill. 2d 499, 515, 702 N.E.2d 545, 553 (1998); *Mechanical Devices* v. *Indus. Comm.*, 344 Ill.App.3d 752, 764, 800 N.E.2d 819, 829 (2003). Section 19(k) penalties and Section 16 attorneys' fees require a higher standard of proof than Section 19(l) penalties. *McMahan*, 183111. 2d at 514-515, 702 N.E.2d at 553; *Mechanical Devices*, 344 Ill.App.3d at 764, 800 N.E.2d at 829-830. Moreover, Section 16 attorneys' fees are not recoverable in the absence of a Section 19(k) penalties award. *Gallentine* v. *Indus. Comm.*, 201 Ill.App.3d 880, 890, 559 N.E.2d 526, 533 (1990).

Based on the foregoing, the Arbitrator finds that Respondent had a reasonable dispute as to whether Petitioner's undisputed accident resulted in an amputation as defined by the Act and further finds that Respondent's conduct was not unreasonable, vexatious and/or in bad faith. Thus, the Arbitrator denies Petitioner's claim for penalties and fees under Sections 19(k) or 16 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

Juan Aleman,
Petitioner,

vs. NO: 15 WC 32913

18IWCC0002

Nation Pizza & Foods,
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, intoxication, causal connection, temporary total disability, medical expenses, and permanent partial disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

In further support of the Arbitrator's conclusions, the Commission specifically notes Dr. Chiodo's testimony that patients intoxicated due to cocaine usage are alert or even "hyperalert" (Tr. 87-88) and that other symptoms of cocaine intoxication include elevated blood pressure and tachycardia (elevated heart rate), as well as impaired judgement. Petitioner's claim that these symptoms were not present is inaccurate; upon his arrival in the ER, his blood pressure was documented as 187/95, 190/108, and 170/88, and his pulse was variously recorded at 98, 110, and 95. Although there may have been other possible causes of Petitioner's tachycardia and elevated blood pressure, these symptoms corroborate his cocaine intoxication.

18IWCC0002

Moreover, the claimant's testimony is lacking in credibility and certainly cannot be taken at face value. He averred to the physicians at the ER that he did not use illegal drugs, when his argument before the Commission was effectively that he only used drugs when the intoxicating effects of them would not have impaired his ability to perform his work duties. Further evidence that the claimant's testimony is lacking in credibility is his assertion that he had used very little cocaine, and had done so days before. Given that the testing demonstrated levels of cocaine metabolite at least sixty-five times the testing cut-off value, and the half-life of cocaine in a user's system is measured in hours, the evidence clearly demonstrates that either the petitioner had used very significant amounts of cocaine days prior, or had used it considerably closer in time to the accident and testing at the ER; regardless, the claimant's testimony cannot be true. The claimant's testimony is further inconsistent in that he asserted that people would use their hands to move the chain in the machinery, which in turn led to his injury; however, the claimant's own supporting witness, a maintenance mechanic, noted that a screwdriver or other tool would actually be used to physically move the chain (see PX5, p.43). This also corroborates the impairment of judgment that would be expected for someone presently under the influence of cocaine.

Dr. Chiodo's conclusion that the causes of the accident were petitioner's use of cocaine and resulting intoxication and impaired judgment may be somewhat conclusory, but are wholly consistent with the evidence adduced. Moreover, the claimant presented no expert testimony to contradict them and the only evidence they presented that the petitioner did not appear intoxicated related to alcohol intoxication – slurred speech and sluggishness – which is not relevant to cocaine intoxication and was clearly distinguished in Dr. Chiodo's testimony. The Commission finds his testimony both credible and persuasive.

Lastly, the Commission notes that regardless of the presumptions inherent in Section 11 of the Act and the statutory intoxication defense, there is a longstanding body of case law that an employee's voluntary intoxication can serve as a defense to a claim of accident under the Worker's Compensation Act. See, e.g., *Paganelis v. Industrial Commission*, 132 Ill.2d 468 (1989). The intoxicating substance is not at issue; both alcohol and illegal narcotics have served as bases for defenses. See, e.g., *Thomas Mokos v. McKernin Exhibits*, 03 IIC 765. The Commission finds that the claimant's actions and the medical testing show clear evidence of chemical intoxication which would suffice to defeat a claim of accident under this case law regardless of the provisions of Section 11 of the Act.

The Commission finds that the petitioner has failed to meet his burden of proof and further finds that the compelling and credible evidence adduced demonstrates persuasively that it was the claimant's own actions and chemically impaired judgment, and not a workplace risk, that caused his injury. Benefits are denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 15, 2016 is hereby affirmed as noted above.

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

18IWCC0002

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: JAN 2 - 2018

Joshua D. Luskin

o-11/01/17
jdl/mcp
68

Charles J. DeVriendt

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 ...(2) a controlled substance listed in the Illinois Controlled Substances 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). Assuming *arguendo* such presumption exists, I believe Petitioner rebutted the same and proved accident. Therefore, I respectfully dissent.

Petitioner testified he ingested cocaine on September 25, 2015 approximately three days prior to his accident. T. 14. Post-accident drug testing confirmed the presence of cocaine in Petitioner's system. RX2; RX4. Petitioner testified on the date of accident, September 28, 2015, he was able to perform his work duties without difficulty. 06/01/16-T. 21. Petitioner testified during his shift prior to the accident, he interacted with approximately 15 co-employees none of whom commented regarding him being impaired. 06/01/16-T. 20. Petitioner testified he worked directly with Mr. Terrance Merritte during his shift. 06/01/16-T. 26. Mr. Terrance Merritte was called to testify on behalf of Respondent. Mr. Merritte testified he worked with Petitioner on the evening of the accident, and therefore, had the opportunity to observe Petitioner. PX5, p. 13-14. Mr. Merritte testified Petitioner did not appear to be intoxicated and stated: "His behavior that night was normal. There was nothing unusual about his behavior that night." *Id.*, p.14.

For the rebuttable presumption to apply, evidence of impairment must be presented. The majority relies on post-accident medical records which evidence Petitioner with an increased heart rate and blood pressure. It is no wonder Petitioner's heart rate and blood pressure were elevated in the emergency room as he was missing part of his right index finger and reporting 10 out of 10 for pain. PX1. There is simply no evidence prior to Petitioner's accident that he was impaired other than the drug testing indicating cocaine in his system. As the Act merely requires "any evidence of impairment," it is arguable the presence of illegal drugs in one's system would satisfy such requirement. Even assuming the rebuttable presumption applies, the preponderance of the admissible evidence overcomes the same.

Dr. Ernest Chiodo testified on behalf on Respondent providing his expert medical opinion concluding Petitioner was intoxicated at the time of his injury, and the intoxication was the cause of his injury. 07/01/16-T. 35; 40. Dr. Chiodo provided two bases for his opinion: 1)

18IWCC0002

the presence of cocaine in Petitioner's system; and 2) the occurrence of the injury. 07/01/16-T. 37. "The proponent of expert testimony must lay a foundation sufficient to establish the reliability of the bases for the expert's opinion. [citation omitted]. If the basis of an expert's opinion is grounded in guess or surmise, it is too speculative to be reliable. [citation omitted]." *Gross v. Illinois Workers' Compensation Commission*, 2011 IL App (4th) 100615WC, ¶24. Neither bases of Dr. Chiodo's opinion withstands scrutiny.

First, Dr. Chiodo testified the drug test indicated Petitioner ingested cocaine within three days of the test. Specifically, Dr. Chiodo testified "so I think it indicates whether or not somebody took cocaine within the last three days." 07/01/16-T. 26. Such testimony is consistent with Petitioner's testimony he ingested cocaine approximately three days prior to his injury. Dr. Chiodo provided no other definitive testimony as to the timing of the consumption of cocaine by Petitioner, and more importantly, the effects of cocaine ingested three days prior. Dr. Chiodo's testimony is speculative in finding Petitioner ingested cocaine immediately prior to the accident.

Second, Dr. Chiodo testified the fact the injury occurred was also the reason why the injury occurred. Ignoring the circular nature of the argument, such opinion is grounded on guess and surmise and disregards the testimonies of both Petitioner and Mr. Merritte. Petitioner testified as follows: "I hit the E-Stop, and I recall seeing the red light on the E-stop. Q. What does the red light indicate? A. It indicates that the conveyor stopped. Sure enough, I remember seeing that E-stop with the red light. I went back underneath the conveyor and started working on it. I grabbed the chain to jump the sprocket a few teeth, and when all of a suddenly just out of nowhere I heard the conveyor starting back up again. And that's why I had the accident." 06/01/16-T. 27-28. Such testimony is consistent with the testimony of Mr. Merritte. Mr. Merritte testified as follows: "Q. As you entered the room, you testified that the machine conveyor was not running? A. Correct...Q. Did you observe Mr. Aleman hit the E-stop? A. I thought he did, but I'm not 100 percent sure. Q. Do you recall if he told you de did? A. Yes, he said he did. Q. Because you wouldn't start working on the machine if you knew that it would start running again; is that correct? A. Exactly." 06/01/16-T. 41-41. Dr. Chiodo's testimony that Petitioner was injured due to his mental impairment is speculative as it is directly contradicted by the unimpeached testimonies of Petitioner and Mr. Merritte regarding the circumstances of the accident.

My dissent should not be read as condoning the use of illegal controlled substances at the work place. 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

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ALEMAN, JUAN
Employee/Petitioner

Case# **15WC032913**

NATION PIZZA & FOODS
Employer/Respondent

18IWCC0002

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:

1948 LIPKIN & HIGGINS
MITCHELL S LIPKIN
222 N LASALLE ST SUITE 2100
CHICAGO, IL 60601

1596 MEACHUM & STARCK
JAMES JANNISCH
225 W WASHINGTON ST SUITE 500
CHICAGO, IL 60606

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

JUAN ALEMAN
Employee/Petitioner

Case #15 WC 32913

V.

18IWCC0002

NATION PIZZA AND FOODS
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on June 1 and July 1, 2016. After reviewing all of the issues, the stipulations of the parties and the evidence, it is hereby found and ordered as follows:

ISSUES:

A. ☐ Was the 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 the petitioner's employment by the respondent?

D. ☐ What was the date of the accident?

E. ☐ Was timely notice of the accident given to the respondent?

F. ☒ Is the petitioner's present condition of ill-being causally related to the injury?

G. ☐ What were the petitioner's earnings?

H. ☐ What was the petitioner's age at the time of the accident?

I. ☐ What was the petitioner's marital status at the time of the accident?

J. ☒ Were the medical services that were provided to petitioner reasonable and necessary?

K. ☒ What temporary benefits are due: ☐ TPD ☐ Maintenance ☒ TTD?

L. ☒ What is the nature and extent of injury?

M. ☐ Should penalties or fees be imposed upon the respondent?

N. ☐ Is the respondent due any credit?

O. ☐ Prospective medical care?

FINDINGS

- On September 28, 2015, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between the petitioner and respondent.
- Timely notice of the accident was given to the respondent.
- In the year preceding the injury, the petitioner earned $52,000.00; the average weekly wage was $1,000.00.
- At the time of injury, the petitioner was 35 years of age, married with two children under 18.
- The parties agreed that the respondent paid $428.55 in temporary total disability benefits.

ORDER:

- The petitioner's request for benefits is denied and the claim is dismissed.

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. Williams

Signature of Arbitrator

July 14, 2016

Date

JUL 15 2016

FINDINGS OF FACTS:

The petitioner, a mechanic, sustained injuries to fingers of his right hand on September 28, 2015, while attempting to get a conveyor belt to operate. He received emergency care at Alexian Brothers Medical Centers and was given a debridement of an open distal phalanx fracture and revision amputation of his right index finger; a debridement of an open fracture, open reduction and internal fixation of articular middle phalanx fracture, extensor tendon repair and wound closure of his middle finger; and a debridement of open fracture, open reduction and internal fixation of middle phalanx fracture, extensor tendon repair and wound closure of his ring finger revision. An alcohol and drug test of the petitioner's urine on September 28th was positive for cocaine which was confirmed by a medical review officer. The results of a cocaine metabolite analysis were 10,710 ng/ml.

Dr. Chiodo, a doctor and toxicologist, opined that cocaine is a stimulant and is unlike a depressant such as alcohol. An individual may appear to be functioning normally and not intoxicated, however, their judgment will be impaired and they will not be functioning in a normal manner. The doctor's opinion was that the petitioner was intoxicated at the time of his injury and cocaine was the cause of his injury.

FINDING REGARDING WHETHER THE PETITIONER'S ACCIDENT AROSE OUT OF AND IN THE COURSE OF HIS EMPLOYMENT WITH THE RESPONDENT:

Based upon the testimony and the evidence submitted, the petitioner failed to prove that he sustained an accident on September 28, 2015, arising out of and in the course of his employment with the respondent.

The petitioner admitted that he ingested cocaine prior to his injury. There is evidence that the petitioner was impaired due to his unlawful use of cocaine, a controlled

substance listed in the Illinois Controlled Substances Act, 720 ILCS 570/102, based on the opinions of Dr. Chiodo, the high level of a cocaine metabolite found in his urine and the fact that the petitioner worked on the gears of a machine without shutting the power off.

There is insufficient evidence to rebut the presumption that the petitioner was intoxicated and that his intoxication was the proximate cause of his injury. Moreover, there is no evidence of another proximate cause for the accident other than his intoxication. The petitioner's testimony that he was not intoxicated is not believable, especially since he thought that he had engaged the emergency shut-off switch before working on the conveyor assembly and used his hands to move the gear chain instead of a tool. There is nothing in the testimony of Terrance Merritte that established his ability to provide a layman's opinion on the intoxication effects of cocaine. It is clear that Merritte believed that slurred speech, loss of coordination and other effects of alcohol impairment were the same for cocaine. His testimony has no probative value. The petitioner is not believable and his request for benefits is denied and the claim is dismissed.

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 down	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Todd Floistad,

Petitioner,

vs.

NO: 12 WC 12034

City of Northlake,

18IWCC0003

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 all of the issues, and being advised of the facts and law, affirms the Decision of the Arbitrator, which is attached hereto and made a part hereof, with the below modifications.

1. Petitioner's temporary partial disability award from September 9, 2013, through December 31, 2013, is vacated.
2. Petitioner is awarded a wage differential of $399.79 per week under section 8(d)(1) of the Act. The differential shall begin on September 9, 2013, and run until Petitioner reaches age 67 or five years from the date of the award, whichever is later. The wage differential represents two-thirds of the difference between what the Commission finds to be Petitioner's average weekly wage and his weekly income following the incident:
    a. Petitioner's average weekly wage was $1,195.93. Petitioner's average weekly wage had been calculated to be $1,243.42, but that figure includes overtime that was deemed voluntary by Petitioner's union contract. The $1,195.93 figure excludes overtime and is based on a yearly income of $62,188.30.
    b. Petitioner's weekly income following the accident was $596.24. The $596.24 figure includes the $487.39 per week in wages Petitioner earned in 2014, and it also accounts for the $450-per-month ($108.85 per week ($450*12 months / 52 weeks)) rent concession he received in exchange for his work. That rent concession agreement was considered to be employment (for purposes of setting the date of maximum medical improvement) in the prior arbitration decision, and the lack of a guarantee that it will continue does not distinguish

18IWCC0003

it from most employment situations. The actual amount of the rent concession is therefore part of Petitioner's wages. The figure does not subtract Petitioner's transportation expenses, which were not sufficiently documented in evidence.

3. The Commission clarifies that Respondent continues to be entitled to a credit of $97,479.82, as described in the prior arbitration decision.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 1/29/2016 is modified as stated herein.

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: JAN 3 - 2018
o:12/1/2017
TJT/knc
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FLOISTAD, TODD
Employee/Petitioner

Case# **12WC012034**

CITY OF NORTHLAKE
Employer/Respondent

18IWCC0003

On 1/29/2016, 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 0.41% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1323 COLLISON LAW OFFICES LTD
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CHICAGO, IL 60603

0507 RUSIN & MACIOROWSKI LTD
MICHAEL E RUSIN
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

18IWCC0003

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

TODD FLOISTAD
Employee/Petitioner

v.

CITY OF NORTHLAKE
Employer/Respondent

Case # **12** WC **012034**

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, Jessica Hegarty Arbitrator of the Commission, in the city of **Wheaton**, on **8/25/2015**. 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [ ] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
[x] TPD [ ] Maintenance [ ] TTD
L. [ ] What is the nature and extent of the injury?
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other **award of 8(d)(1) benefits**

FINDINGS

On **12/2/2011**, 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 ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$64,652.58**; the average weekly wage was **$1243.32**.

On the date of accident, Petitioner was **34** 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 **$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 partial disability benefits of $724.95/week for 17 weeks, commencing 9/3/13 through 12/31/13, as provided in Section 8(a) of the Act.

- Respondent shall pay Petitioner 8(d)(1) benefits, commencing 1/1/14, of $779.46/week until Petitioner reaches age 67 or five years from the date of the final award, whichever is later, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act.

- Petitioner's claim for penalties/attorneys fees under 8(a), 19(k), 19(l), 16, 4(a) 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.

Jessica C. Myatt

Signature of Arbitrator

1/14/16
Date

JAN 29 2016

18IWCC0003

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TODD FLOISTAD, Petitioner,	)	
v.	)	Case No: 12 WC 12034 Wheaton
CITY OF NORTHLAKE, Respondent,	)	

ADDENDUM TO THE DECISION OF THE ARBITRATOR

This case was initially tried before Arbitrator Jessica A. Hegarty in Chicago pursuant to Section 19(b) of the Illinois Workers' Compensation Act on multiple dates starting June 5, 2014 and continuing through November 3, 2014 when proofs were closed. Subsequent to that hearing, a decision was issued on March 27, 2015 in which the Arbitrator made a number of findings, including a causal connection between Petitioner's accident and his then, current state of ill-being. (Arbitrator's Ex. 1)

Neither party appealed, and the findings and conclusions set forth in that decision are final and have become the law of the case.

This matter was again heard before Arbitrator Jessica A. Hegarty in Wheaton, Illinois on August 25, 2014. The issues in dispute are:

- Causal connection
- Petitioner's claim for wage differential benefits under Section 8(d)(1);
- Petitioner's claim for TPD;
- The nature and extent of the injury;
- Penalties and attorney's fees.

STATEMENT OF FACTS

Much of the below stated facts are from the first hearing, the findings and conclusions are incorporated herein.

Petitioner is a 38-year-old male who was employed by the City of Northlake as a Laborer/Supervisor since 1988. On July 18th, 2005, Petitioner was injured while working for Respondent. Petitioner required a laminectomy and fusion with instrumentation from L3 to S1. Petitioner testified that he returned to full duty work because he had a wife dying of cancer and needed health insurance. (Transcript from first hearing at 24) Although he

had aches and pains, he was able to go about his daily tasks once back at work. (Id.) He did not re-injure himself or miss any work due to his back between the time he returned to work and December 2, 2011. (Id. at 25) Prior to December 2, 20122, Petitioner last consulted with his treating surgeon, Dr. Ryon Hennessey, for the 2005 injury in May of 2008. (Id.; Px1 at 24-25.)

It is undisputed that on December 2, 2011, Petitioner suffered a work related accident when a clay wall collapsed as he was repairing a water break. (First Tx. at 28) Petitioner felt the clay wall "clip" his right side and he felt that his right side was twisted. (Id.) Petitioner complained of increased back pain and right groin pain radiating to his right testicle and right S1 dermatone. (Px9)

Petitioner consulted with orthopedic surgeon Dr. Ryon Hennessy on December 16th, 2011, a subsequent MRI and x-rays indicated there was retrolisthesis which, In Dr. Hennessy's opinion, represented instability. (Px9) Dr. Hennessy recommended a laminectomy and fusion of L2-3. (Id.)

Petitioner was examined, at Respondent's request, by Dr. Avi Bernstein, who also agreed that the Petitioner required an extension of the laminectomy and fusion to L2-3.

On September 6, 2012, a revision laminectomy with posterolateral spinal fusion and pedicle screw instrumentation and a posterior lumbar inter-body fusion with an inter-body cage was performed by Dr. Hennesey. Connecting rods locked the construct to the pre-existing hardware from L3 to S1 (Px3 at. 232-239) Intra-operatively, SSEP monitor showed increased EMG signal. Postoperatively, Petitioner demonstrated significant bilateral motor deficits that he did not have preoperatively. (Px9)

On September 24th, 2012, Dr. Hennesey noted most of Petitioner's bilateral deficits had recovered except for a persistent right foot drop. Petitioner completed formal physical therapy and was released by Dr. Hennessey to continue the exercises at home. Petitioner remained off work. (Px9) For approximately a month after the surgery, Petitioner used a stimulator and a walker prescribed by Dr. Hennessey. (Tx at 43) On October 15th, 2012, Petitioner was prescribed an AFO brace for the right foot to assist with ambulation. (Px9)

In January of 2013, Petitioner moved to Mt. Sterling, Illinois. He testified that his home in Elburn was no longer affordable as his injuries prevented him from obtaining over-time pay. Dr. Hennessey informed Petitioner that his injuries would not allow him to return to his job. (First Tx. at 43, 140) Petitioner continued therapy in the Mount Sterling area and continued treatment with Dr. Hennessey.

Petitioner saw Dr. Sokolowski on January 9, 2013, for a second opinion which was agreed to by Respondent. (Px16) The doctor performed an examination, reviewed records and formulated an assessment/plan. Dr. Sokolowski diagnosed Petitioner with lumbar pain, lumbar radiculopathy and bilateral lower extremity weakness, including a right foot drop. (Px7 at 18) He opined that Petitioner would have permanent weakness in his lower extremity. The doctor did not expect complete resolution of his neurologic findings. Dr. Sokolowski recommended a CT myelogram to check the position and stability of the fusion and instrumentation. (Id. at 18)

Petitioner returned to Dr. Hennessey on February 18th, 2013 who prescribed a CT scan to document the status of Petitioner's fusion. (Px9) The CT scan was subsequently performed and reviewed by Dr. Hennessy on March 18th, 2013. The doctor indicated the intra-body graft had bone growth but not a full fusion. He recommended Petitioner continue with the TENS unit and return in two months for follow-up. (Id.)

On June 3, 2013, Petitioner returned to Dr. Hennessy who noted that he was taking Norco again for pain for the first time since October. (Px1 at 6) The doctor indicated that he did not see a great deal of fusion with the inter-body graft but Petitioner's right, greater than left, posterolateral grafts appeared very solid and the hardware was intact. (Id.) He opined that Petitioner would likely be released to a light duty capacity with no lifting of more than 20 lbs. occasionally. He further noted that Petitioner was to utilize an AFO brace. Dr. Hennessey noted that '[c]learly, he is not going to return to his regular job that he had previously." (Id.)

On July 1st, 2013, Dr. Sokolowski again examined Petitioner noting permanent right lower extremity weakness and the need for pain management in perpetuity. The doctor anticipated Petitioner to experience ongoing significant functional limitations including permanent restrictions consisting of:

- No prolonged standing and walking;
- Standing and walking to be limited to 15-minute episodes at a time;
- No bending or squatting;
- No lifting more than 10 pounds;
- No prolonged sitting more than 30 minutes.
- Frequent position changes. (Px7 at 1)

On September 9, 2013, Petitioner saw Dr. Hennessy who placed him at Maximum Medical Improvement ("MMI") with the permanent restrictions outlined by Dr. Sokolowski. He added restrictions of alternating sit/stand every 30 minutes and only to engage in rare bend/squat/kneel positions. "I do not think any further therapy, injections, or surgery will alter those

restrictions." (Px1 at5) The doctor further noted Petitioner will need to replace the AFO brace every two years or so. (Id.)

Respondent scheduled Petitioner for a Functional Capacity Evaluation ("FCE") which Petitioner did not attend based upon his treating physician's advice. Petitioner's benefits were terminated on December 9, 2013 by Respondent. (Px17, Px9 at 82-84)

On December 9th, 2013 Dr. Avi Bernstein examined Petitioner for a second time at Respondent' request pursuant to Section 12 of the Act. Dr. Bernstein opined that given the Petitioner's four level fusion, he should not attempt to work beyond the light duty physical demand level. He issued Petitioner the following restrictions:

- Lifting 25lbs on an occasional basis;
- No repetitive bending;
- He should be allowed to change position as required. (Rx1)

After viewing "some surveillance video", on December 19th, 2013, Dr. Bernstein opined that Petitioner was capable of performing at his pre-injury level of function and had no functional limitations due to his injuries, surgeries or drop foot. (Id.)

On July 3, 2014, Dr. Sokolowski reviewed surveillance video tape of Petitioner carrying plywood, replacing windows, ascending 4 steps of a ladder, and installing siding on a single level home. Dr. Sokolowski modified his permanent restrictions based on his occupational activity to the following:

- Limited bending and squatting;
- Limited ladder climbing (low heights only);
- No lifting great than 35 pounds;
- Limited continuous standing and walking to 30 minute intervals with breaks thereafter and frequent position changes. (Px23)

On February 14th, 2014, Petitioner was seen again by Dr. Hennessy who examined him and indicated his findings remained much the same as the previous exam. (Px9 at 48) Petitioner could not heel or toe walk on the right buthad reasonable strength on plantar flexion to manual muscle testing with some "giving out". (Id.) The doctor commented that "[i]n any event his [Petitioner's] attitude remained strong, and he was trying to do things as he was able." (Id. at 49)

On May 2, 2014, Dr. Hennessy refilled Petitioner's Norco prescription. (Id. at 54)

Petitioner has not been evaluated by a physician since February of 2014.

Petitioner's Testimony on August 25, 2015

Petitioner testified that he established a handyman/construction business in Mount Sterling where he has been exerting himself beyond his physical restrictions. Most of his job referrals come from a local lumberyard. He testified that most jobs take him longer than they should because of his physical limitations. He routinely lifts in the range of 10-50 pounds and uses a variety of carpentry tools in performing his work duties including a tape measure, hammers and saws. Petitioner testified further that occasionally he will hire help to perform jobs.

Petitioner admitted that he built a garage in March 2015. He hired help to assist him in lifting the walls and putting the rafters in place.

According to his testimony, he feels bad in the morning and it takes him a long time to get up out of bed. He experiences pain in his back and legs. Petitioner claims that once he gets up out of bed, he goes to work if he has a job, and works until the pain becomes too great. He claims that he only works two to three hours a day. He takes ibuprofen and lays down when he is in pain. He tries to work full days but takes off work if he feels bad. Petitioner claimed that he used to wear a brace for his foot but, because it broke, no longer does. He did not replace the brace because he does not have any insurance. Petitioner testified that he wears cowboy boots because they have a stiff ankle and they support his foot.

Petitioner occasionally takes hydrocodone from a prior prescription and regularly takes ibuprofen. He has problems sleeping and limits his driving due to pain.

He has not received any vocational rehabilitation or taken any types of classes.

Petitioner produced earning records for 2014 only. He produced a series of photographs showing various projects he had done in 2015. According to the hand written summary of jobs Petitioner prepared, he earned about $20,000.00 in 2014.

Petitioner claimed that he had job expenses from a Ford F250 truck. However, he admitted that he purchased that truck prior to starting his handyman business.

Petitioner testified on cross that he also works for his landlord, Roger Zimmerman. He had testified previously that he was living in a home owned by Roger Zimmerman that he lived in, rent free, in exchange for work services

provided to Mr. Zimmerman. According to his testimony, he worked for Zimmerman at a rate of once a week or so. He reported working on approximately ten different properties for Zimmerman in 2014 and eight different properties for Zimmerman in 2015. At the hearing in August, 2015 Petitioner testified that he continued to live rent free in Zimmerman's home. Petitioner reported that when he worked for Zimmerman, sometimes Zimmerman worked with him. Petitioner reported that sometimes he provided his own tools and sometimes Zimmerman provided tools.

Petitioner testified that he worked primarily in the Mount Sterling area but also has been driving up to an hour and a half for various projects. On cross, Petitioner admitted that he started working as a handyman in 2013 but had no records of the work that he did or his earnings prior to 2014. Petitioner admitted preparing a summary of work that he did in 2014, but denied preparing a tax return for 2014.

Petitioner built a garage in 2015 that he earned $3,000.00 to $4,000.00 for.

Petitioner testified that all of the work he had been doing in his business as Todd Floistad Construction was carpentry work. He has been performing both rough carpentry work and finish carpentry work. Petitioner testified that he bid for jobs that also required electrical, plumbing and concrete work but hired subcontractors to perform those services.

Petitioner has never applied for employment anywhere. The only work that he has done has been his handyman/construction work. Petitioner testified that Roger Zimmerman used to charge him $450.00 a month in rent but now his home is rent free. Petitioner testified that most of the work he does for Zimmerman has been fixing up rental units after people move out.

CONCLUSIONS OF LAW

Whether Petitioner's current condition of ill-being is casually connected to this injury

At the hearing on August 25, 2015, Petitioner testified that he continues to have pain but is unable to see a physician, unable to get a new AFO brace and unable to get his prescriptions filled as he has no insurance and can't afford to pay cash for physician visits or prescriptions. (Tx at 26-28)

Petitioner testified that since his benefits have been cut off, he drinks more to take the edge off the pain and takes over the counter ibuprofen and prescription pain medication when the pain is intolerable. (Id. at 28) Petitioner uses his TENS unit daily. (Id. at 30)

Dr. Sokolowski opined the Petitioner is anticipated to have ongoing functional limitations including:

- No prolonged standing and walking;
- Standing and walking to be limited to 15-minute episodes at a time;
- No bending and squatting;
- No lifting more than 10 pounds;
- No prolonged sitting up to a maximum of 30 minutes;
- Frequent position changes are also required. (Px 7 at 1)

Dr. Hennessy agreed with the restrictions outlined by Dr. Sokolowski. He added restrictions of:

- Alternating sit/stand every 30 minutes;
- Rare bend/squat/kneel positions.

Dr. Hennessey commented that "I do not think any further therapy, injections, or surgery will alter those restrictions." (Px1 at 5) He will also need to replace the AFO brace every two years or so. (Id.)

Dr. Bernstein opined that given the Petitioner's four level fusion, he should not attempt to work activity beyond the light duty physical demand level. He issued Petitioner restrictions as follows:

- Lifting 25 lbs. on an occasional basis;
- No repetitive bending, lifting or twisting;
- Position changes as required. (Rx1)

After viewing "some surveillance video", on December 19th, 2013, Dr. Bernstein amended his opinion asserting that Petitioner is capable of performing at his pre-injury level of function and no functional limitations due to his drop foot or other aspects of his injury and surgery. (Rx1)

The Arbitrator assigns less weight to Dr. Bernstein's December 19th, 2013 report as he did not indicate how much surveillance video he viewed; nor did he indicate what he observed the Petitioner doing in the video. The Arbitrator notes that ten days prior to this report, Dr. Bernstein opined that, "[c]onsidering his neurologic injury and the fact that he has a four level fusion, it is my opinion that this patient should not attempt work activity beyond the light duty physical demand level. He certainly is strong and likely capable of lifting 25lbs on an occasional basis..." (Id.)

Dr. Hennessy testified that, "it wasn't clear by the letter that Dr. Bernstein understood what the pre-injury status was. And again, Mr. Floistad's employment was one of the most physically demanding jobs I have ever encountered in my experience as an orthopedic surgeon. (Px9 at 53)

On July 3, 2014 Dr. Sokolowski reviewed video tape of Petitioner carrying plywood, replacing windows, ascending 4 steps of a ladder, and installing siding on a single level home. Dr. Sokolowski modified his permanent restrictions based on his occupational activity to the following:

- Limited bending and squatting;
- Limited ladder climbing (low heights only);
- No lifting greater than 35 pounds;
- Limit continuous standing and walking to 30 minute intervals with breaks thereafter and frequent position changes. (Px23)

The Arbitrator adopts the opinions of Dr. Hennesey and Dr. Sokolowski. As Petitioner's longtime treating physician and surgeon, Dr. Hennesey is intimately familiar with Petitioner's condition and course of treatment. Dr. Sokolowski instituted Petitioner's restrictions after viewing, presumably, portions of the same surveillance video as did Dr. Bernstein and indicating specifically what he saw Petitioner doing in the video.

Since the 19(b) hearing on this matter, Respondent has produced no evidence of a subsequent accident or injury, or any additional medical evidence.

Based on the evidence contained in the record, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to the work accident he sustained on December 2, 2011.

Whether Petitioner is entitled to TPD from September 9, 2013 to December 31, 2013.

Petitioner claims TPD should be awarded from September 9, 2013 to the present. As of September 9, 2013, Petitioner had reached MMI.

The Arbitrator found, in her prior decision that the Petitioner's average weekly wage is $1,243.32.

Illinois law anticipates that work-related injuries can seriously affect an employee's wage earning future. It demands that employers, such as the Respondent, facilitate vocational rehabilitation:

> *Every employer shall notify each injured employee who has been granted compensation under the provisions of Section 8 of this Act of his rights to rehabilitation services and advise him of the locations of available public rehabilitation centers and any other such services of which the employer has knowledge.* (820 ILCS 305/6/(d) (West 2004).

Complementing this Statute is Commission Rule 7110.70:
Section 7110.10 Vocational Rehabilitation

> *The employer or his representative, in consultation with the injured employee and, if represented, with his or her representative, shall prepare a written assessment of the course of medical care, and, if appropriate, rehabilitation required to return the injured worker to employment when it can be reasonably determined that the injured worker will, as a result of the injury, be unable to resume the regular duties in which engaged at the time of the injury, or when the prepared of total incapacity for work exceeds 120 continuous days, which ever first occurs.*
>
> *The assessment shall address the necessity for a plan or program, which may include medical and vocational evaluation, modified or limited duty, and /or retraining, as necessary.*

Respondent never fulfilled its mandatory obligation under the Act. At no time has Respondent contacted the Petitioner regarding a vocational plan or any other vocational opportunity. The attempt of Julie Bose, Respondent's vocational expert, who did interview the Petitioner and her testimony, failed in all respects to comply with the requirements of the Statute.

Petitioner testified in the first 19(b) hearing, since being cut off, he has been able to do odd jobs and small projects bringing in approximately $300-$600 per month. (First Transcript 60)

The Arbitrator finds that Petitioner is entitled to $724.95 per week from September 9, 2013 through December 3, 2013. (Average of $300-$600 is $450 per month or $103.93 per week. $828.88-103.93=$724.95)

Whether Petitioner is entitled to benefits under section 8(d)1 of the Act

The Act provides that:

> *If, after the accidental injury has been sustained, the employee as a result thereof becomes partially incapacitated from pursuing his usual and customary line of employment, he shall, except in cases compensated under the specific schedule set forth in paragraph (e) of this Section, receive compensation for the duration of his disability, subject to the limitations as to the maximum amounts fixed in paragraph (b) of this Section, equal to 66-2/3% of the difference*

> *between the average amount which he would be able to earn in full performance of his duties in the occupation in which he was engaged at the time of the accident and the average amount which he is earning or is able to earn in some suitable employment or business after the accident.*

To qualify for a wage differential award under Section 8(d)(1), a claimant must prove (1) partial incapacity which prevents him from pursuing his "usual and customary line of employment" and (2) an impairment of earnings. *Gallienetti v. Industrial Commission*, 315 Ill. APP. 3d 721 (2000).

On July 3, 2014, Dr. Sokolowski reviewed video tape of Petitioner carrying plywood, replacing windows, ascending 4 steps of a ladder, and installing siding on a single level home. Dr. Sokolowski modified his permanent restrictions based on his occupational activity to the following:

- Limited bending and squatting
- Limited ladder climbing (low heights only)
- No lifting great than 35 pounds
- Limit continuous standing and walking to 30 minute intervals with breaks thereafter and frequent position changes.

Dr. Sokolowski and Dr. Hennessy have each opined that Petitioner can no longer perform his former occupation. (Px23)

Petitioner produced vocational counselor, Lisa Helma who testified that based on these updated restrictions, Mr. Flagstad's most probable wage earning potential was between $9-$12 hourly with vocational rehabilitation intervention. (Px22)

Petitioner filed a vocational plan with the Commission which details the services Petitioner would need in order to obtain a job in the $9-$12.00 per hour range. (Id.) Ms. Helma testified that without vocational services, "he would still be employable; however, without vocational rehabilitation services, he would be looking at jobs such as cashier, retail clerk, some fast food types of positions; and that's assuming that they would be willing to accommodate his need to change positions." (Tx at 137) When asked what the wage for the above jobs would be, Ms. Helma responded, "They would be a minimum wage type position." (Id. at 137) The minimum wage is $8.25 per hour. (Id. at 138)

Ms. Helma relied on the Dictionary of Occupational Titles to identify positions in which Petitioner would potentially be able to obtain with vocational training and placement. The jobs identified were an office clerk, dispatcher, hotel clerk, security guard, order clerk and customer service representative. (Px22A-F) Ms. Helma testified that Petitioner would need

additional training to secure any of the above jobs. (Tx at 141-154) Ms. Helma indicated an individual who is at an entry level occupation without the skills and experience in the job they are looking for, their hourly rate would be at, "about the bottom 10th percentile..." (Tx at 142)

According to her testimony the starting wages for the jobs she outlined would be slightly lower in Mt. Sterling than the Chicago Metropolitan area.

According to Ms. Helma, the hourly rate of $8.25(minimum wage) should be used to calculate his average weekly wage, yielding an average weekly wage of $330.00. Petitioner would be entitled to $608.88 per week for the duration of the disability or until he is 67 years old. (AWW $1243.32-$330.00 x 2/3)

Petitioner testified that he moved to Mt. Sterling since he was no longer receiving over-time pay and could no longer afford his home in Elgin. (Tx at 43-44) It is clear that over time, double time and the two dollar stipend Petitioner received while working for Respondent made up a large percentage of his income. (Rx3)

Respondent produced vocational counselor Julie Bose who testified that Petitioner's age, education, work history, skill level and physical demand as well as transferability of skills and residual function, are critical in assessing his ability to work from a medical viewpoint. Ms. Bose did not use Respondent's Section 12 examiner, Dr. Bernstein's opinions as to Petitioner's residual function but relied upon the restrictions set forth by Dr. Sokolowski. (Id. at 190)

The Arbitrator notes that Ms. Bose had no letter of engagement. (Tx197) She had no hourly time sheet and did not interview Petitioner. (Id. at 198-200) She did not bring reports or notes from reports despite having worked in her profession for 16 years. (Id. at 183, 201) She did not look at the video surveillance footage, instead, she based her notes on the review of the surveillance report and she did not bring those notes with her to the hearing. (Id. at 200)

Ms. Bose testified that because Petitioner has worked with tools; he could work as a tool counterman, despite his lack of experience in sales and computer software. (Id. at 194) She thought that Petitioner had skills that would transfer to working for as a cost estimator or as a property manager but was unaware of the DOT definition and content of that title (she did know the number, just not the content). (Id. at 209) She conceded that a property manager had an SVP code of 8 which was highly skilled. (Id. at 211). She testified that digging ditches would offer transferable skills to the position of property manager. (Id. at 212) Keyboarding and software knowledge were not important. (Id. at 214) When asked what specific

experience Petitioner had in drafting agreements, stipulating the extent and scope of management responsibilities, services to be performed and costs for services, Ms. Bose answered, "I don't know." (Id. at 209) Ms. Bose used the wages in her report and in her testimony for the 50% of the jobs she was recommending. She testified that a property manager in the state of Illinois made $28.38 and that was the average or 50%, she did not look up the 10%. (Id. at 213)

Ms. Helma noted that without additional training, any placement of Petitioner into a job would be difficult. Many jobs were beyond his reach due to of lack of training, education, experience, and restrictions. Jobs involving cement finishing, truck driving or as an estimator or supervisor would be highly unlikely. Petitioner's lack of training, transferable skills, education, experience and restrictions prevent him from a successful placement.

Ms. Helma testified that based on her research, Petitioner would not be a qualified candidate for a property manager given his level of education and his experience: "It would appear that the position of property manager is more of a business related occupation that would require experience and a bachelor's degree." (Id. at 230) Ms. Helma testified that she utilized the Dictionary of Occupational Titles and current job postings. (Id. at 230) With respect to the property manager job, the wages had increased .37 cents per hour from 2011-2012, not the increase Ms. Bose suggested. (Id. at 232, 238) Ms. Helma further testified that many of the property manager tasks were business related functions rather than trade functions that Petitioner had performed throughout his career with the City of Northlake as a journeyman carpenter. (Id. at 233) Ms. Helma testified that she used the wages and job descriptions from 2011 and that she checked the updated, May, 2012 job descriptions and they had not changed. According to her testimony, Petitioner was not qualified for the positions Ms. Bose had suggested given Petitioner's skill set, education, work history and restrictions.

Lisa Helma
August 25, 2015 testimony

Lisa Helma testified that her opinions as to the medical status, situational status, educational status and vocational history of the Petitioner had not changed. (Tx at 75) Ms. Helma opined that the handyman job's Petitioner has been performing since 2014 are not suitable because they exceed his restrictions. (Id. at 78) She testified that "by working outside of his restrictions there is a greater chance of further injury. By working outside of his restrictions he also had numerous complaints regarding his pain, so again it goes back to he would not be able to maintain that type of employment for a longer duration." (Id. at 77) Ms. Helma opined that with

vocational training consisting of marketable computer skills, Petitioner should be able to find a suitable occupation as an office clerk, administrative clerk, dispatcher, front desk clerk, security guard or customer service representative. (Id. at 78) Without vocational training, he would only be able to obtain a minimum wage job making $8.25. (Id. at 79-80)

Ms. Helma was skeptical of Mr. Floistad finding a minimum wage job, as a cashier, retail clerk or in fast food, because of the accommodation that would need to be made for sitting and standing. She likened the probability of Petitioner finding a minimum wage job to a "needle in a haystack". (Id. at 79) According to her testimony, "the alternating sit and stand" restriction "takes him out of the light and medium occupations that he would otherwise be qualified for given the material handing restriction of the 35 pounds that Dr. Sokolowski offered him." (Id. at 89) Petitioner's inability to work a 40 hour week would have an adverse effect on his employability; "it's a negative factor. Again, it demonstrates that he would be unable to sustain that kind of employment over the course of a career." (Id. at 84) Ms. Helma also testified that Petitioner did not harm his chances of finding a suitable occupation by moving to Mt. Sterling. She indicated that there is only a 2.9% unemployment rate in Brown County (where Mt. Sterling is located) and although there are fewer jobs, there are fewer people looking for jobs. (Id. at 80-81).

Petitioner's testimony
August 25, 2015

Petitioner testified that he has been working above his restrictions since his benefits were terminated in order to provide for his family. (Tx15) He, in essence, conducted his own job search. He testified that although he hires out contractors to do some of the heavy lifting and concrete work he lifts 50 lbs. and regularly goes above all of his restrictions. (Tx at 19-21, 69) Petitioner provided photos of the types of jobs he has been able to perform in 2014 and 2015. (Px35) When Petitioner meets with potential clients he must explain that the job may take longer to complete due to his injury. (Tx at 19) In 2015, Petitioner testified that he built a garage. He had to hire contractors to do the concrete work but he had to lift the truss. After working on the garage for two days, he was off for three days. (Tx 21) He testified he was in excruciating pain and had to stay at home. (Id. at 22) He is unable to work full time. He works an average of 2-3 hours at a time. (Id. at 23) When he does work a full day he would need to be off for a few days after. (Id. at 25) He is unable to take all the jobs that come to him given his condition. (Id.)

Petitioner consumes three ibuprofens as much as twice a day since he has been working above his restrictions. (Id. at 27) Petitioner has also had to take pain medication and has increased his alcohol intake to take the edge off the pain. (Id. at 27-28) Since Petitioner has been working above his restrictions he has pains all through the night and sporadic sleep and his tolerance for driving has gotten shorter. (Id. at 28, 29)

Petitioner testified as to his income from 2014. He produced 1099's and a job log showing a total income of $19,944.49. Petitioner also testified that in addition to the $19,944.49 he receives $450.00 per month ($5400 per year) in free rent working for Roger Zimmerman although he testified there is no written agreement and that arrangement could end tomorrow. (Id. at 67)

Petitioner testified that his expenses associated with running his handyman business in 2014 were $22,870.00. (Px33) He testified that his truck was used for work and that the family used a different car. (Tx at 39) On cross examination, Petitioner did acknowledge that he had the truck prior to starting his handyman business.

The Arbitrator Finds that Petitioner is entitled to an award pursuant to Section 8(d)(1)

The Arbitrator discounts the testimony of the vocational counselor produced by Respondent, Ms. Bose, who testified that she picked up this case by being at a deposition where one of the partners of Respondent's law firm was at. (First Trans 197) She had no letter of engagement. (Id.) She had no hourly time sheet and did not interview Petitioner. (Id. at 198-200) She did not bring reports, or notes from reports, despite having worked in her profession for 16 years. (Id. at 183, 201) She did not actually view the video tape surveillance of Petitioner. Instead, she based her opinion on the notes contained in the surveillance report and she did not bring these notes with her to court. (Id. at 200) She did not know who authored the video tape summaries that she took notes from. (Id.).

She opined that in determining the limitations of the Petitioner in vocational placement; age, education, work history, skill level and physical demand as well as transferability of skills and residual function in order to assess ability to work from a medical viewpoint are all critical. She did not use Respondent's Section 12 examiner, Dr. Bernstein's opinions as to Petitioner's residual function but rather relied upon the restrictions set forth by Dr. Sokolowski. (Id. at 190)

The transferable skills analysis employed by Ms. Bose was weak, non-specific and made little sense. She testified that since Petitioner has worked

with tools; he could work as a tool counterman despite having no experience in sales and not being proficient in computer software. (Id. at 194) According to her analysis, if Petitioner was confronted with book keeping functions or credit client accounts, the fact that he is not proficient with computer software or key stroking was not relevant. (Id. at 214) She testified that Petitioner had transferable skills for a position as a cost estimator or as a property manager but was unaware of the DOT definition and content of that title (she did know the number, just not the content). (Id. at 209) She did admit that a property manager had an SVP code of 8 which was highly skilled. (Id. at 211). She went on to state that digging ditches would offer transferable skills to this highly skilled position of property manager. (Id. at 212) To start in this highly qualified job keyboarding and software knowledge are not important. (Id. at 214) When asked what specific experience Petitioner has in drafting agreements, stipulating the extent and scope of management responsibilities, services to be performed and costs for services, Ms. Bose answered, "I don't know." (Id. at 209) Ms. Bose used the wages in her report and in her testimony for the 50% of the jobs she was recommending. She testified that a property manager in the state of Illinois made $28.38 and that was the average or 50%, she did not look up the 10%. (Id. at 213) To testify that someone with Petitioner's skills and experience could walk into a highly skilled, level 8 job, with no training, and get paid at the 50% rate is not credible.

Respondent has offered no vocational training, benefits or classes. Given the low probability of Petitioner finding a minimum wage job that is willing to accommodate his restrictions, the only job available for Petitioner, although unsuitable and not sustainable, is the handyman job he is currently performing.

The Arbitrator finds that based on the evidence contained in the record, including the testimony of Lisa Helma whom the Arbitrator found to be credible, Petitioner is entitled to an award pursuant to 8(d)(1).

Given the low probability of Petitioner finding a minimum wage job that is willing to accommodate his restrictions, the only job available for Petitioner, although unsuitable and not sustainable, is the handyman job he is currently performing. The Arbitrator relies on Petitioner's 2014 income, without the rent and car payment, when calculating the 8(d)(1) benefits. Petitioner testified there is no guarantee that he will continue to get free rent. Additionally, Petitioner testified that his truck is needed to pull his work trailer and is essential to his job functions.

Petitioner's 2014 income, without the rent and car payment, will be used when calculating his 8(d)(1) benefits. Although Petitioner has a deal worked out with his landlord where he lives rent-free, there is no guarantee that this arrangement will continue.

The Arbitrator finds that Petitioner is entitled to $779.46 per week beginning January 1, 2014 until he reaches the age of 67 under section 8(d)(1).

8(d)(1) calculation

Petitioner's average weekly wage prior to the accident was $1,243.32.

Using income earned in 2014, the Arbitrator finds Petitioner is entitled to $779.46 per week:

AWW =	$487.39
Expenses =	$309.42 per week
2/3 difference =	$779.46

Whether Petitioner is entitled to penalties/attorney's fees under 8(a), 19(k), 19(l), 16, 4(a)

Petitioner claims entitlement to penalties and attorney's fees. The claim for penalties and attorney's fees was raised at the last hearing and denied. The current claim for penalties and fees is also denied. There are no medical bills are issues with respect to TTD in dispute. Petitioner's claim 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 Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Timothy Lloyd,

Petitioner,

vs.

NO: 15 WC 24315

Pepsi, Co.,

18IWCC0004

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causation, wages, medical expenses 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 Comm'n*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Commission modifies the decision of the Arbitrator to find that Petitioner was temporarily totally disabled from 8/20/15, the date Dr. Templin noted that Petitioner was unable to return to work (PXC), through 2/17/16, the date of arbitration, less the one day he returned to work (1/26/16), for a period of 25-1/7 weeks. The Commission finds that the Arbitrator incorrectly commenced TTD the day after Respondent last paid TTD, on 1/15/16, and awarded benefits through arbitration.

The Commission also finds that the Arbitrator incorrectly denied Respondent credit for past TTD paid. The Commission corrects the Arbitration decision to find that Respondent is entitled to a credit for any and all amounts paid on account of this injury pursuant to §8(j) of the Act, including $13,672.02 in TTD, $9,415.12 in "WC medical benefits" and $913.62 in "Short-Term Disability Medical" as stipulated to by the parties at the time of Arbitration. (Arb.Ex.#1).

18IWCC0004

Finally, the Commission corrects the Arbitrator's decision to show that this matter was tried pursuant to §§19(b)/8(a) of the Act. In issuing his decision, the Arbitrator neglected to utilize the proper §19(b) decision form containing the relevant remand language, and the Commission hereby remedies this oversight by noting that "[i]n 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."

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 7/8/16 is modified as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $656.72.82 per week for a period of 25-1/7 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 for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner reasonable and necessary medical expenses in the amount of $22,659.96 pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for the treatment recommendations of Drs. Patel and Templin, including MRI and CT scans as well as fusion surgery, pursuant to §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 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 pursuant to §8(j) of the Act, including $13,672.02 in TTD benefits paid; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers for which Respondent is receiving credit under this order.

18IWCC0004

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $26,000.00. 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: JAN 3 - 2018
o:11/7/17
TJT/pmo
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LLOYD, TIMOTHY
Employee/Petitioner

Case# **15WC024315**

PEPSI CO
Employer/Respondent

18IWCC0004

On 7/8/2016, 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 0.34% 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:

5280 THOMAS LAW
BRIAN C THOMAS
55 W MONROE ST SUITE 3175
CHICAGO, IL 60603

5001 GAIDO & FINTZEN
JUSTIN C KANTER
30 N LASALLE ST SUITE 3010
CHICAGO, IL 60602

18 IWCC0004

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

Timothy Lloyd
Employee/Petitioner

v.

Pepsi Co.
Employer/Respondent

Case # **15** WC **024315**

Consolidated cases: **-0-**

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 **February 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. ☒ 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 **Future medical care, including prescribed fusion.**

18IWCC0004

FINDINGS

On **May 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 the accident.

In the year preceding the injury, Petitioner earned **$42,357.98**; the average weekly wage was **$985.07**.

On the date of accident, Petitioner was **43** years of age, ***married*** with **1** 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 not be given a credit of $-- for TTD, $- for TPD, $- for maintenance, and $ for other benefits.

Respondent is entitled to a credit of $ **[Parties stipulated that Respondent reserves the right to assert 8(j) credits for group health insurance benefits]** under Section 8(j) of the Act.

ORDER

Petitioner proved a causal connection existed between the May 30, 2015 incident and a claimed condition of ill-being of his back.

Based on the Arbitrator's decision on casual connection, Petitioner is entitled to an award of the outstanding medical bills of $22,659.96.

TTD sought from January 15, 2016, through the February 17, 2016, date of hearing is granted at the rate of $656.72.

Respondent is responsible for the recommended treatment including MRI scans and CT scans ordered by Dr. Patel and for the fusion surgery recommended by both Dr. Patel and Dr. Templin.

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

7.8.16
Date

JUL 8 - 2016

18IWCC0004

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS COMPENSATION COMMISSION
IN THE STATE OF ILLINOIS

TIMOTHY LLOYD,	)	
	)	
Petitioner,	)	
	)	Number: 15 WC 024315
vs.	)	
	)	
PEPSI CO.,	)	
	)	
Respondent.	)	

STATEMENT OF FACTS

The Petitioner, Timothy Lloyd, is married with one dependent child. His date of birth is January 17, 1972. He had been working at Pepsi Co., for 15 years as a warehouseman. He worked an average of 50 hours per week. In the course of his work, he utilized a forklift provided by the Respondent and his job duties included, but were not limited to, moving pallets in the warehouse and onto and off of tractor trailers.

On May 30, 2015, Petitioner was performing his regular work duties at Pepsi on a forklift. He was taking loaded pallets out of a trailer into the warehouse. As the trailer was near empty, he loaded his forklift with pallets of material and backed out of the trailer. As he backed out of the trailer and neared the dock plate, the balance of the trailer shifted due to the lack of weight on the front end of the trailer and the trailer fell six inches. Mr. Lloyd and his forklift also fell roughly six inches with the trailer. Mr. Lloyd immediately felt pain in his lower back and reported that pain to his supervisor.

The same day of the injury, Petitioner went to Concentra where he reported pain in his neck, lower back and left leg. Over the next few weeks, Petitioner continued seeing the doctors at Concentra. Petitioner sought treatment at Concentra's Occupational Health Center a total of seven times between May 30, 2015 and July 17, 2015. The doctors at Concentra continued to recommend medication to dull the pain and physical therapy (Respondent's Exhibit 3). The doctors at Concentra also referred Petitioner out for an MRI which was performed on June 25, 2015 (Petitioner's Exhibit C). Over that time, Petitioner's complaints remained constant and consistent: lower back pain on the lower left side of the back. Frustrated by his lack of progress, Petitioner sought treatment with his own physician, Dr. Cary Templin at Hinsdale Orthopedics.

Petitioner initially saw Dr. Templin on August 20, 2015 (Petitioner's Exhibit A). At that time, he complained of low back pain that extended to his left buttock (Petitioner's Exhibit A). Dr. Templin reviewed an MRI taken June 25, 2015, which showed disc degeneration with diffuse broad based disc protrusion at L5-S1; mild broad based disc protrusion at L4-5 (Petitioner Exhibit C, MRI of June 25, 2015). Because he underwent a course of physical therapy without benefit, Dr. Templin recommended epidural steroid injections for Mr. Lloyd's lower back (Petitioner Exhibit A, 8/20/15 visit with Dr. Templin).

Mr. Lloyd underwent three rounds of two injections with Dr. Abusharif at Pain Treatment Centers of Illinois (Petitioner's Exhibit C). Mr. Lloyd had injections on September 9th, September 22nd and October 7th (Exhibit C). Those injections provided no long term benefit. Because of the failure of conservative treatment, Dr. Templin recommended a fusion at the L5-S1 level (Petitioner Exhibit A, visit of November 12, 2015).

Because of the severity of Dr. Templin's recommendation, Mr. Lloyd sought a second opinion from Dr. Alpesh Patel at Northwestern. On December 12, 2015, Petitioner saw Dr. Patel (Petitioner's Exhibit B). On December 12th, Mr. Lloyd complained of pain to his lower back that went down his left leg, occasionally to the back of the knee. After examination and review of Mr. Lloyd's June 2015 MRI, Dr. Patel also suggested a surgical approach to treatment of Mr. Lloyd. Dr. Patel recommended a decompression and fusion at L5-S1 (Petitioner's Exhibit B).

Petitioner testified that he did not recall any injuries or accidents involving his low back prior to May 30, 2015. He did acknowledge that if there was a claim involving his back in May 2012—per Dr. Harel Deutsch's IME report, (Respondent's Exhibit 2)—then he would not refute that report although Petitioner testified he did not specifically recall that incident (and no medical records from the claimed workers' compensation claim were provided by Respondent). Although he didn't specifically remember, it, Petitioner acknowledged if there was a 2012 workers' compensation claim and notation of back pain that he may have had pain back sometime in 2012; however, did not have back pain since that time and certainly had no back pain in the months and years leading up to the May 30, 2015, incident on the fork lift.

At the time of the hearing, Petitioner had been off work since August 2015. Petitioner was paid TTD from August 2015 through January 14, 2016. Petitioner had been taken off work by both Dr. Templin (Petitioner's Exhibit A) and Dr. Abusharif (Petitioner's Ex. C). The week of January 25, 2016, Petitioner was called back to work by Respondent. Petitioner went back to work for a few hours the week of January 25th. Petitioner attempted to work, however, because of the pain associated with working, he stopped working and reported that pain to his supervisor. He has been out of work since. He testified he would like to get the medical treatment his doctors recommended so he can get back to work.

Respondent Pepsi Co., did not provide witness testimony, however, did provide Petitioner's wage statement, Dr. Deutsch's IME report and medical records from Concentra's Occupational Health Center (Respondent's Exhibits 1, 2 and 3).

FINDINGS ON DISPUTED ISSUES

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

The Arbitrator finds that an accident did occur that arose out of and in the course of Petitioner's employment by Respondent. The Petitioner credibly testified that on May 30, 2015, he was on a fork lift exiting the trailer with loaded pallets when the trailer collapsed which sent Petitioner and his fork lift falling six inches. His testimony was corroborated by the consistent history provided within the medical records.

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

The Arbitrator finds that Petitioner's condition of ill-being, the disc protrusions found on MRI at L4-5 and L5-S1 and the aggravation of the pre-existing disc degeneration at L5-S1 are causally related to his accident at work. In so finding, the Arbitrator relies on the credible testimony of the Petitioner, taken together with the medical records of his treating medical physicians.

Petitioner's orthopedic surgeon, Dr. Templin, provided that Mr. Lloyd was injured in a work related incident. That assessment was shared by Dr. Patel, the orthopedic surgeon from

Northwestern who provided Mr. Lloyd a second opinion. Both of these doctors relate Petitioner's current condition to the May 30, 2015, incident at work. Further, the Arbitrator finds Mr. Lloyd credible when he said he did not have complaints of back pain before May 30, 2015.

The Respondent's evidence also suggests that a lower back injury occurred to Petitioner on May 30, 2015. The medical records provided by Respondent show Petitioner complained of back pain immediately after the incident of May 30, 2015. Concentra's doctor, Dr. Sean Salehi, indicated that the low back pain was aggravated by the described work injury. Even the Dr. Deutsch's report notes Petitioner was injured at work—as according to that report he was at maximum medical improvement on September 1, 2015. Nature and extent, not whether Petitioner was injured, was the focus of Dr. Deutsch's report.

Dr. Deutsch also noted that Mr. Lloyd was previously injured his back at work in 2012. However, neither the Respondent nor Dr. Deutsch provided medical records indicating Mr. Lloyd complained of back pain in 2012.

Petitioner carries the burden of providing his case by a preponderance of the evidence. In the present case, the preponderance of the evidence provides that Petitioner's current condition of ill-being is related to the May 30, 2015, work incident. The Arbitrator finds the Petitioner's testimony credible; further that testimony is corroborated by the medical records. There is no evidence Petitioner had back pain in the months and years before the May 30, 2015, incident; and the sole note of prior back pain in 2012—provided only by Dr. Deutsch's report—was not corroborated by any medical records that the Respondent presumptively would have had access to.

Taken all of the evidence together, the arbitrator concludes that Petitioner has proven, by a preponderance of the evidence, that his claimed lower back condition is related to the May 30, 2015, work incident.

G. WHAT WERE PETITIONER'S EARNINGS?

In dispute are Petitioner's earnings. Respondent provided a wage statement of Petitioner showing total earnings of $42,357.98 (which included overtime at straight time). However, Respondent divided total earnings by 52 weeks. When using Respondent's Exhibit 1, which is the wage statement, the Arbitrator notes that the Petitioner actually worked 43 weeks for the prior year and had nine weeks on disability. Therefore, it is more appropriate to divide by 43 weeks to come to an accurate average weekly wage, which is $985.07. This is consistent with the Petitioner's testimony and his Application for Adjustment of Claim, wherein he lists an average weekly wage of $1,000.00. Therefore, the Arbitrator finds that Petitioner's average weekly wage was $985.07

J. HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?

The Arbitrator finds that the medical services rendered to the Petitioner were reasonable and necessary. The Arbitrator finds the Petitioner's testimony, coupled with the medical records, persuasive. All of the medical records provided regarding Petitioner's injuries are consistent. Petitioner did have an injury due to his employment at Pepsi Co. All of the treatment Petitioner has had is related to that May 30, 2015, injury.

As provided for above, Petitioner sought treatment with the doctors at Concentra's Occupational Health Centers and the physical therapists at Athletico. The physicians at

Concentra's Occupational Health Center sent Petitioner out for an MRI which was performed at Matteson MRI. Respondent paid for all of that medical treatment. Payment for that medical treatment is not at issue.

Petitioner started treatment with Dr. Cary Templin on August 20, 2015. Petitioner saw Dr. Templin on August 20, 2015, September 24, 2015 and November 12, 2015. Respondent paid for the first two visits, however, did not pay Dr. Templin's bill from November 12, 2015. The Arbitrator finds Respondent responsible for the outstanding bill of Dr. Templin dated November 12, 2015 (provided in Petitioner's Exhibit D1).

Commensurate with his treatment, Dr. Templin referred Petitioner out for additional treatment with Dr. Abusharif and Pain Treatment Centers of Illinois. Petitioner submitted two sets of bills from Pain Treatment Centers of Illinois. The first showing an outstanding balance of $8,504.63 is for professional fees associated with the treatment. It is interesting to note that Respondent paid the fees associated with the September 9, 2015, injection, but nothing else. Considering the totality of the evidence, the Arbitrator rules that the Respondent is responsible for the outstanding professional services bill from Pain Treatment Centers of Illinois (provided as Petitioner's Exhibit D2).

Petitioner also provided a bill from Pain Treatment Centers of Illinois' Surgical Suites (Petitioner's Exhibit D3). Again, examination of the bills shows Respondent paid for the initial September 9, 2015, injection, however, did not make payment for subsequent treatment. As provided for above, Arbitrator rules that Respondent is responsible for the outstanding bill from the Pain Treatment Centers of Illinois' surgical suites (providing as Petitioner's Exhibit D3).

Finally, Petitioner also submitted the outstanding medical bill from Dr. Alpesh Patel, which, according to testimony, was when Petitioner sought a second opinion of Dr. Templin's surgical

recommendation. The Arbitrator also finds that this medical bill is related to the May 30, 2015, incident and rules that Respondent is responsible for this medical bill as well.

Therefore, the Arbitrator finds that the medical services rendered to the Petitioner were reasonable and necessary. The Arbitrator awards payment of all medical bills presented. Respondent shall pay to Petitioner the reasonable and necessary medical services, pursuant to the medical fee schedule, of: Dr. Cary Templin - $111.00; Pain Treatment Centers of Illinois(professional services) - $8,504.63; Pain Treatment Surgical Suites—$13,539.33; and Northwestern Medicine - $505.00, as provided for in Sections 8(a) and 8.2 of the Act.

K. WHAT TEMPORARY BENEFITS ARE DUE?

The Arbitrator finds that Petitioner is entitled to Temporary Total Disability Benefits from January 15, 2016 through February 17, 2016. The Arbitrator relies on the credible testimony of the Petitioner, taken together with the records of his treating physicians.

After being called back to work by his employer the week of January 25, 2016, he attempted to return to work. Petitioner testified he went back to work because he wanted to see if he could do it and because he needed the money. However, after working a few hours, was not able to continue working without significant pain and stopped working. Prior to this attempt, both Dr. Templin and Dr. Abusharif took Petitioner completely off work because of his low-back injury. The Arbitrator finds the recommendations of Dr. Templin and Dr. Abusharif persuasive and finds that this TTD is due and owing to Petition.

Therefore, Petitioner is entitled to 4 and 5/7 weeks of January 15, 2016 through February 17, 2016. TTD to be paid at a rate of $656.72.

The Arbitrator further rules that Respondent was responsible for the past payment of TTD—between August 20, 2015 and January 14, 2016—and therefore, it does not get a credit for the past TTD paid (toward the current TTD owed).

O. FUTURE MEDICAL CARE

The Arbitrator finds that Petitioner is entitled to future medical care. The Arbitrator has reviewed the medical records submitted by both parties and notes the consistent and continued complaints of back pain throughout the records.

The medical records provide the timeline: Petitioner was initially seen by the Respondent's doctors. Petitioner was first seen by the company doctor on the date of the injury, May 30, 2015. The Respondent's doctors prescribed Naproxen and Ibuprofen and sent Petitioner to physical therapy. After going through this course of treatment and the pain not resolving, Petitioner sought an opinion with his own doctor, Dr. Cary Templin. Dr. Templin took Petitioner off work and started injection therapy with a pain specialist, Dr. Abusharif.

In Dr. Templin's records, Petitioner consistently complained of pain in his lower back that radiated to his left buttock. In Dr. Abusharif's records, Petitioner complains of pain in his lower back that radiates to his left buttock that intermittently radiated down his to his left thigh.

The injection treatment did not provide significant relief. After the failure of injection therapy, Petitioner again saw Dr. Templin. Because of the failure to conservative treatment, Dr. Templin recommended a fusion to treat the injury of May 30, 2015.

Due to this finding, Petitioner sought a second opinion with Dr. Alpesh Patel. The Patel also recommended surgical management. Dr. Patel stated: "I have recommended considering

surgical management. We discussed this would likely involve a posterior minimally invasive decompression and instrument infusion at L5-S1. I would, however, like to get a better MRI as well as a more updated closed MRI scan. We will order that. I have also asked him to get a CT scan of the lumbar spine so we can better assess the degree of bony foraminal narrowing as well for presurgical planning."

Although Dr. Salehi concluded that Petitioner did not need surgery, this conclusion was made on July 17, 2015, and based on the premise that Petitioner "will continue to improve over time" and before the failure of additional physical therapy and injection therapy.

The Arbitrator concludes that by a preponderance of the evidence the future medical treatment recommended by Dr. Templin and Dr. Patel is related to the May 30, 2015, work injury. The Arbitrator orders that the Respondent is responsible for the updated MRI scans and CT scans ordered by Dr. Patel and for the fusion surgery recommended by both Dr. Patel and Dr. Templin.

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

Benjamin Roberts,

Petitioner,

vs.

NO: 15 WC 31010

18IWCC0005

City of Granite City,

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, 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 21, 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.

18IWCC0005

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: JAN 3 - 2018
TJT:yl
o 12/5/17
51

Michael J. Brennan

Kevin W. Lamborn

DISSENT

I respectfully dissent from the finding that Petitioner failed to establish that he suffered an accident that arose out of and in the course of his employment with Respondent.
The record in this case rather clearly shows that Petitioner had a pre-existing, episodic neck problem that was the subject of a flare-up that appeared to be resolving at the time of his accident. The neck condition then became acutely worse for two months—to the point that he could not work—directly following a work activity that he immediately identified as disturbing his neck. He also developed new radicular symptoms immediately after his workplace accident. The exacerbation and new symptoms, and their correlation to Petitioner's work, are noted in contemporaneous treatment records. Those new and remarkably more severe symptoms belie the majority's finding that there was "virtually no difference" between his post-accident and pre-accident conditions, and they provide strong support for the notion that Petitioner suffered an injury on the date of his workplace accident.

The weight of expert medical opinion evidence in this case also supports a finding that Petitioner's condition arose out of and in the course of his work. Petitioner's treating physician opined without qualification that his neck exacerbation was work-related, while Respondent's medical examiner opined only that work was not the "prevailing cause" of Respondent's condition. The latter opinion does not directly refute Petitioner's theory of the case, that he had a pre-existing neck condition that was temporarily aggravated by work activity. The opinion also falls short of a complete defense as a matter of law, since it is well-established that a workplace accident need be only a causative factor, not the lone or primary causative factor, to support an award under the Act. Thus, Petitioner's medical opinion evidence to establish a causal link stands effectively unrefuted. I would find it to be persuasive, and follow it in this case.

18IWCC0005

The weight of expert medical opinion evidence, Petitioner's explanation, his increase in symptoms, and the corroborating medical records together suffice to establish that the temporary exacerbation of Petitioner's neck condition is attributable to his workplace activity. For that reason, I would award Petitioner temporary total disability benefits for the time his neck exacerbation kept him from working: the 5 and 2/7 weeks from September 10, 2015, through November 1, 2015. I would also award medical expenses subject to the fee schedule.

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ROBERTS, BENJAMIN
Employee/Petitioner

Case# **15WC031010**

CITY OF GRANITE CITY
Employer/Respondent

18IWCC0005

On 10/21/2016, 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 0.47% 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:

4463 GALANTI LAW OFFICE
J B PATTI
PO BOX 99
E ALTON, IL 62024

0299 KEEFE & DePAULI PC
JAMES K KEEFE JR
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

18IWCC0005

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

BENJAMIN ROBERTS
Employee/Petitioner

v.

CITY OF GRANITE CITY
Employer/Respondent

Case # **15** WC **31010**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Collinsville**, on **May 25, 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 9, 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 **$62,020.07**; the average weekly wage was **$1,292.08**.

On the date of accident, Petitioner was **34** years of age, ***married*** with **3** dependent children.

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

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

Respondent shall be given a credit of **$0** 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 **$3,691.15** 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 September 9, 2015. 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

October 19, 2016
Date

OCT 21 2016

STATE OF ILLINOIS)
) SS
COUNTY OF MADISON)

18IWCC0005

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

BENJAMIN ROBERTS
Employee/Petitioner

v.

Case #: **15 WC 31010**

CITY OF GRANITE CITY
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner is a maintenance technician for Respondent and alleges an injury to his cervical spine while performing plumbing work on September 8 and 9, 2015. At that time he was 34 years old, married, with three dependent children. He testified he had a prior work injury to his thoracic area, in which he sustained a compression fracture and underwent treatment with Dr. Eavenson and Dr. Sprich. He also sustained a neck injury in July 2014, and underwent treatment with Dr. Eavenson and Dr. Feinberg. He underwent physical therapy and a series of injections and continued working without restriction. He testified that the 2014 neck injury was sustained at work, but that he did not turn in it as he did not want to deal with it. He was progressing with treatment prior to September 9, 2015.

Petitioner testified that he worked a full day September 8 and a half day September 9, 2015, performing plumbing work for Respondent. He was under a sink, pulling out old plumbing and installing new plumbing. He described this as a tight space, about ten inches wide and elevated five inches off the ground, which caused him to lie on his side with his neck unsupported. He reached and extended his arms while in that position to complete the work. He testified that on September 9, 2015, he developed pain and pressure in his neck with radiating symptoms down both arms.

Petitioner testified he had been treating with Dr. Eavenson at Multicare Specialists prior to this time for neck pain and migraines. He explained that prior to the accident he experienced migraine type headaches with neck pain that did not radiate down his arms. After September 9, 2015, however, he had sharp stabbing pains from the neck down the arms. He sought treatment with Dr. Eavenson and reported what he had been doing at work, and an MRI was ordered. He underwent treatment and physical therapy by Dr. Eavenson, which he testified was somewhat different than the treatment he had previously received. He was also placed on work restrictions of no lifting more than either ten or twenty pounds, he could not recall the exact weight limit,

which Respondent could not accommodate. He was off work from September 11, 2015, through November 2, 2015. He used sick days and vacation days for some of the time period, but was otherwise without pay.

Petitioner underwent an MRI on September 11, 2015, which he understood to show a herniation and tear of a disc. He was seen by Dr. Gornet on September 29, 2015, who recommended continued physical therapy with Dr. Eavenson for six weeks, after which it was anticipated he could return to work full duty. He was to follow up with Dr. Gornet in December. Petitioner testified he was not having radicular symptoms at that time.

Petitioner testified he underwent therapy through October 27, 2015, and had good and bad days. He progressively got better and eventually no longer experienced the acute pain or numbness he previously had. He testified that before the accident his pain level was "just some general discomfort", after the accident it was 8-9/10, and during his last few visits with Dr. Eavenson it was 0/10. He was released to full duty without restrictions on November 2, 2015.

Petitioner testified his current symptoms are "nothing". He gets migraines a lot, which was the reason for the majority of his prior treatment, and for which he takes medication prescribed by Dr. Feinberg.

On cross-examination, Petitioner testified he has always had migraines, has treated for them for quite a while, and they are not necessarily from his injury. He further testified he is not having any residual neck problems from his work activities in September 2015 and is "back to normal". Petitioner confirmed that he previously treated with Dr. Barry Feinberg, a pain management physician, that he had undergone a cervical MRI in July 2014, and that he had two cervical injections at that time. He did not recall telling Dr. Feinberg that the neck pain he was having was not related to an injury, but did not dispute Dr. Feinberg's records if they said otherwise. Petitioner conceded he also treated with Chiropractor Eavenson and Therapist Voss for his neck complaints in 2014 and 2015, and in fact treated with them from August 3, 2015, through September 3, 2015, just days before the incident at work. He had a follow up appointment on September 8, 2015, and did not mention to either Dr. Eavenson or Mr. Voss the increased neck pain from work that day, as he testified it did not really increase until the following day. On September 9, 2015, he worked for four hours underneath the sink in the morning, and finished out his work day. He testified the shooting sensation and pain got progressively worse throughout that day. He reported the increased pain to both Dr. Eavenson and Mr. Voss that same day. He believed he also reported shooting pain down his arms that day, as that was a unique and different symptom that he had not previously experienced.

Petitioner testified he returned to Dr. Eavenson on September 10, 2015, and believed he reported his pain was as high as 9/10, but did not dispute if Dr. Eavenson recorded the pain at that time was 5/10. He testified that the acute pain he experienced on September 9 did not take long to subside, but it was followed by general discomfort that kept him in treatment for a while. He had the MRI on September 11, and testified he would have explained all his symptoms at that time, including the pain down his arms. Petitioner conceded he was in a car accident on Sunday, September 13, and explained that the other vehicle sustained a scrape down its side when it caught the corner of Petitioner's truck bumper. He testified he had no increased neck symptoms

from this incident, as there was no jolt when it occurred. He returned to Dr. Eavenson the following day, and agreed the notes from that day indicate he was having shooting symptoms down both arms. He did not tell Dr. Eavenson about the auto accident. He testified that his neck pain fluctuated, with some days being good and some being bad. He conceded that was the history both before and after the incident at work, but testified he had sharp pain and pressure like never before following the incident at work. He further conceded that he was already scheduled to see Dr. Eavenson on September 8 and 9, irrespective of what he did at work on those days.

Petitioner testified he did not tell Dr. Gornet about the auto accident, nor did he tell him he had been treating with Dr. Eavenson in the month leading up to the work incident on September 8 and 9. He understood, however, that Dr. Gornet had received his medical records from Dr. Eavenson. Dr. Gornet reviewed the prior MRI of July 2014, as it was done at his facility and was available. Dr. Gornet, however, did not discuss with him how the new MRI compared to the previous MRI.

Petitioner conceded that he had two prior work injuries for his thoracic spine, for which he underwent injections and eventually received settlements.

On re-direct, Petitioner agreed that he had reported to Dr. Eavenson on August 4 and on September 3 that his neck pain was getting better. On September 8 he reported having a bad day, due to tightening up over a long weekend. He explained he had had a migraine the day before, which was Labor Day, which caused him to be tense and have overall general discomfort. He further explained that the auto accident was not actually an accident, in that the other driver simply caught the edge of Petitioner's steel bumper and scraped the side of his vehicle. There was nothing forceful in the incident. He did not mention the accident to any of his doctors, because "it wasn't necessary, there wasn't anything done". With regard to his level of pain, Petitioner reiterated that it fluctuated from day to day, and even within the same day. He admitted he had pain at 8-9/10 prior to the work incident, but testified that it was related to his migraines. At his last few visits with Dr. Eavenson, his pain had resolved to 0/10.

Following the incident at work, Petitioner sought treatment on September 9, 2015, with chiropractor Ashley Eavenson of Multicare Specialists. He reported significant increase in neck pain working the past two days. It was noted he was a mechanic for Granite City and had been plumbing and lying on his side, having to hold his neck up, and immediately felt a pressure sensation in his neck. He described it as a throbbing, dull, and constant pain. On examination, Petitioner was in no apparent distress but did complain of pain with cervical flexion, extension, and lateral bending. He had positive cervical compression and distraction tests. There was decreased sensation in the left upper extremity when compared to the right. Assessment was cervical disc protrusion and left upper extremity radiculitis. He was to begin physical therapy and work light duty, with no repetitive use of the upper extremities and no pushing, pulling or climbing. PX2.

Petitioner followed up with Dr. Eavenson on September 10, 2015. He reported less pressure in his neck, but stated he felt pain nearly constantly over the suboccipital region. He had less pain on the left side of his neck, and denied any numbness or tingling in the upper

extremities. Examination was unchanged, with positive compression and distraction testing, and paraspinal tenderness especially over the suboccipitals. Cervical x-rays showed straightening of the cervical lordosis, well-maintained disc spaces, and bilateral neural foraminal stenosis at C5-6. Petitioner also underwent physical therapy by Mr. Corey Voss. He reported increased neck pain from working, lying on his side and having to hold his neck, which caused a pressure sensation in his neck. He described the pain as throbbing and constant and rated it as 5/10. On examination, he had tenderness to palpation of the cervical paraspinals and cervical suboccipital muscles. Cervical range of motion was reduced and painful. Upper extremity range of motion and strength were normal bilaterally, and there was decreased sensation in the left arm. Patient was treated and instructed to return three times a week for four weeks. PX2.

On September 11, 2015, Petitioner underwent a cervical MRI, which revealed: (1) C5-6 bulge with superimposed right foraminal herniation and moderate foraminal stenosis, right greater than left; (2) C6-7 bulge with left paracentral superimposed annular tear and herniation and mild bilateral foraminal stenosis; and (3) C3-4 minimal bulge. PX3.

On September 14, 2015, Petitioner returned to Dr. Eavenson and reviewed the MRI. He reported the pain would wake him up at night and that it extended to both upper extremities. He had full upper extremity strength, positive cervical compression and distraction tests, pain with cervical flexion, and decreased extension through the upper thoracic spine. Dr. Eavenson referred Petitioner to Dr. Gornet and instructed him to continue in physical therapy. He underwent therapy that day and reported continued pain down his right arm, with unresolving neck pain. He had tenderness to palpation of the cervical paraspinals and cervical suboccipital muscles. He had reduced range of motion with pain. PX2.

Petitioner returned to Dr. Eavenson and Mr. Voss on September 15, 2015, and reported pain in the left upper trapezius and neck. He underwent chiropractic manipulation and therapy to the upper cervical and thoracic spine regions. PX2.

On September 16, 2015, Petitioner presented to Dr. Rachel Feinberg at Injury Specialists with complaint of low back pain. This appears to be a follow up for a different medical issue. It was noted Petitioner had a new work injury since last seen, and had two bulging discs. The visit appeared to be for the purpose of refilling medications related to the low back, including Norco. The record is unclear whether the visit included an actual physical examination. PX1.

On September 17, 2015, Petitioner returned to Dr. Eavenson and reported he was feeling better than the previous day but still had pain in both upper extremities. It was noted he had slightly improved. Treatment plan included getting Petitioner into see Dr. Gornet as soon as possible, continuing chiropractic manipulation and physical therapy, and continuing work restrictions. PX2.

On September 21, 2015, Petitioner returned to Dr. Eavenson and Mr. Voss and reported his whole spine felt tight, but his neck was feeling better. He denied numbness or tingling in the upper extremities but did have pain that radiated into the upper trapezius bilaterally. On examination, he had decreased cervical motion and pain with right rotation. He also had decreased motion and tenderness in the thoracic region. On September 22, 2015, he returned and

reported pain was at a level of 3/10 but denied numbness or tingling. Cervical motion was improved in all ranges, with slight decrease in lateral flexion to the right. That same day, he had physical therapy and reported his neck was feeling better overall. PX2.

Petitioner returned to Dr. Eavenson and Mr. Voss on September 24, 2015. He reported flexing his neck forward at class the previous night exacerbated his pain, which he rated at 3/10. He had decreased motion and paraspinal pain throughout the cervical and thoracic spine. On September 28 2015, he reported increased pain when he awoke that day, causing him to take a Norco tablet. Examination showed increased tenderness to palpation in the cervical paraspinals, mostly on the right. Cervical range of motion was decreased in all movements. On September 29, 2015, he reported he was feeling better and rated his pain at 6-7/10. Most of the pain was over the right lower cervical spine and into the left trapezius. He had pain with all range of motion movements. He reported he had good and bad days with his neck and headaches, which did not seem to follow any particular pattern. PX2.

On September 29, 2015, Petitioner presented to Dr. Matthew Gornet of The Orthopedic Center of St. Louis, upon referral by Dr. Eavenson. He completed a Medical Information form, and described his accident as "performing duties at work, felt pain in neck" on September 8, 2015, at 8:00 a.m. He completed a pain diagram, noting aching, stabbing, burning, and numbness in his neck and across both shoulders. PX4.

Dr. Gornet noted Petitioner's chief complaint was neck pain with headaches to both trapezius, both shoulders, and the upper back, with tingling in his fingers. Dr. Gornet noted his current problem, at least in its level of severity, began September 8, 2015. On that day he was doing some plumbing and was lying on his side in an awkward ankle, reaching with his arms and pulling plumbing out and replacing it. He noticed an increase in pain and pressure sensation that day. He had been off work since September 11, 2015, and had been treating with Dr. Eavenson with some improvement. Petitioner reported a prior neck and spinal problem in July 2014, which he felt was work related but he did not report it. He had an MRI and physical therapy, did not miss any significant work time, and was doing well. He also had history of a thoracic compression fracture which had been treated with radiofrequency ablations and narcotics by Dr. Barry Feinberg. Petitioner reported his symptoms were constant, made worse with prolonged sitting, reaching, pulling, or fixed head positions, and made better with a change in position. He denied significant radicular symptoms. PX4.

On examination, Petitioner had pain in his neck, upper back, and bilateral trapezius. He had mild restriction of range of motion secondary to pain. Strength and sensation were normal. Cervical x-rays revealed well-preserved disc heights and evidence of stenosis. Dr. Gornet reviewed the MRI dated September 11, 2015, and noted an annular tear with a bilobular herniation left and right at C5-6 and a central herniation with an annular tear at C6-7. Dr. Gornet noted the findings were similar to those on the MRI dated July 2, 2014. Dr. Gornet's impression was that Petitioner had aggravated his underlying cervical condition, and that his symptoms were fairly classic of discogenic neck pain and headaches. He recommended Petitioner remain off work and continue chiropractic and physical therapy services with Dr. Eavenson three times a week for six weeks. He also recommended Petitioner wean off all Norco and instead take

Meloxicam and Cyclobenzaprine. Injections at C5-6 and C6-7 were mentioned as a treatment possibility if other treatment failed. PX4.

Petitioner continued treating with Dr. Eavenson and Mr. Voss. On October 1, 2015, he reported soreness in the right and left sides of his neck which radiated down to both shoulders, and increased pain when he looked down for a long period of time. Range of motion was decreased and produced pain. On October 5 he reported he was not seeing much reduction in his neck pain and he was getting discouraged. He had decreased range of motion and tenderness to palpation in the cervical spine and cervical paraspinals. On October 6 he reported he was very sore on the right side of his neck. He had throbbing pain on both sides of his neck and down into both shoulders. He had tenderness to palpation in the cervical paraspinals and upper trapezius muscles, mostly on the right. On October 8 he reported it was the first day since he started physical therapy that he felt better. His pain was 2/10 and he felt "much better". He had no radiating symptoms down his arms and no pain in his neck. His range of motion had increased to almost normal. On October 12 he reported he was feeling much better, had minimal pain, and denied headaches or upper extremity symptoms. On exam, he had decreased tenderness to palpation in the cervical paraspinals and upper trapezius muscles. Bilateral upper extremity range of motion was within normal limits. On October 13 Petitioner reported soreness in his upper trapezius and scapulae, which he rated as 6/10. He had full range of motion with the exception of left lateral bending, which was restricted secondary to right cervical pain. PX2.

On October 13, 2015, Petitioner returned to Dr. Rachel Feinberg with chief complaint of bilateral shoulder pain and back pain. It does not appear that a physical examination took place, and it appears the appointment was for the purpose of a narcotic medication check and renewal. It is not clear whether this appointment is related to the accident in question, but does not appear to be. PX1.

Petitioner continued treating with Dr. Eavenson and Mr. Voss. On October 15 he reported he was doing a lot better and was relatively pain-free. He had no numbness or tingling in his arms and did not have a headache. He had slight tenderness to palpation in the upper trapezius muscles, but cervical range of motion was full. On October 19 Petitioner reported the right side of his neck was sore but less painful than the prior week. He was feeling much better and rated his pain at 2/10. He had no numbness or tingling, but noted tightness throughout his spine. Range of motion was normal or near normal in the cervical spine and bilateral upper extremities. On October 20 Petitioner reported he was "relatively pain free" and had only mild tightness in his neck. Cervical range of motion was improved. On October 22 he reported the tightness in his neck was nearly gone, and he had no complaints of pain in either side of his neck. He noted the more active he was, the better he felt, and he was pleased with his progress in physical therapy. On October 26 he reported his neck as feeling much better and he was "almost 100% back to normal". He rated his pain at 0/10. On examination, he had decreased tenderness to palpation and improved cervical range of motion. On October 27 Petitioner reported his pain as 0/10. Cervical range of motion was near normal, and he had no palpable tenderness in the cervical spine. PX1.

On November 10, 2015, Petitioner presented to Dr. Barry Feinberg of Injury Specialists. His chief complaint was neck and thoracic pain. It does not appear that a physical examination

took place, and it appears the appointment was for the purpose of a narcotic medication check and renewal. It is not clear whether this appointment is related to the accident in question, but does not appear to be. PX1.

On December 3, 2015, Petitioner returned to Dr. Gornet, who noted Petitioner had been treating with Dr. Eavenson and had been improving. He further noted that Petitioner had seen Dr. Feinberg on November 11 and been given a prescription of Hydrocodone. He reiterated his request that Petitioner wean off all narcotics. Dr. Gornet noted that Petitioner was back to work full duty with no restrictions, and that he seemed to be "trending very positively". He recommended follow up in two months and release at that time if he was doing well. PX4. The Arbitrator notes this is the last medical record from Dr. Gornet.

On December 12, 2015, Petitioner was evaluated by Respondent's Section 12 examiner, Dr. Benjamin Crane of Premier Care Orthopedics and Sports Medicine. Dr. Crane noted Petitioner had a long-standing history of neck pain and occipital migraines, for which he had been receiving chiropractic care for quite some time. Petitioner gave a history of an exacerbation of his neck pain at work on September 8, 2015, moving heavy cast iron pipes and replacing them with PVC. He reported that this exacerbation of his neck pain was no different from any of the previous exacerbations of neck pain, that it was not more severe, and that it did not last longer or cause any radicular type symptoms. He reported he was back to his baseline of mild achiness in his neck, specifically when overdoing his activities, and was very happy with how he was feeling. Examination revealed no restrictions in cervical range of motion, no loss of sensation, and no abnormal testing. Examination of the shoulders was also normal. RX1.

Dr. Crane reviewed the cervical MRI scans from July 2, 2014, and September 11, 2015. He noted the 2014 MRI was relatively normal, without significant disc bulge or joint arthrosis resulting in significant stenosis. He noted the 2015 MRI was also relatively normal, with essentially the same findings as in 2014. Dr. Crane noted Petitioner had a history of intermittent neck pain for many years prior and had been under the care of a chiropractor for many years. He further noted that, by his own admission, the character and nature of Petitioner's pain was not significantly different after his work activities on September 8 and 9, 2015. Dr. Crane opined that Petitioner's cervical condition was not causally connected to his work activities of September 8 and 9, that no further treatment was necessary, and that Petitioner required no restrictions in his activities. He further did not recommend using chiropractic care and physical therapy concurrently, and recommended Petitioner choose one treatment or the other. RX1.

On December 16, 2015, Petitioner presented to Dr. Barry Feinberg. It was noted he returned for repeat evaluation, having last been seen in July. He reported he had done well until September when he was at work installing plumbing, was in awkward positions, looking up and trying to crawl into a very tight space, causing a flare up of his pain. He reported he had cervical pain and eventually thoracic pain, and was off work for a while. Dr. Feinberg noted Petitioner's old MRI scan from July 2014 showed discogenic disease with right C6 nerve root impingement, right C6 radiculopathy, and degeneration at C3-4 and C6-7. Petitioner reported he did not get any relief from physical therapy and had continued pain. His pain was into the neck, on the right more than left, and the suprascapular region, associated with headaches. He also had upper back pain. Dr. Feinberg's diagnoses were cervical spondylosis without myelopathy, cervicalgia, and

thoracic spondylosis without myelopathy. He recommended and ordered a C6-7 facet joint injection by Dr. Rachel Feinberg. Petitioner underwent an injection that day; however, the Arbitrator notes it was done at the C5-6 level, rather than at C6-7. PX1.

On January 5, 2016, Petitioner returned to Dr. Rachel Feinberg with complaints of pain in the right side of his neck. He reported that daily activity increased his pain. It was noted he had done very well with the facet transforaminal injections, that he was not having headaches, and that he had better range of motion. Dr. Feinberg noted Petitioner presented to "help bring his shoulder back", to stabilize his mechanics, and to improve his side bend. He underwent trigger point injections to the right abdominal oblique, latissimus dorsi, right anterior deltoid, and the pectineus. PX1.

Petitioner followed up with Dr. Feinberg on January 26, 2016, with chief complaint of pain in right side of neck, thoracic area, and groin area. He returned on February 23, 2016, with chief complaint of neck and bilateral shoulder pain and back pain. He returned again on March 23, 2016, with chief complaint of pain on both sides of the neck. Petitioner followed up again on April 18, 2016, with chief complaint of neck pain. It does not appear that a physical examination took place on any of these dates, and it appears the appointments were for the purpose of a narcotic medication check and renewal. It is not clear whether these appointments are related to the accident in question, but they do not appear to be. PX1.

PRE-ACCIDENT MEDICAL TREATMENT

Both parties submitted medical records from various providers for treatment prior to Petitioner's work incident. They are reviewed in chronological order.

On February 9, 2012, Petitioner presented to Dr. Eavenson and Mr. Voss. It was noted he was last seen in November 2011. He reported continued mid back pain that was only relieved by pain medication. He also reported that about two weeks prior he had woken up with a stiff neck and had pain of 8/10. He denied any trauma or radiation into the upper or lower extremities, and noted the pain was concentrated to the midline of the cervical spine. Examination revealed pain and decreased motion with flexion and extension, along with palpable tenderness over the midline of the cervical spine. He underwent chiropractic manipulation and physical therapy to the cervical spine. On February 13 he returned and reported his neck felt significantly better but he was still having thoracic pain. It was noted he was seeing a neurosurgeon the following day, that an MRI was scheduled, and that he would most likely need pain management. He underwent chiropractic manipulation and physical therapy to the cervical spine. RX3.

On April 10, 2012, Petitioner presented to Dr. Rodney Lupardus, whose report is contained within Dr. Eavenson's records that were submitted at trial. It is unclear whether Dr. Lupardus is part of Multicare Specialists, but it would appear so. Petitioner reported a history of chronic thoracic back pain after a compression fracture of T10 about three years prior, for which he was treating with a pain management specialist. He reported the pain management clinic told him to find a primary care physician to prescribe pain medication, which caused him confusion and frustration. Petitioner also reported new onset of severe headaches over the past three

months, usually occurring in the occipital area, as well as some neck pain for which he was to be evaluated by a neurosurgeon. On examination, he had minimal tenderness at the base of the occiput, no muscle spasms, and no tenderness in the area of his back pain. Neurological exam, sensation, and strength were normal. Assessment was (1) chronic thoracic back pain secondary to a T10 fracture, for which he was receiving chiropractic care, physical therapy, and upcoming neurosurgical consult; (2) combination tension and migraine headaches occurring in the occipital area, with cervical disc disease possibly contributing to symptoms; and (3) chronic neck pain, for which he was scheduled to be evaluated by a neurosurgeon. RX3.

On May 10, 2012, Petitioner returned to Dr. Lupardus and reported he was feeling better. He had been released by his neurosurgeon following epidural injections, which did not help his back pain. He reported his neck pain was much better, and his headaches were better as long as he avoided alcohol. Examination was mostly normal, with full cervical range of motion, no muscle spasms, and no tenderness. Assessment was thoracic back pain secondary to compression fracture, resolved neck pain, and resolved headaches with abstinence from alcohol. He was to return in four months. RX3.

On March 7, 2013, Petitioner presented to Dr. Helen Blake at Regeneration Orthopedics, upon referral by Dr. Eavenson, with chief complaint of thoracic back pain. He reported a work injury of July 23, 2012, when he had an acute exacerbation of pain while working with a shovel. It was noted he had a prior work injury when a mower he was operating flipped, causing a thoracic compression fracture. He reported constant pain, associated with numbness and tingling, which limited his activities of daily living. He had tried epidural steroid injections, rest, activity modification, TENS stimulation, heat therapy, chiropractic care, physical therapy, and massage therapy, none of which adequately relieved his pain. On examination, he had muscle spasm and pain to palpation throughout his thoracic spine extending from about T6 down into L1. Dr. Blake's assessment was myofascial pain syndrome and chronic compression fracture T10. She administered trigger point injections. Petitioner returned on April 4, 2013, and reported pain relief from the injections, but noted pain was beginning to return. He reported his pain was frequent and at a 6/10 level. He continued to have some limitations in daily activities. Examination revealed spasm and pain to palpation from T4 to L1. Dr. Blake administered additional trigger point injections. Petitioner returned on May 2, 2013, with improvement noted. He underwent another round of trigger point injections. RX5.

On May 30, 2013, Petitioner returned to Dr. Blake and reported no long-term benefit from the injections. He noted he had also previously had three epidural steroid injections from another pain provider. He described his pain as constant and 8/10 that day. Dr. Blake noted Petitioner's treatment options were limited, in that the injections failed to provide long-term relief, but she recommended facet joint injections and possibly radiofrequency ablations. Petitioner followed up on July 11, 2013, and reported his pain continued to be uncontrolled, which he rated at 8/10. Dr. Blake noted Petitioner had previously been on Soma medication from another provider. She advised it was not appropriate in controlling his pain, due to the significant levels of addition and other side effects, and that she would not prescribe it. Petitioner declined additional trigger point injections, and Dr. Blake recommended epidural injections into his thoracic spine. She noted, "There is no good explanation for whether his

chronic fracture is causing this patient such significant pain at this time several years out." RX5. The Arbitrator notes this is the final medical note from Dr. Blake.

On April 4, 2014, Petitioner underwent a thoracic MRI, ordered by Dr. Thomas Brummett. It revealed bulges at T4-5, T5-6, and T7-8. On July 2, 2014, he underwent a cervical MRI, ordered by Dr. Eavenson. The MRI revealed: (1) C3-4 minimal disc desiccation with minimal diffuse annular disc bulge and minimal left neuroforaminal exit stenosis; and (2) C5-6 mild dis desiccation, diffuse annular disc bulge, right foraminal disc protrusion, and moderate right neuroforaminal exist stenosis appearing to impinge upon the right C6 nerve root. PX3.

On July 8, 2014, Petitioner presented to Dr. Feinberg at Gateway Pain Center/Injury Specialists. On that date, he completed a patient history form, listing as his main complaint "severe pain on the right side of my neck, from the top of my skull to the bottom of my shoulder". He noted the pain "started out of nowhere and started to get worse". Looking down, up, and side to side made the pain worse. On the pain diagram he circled the back of the neck and right shoulder area as locations of pain. Dr. Feinberg noted Petitioner was referred by Dr. Mark Eavenson for pain in his neck that radiated to his right shoulder. The pain was pressure-like and sharp at times, and started in June 2014. Dr. Feinberg noted Petitioner's pain was 8/10. He reported severe pain on the right side of his neck, from the top of the skull to the bottom of the shoulder, radiating down the right arm to the elbow. The pain had been increasing and worsening for about six months, and he reported he had undergone a Toradol injection by Dr. Eavenson. He further reported he had seen Dr. Phillips for an EMG/NCS, which he said revealed the pain was not related to his neck. Dr. Feinberg noted the MRI of July 2, 2014, and the results of same. Petitioner also reported a compression fracture of T10 and bulges at T4-5 and T5-6, for which he was previously seeing Dr. Sprich. He wore a back brace for awhile and underwent trigger point injections by Dr. Lee. Following his examination, Dr. Feinberg's assessment was cervical radiculopathy, thoracic compression fracture, thoracic spinal pain, thoracic spondylosis without myelopathy, and lumbar radiculopathy. He ordered MRI scans of the cervical and thoracic spine and administered a transforaminal epidural injection at C5-6 on the right. PX1.

Petitioner returned to Dr. Feinberg on July 22, 2014, and reported pain at the base of his skull down the right side of his neck. He noted the pain was aggravated in the mornings if slept in the wrong position for a long time. Petitioner reported 90% relief of his pain from the injection on July 8, and he underwent a second epidural injection at C5-6 on the right. He returned to Dr. Feinberg on July 29 and reported pain in the neck and thoracic areas, which increased with prolonged activities. He reported improvement of 90-95% with the prior cervical injections. He underwent thoracic paravertebral medial branch nerve blocks at right T7 and left T11. Petitioner returned to Dr. Feinberg on August 19, 2014, and reported pain in the center of the thoracic spine which sometimes radiated around the bilateral ribs. He noted the pain was not happening as often, but that when it did it was still the same level and intensity. On examination, it was noted the location of his pain was the thoracic spine, at and just below the scapula. The neck pain was "100% gone". There were no neurologic deficits, and reflex, motor, and sensory examinations were normal. He underwent thoracic paravertebral median branch nerve blocks at right T6 and left T9. PX1.

Petitioner returned to Dr. Feinberg on November 4, 2014, and reported pain in his mid back. He had relief for one month after the last injection, and noted that any prolonged position aggravated his pain. He reported that his prescription of Norco "went missing" after his daughter's birthday party in October, and he had not had any since that time, and that his pain was returning. He underwent thoracic paravertebral median branch nerve blocks at right T4 and left T8. He returned on November 25 and reported pain in his neck and thoracic regions, with no improvement from the last injection. Examination revealed improved movement in the thoracic spine, but he continued to have positive testings in the thoracic area. He underwent median branch nerve blocks at right T8 and left T3. He returned on December 9 and reported pain in the middle of his back, between the shoulder blades. He had 80% improvement from the last injections for about three or four days, then the pain returned. He had tightness in the right shoulder which radiated up to the neck and all the way to the chest, which worsened with deep breaths. He had some neck pain. He underwent median branch nerve blocks at right T6 and left T9. He returned on January 12, 2015, and reported thoracic pain which was aggravated by prolonged activity. He got three days relief from the last injections, and was able to tolerate activities of daily living by using Norco. PX1.

Petitioner returned to Dr. Feinberg on February 16, 2015, and reported pain in his mid-back, just below the shoulder blades, on a daily basis. He reported he had started a new job in January, in industrial maintenance, and that he used large equipment and awkward positioning. He was continuing to use Norco every four hours for pain. He also reported pain and popping in his right knee following a go-kart accident on February 13. He returned on March 19 and reported pain in the center of his back and bilaterally into the shoulder blades. He again reported he had a new job as a mechanic, working with big machines and in awkward positions. Petitioner had previously been using a back brace, which he could no longer use at work. He indicated his neck pain was gone and that his daily activities were tolerable with the use of medication. He was to continue his home exercises. He returned on March 26 with complaint of pain in his thoracic area, left worse than right. He reported he had been doing a lot more physical labor and that with certain positions the pain worsened. He underwent thoracic paravertebral median branch nerve blocks at right T9 and left T4. PX1.

Petitioner returned to Dr. Feinberg on April 8, 2015, and reported 50% improvement in pain with the last injections, but continued to have pain in the middle of his back which medications did not relieve. On examination, Spurling's maneuver was positive at left C4-5, T4 and right T9. He underwent median branch nerve blocks at left T4 and right T9. He returned on May 11 and reported pain in his thoracic area. He denied neck pain. He underwent median branch nerve blocks at left T4 and right T9. He returned on June 10 for what appears to be a medication review and refill only, without an examination. He followed up on July 17 and reported pain in his lower back and upper thoracic regions. He underwent thoracic radiofrequency ablations at left T3-4 and right T8-9. PX1.

On August 3, 2015, Petitioner presented to Dr. Eavenson and Mr. Voss with complaints of headache and neck pain. It was noted he had a long-standing history of migraines. On examination he had bilateral cervical paraspinal tightness, left greater than right, as well as neck pain with range of motion. He underwent chiropractic manipulation and physical therapy to the cervical spine. He returned on August 4. Examination revealed left cervical tenderness and neck

pain with rotation to the right, left lateral bending, and flexion. The trapezius was tight bilaterally, left worse than right. He underwent chiropractic manipulation and physical therapy to the cervical spine. On August 6 he reported he had a bad day the day before, but was doing much better. Examination revealed tenderness in the left cervical area, neck pain with right rotation and flexion, and trapezius tightness bilaterally. He underwent chiropractic manipulation and physical therapy to the cervical spine. Petitioner returned on August 10, 2015, and reported he was "not 100%, but getting there". Examination revealed suboccipital tenderness bilaterally, neck pain with flexion and lateral bending to the right, and trapezius tightness bilaterally. He underwent chiropractic manipulation and physical therapy to the cervical spine. On August 13 he reported he was feeling better. Examination revealed neck pain with left lateral bending and right rotation, tightness in the left cervical spine, and no tenderness to the right cervical spine. He underwent chiropractic manipulation and physical therapy to the cervical spine. On August 18 he reported the day before was bad, but he was a little better. The right side of his neck was very sore, and the left side was fine. Examination revealed right cervical tenderness, neck pain with right lateral bending and right rotation, and bilateral trapezius tightness. He underwent chiropractic manipulation and physical therapy to the cervical spine. PX2, RX3.

On August 17, 2015, Petitioner returned to Dr. Feinberg for what appears to be a medication review and refill only, without an examination. PX1.

On August 20, 2015, Petitioner returned to Dr. Eavenson and Mr. Voss and reported he was doing better, "about 80%", but still had good and bad days. On examination, he had right cervical tenderness from the occiput through C4, neck pain with right lateral bending and flexion, and compression test produced localized pain at C4 on the right. He underwent chiropractic manipulation and physical therapy to the cervical spine. On August 24 Petitioner reported he was doing much better. Examination revealed right cervical tenderness from the occiput through C3, neck pain with left rotation and flexion, and compression test produced mild to moderate pain at C3 on the right. He underwent chiropractic manipulation and physical therapy to the cervical spine. PX2, RX3.

On September 1, 2015, Petitioner returned to Dr. Eavenson and Mr. Voss and reported he was doing better and not nearly as sore. On examination, he had improved cervical motion, but continued to have neck pain with right lateral bending and flexion, and compression test continued to produce localized pain at C3 on the right. Spurling's test was negative. He underwent chiropractic manipulation and physical therapy to the cervical spine. On September 3 he reported his neck pain and headaches were mostly doing better and that "we're getting there". He still had some soreness. Examination revealed right lower cervical tenderness at C6-7, discomfort with right rotation, and tightness on the right trapezius. He underwent chiropractic manipulation and physical therapy to the cervical spine. He was to "return on Tuesday". On Tuesday, September 8, Petitioner returned to Dr. Eavenson and Mr. Voss and reported pain in the neck, mid back and low back. He stated "his neck tightened up over the long weekend". He reported he was having a bad day with regard to his neck pain and headaches. Examination revealed palpable tenderness along the lower right cervical spine and upper left cervical spine and discomfort with right rotation. He underwent chiropractic manipulation and physical therapy to the cervical spine. PX2, RX3.

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).

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. In so concluding, the Arbitrator finds significant that Petitioner was actively and frequently treating for his cervical complaints immediately prior to his alleged date of accident of September 9, 2015, and that his examinations before and after that date were virtually the same.

Both parties submitted medical records for treatment prior to September 9, 2015, which showed a long-standing history of cervical complaints and treatment dating back to at least February 2012. However, most telling are the records for the month immediately preceding the purported date of accident.

Petitioner was seen by Dr. Eavenson and Mr. Voss on August 3, 4, 6, 10, 13, 18, 20, and 24, and September 1, 3, and 8. On each of those eleven days he complained of neck pain, and reported some days were worse than others. The records show that examinations on all of those days revealed tenderness in the cervical area, cervical pain with range of motion, suboccipital tenderness, and trapezius tenderness. It was noted on August 20 and 24 and September 1 that compression test produced pain. On September 3, Petitioner continued to have cervical tenderness and pain with motion, and was instructed "to return on Tuesday", which was September 8.

When Petitioner presented on September 8 he reported he was having a bad day and that his neck tightened up over the long weekend. He had neck pain, headaches, palpable tenderness along the cervical spine, and discomfort with range of motion. He made no mention whatsoever of any work activities that day that contributed to his pain. Interestingly, when asked on cross-examination why he did not mention the work activities to Dr. Eavenson or Mr. Voss on September 8, he testified that the pain from work activities did not really increase until September 9. Yet, when he saw Dr. Gornet on September 29, 2015, he reported the pain began on September 8 at 8:00 a.m., that "he noticed increase in pain and a pressure sensation that day",

and that "the next day he continued to have pain". The Arbitrator finds Plaintiff's testimony to be lacking in veracity on this issue.

The records from September 9 and 10 from Dr. Eavenson and Mr. Voss continue to show Petitioner had pain and tenderness in the cervical area, pain with motion, pain in the suboccipital region, and positive compression test. There was virtually no difference between Petitioner's complaints and examinations on or after September 9, 2015, and his complaints and examinations in the eleven visits between August 3 and September 8, 2015. Petitioner attempted to establish a change in his condition by testifying that he had new symptoms of pain shooting down his arms, which he had not previously had. However, contrary to Petitioner's testimony, Dr. Eavenson's records of September 9 and 10 contain no mention of such complaints. The Arbitrator finds Plaintiff's testimony to be lacking in veracity on this issue.

The existence of health problems of an employee prior to a work-related injury neither deprives the employee of a right to benefits nor relieves the employee of the burden of proving a causal connection between the employment and the subsequent health problems. *Neal v. Industrial Comm'n*, 141 Ill.App.3d 289, 296 (1st Dist. 1986). It is undisputed that Petitioner had a long-standing history of neck pain, which flared up with activities of daily living, such as sleeping in the wrong position, reading in class, waking up in pain, and even pain "coming out of nowhere". It is further undisputed that Petitioner was actively treating for his neck pain in the month preceding his alleged date of accident. Despite Petitioner's testimony to the contrary, the treatment records clearly show there were consistent complaints and physical findings beginning August 3, 2015, and continuing, virtually unchanged, subsequent to Petitioner's alleged date of accident. The Arbitrator finds significant and persuasive Petitioner's statements to Dr. Crane that this exacerbation of his neck pain was no different from any of the previous exacerbations of neck pain, that it was not more severe, that it did not last longer, and did not cause any radicular type symptoms.

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 he sustained an accident which 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 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

SHAWN PLUMLEE,

Petitioner,

vs. NO: 08 WC 25244

PINCKNEYVILLE CORRECTIONAL CENTER,

18IWCC0006

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 partial disability (PPD), and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all the testimony, exhibits, pleadings, and arguments submitted by the parties.

To receive an award under Section 8(d)1 of the Act, an injured worker must prove (1) that he or she is partially incapacitated from pursuing his or her usual and customary line of employment and (2) that he or she has suffered an impairment in the wages he or she earns or is able to earn. 820 ILCS 305/8(d)1 (West 2002); *Cassens Transp. Co. v. Indus. Comm'n*, 218 Ill. 2d 519, 530-31 (2006). The purpose of a wage differential award "is to compensate an injured claimant for his reduced earnings capacity, and if an injury does not reduce his earning capacity, he is not entitled to compensation." *Gallianetti v. Indus. Comm'n*, 315 Ill. App. 3d 721, 730 (3rd Dist., 2000). Further, such an award "presumes that but for his injuries, the claimant would have been in full performance of his duties." *Dawson v. Workers' Compensation Comm'n*, 382 Ill. App.

3d 581, 586 (5th Dist., 2008). 18IWCC0006

In this claim, the Arbitrator found that Petitioner met only one of these elements; Petitioner did not prove that he was partially incapacitated from pursuing his usual and customary line of employment. However, the Arbitrator found that Petitioner proved the second prong – that he suffered an impairment of earnings as a result of the April 30, 2008 accident.

The Arbitrator noted that although Petitioner testified that Respondent could not accommodate his restrictions, and Respondent's witness, Major Donald Malcolm, admitted that no one with permanent restrictions was allowed to work in Respondent's facility, Petitioner was in fact working full duty as a Security Therapy Aide, a position that, according to the Arbitrator, was within Petitioner's usual and customary line of employment. The Arbitrator found that Petitioner's current employment paralleled his previous work history as a correctional officer in that Petitioner "maintains security for patients in a secure environment, assesses the need for security and intervention, performs security checks and controls and directs patients, which is similar to the core responsibilities of a Correctional Officer." Petitioner argues that the Security Therapy Aide position is not similar to that of a correctional officer, and that he is prevented from working in his usual employment because "Petitioner is banned from being a Correctional Officer." (Petitioner's Brief, pg. 19).

In deciding this issue of Petitioner's alleged partial incapacitation from pursuing his usual and customary line of employment, two Appellate Court opinions demonstrate that this prong is narrowly construed. For example, the employer in *Jackson Park Hosp. v. Ill. Workers' Comp. Comm'n* did not dispute the Commission's finding that the claimant had sustained a work-related permanent partial disability. 2016 IL App (1st) 142431WC ¶39. This is the case in the instant claim. "Under the Act, when a claimant sustains a disability, an issue arises concerning what type of compensation she is entitled to receive, a wage differential award (8(d)(1)) or a percentage-of-the person-as-a-whole award (8(d)(2))." 820 ILCS 305/8(d) (West 2012); *Jackson Park Hosp. v. Ill. Workers' Comp. Comm'n*, 2016 IL App (1st) 142431WC ¶39, citing *Gallianetti v. Indus. Comm'n*, 315 Ill. App. 3d 721, 727 (3rd Dist., 2000). Our Supreme Court has expressed a preference for such wage-differential awards. *Jackson Park Hosp. v. Ill. Workers' Comp. Comm'n*, 2016 IL App (1st) 142431WC ¶39, citing *Gen. Elec. Co. v. Indus. Comm'n*, 89 Ill. 2d 432, 438 (1982).

While Section 8(d)1 of the Act requires a two-prong analysis as indicated above, a claimant is entitled to a PPD award under Section 8(d)2 of the Act when three requirements are met:

> [W]hen the claimant's injuries do not prevent her from pursuing the duties of her employment but she is disabled from pursuing other occupations or is otherwise physically impaired; when her "*injuries partially incapacitate [her] from pursuing the duties of [her] usual and customary line of employment but do not result in an impairment of earning capacity*;" or when the claimant having suffered an "impairment of earning capacity *** elects to waive [her] right to recover under [8(d)(1)]." (Emphasis added). 820 ILCS 305/8(d)2 (West 2012); *Jackson Park Hosp. v. Ill. Workers' Comp.*

18IWCC0006

Comm'n, 2016 IL App (1st) 142431WC ¶41.

Therefore, a close reading of Sections 8(d)1 and 8(d)2 of the Act suggests that what is actually key in "determining which type of PPD award is appropriate is whether the claimant has suffered an impairment of her 'earning capacity.'" *Jackson Park Hosp. v. Ill. Workers' Comp. Comm'n*, 2016 IL App (1st) 142431WC ¶42.

To state it a different way, "[A] percentage-of-the-person-as-a-whole award under 8(d)(2) would be appropriate *only* if she has suffered no loss in her "earning capacity," or having suffered a loss in "earning capacity," she elected to waive her right to an award under 8(d)(1)." *Jackson Park Hosp. v. Ill. Workers' Comp. Comm'n*, 2016 IL App (1st) 142431WC ¶42. Neither factor in this scenario is present in this claim as Petitioner has suffered an impairment of earnings, which neither party is disputing, and Petitioner has not waived his rights under Section 8(d)1 of the Act. Thus, an award under Section 8(d)2 is not appropriate in this instant claim.

Again, to be clear, the main issue in this present claim is not whether Petitioner suffered an impairment of earnings, or whether Petitioner sustained a work-related permanent partial disability, but whether that partial incapacitation precluded Petitioner from pursuing his usual and customary line of employment. A second Appellate Court case is a further example and instructive as to the narrow construction taken when determining what type of PPD benefits to award. In *First Assist, Inc. v. Indus. Comm'n*, the claimant was a registered nurse at the time of her injury and at arbitration. 371 Ill. App. 3d 488, 495 (4th Dist., 2007). However, the Appellate Court found "that all nurses do not perform the same functions." *Id.*

> The claimant testified to the duties of an operating room nurse and the physical requirements of the job, including the requirement that she lift patients on and off of the operating table. However, as an office nurse working for Cardinal Respiratory or a staff nurse working for Capital Care, the claimant was not required to lift patients. There is no question regarding the claimant's restrictions. It is uncontested that she was not permitted to lift more than 25 pounds. Her current position as a staff nurse falls within her restrictions; whereas, the functions of an operating room nurse do not. In addition, Hammond was clear in his testimony that the claimant's restrictions prevented her from working as an operating room nurse, as was the FCE report. Hammond's testimony also made clear the fact that all nurses do not earn the same salary. Operating room nurses are paid substantially more than office nurses or staff nurses, as the claimant's employment history corroborates . . .
>
> Contrary to First Assist's assertion, we do not believe that the Commission's determination that the claimant's usual and customary line of employment at the time of her injury was that of an operating room nurse is "too narrow and restrictive." We believe that the facts in evidence establish that, although all registered nurses might be members of the same profession, they do not all perform the same

> functions. Consequently, we do not believe that the Commission erred when it determined that the claimant's usual and customary line of employment at the time of her injury was that of an operating room nurse. *Id.*

Turning to the claim at bar, there was some confusion on the Arbitrator's part relative to Petitioner's exact restrictions. However, the final version of the restrictions came from Dr. Davidson on May 31, 2011, when he updated Petitioner's "Authorization for Disability Leave and Return to Work" form to correspond with Dr. Kennedy's restrictions of no lifting more than 30 pounds, and occasional bending, twisting, or stooping. Petitioner was also to refrain from inmate contact. (PX3).

There was indication of an alleged disingenuous attempt by Petitioner when searching for work within his restrictions. However, notwithstanding this assertion, there is ample evidence in the record that Petitioner's partial incapacity, due to his restrictions, specifically his restriction to refrain from inmate contact, precluded him from pursuing his usual and customary line of employment as a correctional officer. In fact, Respondent was accommodating Petitioner's restrictions up until the "no inmate contact" limitation was ordered. Not only did Respondent deny Petitioner's request for an accommodation, but their witness, Major Malcolm, testified that employees with permanent restrictions were not allowed to work in Respondent's facility. (T.113).

Further, Petitioner engaged the assistance of the State of Illinois' alternative employment program (AEP), the Department of Rehabilitation Services, as well as vocational counselors referred by both his own attorney and Respondent. None of these entities were successful in helping Petitioner find any employment, let alone employment as a correctional officer. (T.14-16; RX11; RX12).

In consideration of Respondent's position that the Security Therapy Aide position is similar to that of a correctional officer, there are indeed differences as testified to at arbitration and by the evidence in the record. A comparison of the two job descriptions does demonstrate that the duties of a correctional officer are more involved. (RX4; RX10). Petitioner and Respondent's witness, the security shift supervisor at Chester Mental Health Center, Russell Hecht, testified to the different types of patients/inmates at Chester and the low risk and low frequency of violent altercations between such patients/inmates. It should be noted that although Chester Mental Health does house inmates, they are considered patients who, according to Petitioner's unrebutted testimony, are less aggressive, who have earned the right to be on that unit, and who are not kept in prison cells, but in unlocked rooms. This is starkly different from the environment of Respondent's prison, where Petitioner faced all kinds of violence. "Inmate on inmate, inmate on officer, I mean, it's gang related, gang hits. I mean, really, sometimes it never even had anything to do with a person. It just had to do with the uniform, I mean retaliation against an officer." (T.23).

Other than Respondent's argument as contained in its brief, Dr. David Robson, Respondent's Section 12 examiner, was the only person who testified that Petitioner could continue working as a correctional officer; he testified that Petitioner could perform his duties so long as he was in a proper environment and working within his restrictions. Dr. Robson's testimony is not persuasive in light of the record considered in its entirety and as described herein.

18IWCC0006

Thus, in light of the foregoing and in line with *First Assist, Inc. v. Indus. Comm'n*, although Petitioner's current employment may parallel his previous work history as a correctional officer, he is not performing the same functions; it simply cannot be said that a security officer or aide in a mental health facility is the same as a correctional officer working in a prison. Therefore, this Commission finds that Petitioner's injury has precluded him from engaging in his usual and customary line of employment as a correctional officer, he has suffered an impairment of earnings, and is thus entitled to a wage differential award.

As such, Petitioner is entitled to a wage differential award in the amount of $277.23 per week commencing September 16, 2014 (the day Petitioner began working for his current employer, Chester Mental Health) and lasting for the duration of his disability. The Commission calculated the wage differential rate as follows:

Respondent brought in its witness, Major Malcolm, who testified that if Petitioner had continued working for Respondent as a correctional officer, he would be earning approximately $5,305.00 per month plus $100 a month for longevity. (T.94). Major Malcolm's testimony corroborated Respondent's Exhibit 25, which provided the base salary for a correctional officer. (T.29; T.32; RX25). The parties then stipulated that Petitioner was currently employed as a Security Therapy Aide I, and the base monthly salary for that employment is $3,603.00. (T.11). Therefore:

$5,405 – Average Weekly Wage (AWW) is $1,247.31
$3,603 – AWW is $831.46
2/3 of the difference is $277.23

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed May 1, 2017, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that commencing on September 16, 2014, Respondent pay to Petitioner the sum of $277.23 per week for the duration of Petitioner's disability, as provided in Section 8(d)1 of the Act, for the reason that the injuries sustained permanently incapacitated Petitioner from pursuing the duties of his usual and customary line of employment.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner maintenance benefits of $536.26 per week for 188 3/7 weeks, commencing February 2, 2011 through September 15, 2014, as provided in Section 8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall receive a credit of $69,783.50 for temporary total disability (TTD) benefits (*which the parties agreed at the time of arbitration had been appropriately claimed and paid*), $0 for temporary partial disability (TPD) benefits, and $77,783.03 for maintenance benefits, for a total credit of $147,566.53 under Section 8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner

18IWCC0006

interest under §19(n) of the Act, if any.

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

DATED: JAN 4 - 2018

Michael J. Brennan

MJB/pm
O: 12-05-17
052

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PLUMLEE, SHAWN
Employee/Petitioner

Case# **08WC025244**

PINCKNEYVILLE CORRECTIONAL CENTER
Employer/Respondent

18IWCC0006

On 5/1/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.95% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1580 BECKER SCHROADER & CHAPMAN
TODD SCHROADER
3673 HWY 111 PO BOX 488
GRANITE CITY, IL 62040

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

0558 ASSISTANT ATTORNEY GENERAL
NICOLE M WERNER
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

MAY 1 - 2017

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

18IWCC0006

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

Shawn Plumlee
Employee/Petitioner

v.

Pinckneyville Correctional Center
Employer/Respondent

Case # **08** WC **25244**

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 **Herrin**, on **February 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 AGAINST PERMANENCY?
O. ☒ Other **MMI Date; Wage Differential**

FINDINGS

On **April 30, 2008**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned **$41,828.28**; the average weekly wage was **$804.39**.

On the date of accident, Petitioner was **35** years of age, ***married*** with **1** dependent child.

Respondent shall be given a credit of **$69,783.50** for TTD, **$0** for TPD, **$77,783.03** for maintenance, and **$0** in other benefits for which credit may be allowed under Section 8(j) of the Act.

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

ORDER

Respondent shall pay Petitioner maintenance benefits of **$536.26/week** for **188 3/7 weeks**, commencing **February 2, 2011 through September 15, 2014**, as provided in Section 8(a) of the Act.

Respondent shall be given a credit of **$69,783.50** for TTD (*which the parties agreed at the time of arbitration had been appropriately claimed and paid*), **$0** for TPD, and **$77,783.03** for maintenance benefits, for a total credit of **$147,566.53** under Section 8(j) of the Act.

Respondent shall pay Petitioner the sum of **$482.63**/week for a further period of **75 weeks,** as provided in Section 8(d)2 of the Act, because the injuries sustained caused **15% loss of use of the 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.

Melinda M. Rowe Gillman

Signature of Arbitrator

4/26/17

Date

ICArbDec p. 2

MAY 1 - 2017

FILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Shawn Plumlee
Employee/Petitioner

Case # 08 WC 25244

v.

Consolidated cases: N/A

Pinckneyville Correctional Center
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that subsequent to the prior 19(b) arbitration hearing, he continued treatment with Dr. Kennedy and Dr. Feinberg. He testified that after his medical treatment was completed, Dr. Kennedy imposed permanent restrictions including no lifting more than 30 pounds and occasional bending, stooping and twisting.

Petitioner testified that at the time of his injury, he was employed with the Illinois Department of Corrections as a Correctional Officer. He testified that after the injury, he was not able to return to his employment. He testified that he received a letter from the Illinois Department of Corrections on May 9, 2011 indicating that they could not accommodate his restrictions. He testified that after he received his restrictions from Dr. Kennedy, he began a self-directed job search and also signed up for a program with the State of Illinois' Alternative Employment Program, which was designed to place him in another area within the State of Illinois but was not successful.

Petitioner testified that he was sent to the Department of Rehabilitation Services and received job search assistance from them but did not obtain employment through those efforts. He testified that he found employment in Colorado, but was not able to maintain that employment and came back to Illinois and continued to look for work. He testified that he eventually secured employment with the State of Illinois and is working now at the Chester Mental Health Center as a Security Therapy Aide 1. He testified that his current employment with Chester Mental Health Center started on September 16, 2014. He testified that while looking for employment, he had occasion to utilize the State of Illinois' program for veterans for schooling and that he attended classes at SIU-Carbondale. He testified that he is 12-18 hours from earning his Bachelor's degree.

Petitioner testified that with his current job he works midnights on Unit Echo which is a maximum security unit, but that the patients were older and had been there for quite a while. He testified that the patients had established themselves as being not being aggressive towards either themselves or staff, and that it was more of a medium or minimal level unit. He testified that during his employment, he has not sustained any injuries while working for Chester Mental Health Center. He testified that his physical requirements for the job indicate that daily he is doing rounds and that occasionally he will have to escort nurses into a patient's room to give medications. He testified that he does rounds every 15 minutes. He testified that there have been altercations while he has been there, but he has not been involved.

When asked if there was a difference in his mind between the environments at the Illinois Department of Corrections and Chester Mental Health Center, Petitioner responded that at the Illinois Department of Corrections there was one officer for 112 inmates on a unit, whereas at Chester Mental Health Center he had 16-24 patients. He testified that the patients at Chester Mental Health Center were not able to mentally engage you and did not get together to do something, whereas there was higher functioning at Pinckneyville. He testified that the inmates at the Illinois Department of Corrections were disengaged while at Chester Mental Health Center the more you talked to them, the more they liked it and were friendlier. He testified that he had a better rapport with his patients, and that he did not really ever experience any problems and was able to talk himself out of a potential situation.

Petitioner testified that at Pinckneyville Correctional Center, he encountered violence including inmate-on-inmate, inmate-on-officer, gang-related hits and retaliatory actions. He testified that there was violence at his facility now, but was more peer-on-peer. He testified that usually when the staff was hurt, it was moreso related to the staff trying to break up a fight. He testified that the level and amount of violent activity was hard to compare. He testified that he was able to talk someone out of fighting at Chester Mental Health Center, but was rarely able to do that while with the Illinois Department of Corrections.

Petitioner testified that his work history included the U.S. Air Force (from which he was honorably discharged), the Perry County Sheriff's Department where he worked both in corrections and as a patrol officer, Pinckneyville Correctional Center, a brief attempt at work in Colorado and then his current work at Chester Mental Health Center. He testified that his educational background included his having completed high school and an Associate's degree in Criminal Justice. He testified that he is working on a Bachelor's degree. He testified that his current monthly base salary is $3,603.

Petitioner testified that during the time period when he was looking for work, he volunteered coaching a high school football team. He denied having been injured while volunteering. He denied that he was still taking narcotics. He testified that he switched family physicians, and that his new doctor suggested he stop taking pain medications to see how he would do.

On cross examination, Petitioner testified that prior to his 2008 injury, he had had accident in 2006 for which he underwent a 3-level disc replacement. He testified that he returned to work full duty and that he had a second injury when he fell on the stairs. He denied having undergone any additional surgeries after his accident.

On cross examination, Petitioner agreed that he was recommended to undergo an FCE which he believed was performed in September of 2009. He testified that he believed that the FCE indicated that he could return to work with a 40-45 pound lifting restriction, but that once Dr. Kennedy reviewed it he changed the weight restrictions. He denied having returned to work at Pinckneyville Correctional Center with the 40-45 pound lifting restriction before Dr. Kennedy changed it. He agreed that he worked from November 3, 2010 through February 1, 2011. He testified that once the additional restrictions were given, he not able to go back to work.

On cross examination, Petitioner testified that he believed that Dr. Kennedy included the restriction of no inmate contact in early December and that this was the restriction that could not be accommodated. He testified that the restriction did not go into effect until February 1, 2011. He testified that he had been working with the restriction of no inmate contact since Dr. Kennedy gave issued it in early December and that he continued working until February 1st when he was walked out of the facility.

On cross examination, Petitioner agreed that he resigned from Pinckneyville Correctional Center in 2013. He testified that during his job search, he started looking in the local area and also used Monster.com. He agreed that the jobs he applied for included an associate attorney, a registered nurse, an

electrical engineer and a professional truck driver with a Class A CDL. He agreed that he did not have the appropriate licensure for any of these positions.

On cross examination, Petitioner testified that he did not remember when he applied to work at Chester Mental Health Center but was hired in 2014. He testified that he filled out an application. He testified that he was not sure if he indicated that he left Pinckneyville Correctional Center because he took a position with Larimore County Alternative Sentencing Division. He testified that the listed salary of as $2,716 bi-weekly was incorrect. When shown a copy of his application to Chester Mental Health Center as contained in Respondent's Exhibit 19, Petitioner agreed that he was not making $2,716 bi-weekly but rather that he made $16.98 per hour and made a mistake. He testified that he worked in Colorado for approximately three weeks. He agreed that he denied having any disabilities on the application. He further denied having informed anyone during the interview process that he had restrictions.

On cross examination, Petitioner testified that he is currently working as a Security Therapy Aide 1 and is able to perform his job. He testified that he has not had any complaints regarding his work. He testified that as part of his job, he is required to restrain patients if the situation calls for it and that he has done so. He testified that he underwent training on how to properly restrain patients at the beginning of his hiring process. He testified that there can be violent, physical altercations and that there is the possibility of being grabbed from behind.

On cross-examination, Petitioner admitted that Echo Unit is an open ward where the doors are unlocked with community restrooms and that the patients are not locked in their rooms at night. He testified the rules are the patients are to stay in their rooms at night unless they have to use the restroom, but he admitted patients could have a behavioral issue and leave their room. He further admitted that incidents do happen on Echo Unit.

On cross-examination, Petitioner testified that he has worked other shifts and worked a rotating shift for six months. He testified that he has worked the 7 a.m.-3 p.m. shift and the 3 p.m.-11 p.m. shift. He admitted that during those times, the patients are out more and more active. He testified that he also works overtime, meaning that if he is working the midnight shift he gets mandated to the day shift when the patients are out more and more active.

On cross-examination, Petitioner testified he worked as a coach at Pinckneyville Community High School and was paid $2,600 after taxes in 2016. Petitioner testified he is currently working his job at Chester Mental Health Center full duty with no complaints from his supervisor. Petitioner testified he takes over-the-counter medication for his back daily and that he is not required to wear any kind of back brace or protective device.

Russell Hecht was called as a witness by Respondent at the time of arbitration. Mr. Hecht testified that he is employed at Chester Mental Health Center and has worked there for more than 20 years. He testified that he is a Security Therapy Aide 4, which is a supervisor. He testified that when he first started, he was a Security Therapy Aide 1 and is familiar with the Security Therapy Aide 1 position.

Mr. Hecht testified that Chester Mental Health Center is an all-male adult maximum security facility which houses 280 patients. He testified that Chester Mental Health Center gets the more problematic patients from its sister facilities, and that the other population comes from the county jails. He testified that some of the patients have been charged with violent crimes, including murder, assault, battery and rape.

Mr. Hecht testified that as a Security Therapy Aide 1, the essential job functions include providing a safe and secure living for patients, intervening in conflict and providing assistance with daily living needs. He testified that they also provide security for escorting lines. He testified that if there is an

altercation between patients, the Security Therapy Aide 1 would intervene as they are the "front line" and that this could include restraining. He testified that he has seen violent altercations and has also seen Security Therapy Aides be grabbed from behind, pulled backwards and extend themselves.

Mr. Hecht testified that, as part of their job duties, a Security Therapy Aide 1 would need the ability to lift over 50 pounds. He testified that Respondent's Exhibit 21 was an accurate reflection of the responsibilities and duties of a Security Therapy Aide 1, and agreed that the last page of RX21 was a Physical Demand Summary indicating that a Security Therapy Aide 1 would need the ability to lift 51-100 pounds occasionally, anywhere from 21-100 reps a day. He agreed that this would be required of a Security Therapy Aide 1. He testified that the ability to be able to handle patients and to defend against a violent altercation was imperative to a Security Therapy Aide 1.

Mr. Hecht testified that the number of altercations varied, but that there were approximately 20 altercations per week on the low end. He testified altercations occur on a daily basis and that the majority of these altercations are violent. He testified that the staff is trained in non-crisis intervention and controlled holds. He testified that if the patient is more aggressive sometimes the holds do not work, and that a Security Therapy Aide 1 would have to resort to a body containment hold which includes wrapping his arms around the patient's body and taking them to the ground to gain control. He testified that he has seen Security Therapy Aides thrown and injured by patients.

Mr. Hecht testified that he is familiar with Petitioner through his employment at Chester Mental Health Center. He testified that Petitioner is capable of performing his job duties and that he has not heard of any complaints regarding his work. He testified that as a supervisor, he has no complaints regarding Petitioner's work.

On cross-examination, Mr. Hecht testified that Echo Unit is like a step-down unit where long-term patients who have not had problems are transferred. He agreed that Echo Unit would be one of the easier parts of the facility. He testified he does not have day-to-day interaction with Petitioner, but that he does talk to other supervisors regarding staff while doing daily debriefings. He testified reports regarding Petitioner have been positive.

On cross-examination, Mr. Hecht testified that he has been injured less than five times while working at Chester Mental Health Center. He testified that what has really gotten better is staff training and the tools given to deescalate things before they get physical. He agreed that having a good rapport with patients was helpful in controlling potential problems.

On cross-examination, Mr. Hecht testified that lifting 51-100 pounds on Echo Unit on the night shift would probably not occur often and that lifting that weight would be in assisting patients, not lifting boxes. He testified he did not agree with the Physical Demand Summary that indicated a Security Therapy Aide would never lift 11-25 pounds or 26-50 pounds. He testified when doing a physical hold, it is a team approach with three people - two to perform the hold and one as an observer. He testified that if the situation called for additional help, a "Code Red" was called throughout the facility and that additional staff respond to gain control of the situation. He testified that all employees carried a duress system button. He testified that there is a good community of employees at Chester Mental Health Center and that they have each other's backs. He testified that there were no employees with lifting restrictions to his knowledge.

On redirect, Mr. Hecht testified that when he reviewed Respondent's Exhibit 21 (*i.e.*, the job analysis), he thought it was accurate except for the indication that there was no lifting of 11-50 pounds. He testified that there was that type of lifting as sometimes the security staff had to move the patients' commissary boxes. He testified that there are also clothing baskets that come up every day and that the security staff will assist in unloading the buggies and moving the boxes of clothing. He also testified the

security staff also may dump dirty linen barrels, which are 32-gallon barrels of dirty clothes that could weigh up to 100 pounds.

On redirect, Mr. Hecht testified that there are times that the Security Therapy Aides have to lift patients and that the patients can vary in weight. He testified that while Echo Unit is considered a step-down unit, there was still the potential for violent outbursts from the patients. He testified that patients could become ill and that a Security Therapy Aide would have to assist in picking up the patient and placing them on a stretcher. He testified that if there was less lifting on midnights on Echo Unit, there was still the potential that a Security Therapy Aide would have to lift or restrain a patient. He testified that if someone who normally works the midnight shift on Echo Unit works overtime, they could be anywhere on the day shift.

Respondent called Major Donald Malcolm as a witness. Major Malcolm testified that he is employed at Pinckneyville Correctional Center as a Shift Supervisor/Major. He testified that he has been employed at Pinckneyville Correctional Center since it opened in 1998. He testified he started as a Correctional Officer, was promoted to a Correctional Lieutenant and then was promoted to a Shift Supervisor/Major. He testified that he has been in the position for a little over 8 years.

Major Malcolm identified Respondent's Exhibit 25 as a Pinckneyville Correctional Center pay scale that came out of the AFSME handbook. He testified he is familiar with Petitioner and that if he were still employed at Pinckneyville Correctional Center as a Correctional Officer, he would be "stepped out" and would be a step 8 on the pay scale. He testified that Petitioner would be earning $5,305 a month, plus an additional $100 a month for longevity.

Major Malcolm testified that he is familiar with the process of applying from a Correctional Officer to a Sergeant. He testified that the applicant fills out a CMS 100-B promotional application and gets a grade from CMS. He testified that when the promotional position is posted, interviews are set up for the people with "A" grades. He testified that points are given for different factors: annual reviews, education, military service, the verbal interview and written questions. He testified that the people with the highest points are put into seniority order and that it will go by seniority on who gets the promotion. He testified that seniority does not come into play until the very end. He testified that the interview takes into consideration how one conducts himself, answers questions, his appearance and uniform neatness, among other things. He testified that the written portion is like a test where the applicant is given scenarios and will have to write an incident report, and that the points awarded vary and depend on how well an applicant responds to questions in both the verbal and written portions. He testified that a big component in determining who would get the promotion would be who is applying for the position. He testified he has seen people who have 20 years seniority not get through the first part of the process due to not getting enough points in other areas. He testified there are still Correctional Officers currently working at Pinckneyville Correctional Center that started in 1999 who are still Correctional Officers.

Major Malcolm testified that he is one of the Majors that takes part in the promotional process and has done the interviews. He testified that it is usually a panel of three people. He testified that he has seen two Correctional Officers apply for a Sergeant and Lieutenant position where the less-senior officer received the position. He testified that in order to get the promotion to Sergeant, it depends on multiple factors including the applicant's interview, written portion, education, who else applied for the promotion and other outside factors. He testified that in his opinion it would be speculative to say that a Correctional Officer who started in 1999 would be a Sergeant now because of all the different factors in considering promotions.

On cross-examination, Major Malcolm testified that there are some people who do not have the initiative to better themselves through promotion. He testified some people just want to do their 20 years and get out and that others try to interview and promote, but never get the promotion. He testified that the

chances of those with the initiative to try to promote depended on who else was applying as it changed with every posting. He testified points are given for education, military, previous law enforcement experience and previous evaluations. He testified that points are also awarded for how an applicant answers questions in the interview. He testified it does help if someone has previous military and law enforcement experience and an Associate's degree.

On cross examination, Major Malcolm testified that no one with permanent restrictions was allowed in the facility to work.

On redirect, Major Malcolm testified while it does help an applicant to have military background, law enforcement background, and an Associate's degree, it is not a guarantee that they will get promoted to a Sergeant's position. He testified that the way the applicant performs in the interview and test portion would affect their ability to get the promotion and even if they had an excellent background, if a person did not do well on the interview or test they could fail to get the promotion. He testified there has not ever been a time that only one person interviewed for a Sergeant position.

Petitioner was called as a rebuttal witness. Petitioner testified he was brought back to the facility full duty with no restrictions.

The Arbitrator's Decision dated October 24, 2008 was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The Arbitrator found that Petitioner sustained injuries that arose out of and in the course of his employment with Respondent on April 30, 2008, and that Petitioner's injuries were aggravated by the events of April 30, 2008 based on Petitioner's testimony and the office records of Dr. Gornet. The Decision noted that Petitioner previously had back surgery in January of 2007 with three discs replaced, that he had returned to full duty work as a correctional officer and had worked successfully at full duty capacity from July 2007 through April 20 [*sic*], 2008 when he had the injury down the flight of stairs. The Decision further noted that Petitioner testified that he desired to continue with treatment from Dr. Gornet to resolve his current low back pain and numbness into his legs. (PX1).

The medical records of Pinckneyville Community Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. Petitioner was seen on April 30, 2008 in the Emergency Department, at which time it was noted that he fell at work and was having pain to the mid to lower back which was radiating into the right gluteus. The diagnosis was that of a sprain injury to the low back. (PX2).

The medical records of Dr. Robert Davidson were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. Petitioner was seen on May 5, 2008 at which time it was noted that he had been hurt at work and fell down a flight of stairs on April 30, 2008. It was noted that Petitioner had a sudden tight feeling in his back and was seen in the Emergency Room, had x-rays and had radicular pain in the right leg and right hip/buttock into the right thigh. It was noted that Petitioner needed to see Dr. Gornet and was to remain off work. An Authorization for Disability Leave and Return to Work dated February 2, 2011 noted that Petitioner had severe low back pain with pain radiating to the right leg, and that he could not walk or stand for long periods of time without moving or resting. It was noted that Petitioner's back was stable but that he remained in chronic pain, and that no additional surgery was indicated. The Authorization further noted that Petitioner would "never" be able to resume work and that it was Dr. Davidson's opinion that Petitioner was permanently and totally disabled for employment. (PX3).

The records of Dr. Davidson reflect that an Authorization for Disability Leave and Return to Work dated May 31, 2011 noted that Petitioner would be able to resume work on June 6, 2011 but that he would never be able to return to his regular job. The restrictions referenced included no inmate contact, no lifting greater than 30 pounds and occasional bending, stooping and twisting. (PX3).

The medical records of Dr. Matthew Gornet were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. Petitioner was seen on May 19, 2008, at which time it was noted that he stated he was doing very well until April 30, 2008 when he missed a step at work and fell essentially face first down a number of stairs. It was noted that Petitioner used his right arm to grab and try to hold the rail, which caused him to twist fairly rapidly. It was noted that Petitioner had developed increasing low back pain and paresthesias down both legs, particularly the right leg with numbness up to his knee. It was noted that Petitioner felt his pain was somewhat higher than it was in the past, that his exam from a strength standpoint was normal and that his radiographs looked "excellent." An MRI was recommended in addition to a home exercise program, and Petitioner was recommended to use a brace. (PX4).

The records of Dr. Gornet reflect that Petitioner was seen on June 19, 2008, at which time it was noted that the new MRI did not show any adjacent level pathology. It was noted that Dr. Gornet suspected that Petitioner suffered some type of annular injury or soft tissue injury during the twisting accident. Petitioner was recommended to undergo physical therapy. At the time of the August 18, 2008 visit, it was noted that Petitioner had not improved with simple physical therapy. Petitioner was recommended to undergo a CT myelogram, particularly compared to his previous CT scan to look for any occult pars fracture or pedicle fracture that may have occurred at the time of his recent fall. At the time of the September 8, 2008, at which time it was noted that Dr. Gornet had reviewed the CT scan which showed facet changes at 4-5 and 5-1 and "may be indeed" the source of his pain. Petitioner was recommended to undergo facet blocks at 4-5 and 5-1 and possibly facet rhizotomies. It was noted that Petitioner's pain was worse on the right than the left, that Petitioner was asked to go to his local gym and continue to try to exercise in a "low fashion" and that his main problem was that he could not stand or sit for any prolonged period of time. (PX4).

The medical records of Dr. David Kennedy were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. Petitioner was seen on October 8, 2008, at which time it was noted that he was involved in a work-related injury in February of 2006 when he experienced pain in the lower lumbar area and pain and tingling in both legs. It was noted that Petitioner failed to respond to conservative measures and ultimately underwent a three-level artificial disc replacement at L3-4, L4-5 and L5-S1, after which he did well and was able to return to work. It was noted that Petitioner was involved in another work-related injury on April 30, 2008 when he fell down a flight of stairs about 12 steps and that as he tried to arrest his fall, he grabbed an adjacent stair rail and twisted his lower lumbar area. It was noted that Petitioner had had quite a bit of pain in the lower lumbar area, particularly into the right paraspinous area, since that time. It was noted that Petitioner stated that most of his pain was in the right paraspinous area with some degree of pain radiating into the right leg on occasion, and that he had undergone injections which he stated did not help his pain very much. It was noted that Petitioner's pain pattern was different from what he experienced previously, and that Dr. Kennedy was going to obtain the previous studies that were performed and would contemplate a lumbar myelogram with follow-up CT depending on what the studies showed. Petitioner was taken off work as of October 8, 2008 pending further treatment. (PX5).

The records of Dr. Kennedy reflect that on November 13, 2008 Dr. Kennedy had reviewed the records, and that Petitioner's current pain suggested facet syndrome. It was noted that Dr. Kennedy did not think Petitioner needed revision surgery and that he thought facet injections should help. Petitioner was referred to Dr. Feinberg. Petitioner was taken off work as of October 8, 2008 pending further testing/treatment. A work slip was issued on March 10, 2009 taking Petitioner off work as of March 10, 2009 pending EMG results. At the time of the April 8, 2009 visit, it was noted that Petitioner's focal pain persisted and that Dr. Kennedy was going to obtain a follow-up CT scan to see if there was any further treatment relating to facet pathology that could be treated. It was noted that Petitioner had one facet injection and that Dr. Kennedy though it would "probably be worth" another attempt if Petitioner was willing. A Patient Message dated June 3, 2009 noted that Petitioner called and said his attorney told him

to go ahead and get injections. It was noted that Petitioner's information was faxed to Dr. Feinberg. (PX5).

The records of Dr. Kennedy reflect that on October 27, 2009, Dr. Kennedy authored a letter to Petitioner's attorney, indicating that he had reviewed the FCE performed on September 21, 2009. It was noted that Dr. Kennedy opined that based on the FCE, Petitioner should not lift more than 30 pounds or do more than occasional bending, twisting or stooping. It was noted that Dr. Kennedy did not think Petitioner was able to perform his normal activities as a Correctional Officer and would need restrictions on a permanent basis. Dr. Kennedy placed Petitioner at maximum medical improvement. Dr. Kennedy also authored a letter to Petitioner's attorney dated December 14, 2010, indicating that he had been advised that Petitioner had been assigned duties as a Correctional Officer in the general population. It was noted that Dr. Kennedy did not believe that this was in Petitioner's best interest because of the risk of possible dislodgement of the artificial discs that were previously placed in the event of an altercation or other type of violent physical activity. It was noted that Dr. Kennedy thought that Petitioner should be restricted from any type of activity in which the risk of severe unrestrained physical activity to include altercations or physical restraint of prisoners should be completely avoided. (PX5).

The medical records of Dr. Barry Feinberg were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. Petitioner was seen on June 17, 2009, at which time it was noted that he gave a history of an initial injury that occurred to his lower back in February of 2006 when carrying a box of food up steps in the prison when he injured himself. It was noted that Petitioner underwent a three-level disc replacement surgery in January of 2007 after which he underwent a course of rehabilitation and returned to work in July of 2007. It was noted that Petitioner also stated that on April 30, 2008 he reinjured himself after falling face down a flight of steps. It was noted that Petitioner stated that all the pain that he had before the surgery returned and still remained, that he had stiffness, shooting pain, numbness, tingling in the leg and sort of a fatigue, and that it was mostly in his lower back on the right side but did radiate to the left side. It was noted that Petitioner had not worked since the 2008 injury, that in the last 3-4 months he had developed pain up into the left scapula to the neck and to the occiput associated with headaches and that he had massage therapy at his chiropractor's office 7-8 visits without any significant relief of his pain. It was noted that Petitioner's diagnoses included a post-laminectomy syndrome of the lumbar spine, lumbar radiculopathy, thoracic spondylosis without myelopathy and lumbar spondylosis without myelopathy, and that he also had a musculoskeletal pain syndrome associated with the injuries as well as associated with his post-laminectomy syndrome. It was noted that Petitioner required a more comprehensive course of physical therapy to be coordinated with localized injection therapy. (PX6).

The Physical Therapy records from Marshall Browning Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The records reflect that Petitioner underwent therapy for the timeframe of June 23, 2008 through August 4, 2008. (PX7).

The Interpretive Report for X-rays of the Lumbar Spine dated April 30, 2008 was entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The report reflects that the films were interpreted as revealing (1) no definite fracture or subluxation is identified in the lumbar spine; (2) post-operative changes of discectomy noted from L3 through S1 with wafer-shaped metallic implants noted in each of the lower three lumbar disc spaces; (3) lumbar disc spaces appear fairly well maintained; (4) moderate hypertrophic changes at the superior end plate of T12. (PX8).

The Interpretive Report for a Lumbar Myelogram dated September 8, 2008 was entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The report reflects that the films were interpreted as revealing (1) disc replacements [at] L3-4, L4-5 and L5-S1 without significant impression upon the dura or definite root impingement. (PX9).

The Interpretive Report for a CT of the Lumbar Spine dated September 8, 2008 was entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The report reflects that the films were interpreted as revealing (1) disc replacements at L3-4, L4-5 and L5-S1 without recurrent disc herniation or stenosis with only mild facet degenerative changes. (PX10).

The Interpretive Report for a CT of the Lumbar Spine dated May 21, 2009 was entered into evidence at the time of arbitration as Petitioner's Exhibit 11. The report reflects that the films were interpreted as revealing (1) no acute fracture or dislocation identified in the lumbar spine (2) intervertebral disc prosthetic devices as described at L3 through S1 which appear well positioned and normally aligned. (PX11).

The Interpretive Report for a EMG/Nerve Conduction Study dated March 17, 2009 was entered into evidence at the time of arbitration as Petitioner's Exhibit 12. The report reflects that the testing was interpreted as revealing a normal electrodiagnostic study. (PX12).

The Functional Capacity Evaluation dated September 21, 2009 was entered into evidence at the time of arbitration as Petitioner's Exhibit 13. It was noted that the physical demand level demonstrated by Petitioner was that of Light-Medium, that Petitioner gave consistent effort and had good motivation, that overt pain behaviors were absent and that symptom magnification questionnaires were negative. It was noted that Petitioner's current status was not compatible with performing the duties of a Correctional Officer, simply because those duties could not be amended so as to preclude sudden torqueing movements of the spine as would likely occur in a confrontation with a combative inmate. (PX13).

The Letter from IDOC dated May 9, 2011 was entered into evidence at the time of arbitration as Petitioner's Exhibit 14. The letter referenced Petitioner's request for an accommodation to be allowed to work with the restrictions noted by his physician, Dr. Davidson. It was noted that Dr. Davidson had indicated that Petitioner's physical impairment was a Class 5, *i.e.*, "severe limitation of functional capacity; incapable of minimal (sedentary) activity (75-100%)." It was also noted that Dr. Davidson further indicated that Petitioner was temporarily totally disabled from any occupation including his job as a Correctional Officer and that he would "never" be able to resume work in any occupation including Correctional Officer. The letter noted that Petitioner's request was denied. (PX14).

The transcript of the deposition of Dr. David Kennedy was entered into evidence at the time of arbitration as Petitioner's Exhibit 15. Dr. Kennedy testified that he is a board-certified neurosurgeon. He testified that he first saw Petitioner on October 8, 2008, and that he gave a history of having been employed as a Correctional Officer by the State of Illinois and was involved in a work-related injury in February of 2006. He testified that Petitioner was under the treatment of Dr. Gornet and that after failing conservative measures, Dr. Gornet recommended and then proceeded with artificial disc replacement at L3-L4-L5 and L5-S1. He testified that Petitioner returned to work, but was then involved in another injury in April of 2008 where he fell about 12 steps in the work area, and that as he fell he tried to break his fall by grabbing onto a stairwell rail and then twisted his back and had quite a bit of pain in the lower lumbar area and right paraspinous area following the incident. (PX15).

Dr. Kennedy testified that Petitioner's principle complaints were pain in the right lower lumbar area with pain radiating into the right leg on occasion, and that Petitioner had not had any other neurologic deficits or other significant problems other than the pain localized in the right back. He testified that with a history of artificial discs, he had concerns that with the kind of fall Petitioner experienced, the risk of displacement or movement of the artificial disc was of concern. He testified that because of the nature of their placement, there was the possibility for excessive stress to be placed on other parts of the lower back, and that his working diagnosis was that some other portion of the back, typically a facet, was injured in the fall and was exacerbated or as a result of the placement of the artificial discs. (PX15).

Dr. Kennedy testified that he recommended a lumbar myelogram, which revealed that the artificial disc devices were in good position and that there was a little bit of narrowing of the nerve root exit zones at several levels but there did not appear to be any bony fracture or other significant abnormality as a result of the fall. He testified that he recommended injections into the painful area. He testified that after the injections Petitioner returned, but there was no improvement. He testified that he recommended a Functional Capacity Evaluation, after which he recommended that Petitioner lift not more than 30 pounds or do more than occasional bending, twisting or stooping. He testified that he did not feel that Petitioner was capable of performing his normal activities as a Correctional Officer. (PX15).

Dr. Kennedy testified that he believed that Petitioner's current medical problem was related to the fall of April 30, 2008. He testified that after his review of the FCE, he did not feel that Petitioner should perform the duties of a Correctional Officer because he believed that if Petitioner were to have certain movements of the back such as extreme extension, the discs could potentially be displaced. He testified that one of the restrictions that was routinely placed on people with artificial discs even at a single level was that they not perform extension exercises where they tipped backwards, because there was a risk of the disc extruding itself from the disc space. He testified that he thought there were certain high stress moves or positions that could place the discs under excessive stress and cause displacement, which would be a catastrophic event. (PX15).

Dr. Kennedy testified that he did not have any major disagreement with Dr. Robson's indication that Petitioner should not be lifting 51-61 pounds during his work day, and that he should be in the Medium work range level which was a 40-45 pound level. He testified that his restrictions were a little lower, but that he thought it was still in the range that he would consider safe. He testified that Petitioner's treatment protocol was limited to pain medications and that he referred Petitioner back to his family doctor for the ongoing pain management. (PX15).

On cross examination, Dr. Kennedy agreed that it was his understanding that Petitioner had been seeing Dr. Gornet after the April 30th accident and that he had ordered diagnostic testing. He testified that he believed that he eventually reviewed the testing ordered by Dr. Gornet as well as his medical records. He testified that Dr. Gornet's recommendations were that of facet blocks and exercise. He testified that Dr. Gornet had placed Petitioner at maximum medical improvement on January 14, 2008 and did not place any restrictions on his activities after the three level disc replacement was performed. (PX15).

On cross examination, Dr. Kennedy testified that Dr. Gornet had acknowledged that Petitioner was a Correctional Officer but that he did not believe that his release of Petitioner to full duty without restrictions after the disc replacement breached the standard of care. He testified that he was not saying that he agreed with the decision, but that he did not think it was a breach of the standard of care. He testified that he has performed disc replacement surgery approximately 12 times in the last 5-6 years and that he was familiar with Dr. Gornet. He testified that he knew that Dr. Gornet was an advocate and had done many disc replacements, but he did not know how many. When asked if he believed that Dr. Gornet would be in a better position to address potential work restrictions on a disc replacement that he performed and did on numerous occasions, Dr. Kennedy responded that was not necessarily the case. (PX15).

On cross examination, Dr. Kennedy agreed that radiographically Petitioner's lumbar spine was the same prior to the alleged April 30, 2008 date of accident as it was after, but that he was not sure structurally that was the case. He testified that Petitioner had reproducible pain by palpation so he thought there was an injury to the area after the event that was not there before and was still causing pain, but they were not able to visualize it directly on the basis of the studies that had been done. He testified that he knew that Petitioner did not have pain prior to April 30, 2008 based on his description. He agreed that the x-rays that he performed confirmed that there was no displacement of the artificial discs. (PX15).

On cross examination, Dr. Kennedy testified that he based his causation opinion on Petitioner's history and the medical records. He testified that he was aware that Petitioner was a high school football coach but did not see any reason why he should not be doing that. He testified that he thought that Petitioner could weightlift at least as of the FCE. He testified that he has told Petitioner to refrain from particular exercises, but that they were not included in his medical records. He testified that he told Petitioner to refrain from any exercises where he did back extensions and that he told him of this at the time of the first visit. (PX15).

On cross examination, Dr. Kennedy agreed that he reviewed Dr. Robson's report and agreed with him that there was no nerve root impingement. He testified that he agreed with Dr. Robson that there were no abnormalities with the prosthetic placement. He agreed that he would not necessarily disagree with the 40-45 pound lifting restriction that Dr. Robson suggested based on the FCE. (PX15).

On cross examination, Dr. Kennedy testified that he did not have a job description for Petitioner. He testified that he did not know where in the correctional facility that Petitioner worked. He testified that he did not know what position Petitioner worked, nor did he know the level of the security of the correctional facility at which Petitioner worked. He testified that he did not know the likelihood of exertion to altercation in the position that Petitioner worked. (PX15).

On cross examination, Dr. Kennedy agreed that facet arthroscopy was also a term for degenerative arthritis and that the cause would include wear and tear as well as a previous injury. He testified that facet arthroscopy was a condition of aging. When asked if Petitioner described to him how his pain was prior to the April 30, 2008 accident, Dr. Kennedy responded that Petitioner was basically doing fine prior to the accident and then had pain thereafter. (PX15).

On cross examination, Dr. Kennedy testified that Petitioner's last visit with him was on April 8, 2009 and that he noted he was going to do a follow-up CT, which was performed. He testified that he recommended consideration of further injections, but that he did not know if Petitioner underwent those. He testified that he did not know who ordered the FCE. He testified that Petitioner was referred to his office by Petitioner's attorney. He testified that he would not necessarily defer to the surgeon who performed the surgery with regard to work restrictions in a normal case because he thought different physicians could arrive at different judgments. (PX15).

On cross examination, Dr. Kennedy agreed that the surgery that he was referring to with the artificial discs being potential risks for Petitioner as a Correctional Officer were placed prior to the accident at issue. He testified that he would not defer to the surgeon that placed the disks as to whether Petitioner could work full duty. He testified that Petitioner's attorney had referred approximately a dozen clients to his office and that he has returned some of them back to work full duty and that those he had returned back to full duty had undergone surgery. (PX15).

On cross examination, Dr. Kennedy testified that of the 12 disc replacement surgeries that he had done, he had sent someone back to work full duty. He testified that if Petitioner were building a house by himself, he thought it was possible that he could be doing activities that would not be in line with his restrictions. He testified that since the last visit in April of 2009, Petitioner has not been scheduled to be seen again. He agreed that Petitioner was seeing his family physician for medications. He agreed that the nerve conduction study performed in March of 2009 was normal. (PX15).

On redirect, Dr. Kennedy agreed that he had reviewed the IME doctor's report that indicated that he felt that restrictions were appropriate in this case. He agreed that Dr. Robson opined that Petitioner needed to have restrictions in place stemming from this accident. He agreed that it was his understanding that Petitioner could not be a Correctional Officer because of the restrictions placed on him, and that he would agree with the no inmate contact limitation from his current physician, Dr. Davidson. (PX15).

Petitioner's Job Searches were entered into evidence at the time of arbitration as Petitioner's Exhibit 16. The Arbitrator notes that Petitioner applied for a variety of positions including a Business Consultant – Computer Upgrade Project; Sales; Insurance Agent; SQL Server Database Administrator; Associate Attorney; Professional Truck Driver Class A CDL; Project Manager – Oracle Development & Implementation; Medical Social Worker; Mortgage Loan Underwriter Manager; Chief Financial Officer (CFO) – Healthcare; and Stock Broker, among others. (PX16).

The records of Chester Mental Health Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 17. The records reflect that Petitioner indicated on his application for the Security Therapy Aide Trainee position that he left the Alternative Sentencing Department of Larimer County for "personal family matters" and that he left his former position at Pinckneyville Correctional Center in order to take the position with the Larimer County ASD. (PX17).

The Wage Statements from Pinckneyville Correctional Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 18. The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 19.

The CMS Summary of Disability was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The CMS Workers' Compensation Employee's Notice of Injury was entered into evidence at the time of arbitration as Respondent's Exhibit 2. The CMS Supervisor's Report of Injury or Illness was entered into evidence at the time of arbitration as Respondent's Exhibit 3.

The CMS Demands of the Job was entered into evidence at the time of arbitration as Respondent's Exhibit 4. The document pertained to the job title of Security Therapy Aide 1. (RX4).

The CMS Workers' Compensation Witness Report was entered into evidence at the time of arbitration as Respondent's Exhibit 5. The Incident Report was entered into evidence at the time of arbitration as Respondent's Exhibit 6.

The Functional Capacity Evaluation dated September 24, 2009 was entered into evidence at the time of arbitration as Respondent's Exhibit 7. The records were effectively duplicative of those as contained in Petitioner's Exhibit 13. (RX7; PX13).

The IME report of Dr. David Robson dated July 30, 2009 was entered into evidence at the time of arbitration as Respondent's Exhibit 8. The report noted that in the course of Petitioner's work as a Correctional Officer, he fell down a flight of stairs on April 30, 2008 and had been off work since that time. It was noted that Petitioner continued to complain of low back pain, increasing stiffness with his low back, and no significant radicular pain, numbness or tingling. It was noted that Dr. Robson's impression was that Petitioner had an initial work injury in February of 2006, that he was convalescing and doing well until a new injury occurred on April 30, 2008 which aggravated his back condition to the point that it made him symptomatic again and required physical therapy and injections. It was noted that Dr. Robson recommended a FCE and release with restrictions, and that he did not feel any medical/surgical treatment would significantly alter his outcome. It was noted that Dr. Robson believed that Petitioner had reached maximum medical improvement from both injuries and could be released with restrictions based on an FCE. (RX8).

The IME Addendum of Dr. Robson dated December 1, 2009 was entered into evidence at the time of arbitration as Respondent's Exhibit 9. The report noted that the FCE stated that Petitioner worked in a Medium work range, 40-45 pounds, and that he looked at the job description for a Correctional Officer which a couple of hours per day demanded lifting 50-60 pounds, which would exceed Petitioner's restrictions, but that all other restrictions within the demand of the job demonstrated that, based on the FCE, Petitioner could work as a Correctional Officer. It was noted that Dr. Robson felt that Petitioner

was at maximum medical improvement as of July 30, 2009, and that the video did not change his opinion of Petitioner's capabilities and his results from the surgery. (RX9).

The transcript of the deposition of Dr. David Robson was entered into evidence at the time of arbitration as Respondent's Exhibit 10. Dr. Robson testified that he is a board-certified orthopedic surgeon who subspecializes in the treatment of spinal disorders both operatively and non-operatively. He testified that he performs disc replacement surgeries and has performed such procedures approximately 100 times. (RX10).

Dr. Robson testified that he performed an IME of Petitioner on July 30, 2009. He testified that the history he received was that Petitioner had a work-related injury in 2006, underwent disc replacement at three levels in his lumbar spine, was recuperating, returned to work and fell down a flight of steps on April 30, 2008, after which he had increased low back pain and stiffness in his low back. He testified that Petitioner did not have any radicular pain nor did he have any numbness or tingling. He testified that Petitioner reported that after the incident, he had aquatic physical therapy and injections that he did not think long-term gave him a significant amount of relief. (RX10).

Dr. Robson testified that he reviewed various medical records and had films for various diagnostic testing that had been performed. He testified that Petitioner complained to him that he had low back pain centralized to the mid-lumbar area of his spine, and that he indicated that he felt that he could perform his activities of daily living. He testified that Petitioner reported that he was taking Tylenol and Ibuprofen. He testified that on physical examination Petitioner had decreased range of motion of the lumbar spine and hamstring tightness, but that the other portion of the exam including the neurologic evaluation was normal. He testified that in his review of the diagnostic films, he saw no difference whatsoever in the scans that were performed on January 14, 2008 and September 8, 2008, and that the scan from May of 2009 showed no difference either. He testified that the diagnostic studies did not show any nerve root impingement and that the prosthetic devices were placed in the accurate position and well-positioned within the disc space at each level. (RX10).

Dr. Robson testified that his diagnosis was that of an aggravation of the underlying spine condition as a result of the incident where Petitioner fell down the stairs, and that he agreed with the aquatic physical therapy and the injections. He testified that he felt that no further treatment was indicated and that he thought it was appropriate to determine Petitioner's functional level via an FCE. He testified that he believed that Petitioner had attained maximum medical improvement. (RX10).

Dr. Robson testified that he prepared a supplemental report dated December 1, 2009 after he reviewed the FCE performed on September 21, 2009 as well as video surveillance from September and October 2009. He testified that he felt that Petitioner could function in the Medium work range which was the 40-50 pound level, and that he felt that it was reasonable considering the previous injury and the need for his three level disc replacement. He testified that the video surveillance he reviewed did not change his opinions with regard to Petitioner's work ability. (RX10).

Dr. Robson testified that he was provided with the lifting requirements of a Correctional Officer, which was 50-60 pounds for 0-2 hours during the workday and that, if those restrictions met the 40-45 pound level, Petitioner could return to work full duty as a Correctional Officer. He testified that other than the 40-50 pound weight limit, he would place no other restrictions on Petitioner. (RX10).

Dr. Robson testified that he was familiar with disc replacement surgery and that there are studies on disc dislodgement. He testified that the general consensus was that the inner lining could sometimes dislodge as a result of hyperextension of the spine, and that it usually happened in the immediate post-operative period of 6-8 weeks following surgery. He testified that after that a capsule formed around the disc and was self-contained, and that the risk of dislodgement was virtually zero. (RX10).

Dr. Robson testified that he was aware that Petitioner was a Correctional Officer, that he was familiar with the job activities of a Correctional Officer and that he had treated Correctional Officers in the past. He testified that he did not agree with Dr. Kennedy's restriction of no inmate contact because he felt that, given a proper environment, the state of Petitioner's spine would render him safe to deal with a combative inmate. (RX10).

On cross examination, Dr. Robson testified that the "proper environment" to which he was referring was that the disc was healed and that he did not think that there was a risk of dislocation of a disc 3-4 years after the surgery. He testified that anyone had a risk with an inmate, but that he did not think that Petitioner's spine would be at more risk than any other part of his body if an inmate became combative. He testified that the risks associated with the disc dislodging or dislocating depended on what level the disc was at. He testified that at L3-4 the biggest risk would be the aorta, that at L4-5 it would be injury to one of the iliac vessels and that at L5-S1 the person would have pain but not a vascular sequelae. (RX10).

On cross examination, Dr. Robson testified that he was not aware of any studies on disc dislodgement or dislocation on three level disc replacements. When asked what type of force would be necessary for a disc to dislocate in Petitioner's current state, Dr. Robson responded that he did not think it would happen. He testified that the restrictions that he placed on Petitioner were based on the FCE as well as his general knowledge of having an injury that required surgery such as Petitioner had. (RX10).

On cross examination, Dr. Robson agreed that he was aware that as a Correctional Officer there were times they would have to fight an inmate and that they would also have to restrain inmates as well. When asked if he would recommend that Petitioner assist a co-worker by lifting an inmate off during an assault, Dr. Robson responded that he thought that there were techniques that Petitioner had learned in the course of his career to subdue an inmate. He agreed that doing a "bear hug" and twisting and pulling a 180-pound inmate would exceed the lifting restrictions he had placed and that he would not recommend it. (RX10).

On cross examination when asked if Petitioner has ongoing pain, Dr. Robson responded that he did not know. He testified that Petitioner stated that he was sore, but that he saw a video where Petitioner was moving relatively freely over a couple of days. He testified that the video impressed him the fact that Petitioner was mobile and did not hobble, but it did not impress him that Petitioner was doing anything that he should not have been doing or exceeding a restriction. (RX10).

The Cascade Disability Management Initial Vocational Evaluation Report dated July 12, 2010 was entered into evidence at the time of arbitration as Respondent's Exhibit 11. It was noted that Petitioner's strengths included a high school diploma, an Associate's Degree from Rend Lake College in Criminal Justice, a longstanding work history, military service, basic computer skills, a personable demeanor and a desire to return to work within his abilities. It was noted that the barriers to return to work included permanent physical restrictions which precluded him from returning to Correctional Officer work. (RX11).

The DHS Division of Rehabilitation Services Facility Vocational Evaluation Report was entered into evidence at the time of arbitration as Respondent's Exhibit 12. It was noted that it appeared that the main difficulties Petitioner faced related to physical limitations associated with a history of serious low back injury. It was noted that in the evaluator's opinion, the physical limitations presented suggested that alternatives offering better fit for Petitioner's needs were likely to be drawn from occupations classed at the sedentary level of exertion. It was noted that Petitioner was working with the State of Illinois' Alternative Employment Program and that in the interim, he thought it would be a wise use of his time to pursue further education to help qualify him for alternative employment suited to his present needs. The

report noted that there seemed no strong reason to think that Petitioner would not be employable, as long as the job fit with his restrictions and permitted him to take his medications. (RX12).

Various Position Applications were entered into evidence at the time of arbitration as Respondent's Exhibit 14. The records were, in part, duplicative of those as contained in Petitioner's Exhibit 16. (RX14; PX16).

The Factual Photo Surveillance Report dated October 7, 2009 was entered into evidence at the time of arbitration as Respondent's Exhibit 15. The report pertained to surveillance performed on September 24 and 25 and October 2, 2009. It was noted that Petitioner coached a football team for Sparta High School. (RX15).

The Factual Photo Surveillance DVDs were entered into evidence at the time of arbitration as Respondent's Exhibit 16.

The Sparta Football Staff Information was entered into evidence at the time of arbitration as Respondent's Exhibit 17. It was noted that Petitioner was a volunteer. (RX17).

The Wage Statements of Similarly Situated Correctional Officers were entered into evidence at the time of arbitration as Respondent's Exhibit 18. The records were effectively duplicative of those as contained in Petitioner's Exhibit 18. (RX18; PX18).

The Employment Records from Chester Mental Health Center were entered into evidence at the time of arbitration as Respondent's Exhibit 19. The records were effectively duplicative of those as contained in Petitioner's Exhibit 17. (RX19; PX17).

The Position Description was entered into evidence at the time of arbitration as Respondent's Exhibit 20.

The Job Analysis was entered into evidence at the time of arbitration as Respondent's Exhibit 21. The Analysis noted that the Security Therapy Aide 1 position provided security and therapy in an assigned area of the facility to an all-male population and was responsible for ensuring that all of the patient's needs were met in accordance with facility guidelines. The Physical Demand Requirement of the Job was noted to be that of Medium-Heavy. The Analysis was performed on November 9, 2011. The Physical Demand Summary noted that the Security Therapy Aide 1 occasionally (6-33% of the time; 3-12 reps per hour; 21-100 reps per day) lifted 51-100 pounds. (RX21).

The Notice of 19(b) Decision of Arbitrator for 06 WC 37553 and 06 WC 14361 was entered into evidence at the time of arbitration as Respondent's Exhibit 22. The Notice of Arbitrator Decision for 06 WC 27553 and 06 WC 14361 was entered into evidence at the time of arbitration as Respondent's Exhibit 23.

The Notice of 19(b) Arbitrator Decision for 08 WC 25244 was entered into evidence at the time of arbitration as Respondent's Exhibit 24. The exhibit was duplicative of that as contained in Petitioner's Exhibit 1. (RX24; PX1).

The Pinckneyville Correctional Pay Scale was entered into evidence at the time of arbitration as Respondent's Exhibit 25.

Petitioner's Current Pay Information was entered into evidence at the time of arbitration as Respondent's Exhibit 26. The documents reflect that for calendar year 2016, Petitioner's gross earnings were that of $51,253.46 and that for calendar year 2017 (as of February 14, 2017), Petitioner's gross earnings were that of $6,739.68. (RX26).

CONCLUSIONS OF LAW

With respect to disputed issues (F) pertaining to causation and (O) pertaining to maximum medical improvement date, given the commonality of facts the Arbitrator addresses both issues concurrently.

The Arbitrator at the outset states that, based on the records entered into evidence, it is arguably unclear to the Arbitrator under which set of restrictions Petitioner is current working. The evidence reflects that Petitioner underwent an FCE on September 29, 2009, at which time it was noted that the physical demand level demonstrated by Petitioner was that of Light-Medium, that he gave consistent effort and had good motivation, that overt pain behaviors were absent and that symptom magnification questionnaires were negative. The FCE noted that Petitioner's current status was not compatible with performing the duties of a Correctional Officer, simply because those duties could not be amended so as to preclude sudden torqueing movements of the spine as would likely occur in a confrontation with a combative inmate. (PX13). On October 27, 2009 in a letter directed to Petitioner's attorney, Dr. Kennedy opined that based on the FCE, Petitioner should not lift more than 30 pounds or do more than occasional bending, twisting or stooping. It was noted that Dr. Kennedy did not think Petitioner was able to perform his normal activities as a Correctional Officer and would need restrictions on a permanent basis. (PX5).

Thereafter on December 1, 2009, Dr. Robson issued an IME Addendum report which noted that the FCE stated that Petitioner worked in a Medium work range, 40-45 pounds, and that he looked at the job description for a Correctional Officer which a couple of hours per day demanded lifting 50-60 pounds which would exceed Petitioner's restrictions, but that all other restrictions within the demand of the job demonstrated that, based on the FCE, Petitioner could work as a Correctional Officer. It was noted that Dr. Robson felt that Petitioner was at maximum medical improvement as of July 30, 2009, and that the video did not change his opinion of Petitioner's capabilities and his results from the surgery. (RX9).

Thereafter on December 14, 2010, Dr. Kennedy authored another letter to Petitioner's attorney, indicating that he had been advised that Petitioner had been assigned duties as a Correctional Officer in the general population. Dr. Kennedy noted that he did not believe that this was in Petitioner's best interest because of the risk of possible dislodgement of the artificial discs that were previously placed in the event of an altercation or other type of violent physical activity. It was noted that Dr. Kennedy thought that Petitioner should be restricted from any type of activity in which the risk of severe unrestrained physical activity to include altercations or physical restraint of prisoners should be completely avoided. (PX5).

Subsequent thereto on February 2, 2011, Dr. Davidson issued an Authorization for Disability Leave and Return to Work which noted that Petitioner had severe low back pain with pain radiating to the right leg and that he could not walk or stand for long periods of time without moving or resting. Dr. Davidson noted that Petitioner's back was stable but that he remained in chronic pain, and that no additional surgery was indicated. Dr. Davidson further noted that Petitioner would "never" be able to resume work and that it was his opinion that Petitioner was permanently and totally disabled for employment. (PX3). The Arbitrator notes that the letter from IDOC dated May 9, 2011 -- which was entered into evidence at the time of arbitration as Petitioner's Exhibit 14 -- referenced Petitioner's request for an accommodation to be allowed to work with the restrictions noted by his physician, Dr. Davidson. The letter noted that Dr. Davidson had indicated that Petitioner's physical impairment was a Class 5, *i.e.*, "severe limitation of functional capacity; incapable of minimal (sedentary) activity (75-100%)." The letter also noted that Dr. Davidson further indicated that Petitioner was temporarily totally disabled from any occupation including his job as a Correctional Officer and that he would "never" be able to resume work in any occupation including Correctional Officer. The letter indicated that Petitioner's request was

denied. (PX14). As such, the Arbitrator infers that such denial was based on the restrictions referenced by Dr. Davidson.

Thereafter on May 31, 2011, Dr. Davidson issued yet another Authorization for Disability Leave and Return to Work, which noted that Petitioner would be able to resume work on June 6, 2011 but that he would never be able to return to his regular job. The restrictions referenced included no inmate contact, no lifting greater than 30 pounds and occasional bending, stooping and twisting. (PX3).

That said, the Arbitrator notes that while multiple iterations of restrictions have been issued in the case that have varied in some way, shape or form, it appears to the Arbitrator that ***all*** of the physicians in the case agreed that Petitioner requires permanent restrictions related to his current condition of ill-being. As a result thereof, the Arbitrator finds that Petitioner has met his burden of proving that his current condition of ill-being is causally related to the accident. The Arbitrator further finds that Petitioner attained maximum medical improvement as of the date of his release by Dr. Kennedy on October 27, 2009.

With respect to disputed issue (K) pertaining to maintenance benefits, the Arbitrator notes that the parties stipulated that Petitioner was paid temporary total disability benefits from April 30, 2008 through October 27, 2010 for a total amount of $69,783.50; that no benefits were paid from February 11, 2011 through October 1, 2011; and that maintenance benefits were paid from October 2, 2011 through September 15, 2014 for a total amount of $77,783.03. (AX1).

The Arbitrator finds that, in light of the Arbitrator's finding as to the issue of causation and in further light of Petitioner's testimony that Respondent could not accommodate his restrictions and Major Malcolm's admission on cross examination that no one with permanent restrictions was allowed in Respondent's facility to work, Petitioner is entitled to maintenance benefits for the timeframe of February 2, 2011 through September 15, 2014.

With respect to disputed issues (L) pertaining to the nature and extent of Petitioner's injuries and (O) pertaining to Petitioner's alleged wage differential claim, given the commonality of facts the Arbitrator addresses both issues concurrently.

"To receive an award under section 8(d)(1), an injured worker must prove (1) that he or she is partially incapacitated from pursuing his or her usual and customary line of employment and (2) that he or she has suffered an impairment in the wages he or she earns or is able to earn." *Cassens Transport Co. v. Industrial Comm'n*, 218 Ill.2d 519, 844 N.E.2d 414 (Ill. 2006). Having reviewed and considered the entirety of the evidence in the case, the Arbitrator finds that one of these elements has not been met.

In the case at bar, the Arbitrator finds that Petitioner has not been partially incapacitated from pursuing his usual and customary line of employment. While Petitioner testified that Respondent could not accommodate his restrictions and Major Malcolm admitted on cross examination that no one with permanent restrictions was allowed in Respondent's facility to work, the evidence reflects that Petitioner is currently employed in a job that falls in the Medium-Heavy physical demand requirement and that he is currently working full duty in a position that requires lifting up to 100 pounds. (RX4). Petitioner admitted on cross examination that he is capable of performing all of his job duties. The Arbitrator finds that the position of a Security Therapy Aide 1 is within Petitioner's usual and customary line of employment. Petitioner testified his employment history includes working at the Perry County Sheriff's Department in corrections and as a patrol officer and working as a Corrections Officer for Respondent. The Arbitrator finds that Petitioner's current position as a Security Therapy Aide 1 is similar as he maintains security for patients in a secure environment, assesses the need for security and intervention, performs security checks and controls and directs patients, which is similar to the core responsibilities of

a Correctional Officer. As such, the Arbitrator finds that Petitioner has not been partially incapacitated from pursuing his usual and customary line of employment and is therefore not entitled to a wage differential.

With respect to the issue of permanent partial disability, the Arbitrator notes that Petitioner was 35 years old at the time of his injury and is currently 44 years of age. While the evidence suggest that Petitioner is currently earning less than he did while employed for Respondent, he is apparently working full duty with no restrictions for Chester Mental Health Center. Furthermore, Petitioner testified that he currently takes over-the-counter medications daily for his back, but did not testify to any current symptoms regarding his back or difficulties performing his activities of daily living. Additionally, the Arbitrator notes that the medical records entered into evidence at the time of arbitration reflect that Petitioner has not sought medical treatment for his back for several years. Finally, Petitioner admitted that he works without any type of brace or protective device and is capable of working overtime, and that he also coaches high school football for which he is compensated.

Based upon the foregoing, having reviewed and considered the evidence in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of 15% loss of use of the person-as-a-whole as provided in Section 8(d)2 of the Act.

With respect to disputed issue (N) pertaining to Respondent's claimed credit against permanency, the Arbitrator finds that Respondent shall be given a credit of $69,783.50 for TTD (*which the parties agreed at the time of arbitration had been appropriately claimed and paid*), $0 for TPD, and $77,783.03 for maintenance benefits, under Section 8(j) of the Act. As the amount of maintenance benefits already paid by Respondent does not exceed the amount for which maintenance benefits have been awarded to Petitioner, the Arbitrator finds that Respondent is not entitled to a credit against the permanency award issued herein.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROBERT PATE, SR.,

Petitioner,

vs.

NO: 16 WC 29683

18IWCC0007

WILD CAT HILLS UG MINE,

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 partial disability (PPD), and being advised of the facts and applicable law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all the testimony, exhibits, pleadings, and arguments submitted by the parties.

In her Decision, the Arbitrator applied the facts to Section 8.1(b) of the Act in arriving at 7.5% loss of use of the body as a whole pursuant to Section 8(d)2 of the Act. Although the Commission agrees with the Arbitrator's well-reasoned Decision, the Commission finds the Arbitrator's award is low given the nature and extent of Petitioner's injuries in this claim.

18IWCC0007

As of result of the October 10, 2015 accident, Petitioner sustained a full-thickness rotator cuff tear in his left shoulder. Petitioner necessitated and underwent injections, arthroscopy for the left shoulder, as well as a subacromial decompression and open rotator cuff repair, and physical therapy. (PX3; PX4; PX5; PX6). Significant weight should have been afforded to Section 8.1(b)(v) of the Act.

Based on the above, the Commission finds an award of 12.5% loss of use of the body as a whole more appropriate for the type of injury sustained by Petitioner, the level of treatment undertaken for his condition, and evidence of his disability.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed June 15, 2017, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $755.22 per week for a period of 62.5 weeks, as provided in Section 8(d)2 of the Act, for the reason that the injuries sustained caused 12.5% loss of use of the body as a whole.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $47,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: JAN 4 - 2018

MJB/pm
D: 12-05-17
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PATE SR, ROBERT
Employee/Petitioner

Case# **16WC029683**

WILD CAT HILLS UG MINE
Employer/Respondent

18IWCC0007

On 6/15/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.10% 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:

0969 RICH RICH & COOKSEY PC
THOMAS C RICH
6 EXECUTIVE DR SUITE 3
FAIRVIEW HTS, IL 62208

0299 KEEFE & DePAULI PC
NEIL A GIFFHORN
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

18IWCC0007

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Robert Pate, Sr.
Employee/Petitioner

v.

Wild Cat Hills UG Mine
Employer/Respondent

Case # **16** WC **29683**

Consolidated cases: **N/A**

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Herrin**, on **May 10, 2017.** By stipulation, the parties agree:

On the date of accident, **October 10, 2015**, 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's earnings were **$108,992.00** and the average weekly wage was **$2,095.00**.

At the time of injury, Petitioner was **58** years of age, ***married,*** with 0 dependent children.

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

Respondent shall be given a credit of **$1,167.30** for TTD, **$0** for TPD, **$0** for maintenance, and **$8,307.40** for other benefits, for a total credit of **$9,474.70.**

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

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

ORDER

Respondent shall pay Petitioner the sum of **$755.22/week** for a further period of **37.5** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **7.5% loss of use of the person-as-a-whole.**

Respondent shall pay Petitioner compensation that has accrued from **April 15, 2016** through **May 10, 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.

Melinda M. Grace Gillman

Signature of Arbitrator

6/12/17

Date

ICArbDecN&E p 2

JUN 15 2017

18IWCC0007

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Robert Pate, Sr.
Employee/Petitioner

Case # 16 WC 29683

v.

Consolidated cases: N/A

Wild Cat Hills UG Mine
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he is a Mine Face Supervisor for Respondent. The parties stipulated that on October 10, 2015, Petitioner was throwing large sheets of metal and felt immediate pain in his left shoulder. (AX1). At arbitration, Petitioner testified that despite the improvement resulting from surgery and therapy, he still experiences sharp pain when he uses his left arm. He testified that he has difficulty at work when hanging cables overhead or reaching for any overhead objects and that lifting over his head still gives him trouble. He testified that his hobby of motorcycle riding has been adversely affected. He further testified that his sleep has been disturbed in that when he sleeps on his left side, he wakes up at night.

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. James Alexander were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on November 16, 2015, at which time it was noted that he had pain in the left shoulder that was worse at night. It was noted that the pain was in the glenohumeral joint, that it was in the acromioclavicular joint and that it was in the subacromial region. It was noted that Petitioner was working full time, that he had no job problems or incidents and that he had no previous work injury. The assessment was noted to be that of bursitis of the left shoulder and articular cartilage disorder of the shoulder region. Petitioner was given injections into the left shoulder joint. Petitioner was also ordered to undergo x-rays of the shoulder. (PX3).

The medical records of Dr. James Goris/Orthopaedic Associates were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen on December 16, 2015, at which time it was noted that he presented with diffuse pain in the left shoulder. It was noted that Petitioner complained of stiffness and that he complained of popping at the time of the injury that had continued. It was noted that Petitioner had radiation of pain down into the arm and that he had limited motion to lift the arm above his head due to discomfort. The assessment was noted to be that of (1) tendinitis of the left shoulder; (2) primary osteoarthritis of the left shoulder. Petitioner was recommended to undergo an MR arthrogram. At the time of the December 30, 2015 visit, Petitioner was seen for the results of his MR arthrogram. It was noted that his symptoms were the same. It was noted that the small amount of contrast estravasation into the subacromial bursa was compatible with a small full-thickness

rotator cuff tear. The assessment was noted to be that of sprain of left rotator cuff capsule. Petitioner was recommended to proceed with surgery. (PX4).

The records of Dr. Goris reflect that Petitioner was seen on February 5, 2016. at which time it was noted that he was doing well and had stopped taking his pain medication on Tuesday. It was noted that the shoulder had popped a couple of times since surgery. At the time of the February 26, 2016 visit, it was noted that Petitioner stated that he was doing pretty well and had no complaints. It was noted that Petitioner had been working on the exercises on his own and had done well. Petitioner was instructed to start formal physical therapy. At the time of the March 18, 2016 visit, it was noted that Petitioner's arm was getting better for him and that his motion was improved. It was noted that Petitioner reported that he had some aching pain every once in a while. Petitioner was recommended to continue physical therapy. At the time of the April 15, 2016 visit, it was noted that Petitioner stated that he was getting along just fine and that he did not have much in the way of pain, only if he slept on it wrong. Petitioner was recommended to continue with the stretching exercises at home. It was noted that Petitioner could return to activities of daily living as comfort allowed and that it was unlikely that doing so would cause any structural damage or accelerate any degenerative process. (PX4).

The medical records of Deaconness Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner underwent a left shoulder arthrogram on December 22, 2015, which was interpreted as revealing small amounts of contrast extravasation into the subacromial bursa compatible with a small full-thickness rotator cuff tear. Petitioner underwent surgery by Dr. Goris on January 28, 2016, which was that of a left shoulder arthroscopy with subacromial decompression and mini open rotator cuff repair. Both the pre- and post-operative diagnoses was noted to be that of left rotator cuff tear. (PX5).

The medical records of Joyner Therapy Service 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 March 3, 2016 through April 14, 2016. The Discharge Note noted that Petitioner had been released by his physician and had met all of his goals with skilled care. At the time of the April 14, 2016 visit, it was noted that Petitioner felt like he was doing well, was not having any pain and was able to perform all of his work tasks. (PX6).

The Wage Statement/Accident Reports were entered into evidence at the time of arbitration as Petitioner's Exhibit 7.

The Payment Log was entered into evidence at the time of arbitration as Respondent's Exhibit 1.

CONCLUSIONS OF LAW

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injury, and consistent with 820 ILCS 305/8.1b, permanent partial disability shall be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of Section 8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. No single enumerated factor shall be the sole determinant of disability. *Id.*

With respect to Subsection (i) of Section 8.1b(b), the Arbitrator notes that no AMA rating was offered by either party. The Arbitrator places no weight on this factor when making the permanency determination.

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that the record reveals that Petitioner was employed as a Mine Face Supervisor at the time of the accident and that he has returned to this position with Respondent. The Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 58 years old on his date of accident. Given the advanced age of Petitioner and the fact that the medical records lack any reference to his having been placed under any restrictions, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (iv) of Section 8.1b(b), the Arbitrator notes that, following his work injury, Petitioner returned to his position as a Mine Face Supervisor for Respondent. As there was no direct evidence of reduced earning capacity contained in the record, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (v) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that he still experiences sharp pain when he uses his left arm. He testified that he has difficulty at work when hanging cables overhead or reaching for any overhead objects and that lifting over his head still gives him trouble. He testified that his hobby of motorcycle riding has been adversely affected. He further testified that his sleep has been disturbed in that when he sleeps on his left side, he wakes up at night. At the time of the April 15, 2016 visit, it was noted that Petitioner stated that he was getting along just fine and that he did not have much in the way of pain, only if he slept on it wrong. Petitioner was recommended to continue with the stretching exercises at home. It was noted that Petitioner could return to activities of daily living as comfort allowed and that it was unlikely that doing so would cause any structural damage or accelerate any degenerative process. (PX4). The Arbitrator concludes that Petitioner's evidence of disability at the time of arbitration, namely his continued complaints and limitations, were corroborated by his treating records entered into evidence at the time of arbitration. The Arbitrator accordingly places greater weight on this factor in determining permanency.

The Arbitrator notes that the determination of permanent partial disability benefits is not simply a calculation, but an evaluation of all of the factors as stated in the Act in which consideration is not given to any single factor as the sole determinant. Based on the above factors and the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of **7.5% loss of use of the person-as-a-whole** as provided in Section 8(d)2 of the Act.

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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOSEPH BOWEN,

Petitioner,

vs.

NO: 14 WC 15914

18IWCC0008

WILLIAM A. NIEKAMP
TRUCK SERVICE,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission vacates the award of Section 19(k) penalties and attorney fees pursuant to Section 16 of the Act. In so doing, the Commission notes that a legitimate dispute existed as to whether a compensable accident occurred on April 14, 2014. While the Commission agrees with the finding of a compensable accident, there existed conflicting evidence as to how the accident occurred. The Petitioner testified that his right knee gave way while climbing into the cab of his semi-truck. Respondent's witnesses testified that the Petitioner informed them that his right knee gave out while walking across the parking lot to his semi truck. Because of the conflicting testimony, the Commission finds that Respondent's actions were not unreasonable or vexatious as there existed a good faith defense to the incident. Thus, Section 19(k) penalties and attorney fees pursuant to Section 16 are not appropriate. The award of Section 19(l) penalties is affirmed.

The Commission affirms the PPD award of twenty percent loss of use of the right leg but

18IWCC0008

clarifies the Decision as stated below.

Pursuant to Section 8.1(b) of the Act, the Commission gives no weight to subsection (i) as an impairment report was not offered by either party. The Commission assigns moderate weight to subsection (ii) as Petitioner works as a truck driver and uses his right leg to drive the truck. Because of his knee injury, Petitioner is more prone to experience the effects of his injury while performing his job duties. The Commission assigns little weight to subsection (iii) noting that Petitioner returned to work following his injury and subsequently left his job on his own accord. No evidence was offered that his age impacted his ability to perform his job duties. The Commission assigns little weight to subsection (iv) as Petitioner returned to work earning $10.00 per hour but was paid TPD benefits to compensate for the reduced pay. Petitioner then left respondent's employ and no evidence of a reduced earning capacity was offered. The Commission gives greater weight to subsection (v). Petitioner underwent right knee surgery due to his injury. While he had pre-existing issues, Petitioner could work until the injury and surgery was only necessary following the injury. Petitioner testified that he has more pain because of the injury.

Further, the Commission has searched its records and takes judicial notice of the fact that there is no record in its system which establishes that Respondent is entitled to a credit for a prior award to the right leg. Though the Petitioner admitted upon cross-examination that he received $10,000.00, and that said sum might or could have represented 20 to 22.5% of the leg, to find such a credit without some documentation would be speculative at best and plain error.

Therefore, the Commission affirms the award of 20% loss of use of the right leg.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on April 6, 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 $540.61 per week for a period of 13-6/7 weeks, commencing April 15, 2014 through July 20, 2014, 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 temporary partial disability benefits of $440.61 per week for a period of 6 weeks, commencing July 21, 2014 through August 31, 2014, as provided in Section 8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $486.55 per week for a period of 43 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused 20% loss of use of the right leg, as provided in Section 8(e) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $9,023.53 for medical expenses under §8(a) of the Act and subject to the medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay

18IWCC0008

penalties of $10,000.00 as provided in Section 19(l) 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 hold Petitioner harmless for the medical expenses paid by Petitioner's spouse's health insurance, Blue Cross Blue Shield, of $19,475.27.

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 $50,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 4 - 2018

Michael J. Brennan

MJB/tdm
O: 12/5/17
052

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BOWEN, JOSEPH E
Employee/Petitioner

Case# **14WC015914**

WILLIAM A NIEKAMP TRUCK SERVICE INC
Employer/Respondent

18IWCC0008

On 4/6/2017, 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 0.91% 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

3150 JAMES M KELLY LAW FIRM
7817 N KNOXVILLE AVE
PEORIA, IL 61614

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

Joseph E. Bowen
Employee/Petitioner

v.

William A. Niekamp Truck Service, Inc.
Employer/Respondent

Case # **14 WC 15914**

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**, on **February 1, 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 **Hold harmless**

FINDINGS

On **April 14, 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 **$42,167.36**; the average weekly wage was **$810.91**.

On the date of accident, Petitioner was **46** years of age, ***married*** 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 **$-0-** for TTD, **$-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

Medical benefits

Respondent shall pay reasonable and necessary medical services of $9,023.53, as provided in Sections 8(a) and 8.2 of the Act.

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 hold Petitioner harmless for the medical expenses paid by Petitioner's spouse's health insurance, Blue Cross/Blue Shield, of $19,475.27.

Temporary Partial Disability

Respondent shall pay Petitioner temporary partial disability benefits of $440.61/week for 6 weeks, commencing 07-21-2014 through 08-31-2014, as provided in Section 8(a) of the Act.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $540.61/week for 13 6/7 weeks, commencing 04-15-2014 through 07-20-2014, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $-0- for temporary total disability benefits that have been paid.

Permanent Partial Disability: Schedule injury (For injuries before 9/1/11)

Respondent shall pay Petitioner permanent partial disability benefits of $486.55/week for 43 weeks, because the injuries sustained caused the 20% loss of the right leg, as provided in Section 8(e) of the Act.

Penalties

Respondent shall pay to Petitioner attorneys fees of **$7,726.75**, as provided in Section 16 of the Act; penalties of **$19,316.8**, as provided in Section 19(k) of the Act; and **$10,000.00**, as provided in Section 19(l) of the Act.

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

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

Edward Lee
Signature of Arbitrator

3/31/17
Date

APR 6 - 2017

Accident and Causal Connection

The Arbitrator finds that the Petitioner sustained an accident that arose out of and in the course of his employment by Respondent on April 14, 2014.

The Petitioner testified that on the afternoon of April 14, 2014, he was in Alsip, Illinois at the New Process Steel Company to pick up a load of steel. He testified that he injured his right knee as he was climbing up into the cab of the semi-tractor trailer he was driving. He stated that there are two steps on the fuel tank. He stated that he had opened the door of the cab. He stated that he put his left foot on the bottom rung, then his right foot on the next rung, grabbed a hold with his right hand, and when he put all his weight on the right knee it "blew like a shotgun going off," and he immediately noticed "terrifying" pain and swelling in his right knee. He testified that he was in so much pain that he needed help getting out of the cab to get to the bathroom, as he was in so much pain he was afraid he was going to shit on himself. He called another driver, Chris Bennett, on the CB radio to come and help him out of the cab and to assist him, so he wouldn't fall, to walk into the building to use the restroom.

The Petitioner stated he told Chris Bennett how the injury occurred and also called the Respondent's owner, Adam Niekamp, and told him what had happened. The Petitioner stated that he told Adam Niekamp, "I told him I walked in and I signed in and when I was getting back into the truck, when I was trying to get into the truck my knee just blew up." *(R. 20)*

Both Chris Bennett and Adam Niekamp stated that the Petitioner told them that when he was walking back to the truck his knee gave out and he fell to the ground.

The Petitioner got another driver to secure his load on the flatbed and drove back to Quincy. The Petitioner went to the Blessing Hospital emergency room and was seen on April 15, 2014 at 3:00 a.m. The ER record includes a history of injury to his right knee at "3:30 p.m. yesterday" at work "when getting into his semi and bearing weight on his right leg, felt and heard a pop and had sudden onset pain with inability to bear weight." The words "constant" and "sudden onset," "still present," "severe,"

"swelling," and "tenderness" were circled. Also noted was "longstanding problems with the right knee" and that the Petitioner had undergone previous neck surgery, back surgery, and right knee arthroscopy.

On physical exam the Petitioner was noted to be anxious and obese and to have tenderness and swelling of his right knee, limited range of motion, and unable to bear weight. The clinical opinion was "internal derangement of knee."

The ER face sheet states, "Accident – Employment Related." *(Pet. Ex. 7)*

The Arbitrator notes that the Petitioner acknowledged having had bilateral knee pain for a long period and that he had undergone a diagnostic arthroscopy of his right knee with removal of a loose body on December 4, 1997 by Dr. Olson at Blessing Hospital. The operative report stated that the Petitioner had early degenerative joint disease and that there was no meniscal pathology and that the ligaments were intact and stable. *(Pet. Ex. 6)*

The Quincy Medical Group records reflect that the Petitioner was released by Dr. Olson to return to work full duty on February 6, 1998. The Petitioner was seen again by Dr. Olson on February 13, 1998, for aching pain in his right knee. Dr. Olson felt that the Petitioner's request to work full duty had been premature and that the Petitioner should have a couples of months of limited duty with 50% sedentary duty and no kneeling or squatting, and then full duty after that.

The only other time that the Petitioner was seen for his right knee after that, until after his April 14, 2014 injury, was on December 22, 1999, which appears to have been mostly for low-back related complaints, with a note that the right knee was swollen with some medial joint line tenderness and early osteophyte formation. Dr. Olson recommended "acute weight loss in terms of his knee and back." Soon thereafter Dr. Olson referred the Petitioner to a neurosurgeon, Dr. Morris, for back pain.

The records reflect no further treatment for the right knee after December 22, 1999, until the Petitioner was seen at the Blessing Hospital ER in the early morning of April 15, 2014, after his right knee injury of April 14, 2014. *(Pet. Ex. 3)*

On April 16, 2014, the Petitioner was seen by Steven DeMont, physician's assistant to Dr. Crickard at Quincy Medical Group. The history section states, "He was pulling himself up on his truck on 4/14 when he and his son *[sic]* right knee pain and giving out. Her allow *[sic]* pop and felt a sharp pain like a cutting across the back side of the knee. He had an arthroscopy with Dr. Olson about 17 years ago he says. He had a good recovery after that and has not had a lot of knee problems. He now has 10 out of 10 pain that can be sharp, dull, stabbing, throbbing, aching and burning at different times and is constant. There is swelling and weakness associated and it gives way. He has had no significant locking. Symptoms are stable despite some pain medication. They are worse with standing, walking and sitting." The record was later corrected by Mr. DeMont, who stated, "The voice recognition system operated poorly on some of the initial encounter note. Under history of present illness, the second and third sentences should read: "He was pulling himself up into his truck on 4/14 when he had sudden right knee pain and giving way. He heard a pop and felt a sharp pain like a cutting across the back side of his knee." *(Pet. Ex. 4)*

An MRI of the right knee was done on May 5, 2014, at Blessing Hospital that showed marked osteoarthritis, moderate joint effusion, and degenerative menisci with tears throughout the posterior horn and body of the medial meniscus and posterior horn of the lateral meniscus. *(Pet. Ex. 7)*

On May 10, 2014, Dr. George Crickard, Petitioner's treating orthopedic surgeon at Quincy Medical Group, saw the Petitioner. Dr. Crickard stated that the Petitioner was well known to him in that they played football together at Quincy High School. The history was, "He states that he was in Chicago about a month ago, stepping up into his truck, when he felt a pop. He has had pain ever since..... He had an MRI on May 5, 2014 which showed tri compartment arthritis but also meniscal tears. He is status post right knee arthroscopy by Dr. Craig Olson in the past."

Dr. Crickard's impression was "Right knee medial and lateral meniscal tears with osteoarthritis."

Dr. Crickard's plan was, "He has had arthritis in that knee for a number of years more than likely. His symptoms are new with an injury at work. More probably than not, his right knee medial and lateral meniscal tears came from his work injury. He wished to have a scope done. I agree." *(Pet. Ex. 4)*

Dr. Crickard performed a right knee arthroscopy at Blessing Hospital on June 2, 2014, which included debridement of both medial and lateral meniscal tears. *(Pet. Ex. 8)*

The Respondent had the Petitioner examined on July 17, 2014 by Dr. Kevin Walsh. Dr. Walsh opined that the "work event" of April 14, 2014 did not cause, aggravate, nor accelerate his arthritis. Dr. Walsh also stated, "The meniscal pathology treated by the orthopedic surgeon was for a degenerative condition not caused, aggravated or accelerated by a work injury." *(Resp. Ex. 1)*

The Petitioner is 6'3" tall, weighs 330 pounds, and is left handed.

With regard to the conflict in testimony between the Petitioner's description of his injury and that of the Respondent's two witnesses, Adam Niekamp and Chris Bennett, the Arbitrator finds the Petitioner's testimony to be credible. This is true particularly in light of the medical records, which are very consistent with Petitioner's testimony.

The Arbitrator finds the Petitioner to have testified credibly and that the Petitioner is a refreshingly simple, down-to-earth man with no indication of any dishonesty in his testimony. Further, the Petitioner's description of his accident is consistent with the type of injury he sustained, involving either aggravation of previously asymptomatic meniscal tears, or brand new tears. Also, the Petitioner testified that he filled out an accident report at Respondent's request, but Respondent did not place his report into evidence.

It is clear that the accidental injury suffered by Petitioner arose from a risk to which the general public is not exposed, namely pulling oneself up into the cab of a semi-tractor trailer truck.

Further, the Respondent's witnesses' claim that the Petitioner said he was standing and/or walking on the blacktop near his truck and suddenly fell to the ground with severe knee pain is very improbable, in particular because nowhere in the medical records is such an event described.

Causal Connection

The Arbitrator finds that a causal connection exists between the Petitioner's April 14, 2014 right knee injury at work and his subsequent treatment, including arthroscopic surgery, and the current condition of ill-being of his right knee.

The Arbitrator relies upon the credible testimony of the Petitioner, the medical records and the opinion of the treating orthopedic surgeon, Dr. Crickard, that the Petitioner had osteoarthritis in his right knee for years, that the Petitioner's symptoms of severe pain and swelling were new with the work injury of April 14, 2014, and that more probably than not the right knee medial and lateral meniscal tears came from his work injury.

This opinion is buttressed by the fact that the Petitioner had no treatment for his right knee for over 15 years and that his 1997 arthroscopic surgery showed no tears and only a loose body, which was removed by Dr. Olson.

Dr. Walsh's opinions cannot be given much weight. Because the Respondent did not provide Dr. Walsh with any records prior to 2005, Dr. Walsh had no way of knowing that the 1997 arthroscopic operative report showed no meniscal tears. In addition, Dr. Walsh appears to have misstated some of what the Petitioner told him, such as that he cannot run wind sprints and the he did not report the injury until after he returned from Alsip to Quincy.

Dr. Walsh's opinions have been found in the past to be unpersuasive by arbitrators and the Commission. See *Perez v. Astoria Living and Rehabilitation* 10 WC 19850 (13 IWCC 0156) and *Vargas v. Lifetouch Portrait Studios* 12 WC 038709.

The Arbitrator finds the evidence overwhelming that, at a minimum, the Petitioner's April 14, 2014 work injury was a contributing cause of his right knee condition of ill-being, which required arthroscopic surgery by Dr. Crickard.

TTD

The Arbitrator awards TTD for the period of 13 6/7 weeks, April 15, 2014 through July 20, 2014, consistent with the medical records and Petitioner's testimony, having found for Petitioner on the issues of accident and causation.

Medical Expenses

The Arbitrator finds Respondent liable for the following medical expenses, consistent with finding for Petitioner on the issues of accident and causal connection.

Clinical Radiologists	$ 61.50
Quincy Medical Group	$ 5,971.18
Blessing Hospital	$ 2,990.85
TOTAL:	$ 9,023.53

In addition, the Arbitrator finds the Respondent liable for the $19,475.27 in medical expenses paid by Petitioner's spouse's group health carrier, Blue Cross/Blue Shield and orders the Respondent to hold Petitioner harmless from reimbursing Blue Cross for its payments, for which the Respondent is liable.

TPD

The Arbitrator finds Respondent liable for temporary partial disability benefits of $490.61 per week for the six-week period from July 21, 2014 through August 31, 2014.

There was no dispute that when the Petitioner returned to work on July 21, 2014, his pay was cut to $10.00 per hour, and he was given only a maximum of three hours per day of work by Respondent. The Petitioner testified that the Respondent gave him an old truck into which he barely fit and which he felt was unsafe. The Petitioner testified that after three weeks at most he quit and began looking for other work, which he found and began as of September 1, 2014. Thus, the Petitioner should receive TPD benefits for this six-week period.

Nature and Extent

The Arbitrator finds that the injury of April 14, 2014 caused impairment of 20% of the right leg over and above whatever previous impairment the Petitioner received.

The Petitioner testified that he was paid $10,000.00, which he thought represented 20% or 22½% loss of his right leg relating to his 1997 right knee injury at work with another employer. The Petitioner stated he was unrepresented, and this appears to have been a *pro se* settlement.

The Respondent is entitled to credit for the PPD represented by this settlement. Respondent stated that a record of this settlement was included in Respondent's Exhibit 3. Petitioner's attorney stated that this was not included in his copy of the exhibits that Respondent gave him. The Arbitrator gave Respondent an opportunity to make sure that this document was included in its exhibit. Respondent is not entitled to credit for the prior settlement without providing the Arbitrator with proper documentation of it.

Petitioner testified that Dr. Crickard's arthroscopic surgery helped a lot in diminishing the pain and discomfort in his right knee. However, the Petitioner is now missing portions of both his right medial and lateral menisci and has, according to Dr. Walsh, inability to extend his right knee more than 15° of full extension and can flex to no more than 95°.

Penalties and Attorneys Fees

The Arbitrator finds that the Respondent shall pay penalties under Secs. 19(l) and 19(k) and attorneys fees under Sec. 16, because the Arbitrator finds that the Respondent's refusal to pay the Petitioner any TTD, TPD, or medical benefits was unreasonable and vexatious.

The Arbitrator finds that the Respondent's claim that the Petitioner stated that his injury occurred when he was walking and felt sudden pain in his right knee and it gave out was concocted by Respondent and was not made in good faith.

Further, the Petitioner had no treatment for his right knee for over 15 years, no recorded problems with the right knee since 1999, and no indication of any meniscal tears at that time. Dr. Walsh's opinion that the Petitioner's right knee condition was entirely pre-existing and unrelated to Petitioner's April 14, 2014 work injury is without any reasonable basis, in particular when the medical records prior to 2005 were not provided to Dr. Walsh by Respondent, and also in light of Dr. Crickard's causal connection opinion on behalf of the Petitioner.

The unpaid TTD is $7,491.31. The unpaid TPD is $2,643.66. The unpaid medical of $9,023.53, plus the medical expenses paid by Blue Cross of $19,775.27 total $28,498.80.

The Sec. 19(l) penalty is the maximum permitted, $10,000.00.

The Sec. 19(k) penalty is 50% of the unpaid TTD, TPD, and medical expenses, or $19,316.89 (50% x $38,633.77).

The Sec. 16 attorneys fees are 20% of the unpaid TTD, TPD and medical expenses, or $7,726.75 (20% x $38,633.77).

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

Brian Eyster,

Petitioner,

vs.

NO: 09 WC 52521

18IWCC0009

Kurt's Carstar,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causation, medical expenses, TTD, TPD 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 notes that to qualify for a wage differential award, a claimant must prove: (1) a partial incapacity that prevents him from pursuing his usual and customary line of employment and (2) an impairment of earnings. 820 ILCS 305/8(d)1 (West 2000); *First Assist, Inc. v. Industrial Commission*, 371 Ill.App.3d 488, 494, 867 N.E.2d 1063, 311 Ill.Dec. 77 (2007).

The Commission affirms the Arbitrator's determination that Petitioner satisfied his burden of proof on both counts, based on the opinion of Dr. Ghanayam as to his current restrictions, the FCE conducted at ATI on 5/16/11 showing that he was capable of only LIGHT physical demand level work, and the opinion of vocational counselor Mr. Pagella to the effect that Petitioner was unable to return to his prior occupation of head painter. Along these lines, the Commission finds the opinions and findings of Dr. Mirkin, the Apex Network FCE on 10/13/10 and vocational consultant Mr. Zuccarello to be less persuasive.

18IWCC0009

However, the Commission modifies the decision of the Arbitrator to find that Petitioner was entitled to a wage differential award in the amount of $392.47 per week commencing 7/28/11, or the date after Dr. Ghanayam found Petitioner to be at MMI, and continuing for the duration of his disability.

In support of this finding, the Commission notes that Petitioner's average weekly wage on the date of accident was $1,007.77, per the stipulation of the parties (Arb.Ex.#1), or $25.19/hour based on a 40-hour work week ($1,007.77 ÷ 40 hours). Furthermore, Mr. Mueller, the owner of Kurt's Carstar, testified that for the past six (6) years he has paid raises to his non-union employees, such as Petitioner, of $.25/hour per year. (T.104-105). Along these lines the Commission finds the testimony of Mr. Mueller more credible than Petitioner as to the amount of raises that Respondent paid its employees during the period in question.

Thus, from the date of the accident (8/25/09) until the date of MMI (7/28/11), or over the course of approximately two (2) years, Petitioner would have received raises totaling $.50/hour ($.25/hour for each year), bringing his hourly rate to $25.69. As a result, the Commission finds that Petitioner would have been earning $1,027.60 per week as of the commencement of the wage differential award on 7/28/11. ($25.69 x 40 hours/week).

Petitioner testified that he currently earns $11.55/hour working 36 to 40 hours per week for Wal-Mart. (T.54). Based on an average of 38 hours per week, the Commission finds that Petitioner is currently earning or capable of earning $460.00/week ($11.55 x 38 hours).

Therefore, the Commission finds that commencing 7/28/11 Petitioner is entitled to a wage differential award pursuant to §8(d)1 of the Act in the amount of $392.47, or 2/3rds of the difference between the amount he would have been earning, but for the injury, and the amount that he is currently capable of earning (⅔ [$1,027.60 - $438.90]).

Furthermore, the Commission corrects several clerical errors in the Arbitrator's decision. Specifically, the Commission corrects the Arbitrator's decision to show that Petitioner was entitled to temporary total disability from 8/26/09 through 3/17/11, for a period of 81-2/7 weeks (not 81-1/7) and temporary partial disability from 3/18/11 through 7/27/11, for a period of 18-6/7 weeks (not 18-5/7). In addition, the Commission corrects the transcript to include a complete copy of Mr. Zuccarello's deposition at RX6 and removes the proposed decision included with the surveillance report submitted at RX8.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 7/21/16 is modified as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $671.85 per week for a period of 81-2/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

18IWCC0009

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $541.47 per week for a period of 18-6/7 weeks, that being the period of temporary partial disability under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner reasonable and necessary medical expenses in the amount of $3,663.87, as well as charges by Dr. Anne Christopher for dates of service of 10/26/09, 11/30/09 and 2/3/10 should those bills ever be presented for payment in addition to out-of-pocket payments made to Dr. Kazdan in the amount of $100.00, pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that commencing on 7/28/11, Respondent pay to the Petitioner the sum of $392.47 per week for the duration of his disability, as provided in §8(d)1 of the Act, for the reason that the injuries sustained permanently incapacitate him from pursuing the duties of his usual and customary line of employment.

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.

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: JAN 5 - 2018
o:11/21/17
TJT/pmo
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

EYSTER, BRIAN
Employee/Petitioner

Case# **09WC052521**

KURTS CARSTAR
Employer/Respondent

18IWCC0009

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:

4642 O'CONNOR & NAKOS LTD
MATT WALKER
120 N LASALLE ST 35TH FL
CHICAGO, IL 60602

2593 GANAN & SHAPIRO PC
ROBY M JAVORONOK
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

18IWCC0009

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

BRIAN EYSTER
Employee/Petitioner

v.

KURTS CARSTAR
Employer/Respondent

Case # **09** WC **52521**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **August 21, 2014 and April 8, 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 **August 25, 2009**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$52,403.36**; the average weekly wage was **$1,007.77**.

On the date of accident, Petitioner was **41** years of age, ***married*** with **2** 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 **$20,213.04** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$20,213.04**.

Respondent is entitled to a credit of **$351.70** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $671.85/week for 81 1/7 weeks, commencing August 26, 2009 through March 17, 2011, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $20,213.04 for temporary total disability benefits that have been paid.

Respondent shall pay Petitioner temporary partial disability benefits of $541.47 /week for 18 5/7 weeks, commencing March 18, 2011 through July 27, 2011, as provided in Section 8(a) of the Act.

Respondent shall pay reasonable and necessary medical services of $3663.87, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall hold Petitioner safe and harmless for any claims for reimbursement from group health insurance provider Optum / Ingenix / United Healthcare. Respondent shall be responsible to pay the charges incurred for treatment with Dr. Anne Christopher for service dates of October 26, 2009, November 30, 2009, and February 3, 2010 should those bills ever be presented by the provider to Petitioner for payment. Payments shall be made in accordance with the fee schedule, and Respondent shall provide documentation with regard to said fee schedule payment calculations to the Petitioner. Respondent shall reimburse Petitioner directly for the $100.00 in out of pocket payments made to Dr. Kazdan.

Respondent shall pay Petitioner wage differential disability benefits in the amount of $558.55 / week for 159 6/7 weeks from July 28, 2011 through August 20, 2014, for a total of $89,288.21. Commencing on August 21, 2014, Respondent shall pay Petitioner wage differencial disability benefits in the amount of $383.25 per week for the duration of the disability, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)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.

Edward Lee

Signature of Arbitrator

7/21/16

Date

JUL 21 2016

18IWCC0009

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BRIAN EYSTER,	)	
	)	
Petitioner,	)	
	)	
v.	)	**09 WC 52521**
	)	
KURTS CARSTAR,	)	**Arbitrator Lee**
	)	
Respondent.	)	
	)	

ARBITRATION DECISION

STATEMENT OF FACTS

Petitioner was employed as the head painter at Kurt's Carstar, an automotive collision repair center. He began working as the head painter in August of 1994. His hours were from 7:00 AM through 5:30 PM. The Petitioner testified extensively about his job duties, which included: ordering supplies; stocking supplies; prepping, sanding, masking, painting, and buffing vehicles. He was required to lift, push, and pull items of varying size and weight. He would bend, stoop, and kneel when prepping and painting vehicles. Once or twice a week, he would push vehicles into the building and onto a frame rack.

Petitioner was injured on August 23, 2009. Petitioner testified that he had asked his helper to move a 5-gallon drum full of sludge. The 5 gallon drum was so full that it could no longer be used, and weighed approximately 75 pounds. The helper did not move the drum.

Petitioner bent down and grabbed the handle of the drum. He picked it up and slung the drum to the right. He immediately experienced burning pain in his back.

Petitioner continued to work. He finished painting the vehicle, and left work at the scheduled time. By the time arrived at his house, Petitioner could barely crawl out of the car. He called his father, who advised him to lay down on the floor and put his feet upon the couch to help elongate his back. When Petitioner woke up the next morning, he could barely move. He called and reported the injury to Kurt (the owner of the shop), and went to see his primary care physician, Dr. Daniels.

When Petitioner arrived at his doctor's office, he was advised that his pain levels were too high for him to be treated there. One of the nurses put Petitioner in a wheelchair, and took him to the emergency room at St. Anthony's Health Center.

An MRI taken on September 24, 2009. On September 28, 2009, Dr. Daniels read the MRI as revealing disc bulging and tearing at L3-L4 with encroachment on the right accompanied by numbness and pain into the right thigh and buttocks. Dr. Daniels charted a positive straight leg raise on the right side.

Petitioner was seen by Dr. Paul Matz on October 13, 2009 per the recommendation of the workers' compensation nurse case manager. Dr. Matz recorded an impression of back pain after a work related injury on September 25, 2009. Dr. Matz charted a history, noting that Petitioner had injured his back while lifting a 5-gallon can. Dr. Matz wrote that the pain was chronic since the accident 18 days ago, and that Petitioner was experiencing tingling down the right side of the leg with pain, especially when lying down at night.

Dr. Matz diagnosed lumbar disc disease, causing compression of the right lateral recess since Petitioner's work-related accident. Dr. Matz opined that Petitioner was a likely candidate for surgery.

Injections were performed by Dr. Anne Christopher on October 26, 2009 and again on November 30, 2009. Petitioner followed up with Dr. Matz on December 11, 2009. Dr. Matz noted that Petitioner did not respond to the injections and recommended a right L3-L4 laminotomy, foraminotomy and discectomy.

Petitioner presented for a Section 12 exam on December 18, 2009, with Dr. Peter Mirkin. Dr. Mirkin diagnosed Petitioner with pre-existing degenerative disc disease, disc bulging at L3/4 on the right and symptom magnification. He placed Petitioner on a 45 pound lifting restriction and recommended work hardening. Dr. Mirkin opined that Petitioner would be at MMI in 2-3 weeks, and that Petitioner was not a candidate for surgery.

Petitioner followed up with Dr. Anne Christopher on February 3, 2010. Dr. Christopher diagnosed a lumbar disc herniation at L3-4 with radiculopathy. She also noted lumbar spondylosis with facet syndrome at L3-4, L4-5 and L5-S1 with segmental rotation along with sacroiliitis and biomechanical dysfunction. She recorded tenderness over the disc space at L3-4 and L4-5, and hypertonicity over right greater than left posterior hip and gluteus muscles.

On March 17, 2010, Petitioner saw Dr. Kazden, who noted 6 months of severe lower back pain and radiating numbness to the right leg. Dr. Matz saw Petitioner again on April 9, 2010. Dr. Matz requested an opportunity to review the MRI scans. After reviewing the films, Dr. Matz noted some improvement in the L3-4 disc, and recommended against surgery. He

noted that Petitioner was not yet at MMI, and placed him on a 50 pound maximum lifting restriction. Petitioner was referred to pain management.

An injection was performed by Dr. Brummet on May 21, 2010. Petitioner was taken completely off of work by Dr. Kazdan on August 18, 2010.

On October 13, 2010, Petitioner was referred to Apex Physical Therapy for an FCE at the behest of the Workers' Compensation Insurance Carrier. The FCE was performed by Vic Zuccarello, who testified in this matter via evidence deposition on January 29, 2013.

On May 16, 2011, Petitioner underwent an FCE at ATI Physical Therapy, and was then examined by Dr. Alexander Ghanayem at the request of his attorney. Dr. Ghanayem testified in this matter via evidence deposition on September 5, 2012. Dr. Mirkin, Respondent's examining physician, testified on September 24, 2012.

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

To obtain compensation under the Act, a claimant must prove that some act or phase of his employment was a causative factor in his ensuring injuries. *Land & Lakes Co. v. Industrial Comm'n*, 359 Ill. App. 3d 582, 592 (2005). An accidental injury need not be the sole or principal causative factor, as long as it was a causative factor in the resulting condition of ill-being. *SISBRO v. Industrial Comm'n*, 207 Ill.2d 193, 205 (2003).

"A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury." *International Harvester v. Industrial Comm'n*, 93 Ill. 2d. 59, 63-64 (1982). "Causal connection between work duties and a

condition 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." *Darling v. Industrial Comm'n,* 176 Ill. App. 3d 186, 187 (1988).

In this case, there is no dispute that a work accident occurred on August 25, 2009. Prior to the work accident, Petitioner was performing his job duties up until August 25, 2009 without restrictions or complaints. His physical restrictions and complaints are well documented in the record as being consistent and chronic since the date of the work injury.

Dr. Mirkin, the Section 12 examining physician, testified that Petitioner was magnifying his symptoms, that could return to work full duty, and was at maximum, medical improvement by June of 2010. This conflicted with the recommendations put forward by Dr. Matz, who had placed Petitioner on a 50 pound lifting restriction in April and with Dr. Kazdan's recommendation that Petitioner be off of work due to his back pain in August of 2010. Dr. Mirkin acknowledged that 80% of the Section 12 exams he performed in workers' compensation matters were for the defense.

Dr. Ghanayem, who served as the expert for the Petitioner, opined that Petitioner's current condition of ill-being was causally connected to his work injury. Dr. Ghanayem noted that the mechanism of injury, the nature of how the symptoms evolved, and the nature of the disease process as seen on the MRI scans supported his opinion. Dr. Ghanayem did agree with both Dr. Mirkin and Dr. Matz that surgery was not indicated. Dr. Ghanayem testified that of the independent medical exams he performs, 65% are performed for Respondents, 30 percent by agreement of the parties, and 5% on behalf of Petitioners.

After reviewing the medical records, and taking into account the testimony of the Petitioner and the medical experts, the Arbitrator adopts the medical opinions of Dr. Ghanayem, and finds that Petitioner has proven by a preponderance of the credible evidence that his current condition of ill-being is causally connected to the work accident that occurred on August 25, 2009. Causal connection is supported not only by expert testimony, but by the chain of evidence beginning with Petitioner's work accident on August 25, 2009, the medical records detailing his complaints, course of treatment, and ending with the exam by Dr. Ghanayem on July 27, 2011.

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?

Section 8(a) of the Act provides in relevant part: "The employer shall provide and pay for all necessary first aid, medical surgical and hospital services thereafter incurred, limited, however, to that which is reasonably required to cure or relieve from the effects of the accidental injury."

Petitioner has reached maximum, medical improvement. Dr. Ghanayem testified that "there's really nothing else for him to try. He's been on medications. He's had injections. He's had an appropriate nonsurgical course of treatment. He has functionality. It's time for him to move on, accept what he's got and be done with it." *See Petitioner's Exhibit #14*, p.15. Dr. Mirkin's only noted cause for concern as far as the medical treatment was a wariness surrounding the need for injections. The Petitioner underwent an FCE per Dr. Mirkin's recommendation on October 13, 2010, followed by a second FCE on May 16, 2011 at ATI Physical Therapy. Petitioner's entire course of treatment was conservative in nature.

The Arbitrator awards the medical bills as put forth in Petitioner's Exhibit #16. The Respondent shall pay $3,663.87 for medical services, as provided in Section 8(a) of the Act. The amount of $3,663.87 takes into account the payments made by the workers' compensation insurance carrier, including their claim for credit. Respondent shall hold Petitioner safe and harmless for any claims for reimbursement from group health insurance provider Optum/ Ingenix/United Healthcare. Respondent shall be responsible to pay the charges incurred for treatment with Dr. Anne Christopher for service dates of October 26, 2009, November 30, 2009 and February 3, 2010 should those bills ever be presented by the provider to Petitioner for payment. Payments shall be made in accordance with the fee schedule, and Respondent shall provide documentation with regard to said fee schedule payment calculations to the Petitioner.

Respondent shall reimburse Petitioner directly for the $100.00 in out-of-pocket payments made to Dr. Kazdan.

K. What temporary benefits are in dispute?

TTD

A claimant is temporarily and totally disabled from the time an injury incapacitates him from work until such time as he is as far recovered or restored as the permanent character of his injury will permit. *Archer Daniels Midland Co. v. Industrial Comm'n,* 138 Ill. 2d 107 (1990). To be entitled to TTD benefits, it is a claimant's burden to prove not only that he did not work, but also that he was unable to work. *Interstate Scaffolding, Inc. v. Industrial Comm'n,* 236 Ill. 2d 132, 148 (2010); *Westin Hotel v. Industrial Comm'n,* 372 Ill. App. 3d 527, 542-43 (2007).

Petitioner was injured on August 25, 2009. He completed his work that day, and sought medical treatment beginning on August 26, 2009. On August 26, 2009, Petitioner was placed on restrictions of no lifting over 50 pounds by the ER physician at St. Anthony's Health Center. From that time until he began working at Wal-Mart on March 18, 2011, Petitioner was either off work or on restrictions per the recommendations of all of the doctors involved in his claim. Petitioner was told by Debbie White that the Respondent could not take him back to work with any restrictions. Petitioner identified Debbie White as an employee of the workers' compensation insurance carrier.

The Arbitrator awards temporary total disability benefits to the Petitioner in the amount of $671.85 per week for a total of 81 1/7 weeks, totaling $54,515.83. Respondent shall receive a credit for temporary total disability benefits paid in the amount of $20,213.04.

TPD

Petitioner testified that once he was informed by Debbie White that he would no longer have a job with the Respondent, he began looking for work. He was able to secure work with Wal-Mart, and began working part-time on March 18, 2011. Petitioner followed up with Dr. Kazdan on April 4, 2011. Dr. Kazdan noted that the pain was still not controlled, that Petitioner was standing a lot, and that his back was tender. Dr. Kazdan also charted that Petitioner was trying not to overuse Vicodin. On July 27, 2011, Petitioner was placed at Maximum, Medical Improvement by Dr. Ghanayem following the May 16, 2011 FCE at ATI Physical Therapy.

A temporary partial disability benefit is awarded when an employee (1) is able to work, but with a temporary decrease in wage-earning capacity or (2) is not capable of returning to substantially similar employment, but is able to perform other work consistent with his or her

disability. See Modern Workers Compensation § 200:7 (West 2003). In Illinois, Section 8(a) of the Act provides that a claimant is entitled to temporary partial disability (TPD) benefits when he "is working light duty on a part-time basis or full-time basis and earns less than he *** would be earning if employed in the full capacity of the job or jobs." 820 ILCS 305/8(a).

At the time he began working at Wal-Mart, Petitioner had not yet been placed at MMI by Dr. Alexander Ghanayem. Petitioner testified that his wage increases with the Respondent were usually .50/hour each year. At the time of Petitioner's injury, he was earning $1,007.77 per week, which if divided by 40 hours comes to $25.19/hour. If Petitioner had received pay increases of .50/hour from the time of his injury in 2009 until he began at Wal-Mart on March 18, 2011, his rate of pay would have increased by $1.00 per hour. This means he would have been expected to earn $26.19/hour with the Respondent, or $1,047.60 per week as of March 18, 2011.

Petitioner earned a gross amount of $4,405.31 between March 18, 2011 and July 27, 2011, the date on which he was placed at maximum medical improvement by Dr. Alexander Ghanayem. Had he been receiving his full pay while working for Respondent, he would have earned $19,605.09. Two thirds of the difference for the time period of TPD comes to $10,133.22 for TPD benefits due and owing from March 18, 2011 through July 27, 2011.

L. What is the nature and extent of the injury?

To qualify for a wage differential award, a claimant must prove: (1) a partial incapacity that prevents him from pursuing his usual and customary line of employment and (2) an impairment of earnings. 820 ILCS 305 / 8(d)(1); *First Assist, Inc. v. Industrial Comm'n*, 371 Ill. App.3d 488, 494 (2007).

18IWCC0009

Petitioner was placed at maximum medical improvement by Dr. Ghanayem on July 27, 2011. Dr. Ghanayem opined that Petitioner was not capable of returning to full duty work as a head painter for the Respondent. Based upon the testimony of both Petitioner and the Respondent's witness Kurt Mueller, the Arbitrator finds that Petitioner is unable to perform full duty work as a head painter for the Respondent, and that no accommodation has been forthcoming from Respondent.

Mr. Edward Pagella, a certified rehabilitation counselor at Health Connection of Illinois, evaluated the Petitioner in October of 2011. Mr. Pagella testified that at the time he met with the Petitioner, the Petitioner was at maximum medical improvement, and was released to the light physical demand level, capable of lifting 30 pounds based upon the functional capacity evaluation dated May 16, 2011.

Mr. Pagella testified that Petitioner was not capable of returning to his usual and customary line of employment, but that Petitioner had secured part time employment at Wal-Mart earning $9.25 per hour. It was Mr. Pagella's opinion that Petitioner was highly motivated, and that he would be in a position to increase his earning ability going forward. This, in fact, is exactly what happened. At the time of the hearing, Petitioner testified that he is now working full time for Wal-Mart, earning $11.55 per hour.

The Arbitrator awards wage differential benefits in the amount of $558.55/week for 159 6/7 weeks from July 28, 2011 through August 20, 2014, for a total of $89,288.21. As of the date of hearing, the Arbitrator awards wage differential benefits in the amount of $383.25 per week based upon Petitioner earning $11.55 per hour for 38 hours per week at Wal-Mart as opposed to the $1,013.77 per week he would be earning if he were capable to work full time for the

18IWCC0009

Respondent. The $1,013.77 is based upon Petitioner's weekly wage at the time of the injury, increased by .50 per year in accordance with the evidence presented at the time of the hearing.

Wage differential benefits in the amount of $383.25 per week shall be paid for the duration of Petitioner's disability.

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 Choose direction	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Christina Harris,

Petitioner,

vs.

NO: 15 WC 22495

18IWCC0010

Great Dane Trailers,

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 all of the issues, and being advised of the facts and law, affirms the Decision of the Arbitrator, which is attached hereto and made a part hereof, with the below modification.

The Commission finds that Petitioner's functional capacity evaluation (FCE) was not requested by any medical professional, but instead suggested by the arbitrator in the lead up to the hearing. The report provided evidence of the nature and extent of Petitioner's injury for purposes of determining Petitioner's permanent award, but it was not a medical expense. Because the Act allows awards of only those medical expenses that are necessary to cure or relieve the effects of a work-related injury (820 ILCS 305/8(a)), the cost of the FCE is not compensable.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated September 26, 2016, is modified to exclude the cost of the FCE from Petitioner's compensable medical expenses, but is otherwise affirmed and adopted.

18IWCC0010

Bond for the removal of this cause to the Circuit Court is hereby fixed at the sum of $2,000.00. 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: JAN 5 - 2018
o:12/18/17
TJT/knc
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HARRIS, CHRISTINA
Employee/Petitioner

Case# **15WC022495**

GREAT DANE TRAILERS
Employer/Respondent

18IWCC0010

On 9/26/2016, 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:

0225 GOLDFINE & BOWLES PC
KEVIN ELDER
4242 N KNOXVILLE AVE
PEORIA, IL 61614

1872 SPIEGEL & CAHILL PC
MILES P CAHILL
15 SPINNING WHEEL RD SUITE 107
HINSDALE, IL 60521

18 IWCC0010

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

CHRISTINA HARRIS,
Employee/Petitioner

v.

GREAT DANE TRAILERS,
Employer/Respondent

Case # **15** WC **22495**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Rock Island**, on **9/7/16**. 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 **1/30/15**, 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 **$27,479.40**; the average weekly wage was **$528.45**.

On the date of accident, Petitioner was **41** years of age, ***single*** with **no** dependent children.

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

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

Respondent shall be given a credit of **$4,023.28** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$21,434.64** for statutory loss benefits equal to 100% loss of use of the right index finger and 40% loss of use of the right middle finger, for a total credit of **$25,457.92**.

Respondent is entitled to a credit of **$00.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $352.30/week for 9-1/7 weeks, commencing 1/31/15 through 2/22/15, 3/24/15 through 4/12/15, and 6/9/15 through 6/29/15, as provided in Section 8(b) of the Act.

The parties have stipulated that all reasonable and necessary medical bills related to treatment of petitioner's right hand following the injury on 1/30/15 have or will be paid pursuant to Sections 8(a) and 8.2 of the Act, with the exception of the costs associated with Functional Capacity Evaluation. The Arbitrator finds the Respondent shall pay reasonable and necessary medical services associated with the Functional Capacity Evaluation on 6/8/16, as provided in Sections 8(a) and 8.2 of the Act.

Respondent has or shall pay Petitioner permanent partial disability benefits of $317.07/week for 164.50 weeks, because the injuries sustained caused the 100% loss of the right index finger, 50% loss of the right middle finger, and 50% loss of the right 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.

Signature of Arbitrator

9/22/16
Date

SEP 26 2016

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 41 year old left hand dominant assembler, sustained an accidental injury to her right hand that arose out of and in the course of her employment by respondent on 1/30/15. On 1/30/15 petitioner was working as a final assembler. Her duties included taking trailers and making sure there were no water leaks. If there was a leak in the trailer petitioner would caulk the leak. After checking for leaks the petitioner would pull the trailer out of the water bay and wash the trailer. She would also make sure the floor screws were flush. In performing these duties petitioner would use impact drills while on her hands and knees. She also used a ladder to wash the walls and ceilings of the trailers. Petitioner used hammers, caulk guns, a wrench and rags.

On 1/30/15 while pulling the trailer out of the water bay petitioner noticed that the cable had gone to one side. As she put her right hand on it to straighten it out her right hand got stuck in the cable wench. Petitioner was wearing a glove. As she pulled her hand out she noticed that her index finger and the glove surrounding it were cut off. She testified that the bone of her right index finger was sticking up through the glove and her middle finger was cut.

Petitioner then went to Robert, her team leader, then to the safety person and first aid. In first aid her glove was removed and her right hand was wrapped. Petitioner was taken by ambulance to the emergency room at St. Luke's Hospital in Kewanee, IL. She was diagnosed with an amputation of the finger and fingertip. There she was stabilized and then taken to St. Francis in Peoria. An examination revealed amputation of the right middle finger at DIP, and right amputated index finger at the PIP with flexor tendon attached.

Petitioner treated with Dr. Williams. On 1/30/15 Dr. Williams performed a right index finger amputation through the proximal interphalangeal joint, and right middle finger amputation to the right distal interphalangeal joint. Petitioner's post-operative diagnosis was traumatic amputations of the right index and middle finger. Petitioner followed-up post-operatively with Dr. Williams.

On 1/31/15 petitioner returned to the emergency room at St. Luke's complaining of right hand pain. She was given 2 shots and discharged. On 2/2/15 she returned for ongoing pain. Petitioner was given Dilaudid.

On 2/5/15 petitioner presented to Dr. Williams. He dressed her wounds and continued her off work. He was of the opinion that she should return in 2 weeks for suture removal and would need therapy in the future for strength and motion until she reached maximum medical improvement.

On 2/19/15 petitioner's suture's were removed. Dr. Williams noted that petitioner would begin therapy for motion in a month. He placed petitioner on light duty for the next month with full use of the right hand

beginning on 2/23/15. He gave petitioner a prescription for a certified hand therapist. He also discussed index finger ray amputation as a final procedure to help restore some function.

On 3/19/15 petitioner followed-up with Dr. Williams. She indicated that she wanted to undergo the recommended surgery. As a result, Dr. Williams stopped therapy until after the procedure.

On 3/24/15 petitioner underwent a right index finger ray resection performed by Dr. Williams. Petitioner's post-operative diagnosis was right index finger amputation. Petitioner followed up post-operatively with Dr. Williams.

On 4/6/15 petitioner reported to Dr. Williams that her right middle finger sensation continued to improve. Petitioner's sutures were removed. He released petitioner to work on 4/13/15 with one hand restriction in a clean environment, with full use of the left hand and no use of the right hand. He also started petitioner back in therapy.

On 5/7/15 petitioner returned to Dr. Williams. Dr. Williams continued petitioner on one handed work that included full use of the left hand and 1 pound use of the right hand. He released her from her clean environment restrictions. He continued petitioner with desensitization and work on strengthening.

On 6/4/15 Dr. Williams indicated that petitioner was unable to work from 6/9/15 through 6/15/15 pending work comp approval of right index finger tenotomy.

On 6/9/15 petitioner underwent a right index finger tenotomy of extensor digitorum communis and proprius tendons. This procedure was performed by Dr. Williams. Petitioner followed up post-operatively with Dr. Williams.

On 6/10/15 petitioner complained of decreased range of motion and increased pain. The therapist noted weak hand grip and difficulty with fine manipulative tasks, and decreased ability to push with arm.

On 6/18/15 petitioner returned to Dr. Williams. He continued petitioner off work and in occupational therapy. She was instructed to return for suture removal in 2 weeks.

On 6/29/15 petitioner followed-up with Dr. Williams. He placed her on a 5-10 pound restriction on the right, and full use of the left hand for the remainder of the week.

On 7/27/15 petitioner returned to Dr. Williams. Dr. Williams noted full motion and good strength. He was of the opinion that petitioner had reached maximum medical improvement and was released on an as needed basis. He did not provide petitioner with permanent restrictions.

On 6/8/16 petitioner underwent a Functional Capacity Evaluation to establish functional abilities and deficits of the right hand. This evaluation was recommended by the Arbitrator during a pretrial earlier this year, wherein the parties were trying to determine the nature and extent of petitioner's injury. Petitioner's effort was maximal and consistent. Her pain behaviors were appropriate and consistent.

Petitioner reported an altered sensation of the residual 3rd digit; pain with sustained gripping activities of the right hand; and phantom limb sensations 2-3x a week with pain and limited function, occurring primarily at night and disturbing her sleep. Petitioner estimated her current ability level at 40% of pre-injury abilities. She reported the following functional limitations during her daily activities: limited utensil use in the right hand while eating; marked loss of previous typing activities, self reported in excess of 100 words per minute; limited use of right hand in recreational activities; decreased tolerance and high fatigue level of right hand when using power tools; and difficulty grooming and bathing with the right hand.

The examiner noted marked alteration of light touch sensation of the 3rd digit of the right hand, with only deep pressure sensation preserved; mild alteration of light touch sensation of the 4th digit of the right hand; and marked deficit in point 2 discrimination of the 3rd digit of the right hand.

Petitioner was found to be currently functioning at an overall light physical demand level with marked deficits of the right hand. It was noted that petitioner worked as a trailer assembler with an overall physical demand level in the medium to heavy physical demand range. Petitioner did not demonstrate the ability to return to unrestricted duty as an assembler. It was noted that petitioner was working as a washer. It was noted that petitioner demonstrated mild deconditioning, limiting her tolerance to sustained overhead reaching and stair climbing. Petitioner demonstrated marked limitations of unilateral right and bilateral hand fine motor abilities including 1) right hand grip strength below the 5th percentile; 2) right hand lateral pinch strength less than the 1st percentile; 3) right hand tip strength in the 25th percentile; 4) and fine motor testing for right hand abilities that was below the 5th percentile and bilateral fine motor coordination that was below the 5th percentile.

David Bishop, Jr., General Foreman for respondent, was called as a witness on behalf of respondent. Bishop has worked for respondent for 4 years. He testified that petitioner had worked for him when she worked in the final area. Bishop testified that employees are moved according to respondent's manpower needs. He testified that petitioner was not moved due to her condition, but rather to the respondent's manpower needs. He testified that petitioner is able to perform multiple jobs for respondent. He testified that Dr. Williams did not restrict petitioner's use of caulk guns.

Petitioner is still working for respondent. Her current job is final wash of trailers. She testified that her job duties had changed from before accident. Petitioner testified that she currently wipes down trailers and uses her right hand a little more than before. Petitioner puts on lights and mud flaps when needed with nuts and bolts using her 3rd and 4th fingers of the right hand. Although petitioner is left hand dominant she stated that she can no longer use caulking guns, and that is why she has her new position. She also reported a lot of pain when using her right hand a lot. Petitioner also reported diminished strength in her right hand. Petitioner stated that she cannot lift a milk jug or hold silverware in her right hand. She also reported other fine motor skill problems such as putting on jewelry and buttoning shirts. Petitioner testified that she used to type 150 works a minute and now types between 30-40 words a minute. Petitioner testified that prior to the accident she worked various jobs for respondent based on the needs of the respondent. Since being released petitioner has continued to move around in various jobs depending on the needs of the respondent.

Petitioner is currently on light duty doing a job sorting rivets due to an unrelated injury to her left arm.

Petitioner was paid benefits for her statutory losses.

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

The respondent had initially identified this as an issue on the Request for Hearing. At the end of the hearing the respondent removed this issue and stipulated that petitioner's current condition of ill-being as it relates to her right hand is causally related to the injury. By stipulating to this respondent still claims that the nature and extent of the petitioner's right hand injury as a result of the incident is still in dispute. This issue will be addressed in Section L below.

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 sole issue as it relates to medical services is the outstanding bill for the Functional Capacity Evaluation (FCE). On 5/12/16 the parties appeared before this Arbitrator for a pretrial with respect to this case. The parties were discussing the nature and extent of the petitioner's injury. The parties stipulated at that time that the petitioner had a 100% statutory loss of the right index finger and 50% statutory loss of the right middle finger. There was some discussion as to whether or not the petitioner was entitled to a loss of use of the right hand in addition to the statutory losses described herein. The arbitrator recommended that a Functional Capacity Evaluation be performed in order to establish the functional abilities and deficits of the right hand. The petitioner underwent the recommended FCE on 6/8/16.

Now there exists a dispute as to which party is responsible for the payment of this evaluation. The arbitrator finds that in an effort to determine the nature and extent of petitioner's injury, the best evidence would

be to fully understand petitioner's abilities and deficits, and the FCE provided this information. For that reason the arbitrator finds the Functional Capacity Evaluation recommended during the pretrial constitutes a medical service that is reasonable and necessary in determining the nature and extent of petitioner's injury. As such, the arbitrator finds the respondent shall pay all reasonable and necessary medical expenses associated with the FCE performed on 6/8/16, pursuant to Sections 8(a) and 8.2 of the Act.

K. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

The parties agree that the petitioner was temporarily totally disabled from 1/31/15 through 2/22/15, and 3/24/15 through 4/12/15. Petitioner claims he was also temporarily totally disabled from 6/9/15 through 6/29/15. With respect to this last period, respondent claims petitioner was only temporarily totally disabled from 6/9/15 through 6/25/15. A dispute exists as to whether or not petitioner was temporarily totally disabled from 6/26/15 through 6/29/15.

On 6/18/15 Dr. Williams continued petitioner off work. On 6/29/15 petitioner next followed-up with Dr. Williams. At that time he placed petitioner on a 5-10 pound restriction on the right, and full use of the left hand for the remainder of the week.

Based on Dr. Williams opinions as indicated in his medical records for 6/18/15 and 6/29/15, the arbitrator finds the petitioner was temporarily totally disabled from 6/26/15 through 6/29/15. The arbitrator bases this finding on the fact that after Dr. Williams continued petitioner off work on 6/18/15, petitioner did not again present to Dr. Williams until 6/29/15, when he released her to restricted work.

Respondent shall receive credit for the **4,023.28** it has already paid in temporary total disability benefits.

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

As a result of the accident on 1/30/15 petitioner underwent three surgical procedures performed by Dr. Williams. On 1/30/15 Dr. Williams performed a right index finger amputation through the proximal interphalangeal joint, and right middle finger amputation to the right distal interphalangeal joint. On 3/24/15 petitioner underwent a right index finger ray resection performed by Dr. Williams. On 6/9/15 petitioner underwent a right index finger tenotomy of extensor digitorum communis and proprius tendons. On 7/27/15 petitioner returned to Dr. Williams. Dr. Williams noted full motion and good strength. He was of the opinion that petitioner had reached maximum medical improvement and released petitioner on an as needed basis.

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 final assembler on 1/30/15. She testified that her job duties after the accident had changed from what they were before accident. Petitioner testified that she currently wipes down trailers and uses her right hand a little more than before. Petitioner puts on lights and mud flaps when needed with nuts and bolts using her 3rd and 4th fingers of the right hand. Although petitioner is left hand dominant she stated that she can no longer use caulking guns, and that is why she has her new position. Bishop testified that employees are moved according to respondent's manpower needs. He testified that petitioner was not moved due to her condition, but rather to the respondent's manpower needs. He testified that petitioner is able to perform multiple jobs for respondent. He testified that Dr. Williams did not restrict petitioner's use of caulk guns. The results of the Functional Capacity Evaluation showed that petitioner did not demonstrate the ability to return to unrestricted duty as an assembler, although she has been able to perform the duties of many of respondent's jobs. Based on these facts, the Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 41 years old at the time of the accident. Although petitioner is able to perform multiple jobs for respondent and was returned to full duty work without restrictions by Dr. Williams in July of 2015, the arbitrator finds it significant that based on the FCE performed in June of 2016, petitioner is not capable of performing all the duties associated with her pre-injury job, despite the fact that she continues to be able to work various jobs for respondent. Based on these findings, 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 that no evidence was offered with respect to this issue. Because of this the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that when petitioner last followed up with Dr. Williams on 7/27/15 he noted full motion and good strength. He was of the opinion that petitioner had reached maximum medical improvement and was released on an as needed basis. He did not place petitioner under any restrictions.

On 6/8/16 when petitioner presented for her Functional Capacity Evaluation she reported an altered sensation of the residual 3rd digit; pain with sustained gripping activities of the right hand; and phantom limb sensations 2-3x a week with pain and limited function, occurring primarily at night and disturbing her sleep. She estimated her current ability level at 40% of pre-injury abilities. She reported the following functional limitations during her daily activities: limited utensil use in the right hand while eating; marked loss of previous typing activities, self reported in excess of 100 words per minute; limited use of right hand in recreational

activities; decreased tolerance and high fatigue level of right hand when using power tools; and difficulty grooming and bathing with the right hand.

The examiner also noted marked alteration of light touch sensation of the 3rd digit of the right hand, with only deep pressure sensation preserved; mild alteration of light touch sensation of the 4th digit of the right hand; and marked deficit in point 2 discrimination of the 3rd digit of the right hand.

Following the examination it was noted that petitioner demonstrated marked limitations of unilateral right and bilateral hand fine motor abilities including 1) right hand grip strength below the 5th percentile; 2) right hand lateral pinch strength less than the 1st percentile; 3) right hand tip strength in the 25th percentile; 4) fine motor testing for right hand abilities below the 5th percentile and bilateral fine motor coordination below the 5th percentile.

Because petitioner clearly has some physical limitations with respect to her right hand, 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 100% loss of use of right index finger, 50% loss of use of right middle finger, and 50% loss of use of right hand pursuant to §8(e) of the Act.

Respondent shall receive credit for the **$21,434.64** it has already paid in statutory losses of the right index finger and right middle finger.

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

Lee Skein, Jr.,

Petitioner,

vs. NO: 12 WC 21580

Jernberg Industries, Inc.,

Respondent.

18IWCC0011

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 prospective medical care and temporary total disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. However, the Commission corrects an error located within the Arbitrator's Decision. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

On page 35 of the Arbitrator's Decision it is noted that the Arbitrator accepted and adopted the opinion of Dr. Kodros that Petitioner requires surgery to relieve the effects of his June 19, 2012 work injury to his right foot and ankle. The Commission notes that said opinion was offered by Dr. Kadakia, not Dr. Kodros. Accordingly, the Commission corrects the Arbitrator's ruling, and holds that it is relying on the surgical opinion of Dr. Kadakia.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 8, 2017 is hereby affirmed and adopted.

18IWCC0011

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 $72,800.00. 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: JAN 5 - 2018
O:11/9/17
DLG/wde
45

David L. Gore

Stephen Mathis

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SKEINS JR, LEE
Employee/Petitioner

Case# **12WC021580**

12WC009727

JERNBERG INDUSTRIES INC
Employer/Respondent

18IWCC0011

On 5/8/2017, 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 0.97% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0307 ELFENBAUM EVERS & AMARILIO
JOSEPH D AMARILIO
940 W ADAMS ST SUITE 300
CHICAGO, IL 60607

0532 HOLECEK & ASSOCIATES
JEFF C GOLDBERG
161 N CLARK ST SUITE 800
CHICAGO, IL 60601

STATE OF ILLINOIS)

)SS.

COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Lee Skeins, Jr.
Employee/Petitioner

v.

Jernberg Industries Inc.
Employer/Respondent

Case # **12 WC 21580**

Consolidated cases: **12 WC 9727**

18IWCC0011

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 **3/23/2016**. 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

B. ☐ 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, **June 19, 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 **$28,354.56**; the average weekly wage was **$545.28**.

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 **$8,353.24** 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 Petitioner temporary total disability benefits of **$363.52** per week for **198 & 6/7** weeks, for the periods commencing **June 20, 2012** through **May 27, 2013** and from **May 30, 2013** through **March 23, 2016**, as provided by §8(b) of the Act.

Respondent shall pay Petitioner's claim-related medical bills for care and treatment for Petitioner's right foot and ankle, from the date of accident, 6/19/2012, through March 23, 2016, including outstanding medical bills totaling **$119.50** and bills paid by Petitioner totaling **$284.16**, pursuant to§8(a) of the Act and adjusted in accord with the medical fee schedule as provided in §8.2 of the Act.

Respondent shall authorize and pay for Petitioner's prospective medical care, including the peroneal tendon surgery recommended by Dr. Kadakia and all reasonable and necessary post-operative rehabilitative care.

Respondent shall pay Petitioner benefits that have accrued from **June 19, 2012** through **March 23, 2016** and shall pay the remainder of the award, if any, in weekly payments.

Petitioner failed to prove that he is entitled to penalties and attorney's fees.

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

May 2, 2017
Date

ICArbDec19(b)

MAY 8 - 2017

Lee Skeins, Jr., v. Jernberg Industries, Inc.
12WC 9727, consolidated 12 WC 21580

INTRODUCTION

These matters proceeded to hearing before Arbitrator Steven Fruth. The disputed issues were:

12 WC 9727 (DOI 3/2/2012, hand & wrist): ***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 temporary benefits are in dispute? TTD; ***M:*** Should penalties be imposed upon Respondent?

12 WC 21580 (DOI 6/19/2012, foot & ankle): ***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; ***M:*** Should penalties be imposed upon Respondent?

Petitioner and Ronald Farnaus testified at trial.

FINDINGS OF FACT

Petitioner Lee Skeins testified that he was hired by Respondent Jernberg Industries in October 2011 as a saw operator in the steel forging plant. He testified to only completing the 9th grade. He began as a helper on third shift, and later transferred to first shift as a lead saw operator. The job involved operating three large automatic saws which cut steel bars into "billets" of specified lengths. Each saw machine made one cut every five to ten seconds. Petitioner described the steel bars as 100 feet in length and in diameters ranging from baseball-size to softball-size. Billets then automatically moved by conveyor to be fabricated into pinions. He also occasionally helped press operators change out dies.

Petitioner testified that the cut billets weighed between 3 and 18 pounds when cut correctly; however, variations in weight could cause incorrectly cut billets to weigh as much as 20 pounds. These incorrectly cut billets (scrap) were generally the only materials Petitioner handled manually; the rest traveled directly to the forging presses by conveyor. As a saw operator, Petitioner was responsible for retrieving scrap billets from a "reject box" on each machine and tossing them into a scrap bin located about 6 feet away. He would have to make adjustments to the saw to correct errors in cutting

billets.

Petitioner testified that the 3 machines he operated produced a large quantity of scrap billets. He identified Petitioner's Exhibit #12, page 1, as a photo of a scrap bin filled with scrap or defective billets. He testified that he typically filled between 3 and 5 such bins with scrap billets in the course of a shift. At times he had to move quite fast to clear out the volume of scrap billets and adjust the machinery. Petitioner testified that all his job duties were performed on his feet.

In addition to operating saw machines, Petitioner testified that he periodically had to use a metal pry bar to clear the conveyor belt when billets became jammed. This required using both hands with great force. When the saw machines were down, he was assigned to the sandblaster line, hanging the finished pinions on a conveyor that fed them into the sandblaster. He testified that this required reaching both to the side and overhead to hang pinions weighing 5 to 10 pounds each. Petitioner testified that he also periodically helped press operators change dies or drove a forklift.

Petitioner testified that he had never injured his left arm, hand, or shoulder and had never been treated for problems with his left hand, arm, or shoulder. Prior to his job with Respondent, Petitioner worked for a cabinet company. He installed cabinets and countertops. This required lifting and moving and pushing objects weighing more than 20 pounds. We usually head dollies and there are always two people. The cabinets' weight, "it depends." The highest weight Petitioner would have to lift without another person was 15 to 20 lbs. They were standard kitchen cabinets: 28 inches by 24 inches. Two people were required to mount a cabinet on a wall.

Petitioner testified that on March 2, 2012, he injured his left wrist while throwing scrap billets, which he estimated weighed about 8 pounds. His injury was witnessed by coworkers Darwin Moore and Joseph Hughes. He testified that he felt immediate pain, but kept working and completed his shift. When he returned to work the next day, he tried to pick up a billet, and felt a shock-like sensation in his wrist, travelling up his arm. Petitioner reported his injury to Arturo, the foreman, who tried to apply a wrist wrap. When this did not help, Arturo instructed Petitioner to go to Mercy Hospital. Petitioner testified that he was given first aid at Mercy Hospital's emergency room, and then reported to Concentra, the company's chosen occupational clinic.

Petitioner was first seen at Concentra Medical Centers (Concentra) on March 5, 2012 (PX #2). Petitioner complained of injuring his left arm when he threw a billet at work March 2. Petitioner reported mild sharp pain at first which became severe the next day, March 3. Dr. Rolando Garces noted dorsal and volar left wrist pain, worse with repetitive grasping. There was mild swelling and decreased range of motion of the

left wrist. X-rays were negative for fracture. Dr. Garces diagnosed wrist sprain and prescribed therapy, medication, light duty with a 5 pound lifting maximum, and a wrist brace.

Petitioner testified that he also visited the Alivio Medical Center for the pain in his hand and arm on March 7, 2012 for a second opinion after the Emergency Room consult at Mercy Hospital (PX #3, 12 WC 9727). Hand grip was diminished; range of motion was full but slow. March 3, 2012 x-rays were negative for acute injury. The diagnosis was left wrist sprain.

Petitioner returned to Concentra on March 8, 2012 (PX #2). He complained that his left wrist pain was 7/10. He described the pain as sharp and intermittent. Petitioner had reduced grip strength and range of motion in his wrist. Dr. Gregory O'Neill noted unimproved wrist sprain. Petitioner was directed to continue therapy for 2 weeks. Dr. O'Neill also continued work restrictions. Petitioner returned on March 14, reporting that modified duty at work caused increased pain, which he rated 10/10. Dr. O'Neill recommended referral to a hand specialist.

On March 15, 2012 Petitioner saw hand specialist Dr. Nolan Lewis at Concentra (PX #2). Dr. Lewis noted limited wrist motion and 8/10 pain on gripping. He increased Petitioner's light duty restrictions, prescribing a wrist splint and no use of the left hand, and ordered an MRI of the left wrist to rule out ligament injury. The MRI demonstrated severe carpi ulnaris tendinopathy with partial interstitial tearing, tenosynovitis, and probable subsheath injury (PX #2).

On March 21, 2012 Petitioner saw Dr. Joel Augustin at Rush Family Physicians [Rush Family] (PX #4, 12 WC 9727). Petitioner reported left wrist and left forearm pain going into the left shoulder. Pain was at 5/10 level at rest and 9/10 with mobilization. Dr. Augustin noted shoulder pain when raising the left arm with limited mobility and numbness in the arm, also tingling is worse in thumb. Petitioner could not lift the shoulder past 90°. Dr. Augustin took Petitioner off work through March 27, released him to return to work March 28, prescribed Tramadol for pain, and referred him for an orthopedic consultation. Dr. Augustin noted a left shoulder MRI would be obtained "through his work".

Petitioner returned to Dr. Augustin March 22, 2012 to pick up a referral to hand surgery (PX #4, 12 WC 9727). Petitioner had had the wrist MRI that day. His complaints were unchanged. A left shoulder MRI was ordered along with physical therapy for the shoulder.

On March 23, 2012, Petitioner saw hand specialist Dr. Gordon Derman for his left wrist problems (PX #5, 12 WC 9727). Petitioner gave a history of left wrist pain on March 2, 2012 while throwing an 8 pound piece of steel into a scrap bin at work, followed by severe pain and swelling the next day. Petitioner reported working 48 hours per week and often handled several hundred scrap pieces per day. He reported wrist pain radiating up into the left arm and shoulder, with limited shoulder mobility. Dr. Derman found swelling and pain at the wrist, with positive Phalen's and Tinel's signs, and thumb numbness with tenderness along the tendon at the base of the thumb. Dr. Derman diagnosed severe tendonitis at the extensor carpi ulnaris tendon, significant carpal tunnel syndrome, radial tunnel syndrome, and mild DeQuervain's syndrome at the thumb. Dr. Derman believed that all of these problems were related to Petitioner's work injury. Petitioner's left arm was immobilized in a fiberglass cast.

Dr. Derman kept Petitioner off work and saw him on a weekly basis for the next 6 weeks (PX #5, 12 WC 9727). On April 13, 2012, he re-casted Petitioner's arm and administered a steroid injection to the ulnar side of the wrist. Dr. Derman also noted that Petitioner's shoulder MRI showed rotator cuff tendinosis and referred him to shoulder specialist Dr. Charles Bush-Joseph.

On April 20, Dr. Derman noted that Petitioner had started therapy for his wrist. He also noted numbness of the thumb with thickening of the digital nerve. On April 25, 2012, Dr. Derman removed the cast and administered two injections to the wrist due to worsening pain: one to the flexor carpi ulnaris tendon and the other to a painful trigger point in the wrist at the triangular fibrocartilage complex (TFCC). By May 4, 2012, Dr. Derman noted improvement in the wrist and forearm, although not in the shoulder.

On May 11, 2012, at Respondent's request, Petitioner was examined pursuant to §12 of the Act by orthopedic surgeon Dr. Michael Cohen (PX #6, 12 WC 9727 & RX #10). Dr. Cohen reviewed Petitioner's medical records and the job description for Petitioner's job. He noted the job description stated that "the majority of the work is automated." Dr. Cohen noted Petitioner's history of left wrist pain and swelling after throwing a piece of steel at work, which was initially diagnosed as a wrist sprain. Dr. Cohen reviewed Petitioner's medical care to date, including Norco for pain. He noted the March 22 MRI showed severe extensor carpi ulnaris tendinopathy.

Dr. Cohen noted that Petitioner had been under the care of a hand surgeon since March 23, 2012, adding "I believe he was diagnosed with tendinitis and possible radial tunnel syndrome". Petitioner reported receiving 4 cortisone injections and therapy for his wrist, which was still painful. He also reported shoulder pain and thumb numbness. There was decreased left wrist motion and strength due to pain. He noted tenderness in

two areas: the ECU (extensor carpi ulnaris) tendon and the TFCC, "TFCC greater then ECU". There was no evidence of median neuropathy at the left wrist.

Dr. Cohen diagnosed ECU tendinopathy and a TFCC injury of the left wrist. He related these injuries to Petitioner's work accident, noting there were no pre-existing conditions that would cause this condition. He opined that treatment to date had been reasonable and appropriate. Dr. Cohen recommended an ulnocarpal cortisone injection and possibly a TFCC injection, therapy, with possible arthroscopic surgery if the problem persisted. He also recommended light duty work with limited use of the left hand as a "light assist" to the right hand.

On May 11, 2012, Petitioner also saw orthopedist Dr. Charles Bush-Joseph at Midwest Orthopaedics at RUSH for his left shoulder (PX #6, 12 WC 9727). Petitioner reported shoulder pain gradually increasing since the wrist injury of March 2, 2012, with decreased mobility in abduction and internal rotation. Dr. Bush-Joseph noted Petitioner's history of wrist pain and prior treatment, including the March 22 MRI. On examination Dr. Bush-Joseph found reduced left shoulder motion. There were negative Speed's and Yergason's signs. Strength testing was normal but painful. There was mild numbness in the left thumb. An April 5 MRI showed no rotator cuff tear of acute pathology. Dr. Bush-Joseph diagnosed rotator cuff tendinosis secondary to ECU tendinopathy secondary and wrist injury at work. Given the lack of an acute tear Dr. Bush-Joseph felt surgery was not necessary. He kept Petitioner off work and prescribed physical therapy and considered an AC joint cortisone injection.

Petitioner returned to Dr. Bush-Joseph on May 25, 2012 (PX #6, 12 WC 9727). Petitioner complained of continued left shoulder pain and restricted motion after physical therapy. Dr. Bush-Joseph noted slightly decreased shoulder range of motion. Dr. Bush-Joseph recommended continued therapy but considered a subacromial injection if therapy failed. He limited Petitioner to light duty work 5 pound limits and no use of the left arm.

On June 8, 2012, Dr. Bush-Joseph noted no real progress with physical therapy (PX #6, 12 WC 9727). He administered a "second" cortisone injection, and prescribed light duty with no repetitive overhead lifting or reaching. There is no note for the "first" shoulder injection. Dr. Bush-Joseph continued the previous work restrictions.

Petitioner testified that he reported to light-duty work on June 19, 2012. While walking through an overhead door, he was struck from behind by an industrial scooter, a vehicle similar to an electric golf cart but heavier. The cart drove over the outside of his right foot and stopped, pushing his foot inward. The driver asked if he was okay, to which he responded, "You're on my foot, get off!" The man then drove away and

Petitioner's foot was freed. He testified that Joanne from Human Resources drove him to Concentra for treatment.

At Concentra (PX #2, 12 WC 21580), Petitioner reported that a small truck ran over his right foot on the lateral aspect. The doctor noted pain complaints of 9/10 and a moderate limp. He prescribed medications, a cold pack and physical therapy, and work restrictions of sitting 95% of the time. Petitioner testified that he was driven to Concentra, the company clinic, where he was taken off work. He remained off work while being treated by three Rush physicians: Dr. Gordon Derman, Dr. Charles Bush-Joseph, and Dr. Simon Lee.

Petitioner was also seen at Rush Family Physicians (Rush Family) on June 19 (PX #3, 12 WC 21580). He complained of right foot pain after a "golf car" ran over his foot at work. He reported that immediate care found no fractures. He complained of intense pain, 9/10, but was walking without assistance. He had full but painful motion. No swelling was noted. The ankle was tender to palpation. Dr. Miguel Salas diagnosed a right ankle sprain and kept off work until June 22, 2012. He also prescribed tramadol and hydrocodone for pain.

Petitioner returned to Rush Family June 25, 2012, where he saw Dr. Gina Kring (PX #3, 12 WC 21580). He complained of continued right ankle pain. He reported a June 22 emergency room visit for his continuing pain. It was noted that Dr. Salas had released him to sedentary work. It was also noted that he was unable to use 2 crutches due to his left shoulder injury. Petitioner now had swelling and bruising in the ankle. Strength and motion were now limited. Petitioner was again diagnosed with a right ankle sprain and referred to orthopedic surgeon Dr. Holmes. Dr. Kring also ordered an MRI. Petitioner was restricted from regular work duties through July 2 and pain medication was continued.

The MRI was done June 28, 2012 (PX #7, 12 WC 21580). It revealed abnormal peroneal tendons. A significant tear of the peroneus brevis was not ruled out.

On June 29,2012, Dr. Bush-Joseph noted that Petitioner's shoulder pain was unimproved despite physical therapy and injections, while his range of motion was worse (PX #6, 12 WC 9727). Petitioner's range of motion was still limited. He noted that Petitioner's primary diagnosis was left shoulder pain of unknown etiology. Dr. Bush-Joseph recommended physical therapy and corticosteroid injections and a possible diagnostic arthroscopic surgery and a possible subacromial decompression a bursectomy. He also recommended that Petitioner continue with light duty work restrictions.

On July 2, 2012 Petitioner saw Dr. Simon Lee at Midwest Orthopedics at RUSH (PX #5, 12 WC 21580). Petitioner gave a history of the June 19 work accident in which a large golf cart had rolled on top of his right foot, with progressively worsening pain and difficulty weight-bearing. Petitioner used a crutch to ambulate. There was no history of prior foot trauma or complaints. Dr. Lee noted pain along the peroneal tendons, extending into the anterior tibia, with limited active range of motion. He reviewed Petitioner's MRI, noting edema around the peroneal tendons but no frank tear. In a letter to workers' compensation adjuster Vicky Breitberg, Dr. Lee described the injury as an ankle contusion with concurrent sprain as a result of the work accident on June 19, 2012. He placed Petitioner in an ASO ankle brace, and prescribed physical therapy and sedentary duty with ground-level work only and no use of steel-toed boots.

Petitioner had an MRI arthrogram of the wrist ordered by Dr. Derman on July 12, 2012, which found a TFCC defect in addition to the tendonitis noted earlier (PX #5 & PX #6, 12 WC 9727). On August 3, 2012, Dr. Mark Cohen reviewed the MRI, noting also that Petitioner's pain and tenderness persisted, especially with gripping. He recommended arthroscopic surgery. Dr. Derman saw Petitioner the same day, and endorsed Dr. Cohen's plan (PX #5, 12 WC9727). Dr. Derman also explained that Petitioner's ongoing thumb numbness was "absolutely causally related to the workplace activities" and would likely require further surgery to remove scarring to the nerve. Respondent's nurse case manager was present.

Petitioner returned to Dr. Lee on July 16 (PX #5, 12 WC 21580). He reported attending physical therapy three times per week with only mild improvement. Petitioner reported that he was unable to fully bear weight in his ankle. Dr. Lee noted continued pain and apprehension to ankle movement in all ranges. He prescribed a Flector patch for pain and continued physical therapy, encouraging Petitioner to discontinue use of the crutch as much as possible. Dr. Lee also continued Petitioner's sedentary work restrictions.

On July 18, 2012, orthopedist Dr. Aaron Bare examined Petitioner's shoulder at Respondent's request pursuant to §12 of the Act (RX #9). Dr. Bare diagnosed adhesive capsulitis, which he thought was related to the accident of March 2, 2012. Dr. Bare opined that surgery was not necessary, but stated that Petitioner would benefit from conservative care including stretching, physical therapy, anti-inflammatory medication and perhaps a cortisone injection. He opined that shoulder manipulation under anesthesia should be considered when Petitioner has his wrist surgery.

Dr. Bare referred to a job description which he stated indicated "not much, if any" overhead work. He concluded that no specific restrictions were needed for Petitioner's shoulder stiffness. He opined that Petitioner's shoulder should be at MMI within 3 to 4

months without manipulation or within 2 to 3 months with manipulation. On August 24, 2012, Dr. Bush-Joseph endorsed Dr. Bare's plan for shoulder manipulation (PX #6, 12 WC 9727).

Petitioner returned to Rush Family for follow-up for his ankle on July 20, 2012 (PX #3, 12 WC 21580). It was noted that he had seen "Dr. Li" [*sic*] for peroneal tendon sprain. Bruising had resolved but the ankle was still swollen. Petitioner complained of lateral malleolus popping. He also complained of tingling in the toes. He reported 10/10 pain. Vital signs were essentially normal. The examination revealed full but painful motion. An air cast was applied. Petitioner was referred for assessment for possible DVT and referred back to Dr. "Li". Pain medication was continued, as well as work restrictions.

On July 21, 2012, Petitioner was seen in the Rush emergency department on advice of Dr. Rothschild of Rush Family (PX #4, 12 WC 21580). He reported increased pain and swelling since trying to resume weight-bearing on the foot. A venous Doppler study was conducted which ruled out deep venous thrombosis as a cause of Petitioner's ankle pain. Petitioner returned to Rush Family Physicians two days later and saw Dr. Kring, who prescribed an aircast for his ankle. (PX #3, 12 WC 21580) On July 24, 2012, Dr. Lee ordered an ultrasound of Petitioner's right foot for "tendonitis-peroneal" (PX #5, 12 WC 21580).

Petitioner was seen at Rush Family again on July 23, 2012 (PX #3, 12 WC 21580). Petitioner's complaints and clinical exam findings were essentially unchanged, including 4/5 strength with inversion and eversion. Pain was rated at 10/10. Vital signs were within normal limits. A June 28 MRI showed abnormalities of the peroneus brevis and peroneus longus. Dr. Gina Kring noted her impression that Petitioner's complaints were out of proportion with an ankle sprain when there was full ankle strength. She diagnosed ankle sprain and right peroneal tendinitis. She urged Petitioner to closely follow with "Dr. Lee/Foot Ortho".

On August 1, 2012, at Respondent's request, Petitioner was evaluated by orthopedic surgeon Dr. Steven Kodros pursuant to §12 of the Act. Dr. Kodros reviewed the records of Dr. Kring, the June 28 MRI, and Petitioner's first two visits to Dr. Lee (RX #11). Petitioner testified that Dr. Kodros touched his ankle but did not try to manipulate it, and did not ask about the standing requirements of his job. Dr. Kodros diagnosed Petitioner with a simple contusion and sprain, and judged his pain complaints to be disproportionate for such an injury. Dr. Kodros noted subtle abnormalities on the post-injury MRI study are most likely not clinically significant with respect to Petitioner's current complaints. Dr. Kodros recommended further physical therapy, periodic icing, and use of the ASO brace as needed. However, he saw no need

to restrict the wearing of work boots, and released Petitioner for full-duty work with respect to his right foot injury. Dr. Kodros did not review any diagnostic studies or treatment records subsequent to July 16, 2012, such as the August 13, 2012 ultrasound. Dr. Kodros' report was faxed to Dr. Lee on August 14, 2012.

The ultrasound ordered by Dr. Lee was performed August 13, 2012 (PX #5, 12 WC 21580). The results were consistent with tendinitis and tenosynovitis of the peroneal tendon. The radiologist's report noted thickening of the tendon, fluid collection, and a possible partial thickness tear, although no discrete tear was visualized.

Petitioner returned to Rush Family on August 15, 2012 with complaints of 9/10 ankle pain when standing or walking. Petitioner reported that his wrist surgery was scheduled for September 11. Norco relieved his pain. The clinical presentation was unremarkable. Dr. Augustin continued Petitioner's restricted Petitioner from work until August 27, 2012.

On August 27, 2012 Dr. Lee re-evaluated Petitioner and diagnosed of severe peroneal tendonitis (PX #5, 12 WC 21580). He continued Petitioner's work restrictions, noting that Petitioner had been unable to discontinue the Aircast and reported worsening instability in the ankle. Dr. Lee also noted a "palpable audible pop" and pain with dorsiflexion and eversion of the ankle. In a letter to the workers' compensation adjuster, Dr. Lee explained that he had administered a Lidocaine injection to the peroneal tendon for diagnostic purposes. Depending on the response to this injection Dr. Lee would consider surgical options. The next day, August 28, Dr. Lee reported to the adjuster that the injection had temporarily relieved Petitioner's pain and mechanical symptoms. Based on clinical exam findings, as well as the response to the injection, Dr. Lee recommended surgery. Dr. Lee continued Petitioner's work restrictions, and recommended use of the Aircast as needed.

On August 30, 2012, Dr. Lee again recommended surgery (PX #5, 12 WC 21580). In a letter to the adjuster, Dr. Lee explained that the temporary improvement achieved by the Lidocaine injection further confirmed his diagnosis of peroneal tendon pathology. Dr. Lee wrote "Based on these findings, as well as his positive MRI and ultrasound reports, I am now recommending surgical intervention for this continued deformity". The specific procedure recommended was a peroneal tendon debridement along with possible tenodesis repair and/or a groove deepening procedure, depending on the exact findings at surgery. Dr. Lee then called the Petitioner to explain the recommendation for surgery.

Petitioner testified that he was preparing to have the foot surgery, but it was not authorized. On September 4, 2012, he contacted Dr. Lee's office regarding his work

restrictions. Dr. Lee advised Petitioner that he may discontinue the Aircast and resume all normal activities (PX #5, 12 WC 21580). He may wear steel-toed boots. On September 6, Petitioner reported to Dr. Kring at Rush Family that his surgery had been cancelled and "workman's comp" had recommended he return to work on September 4 (PX #3, 12 WC 21580). Dr. Kring noted continued pain and reliance on the Aircast. She prescribed work restrictions until his follow-up visit with Dr. Lee: "sitting only, unable to wear heavy steel toe work boots." On September 11, 2012, Respondent sent Petitioner a written warning for "absenteeism/tardiness" (PX #10, 12 WC 21580).

Petitioner was seen again at Rush Family on September 6, 2012 (PX #3, 12 WC 21580). He complained of 9/10 right ankle pain at worst, 8/10 when non weight-bearing. He also complained that he was unable to tolerate work boots without increased pain. Motion was still diminished as well as inversion and eversion strength. Dr. Kring's diagnosis was tendonitis. She continued Petitioner's sedentary work restrictions.

Petitioner testified that he had surgery September 11, 2012 by Dr. Cohen on the advice of Dr. Derman, who felt Dr. Cohen was best qualified to repair the TFCC injury. The surgery included repair and debridement of a tear of the TFCC at the radial insertion with ulnocarpal synovitis (PX #6, 12 WC 9727). The shoulder manipulation recommended by Dr. Bush-Joseph, along with a subacromial cortisone injection, was also performed. Petitioner testified that he had originally been scheduled by Dr. Simon Lee to undergo surgery on his right foot on September 14, 2012, which would require using crutches, and had planned to postpone the wrist surgery for that reason. However, the foot surgery was not authorized.

Dr. Lee again saw Petitioner again on September 24, 2012 (PX #5, 12 WC 21580). His letter to the workers' compensation adjuster noted that Petitioner had had "an IME performed with Dr. Steven Kodros, who felt there is no significant pathology or issue that required any surgical intervention or issues." Dr. Lee's examination revealed continuing crepitus and a snapping sensation with ankle circumduction. He also noted Petitioner's persistent pain and difficulty wearing work boots. He wrote "[U]ultimately, however, this is not corresponded with any type of objective findings or studies. However, he does have crepitus of the tendon without any significant symptoms." Dr. Lee administered a second injection to the peroneal tendon, which, like the first, appeared to improve symptoms. He also gave Petitioner "light to sedentary" work restrictions.

Petitioner had two more appointments with Dr. Lee (PX #5, 12 WC 21580). On October 15, Dr. Lee noted that Petitioner was still off work and continued to use the Aircast. Dr. Lee diagnosed "peroneal tendinitis with possible instability," but indicated

that Petitioner's symptoms were greater than expected and there were "no significant diagnostic studies to indicate his pathology." He ordered a triple-phase bone scan to rule out "inflammatory changes" and continued Petitioner's light-to-sedentary work restrictions.

On November 8, 2012, Dr. Lee advised Petitioner that the bone scan was normal. In his letter to the adjuster, he also referred to the Petitioner's prior ultrasound as normal (PX #2, PX #5, 12 WC 21580). Dr. Lee noted that Petitioner was having trouble sleeping due to pain, and found pain along the peroneal tendon and "popping elicited with ankle circumduction." However, he advised that "there is nothing left to offer the patient," and discharged Petitioner to full-duty work (RX #2). Petitioner testified that Dr. Lee never explained to him why he was no longer recommending surgery. He testified that Dr. Lee gave him a shot, released him and "told me, Hope you get better."

There was no documentation in Dr. Lee's November 8 note or billing that an injection was administered.

Petitioner saw Dr. Augustin at Rush Family on November 21, 2012 for left shoulder complaints of 7/10 pain. Dr. Augustin found decreased left shoulder motion. The remainder of the exam was unremarkable.

The records of Midwest Orthopedics at RUSH (PX #6, 12 WC 9727) document several months of post-operative care for Petitioner's left wrist and shoulder, including physical therapy and cortisone injections to the shoulder. On January 25, 2013, Dr. Cohen noted that Petitioner was "doing adequately" with continued left wrist pain, but improved range of motion. Dr. Cohen recommended Petitioner undergo an FCE to determine his permanent restrictions. Dr. Bush-Joseph also recommended an FCE. He noted that Petitioner's shoulder pain and stiffness had not improved much, but "unfortunately we have no further nonoperative measures to offer him," and surgery was unlikely to help in his case.

The FCE was performed at ATI Physical Therapy on January 31, 2013, and found Petitioner's performance to be valid (PX #4, 12 WC 9727 & PX #6, 12 WC 9727). Petitioner demonstrated LIGHT to MEDIUM functional capabilities, below the requirements of his job as a saw operator, which was rated as Medium. The report noted that no actual job description was available. Petitioner's tolerance for simple grasping with the left hand was rated as occasional, with fine grasping rated as minimally occasional. His lifting tolerances on the left were given as 10 pounds frequent and 26 pounds occasional at desk or chair level, with above-shoulder lifting rated at 4 pounds frequent and 17 pounds occasional.

Dr. Cohen prepared a work status report February 5, 2013 (RX #13), after Petitioner's wrist surgery on September 11, 2012 and review of the January 31, 2013, FCE. Dr. Cohen opined that Petitioner could work at a light to medium demand level. He noted that these restrictions were permanent.

Petitioner returned to Dr. Derman February 8, 2013. He reported continued left thumb pain and numbness along with numbness and tingling in the thumb and first two fingers (PX #5, 12 WC 9727). Dr. Derman noted that these symptoms had been present since his first examination in March 2012, but the insurer apparently did not consider them work-related injuries. There was also a tender point just above the palm crease, suggesting swelling in the region of the median nerve, and another along the digital nerve of the thumb. Dr. Derman's working diagnosis was carpal tunnel syndrome plus neuritis of the digital nerve, and he discussed surgery with Petitioner, who indicated he would need to coordinate this with his employer.

On February 19, 2013, Dr. Derman performed surgery left carpal tunnel release and microneurolysis of the median nerve (PX #7, 12 WC 9727). Dr. Derman also removed two lipomas or fatty growths causing pressure on the nerve: one within the carpal canal, and a larger one at the tender point previously identified. Following surgery the Petitioner's arm was placed in a cast for protection. On February 22, 2013 Dr. Derman started Petitioner in physical therapy. Based on the findings at surgery, he explained that post-traumatic swelling following the accident was the most likely cause of Petitioner's carpal tunnel syndrome (PX #5, 12 WC 9727).

On March 22, 2013, Petitioner was evaluated by hand surgeon Dr. Michael Vender pursuant to §12 of the Act (RX #3). Petitioner testified that the exam was very brief. Dr. Vender noted the recent surgical scar. Petitioner testified that Dr. Vender then "stopped right there and asked who did the surgery and what happened, and that was it."

In his March 25, 2013 report Dr. Vender recorded a history of a left wrist injury on March 2, 2012 while throwing a piece of steel. He reported immediate pain in the ulnar aspect of the wrist. Petitioner "was felt to have an abnormality of the wrist," he wrote, for which he had arthroscopic surgery in September 2012. The post-operative diagnosis was internal derangement. Petitioner was later diagnosed as having carpal tunnel syndrome, for which he had release surgery February 19, 2013. He reported noted numbness and tingling in the thumb, index and middle fingers prior to the more recent surgery. Since the surgery Petitioner complained of pain in the thumb, index, and middle fingers. He had pain in the thenar eminence since the original injury.

On examination Petitioner had full motion in the left elbow and left wrist motion symmetric with the right. Motion of the fingers was normal. The ulnar pisotriquetral joint was tender on palpation. Dr. Vender's diagnosis and impression was status post left wrist arthroscopy with debridement of triangular fibrocartilage complex and status post carpal tunnel release.

Dr. Vender opined that Petitioner's September 2012 left wrist arthroscopy for an abnormality of the triangular fibrocartilage complex was "consistent" with the March 2, 2012 accident. He noted that Petitioner was at risk of carpal tunnel syndrome because of his body mass index. However, he opined that Petitioner was at MMI for the wrist injury.

Dr. Vender also opined that the carpal tunnel syndrome and the thumb symptoms were not causally connected to the accident. In support of this opinion, Dr. Vender noted that "early records" did not indicate an injury to the thumb. He noted that the July 9, 2012, EMG was normal. Dr. Vender opined that Petitioner would require several more weeks to recover from the carpal tunnel surgery, but this was not related to the work accident. He opined that Petitioner should reach MMI within 3 months of the surgery. Dr. Vender expected return to work without restriction within "the next several weeks".

Dr. Vender's opinions were without the benefit of review of the most recent operative report. In fact, Dr. Vender did not specifically state what medical records he did review. In addition, Dr. Vender noted "I do not believe the need for the wrist exploration of the left wrist and carpal tunnel was not related to his identified wrist injury".

On May 15, 2013, Dr. Derman noted that Petitioner was recovering well from his carpal tunnel procedure, but continued to have problems with the thumb. Dr. Derman advised him to consider further surgery if no improvement was seen in the next six weeks (PX #5, 12 WC 9727). He released Petitioner for light duty work, with taping of the left wrist and a five-pound lifting restriction. On May 21, 2013, Petitioner saw Dr. Kring at Rush Family, who released him to work within Dr. Derman's light duty restrictions. However, she also issued a note recommending he be allowed to wear his own shoes as "wearing the standard heavy work boots worsens his right ankle pain" (PX #10, 12 WC 9727). Dr. Kring also referred Petitioner to podiatrist Dr. Allan Shoelson.

Petitioner was evaluated by Dr. Shoelson on May 23, 2013 (PX #6, 12 WC 21580). Dr. Shoelson diagnosed chronic peroneal tendonitis with subluxation of the right ankle, related to an injury one year ago. Petitioner also issued a work status note stating that Petitioner could not return to work as a fork truck driver due to a painful ankle

condition, and a treatment plan would be determined in two weeks.

Petitioner testified that upon returning to work, his light-duty assignments included hanging pinions on the conveyor to the sandblaster, and taking inventory of parts in both indoor and outdoor bins. Petitioner testified that this required some lifting of pinions in order to check the part numbers. He also testified that the outdoor bins were often located on gravel or uneven and muddy ground, which put additional stress on his injured right foot. He was not offered any sedentary or desk duty. Petitioner testified that he also operated a forklift occasionally, which was seated work, but never for more than one or two hours per day. His request to wear his own shoes rather than standard work boots was denied.

On May 29, 2013, Petitioner returned to Dr. Derman, who noted wrist pain and swelling after returning to work (PX #10, 12 WC 9727). Dr. Derman took Petitioner off work through June 3, 2013.

On June 3, 2013, Petitioner returned to Dr. Shoelson, who recommended immobilization of the ankle for four weeks in a fiberglass cast (PX #6, 12 WC 21580). He issued a work status note stating that Petitioner's ankle would be casted later that week, and restricting him to "mostly sitting work" in the meantime (PX #9, 12 WC 21580). On June 7, 2013, Dr. Shoelson applied the cast, and restricted Petitioner to "sitting work only" for the next four weeks.

Petitioner testified that Respondent's attendance policy assigned a point for each absence, and he had been charged points for absences due to his injuries. He was terminated for having nine points (PX #9, 12 WC 21580). On June 10, 2013, Petitioner received a notice from Respondent that he had been suspended pending discharge, for violations of the attendance policy resulting in nine attendance points (PX #10, 12 WC 21580). On July 22, 2013, Respondent notified Petitioner of his termination.

On July 15, 2013, Petitioner returned to Dr. Shoelson, who removed the cast and noted that the "peroneal tendon still pops" audibly (PX #6, 12 WC 21580). He administered a cortisone injection and prescribed home exercise. On August 12, 2013, Dr. Shoelson concluded that Petitioner's "chronic peroneal tendonitis/subluxation" had not responded to conservative care, and referred him back to Dr. Simon Lee for surgery. Petitioner testified that he tried to schedule an appointment with Dr. Lee, but this was not authorized.

Petitioner testified that Respondent's attendance policy assigned a point for each absence, and he had been charged nine points for absences related to his right foot and

left arm restrictions. On June 10, 2013, Petitioner was informed by Respondent that he had been suspended pending discharge for violations of the attendance policy resulting in nine points (PX #11, 12 WC 9727). On July 22, Respondent notified Petitioner of his termination.

Petitioner continued to see Dr. Derman, who eventually decided that further surgery to address the thumb problems was not warranted (PX #5, 12 WC 9727). On May 21, 2014, Dr. Derman released Petitioner from his care. He noted that Petitioner continued to have intermittent wrist pain, particularly with ulnar deviation and flexion of the wrist, along with some sensory loss. Dr. Derman declared Petitioner at MMI with regard to the left hand and wrist, with a permanent lifting restriction of 10 pounds.

Petitioner testified to ongoing limitations in his left hand and arm, including a ten-pound lifting restriction with no overhead work. He testified to pain when his wrist was flexed or pulled to the side. This caused pain when carrying a gallon of milk or an object of similar weight. Petitioner testified that his thumb was "much better," but still had some numbness. Petitioner also testified to limited shoulder mobility. He demonstrated the maximum sideways elevation of his left arm, which was slightly above 90° or at shoulder level.

Petitioner also testified that he had not had any paid benefits since Respondent terminated him in June 2013. He had not looked for work because his right foot injury seriously limited his ability to stand and walk, and he had not been able to get surgery. Petitioner testified that his symptoms today are the same as when he saw Dr. Kadakia in 2015 and the same as when he saw Drs. Lee, Kodros, and Shoelson. He still wants to have the surgery recommended by Dr. Kadakia, which is the same as recommended by Dr. Lee.

On March 11, 2015, Petitioner was evaluated by orthopedic surgeon Dr. Anish Kadakia pursuant to §12 of the Act. Dr. Kadakia reviewed Petitioner's records from Concentra, Dr. Gina Kring, Dr. Simon Lee, and the IME by Dr. Steven Kodros. Dr. Kadakia also reviewed various x-ray and MRI imaging. He noted the history of Petitioner's medical care up to the IME.

Dr. Kadakia noted Petitioner's history of accident in which an electric cart struck his right foot on the posterolateral aspect and had remained on the foot for 2-3 seconds. The MRI report from June 28, 2012 showed abnormalities of the peroneus brevis and longus. His review of the MRI images revealed tendinosis and a split tear of the distal peroneus brevis. Dr. Kadakia also noted Dr. Lee's records including the ultrasound report, the results of the diagnostic injection, and the palpable and audible pop elicited at the ankle. He noted Dr. Lee's August 30, 2012 recommendation for surgery,

described as a "peroneal tendon exploration, debridement, repair and possible tenodesis versus groove deepening." On physical exam, Dr. Kadakia found pain over the peroneal tendons, increased with active resistive movement. He noted that he heard snapping in the peroneal tendons when Petitioner circumducted his foot, and could actually feel them snap within the groove posterolaterally.

Based on the above review of the records and clinical findings, Dr. Kadakia opined that the only logical diagnosis is peroneal tendinitis vs. tendinosis vs. clearly obvious intrasheath peroneal subluxation, which was related to Petitioner's work injury. Dr. Kadakia recommended surgery, preceded by a repeat MRI and/or dynamic ultrasound to evaluate the current status of the tendons. He noted that Petitioner's symptoms had been consistent for over two years, and failure to operate risked further damage to the tendons as well as continued disability. Dr. Kadakia's surgical recommendation was essentially the same as Dr. Lee's recommendation.

Dr. Gordon Derman testified by evidence deposition on June 11, 2014 (PX #1, 12 WC 9727). He is currently chair of the plastic surgery department and director of hand and upper extremity surgery at Rush University Medical Center. Dr. Derman explained that as a hand and plastic surgeon he specialized in nerve, tendon and other soft tissue injuries. Carpal tunnel surgeries are among his most frequent procedures. Orthopedic hand surgeons such as Dr. Mark Cohen perform more procedures involving the wrist bones, which is why he had referred Petitioner to Dr. Cohen for the TFCC repair.

Dr. Derman confirmed that Petitioner's left arm and wrist problems, and the two surgeries to address them, were causally related to the accident of March 2, 2012 (PX #1, 12 WC 9727). This included both the TFCC defect repaired by Dr. Cohen's September 2012 surgery and the carpal tunnel and thumb symptoms addressed in his own surgery in February 2013. Dr. Derman explained that repetitive work activities can result in narrowing of the carpal tunnel. However, this may not produce symptoms until a trauma results in swelling, resulting in a sudden onset of carpal tunnel syndrome. The lipomas or fatty deposits Dr. Derman had removed from Petitioner's forearm could likewise have developed gradually until aggravated by the wrist trauma. They could also have resulted directly from the trauma itself. Dr. Derman had reviewed Dr. Vender's report and saw nothing that would change his causal opinion.

Dr. Derman opined that Petitioner should not try to return to work similar to his former job, as this would be "asking for trouble." The weakened TFCC ligament could be further damaged, or his CTS could recur. Petitioner reported some wrist pain on lifting objects in the 10-pound range, and it would not be good for him to do so repeatedly.

Dr. Kadakia testified by evidence deposition October 7, 2015 (PX #1, 12 WC 21580). Dr. Kadakia is a board-certified orthopedic surgeon specializing in foot and ankle surgery. He does several hundred surgeries per year, and is an associate professor at Northwestern University's Feinberg School of Medicine. He performs no more than three or four medico-legal examinations per year.

Dr. Kadakia reviewed Petitioner's records from Concentra, Dr. Gina Kring, Dr. Simon Lee, and the IME by Dr. Steven Kodros. Dr. Kadakia also reviewed various x-ray and MRI imaging. His testimony was a basic reiteration of his own IME report of March11, 2015.

In Dr. Kadakia's opinion, Petitioner's accident was the cause of his subsequent foot and ankle symptoms. He testified that postero-lateral portion of the foot, which was injured in Petitioner's June 2012 accident, contains the peroneal tendons. Petitioner's ultrasound "clearly demonstrated the subluxation of the tendons," and his MRI showed peroneal tendon abnormalities. The only logical explanation for these findings was a peroneal tendon injury. He noted that Dr. Kodros' opinion was rendered without seeing the ultrasound report.

Dr. Kadakia testified that the peroneal tendon injection given by Dr. Lee was a standard diagnostic procedure. If it gives temporary relief, as it did in Petitioner's case, the only logical conclusion is that the tendon is the source of pain. The popping and snapping detected by Dr. Lee is also a standard test for peroneal tendon subluxation. Dr. Kadakia testified that those are not subjective symptoms, but objective signs which cannot be faked. He had been able to hear and feel the snapping on his own physical exam, which reproduced Dr. Lee's findings. Petitioner's subjective complaints were consistent with those objective findings, as well as the diagnostic studies. Dr. Kadakia testified that he had found no evidence of symptom magnification, noting that Petitioner had complained of pain only in the peroneal tendon area where the injury was situated. He also testified that Petitioner's normal bone scan had simply ruled out any non-tendon causes for his pain.

Dr. Kadakia testified that there was "no other logical solution" to Petitioner's problems than surgery. The procedure he recommended was standard, and was the same one Dr. Lee had recommended. After surgery and 6 to 9 months of rehabilitation, many patients recover 100%. He testified that his recommendation for a repeat MRI was not necessary to confirm the diagnosis, but only to check for possible worsening of the condition before surgery.

Dr. Kadakia also testified that Petitioner's time off work since the injury was reasonable and related to his injury. Petitioner reported pain after standing 1-2 hours. Dr. Kadakia's exam also found pain with side-to-side movement or eversion, and continued tendon snapping when he circumducted or rotated the foot. Such patients typically had problems with uneven surfaces including "grass, gravel, ladders, inclines", which can further damage the tendon, and he would restrict them to walking on level, man-made surfaces. Standing and walking typically caused increased pain as the day went on. Dr. Kadakia testified that he was not aware of Petitioner's exact job duties. However, he understood the job as factory labor done in standing all day: "It's not a sit-down job, and he's not standing in a retail store."

Dr. Kadakia that Petitioner could not return his job until his foot problem was fixed. Dr. Kadakia did not make mention of petitioner's specific job duties. He knew, in general, what Petitioner's job was, but he did not ask the petitioner about his job duties, nor did he see a job duty description. Dr. Kadakia believed Petitioner's job duties were "heavy labor." Dr. Kadakia believed Petitioner could operate a forklift with discomfort.

Ronald Farnaus was called to testify by Respondent. He testified that he has worked for Respondent since 2001, starting as an hourly laborer and working his way into management. At the time of Petitioner's injury he was the plant manager at Respondent's Pershing plant where Petitioner worked. He had known Petitioner but had not supervised him directly; as plant manager, the direct supervisors reported to him. Mr. Farnaus did not recall Petitioner's restrictions or the process by which he had been assigned light duty tasks, but testified he would have been consulted as part of that process.

Mr. Farnaus testified that the saw operator position requires constant standing, with some walking inside the plant. A worker assigned to inventory work on light duty would have to walk outdoors, but the bins he checked would sit on concrete pads and thus he would not generally have to walk in mud. Mr. Farnaus also testified that every employee was trained to operate a forklift, and workers on light duty could be assigned this task. Mr. Farnaus identified Respondent's Exhibit #16 as a job description for a forklift operator. He agreed that the actual position title had been left blank, and that "Forklift" had been handwritten in the corner. Respondent conceded that "forklift operator" was later added by hand, and these words were redacted from its RX #16.

Mr. Farnaus testified that he was familiar with the saw operator's job, having performed it himself for about a year in the early 2000's. He disagreed with Petitioner's testimony that the job required repetitive handling of large numbers of scrap billets, and testified that production of scrap billets was minimal if the machines are running properly and are maintained properly by the saw operator. Mr. Farnaus testified that he

could not recall how many scrap billets he had handled per week as a saw operator, as it had been a long time. He said it was no more than 50. He testified that a saw operator's job required no repetitive wrist or hand motion, but added that if they're not properly maintaining and monitoring the machine, there could be repetitive pick-up. On cross-examination, when shown the photographs of scrap bins in Petitioner's Exhibit #12, Mr. Farnaus testified that the time required to fill a bin with scrap would depend on the operator's skill. He testified that he did not know Petitioner's error rate and did not recall whether Petitioner would have filled 3 to 5 bins per day with scrap billets.

Mr. Farnaus testified that billets generally weighed between 5 and 18 pounds and were 4 to 12 inches in length. Defective billets were deposited in a scrap bin across the aisle, which he estimated to be 10-12 feet from the saw. However, he testified that billets were dropped, not thrown, into the bin. Throwing billets was contrary to good safety practices, and saw operators were trained accordingly. Mr. Farnaus also testified that a saw operator could also work in final processing if he were trained, hanging pinions on racks to enter the sandblaster. He testified that this job did not require above-shoulder reaching, and had been designed this way to avoid damaging the shoulder. On cross-examination, Mr. Farnaus agreed that a scrap billet could weigh as much as twenty pounds or more, if the machine were not properly set up. He testified that he did not know if Petitioner had ever been disciplined for throwing scrap billets, and in fact he has seen saw operators throw billets.

When shown Respondent's Exhibit #15, a job description form titled "Cell Operator—Saws", Mr. Farnaus initially testified that it was a "demand profile for someone who would potentially be on light duty." Asked if it also applied to saw operators in general, he said "Yes." The document was dated March 13, 2012 and approved by Joanne Brunner from Human Resources. It identified 3 levels of lifting: up to 5 pounds, which was rated "little"; 10 pounds, rated "moderate," and 20+ pounds, which was rated "never required". RX #15 also indicated that the job never required fingering, throwing, cutting, repetitive wrist motion, or repetitive hand motion. Mr. Farnaus confirmed that the job required no reaching out and no fingering. On cross-examination, Mr. Farnaus agreed that Respondent's Exhibit # 15 would not reflect how often the operator would lift a billet approximating 18 pounds: "It does not say that." He also testified that he did not know what "fingering" referred to. Mr. Farnaus testified that he did not create the form, although he would have advised Human Resources in creating it.

CONCLUSIONS OF LAW

12 WC 9727 (DOI 3/2/2012, right upper extremity):

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

The Arbitrator notes that treating physicians and Respondent's various examining physicians all found that Petitioner suffered an injury to his left wrist and hand as a result of a work accident while lifting and throwing steel billets on March 2, 2012.

Dr. Derman opined that repetitive stress linked to handling a high volume of steel billets had contributed to Petitioner's injuries. However, he also found that Petitioner's symptoms had first appeared in the form of an acute injury while lifting and throwing an eight-pound billet on March 2, 2012. Dr. Derman concluded that the considerable early swelling produced by the acute wrist injury had resulted in the Petitioner's carpal tunnel and thumb symptoms. Dr. Derman's opinion was documented in his first examination, further confirmed by his findings at surgery and articulated in detail in his deposition testimony.

Dr. Cohen, Respondent's first §12 examiner, also confirmed a causal connection between Petitioner's accident and his wrist injury, which he diagnosed as a TFCC defect with tendonitis. Dr. Cohen did not review Petitioner's job duties in detail or discuss the role of repetitive stress in causing Petitioner's acute injury of March 2, 2012. He was not provided with Dr. Derman's additional diagnoses or asked to render an opinion on them, and his discharge notes acknowledge Petitioner's ongoing pain and functional restrictions. The records of the company clinic and of Alivio Medical Center likewise describe an acute injury suffered while throwing a piece of steel at work, as did Petitioner's primary care providers at Rush Family Physicians.

Regarding Petitioner's left shoulder, Respondent's second examiner, Dr. Bare, found his symptoms to be causally connected to the accident and resulting wrist injury. Dr. Bare's opinion echoed that of Dr. Bush-Joseph, Petitioner's treating shoulder surgeon. Dr. Bush-Joseph's final note acknowledged that Petitioner's shoulder pain and stiffness had shown minimal improvement, and there is no evidence that he reviewed the Petitioner's FCE or imposed any final restrictions.

Respondent's third §12 examiner, Dr. Vender, also concurred that Petitioner's wrist injury was causally connected to his accident of March 2, 2012, as well as the necessity of the initial wrist surgery performed by Dr. Cohen. However, he opined that Petitioner's carpal tunnel syndrome and his thumb symptoms were not causally connected to the accident, and the second surgery performed by Dr. Derman to address these conditions was not related to the work injury. However, Dr. Vender's opinion was based on his statement that "early records" did not mention carpal tunnel or thumb

pathology, and his §12 report reflects his impression that these symptoms may have appeared only after the successful first surgery.

Dr. Vender's impression is inconsistent with the medical evidence. In fact, Dr. Derman's initial examination of Petitioner on March 23, 2012, three weeks after the accident, diagnosed both carpal tunnel syndrome and de Quervain's syndrome at the thumb. Petitioner's family doctor had also documented his thumb symptoms two days previously. Dr. Nolan, the hand specialist at Respondent's company clinic, also noted pain on both sides of the wrist, although his notes do not address Petitioner's thumb.

Dr. Vender's report does not list the "various records" he was reviewed, other than noting his lack of the February 2013 operative report. Dr. Vender failed to mention either Dr. Cohen or Dr. Derman, and makes no references whatsoever to their records. Regarding diagnosis and treatment, Dr. Vender could only state that Petitioner "was felt to have an abnormality of the wrist" and underwent surgery for "internal derangement." This incomplete review of records led to an inability even to clearly state what surgical procedures were performed or by whom is not the basis for an expert medical opinion with any certainty. Dr. Vender's opinion is further questioned due to Petitioner's testimony that the physical exam was similarly cursory. The Arbitrator therefore rejects Dr. Vender's theory of two separate wrist and hand conditions, one related and one unrelated to the accident, because of Dr. Vender's narrow scope of understanding of Petitioner's medical history.

Respondent presented evidence to dispute Petitioner's account of the repetitive nature of his job. However, all three of Respondent's §12 examiners agreed that Petitioner sustained an acute injury while throwing a piece of steel at work. Dr. Derman, while opining that repetitive work played a role in the etiology of Petitioner's injury, likewise recognized an acute injury on March 2, 2012, and noted a lack of any symptoms prior to that date. Dr. Cohen also noted the lack of pre-existing complaints or symptoms prior to the accident.

In addition, Petitioner's unrebutted testimony as to he was able to fully perform his job duties prior to the accident further supports the evidence of causality.

The Arbitrator therefore adopts the opinions of treating surgeon Dr. Derman as more persuasive than those of Dr. Vender, which were based on a single §12 examination and limited record review. The Arbitrator concludes that Petitioner's current left upper extremity symptoms of the thumb, wrist, forearm, and shoulder are all causally connected to his accident of March 2, 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?

Having found causal connection for all of Petitioner's left upper extremity complaints, the Arbitrator finds all treatment received for those symptoms through May 21, 2014 to have been reasonable, necessary and related to his work injury. Dr. Cohen, who released Petitioner in February 2013, nonetheless noted ongoing wrist pain and imposed permanent restrictions. The Arbitrator adopts Dr. Derman's opinions as to causation and the necessity of further treatment as more credible and persuasive than the opinions of Respondent's examiner, Dr. Vender. The medical bills contained in Petitioner's Exhibit #9 are Respondent's liability, to be adjusted in accord with the fee schedule provided by §8.2 of the Act.

L: What temporary benefits are in dispute? TTD

Petitioner was discharged by Dr. Cohen on February 5, 2013 with permanent restrictions pursuant to a valid FCE. The FCE noted Petitioner's performance was below the level of his former position as a saw operator, with minimal left hand grasping restrictions. Continuing wrist pain was noted. Following further surgery, Dr. Derman released Petitioner to light duty work on May 15, 2013, while continuing post-operative treatment. Meanwhile, Petitioner's family doctor and his podiatrist had imposed sedentary restrictions relating to his separate right foot injury, which Respondent did not accommodate.

Following a brief return to light duty work, Petitioner returned to Dr. Derman with increased swelling and pain in the left wrist. On May 29, 2013, Dr. Derman took Petitioner off work through June 3, and then a 5 pound lifting restriction thereafter. At that time, Petitioner had sedentary duty based on restrictions placed by podiatrist Dr. Shoelson for the right foot injury. On June 10, 2013, Respondent suspended Petitioner, and terminated him shortly thereafter for an accumulation of absences related to his left wrist and right foot injuries.

There was no competent evidence that the work restrictions placed by Petitioner's treating physicians on his work with his upper extremity were unreasonable of unnecessary. There was no competent evidence that refuted Petitioner's testimony about his difficulties in performing his light duty assignment, which was corroborated by Dr. Derman's off-work note of May 29, 2015. The Arbitrator finds that the light duty work offered by Respondent also exceeded the Petitioner's restrictions.

Finally, it is undisputed that at the time of Petitioner's termination he was on

temporary light duty and under medical treatment. Because he had not reached maximum medical improvement, he was thus entitled to TTD following his termination. The Arbitrator therefore finds that Petitioner remained eligible for TTD payments through May 21, 2014, when Dr. Derman released the Petitioner with permanent restrictions, and for maintenance payments from May 22, 2014 through the date of trial.

However, the Arbitrator notes that TTD has been paid through the date of trial in the companion case, 12WC 21580, concerning Petitioner's right foot injury. In view of that award, and to eliminate duplication, the Arbitrator therefore awards TTD in this case from March 21, 2012, when Petitioner's physician first took him off work, through June 19, 2012, when he reported for light-duty work and suffered his second accident to the right foot, or a total of 13 weeks.

M: Should penalties be imposed upon Respondent?

Petitioner filed a motion for fees and penalties in this case on April 4, 2014 (PX #13). The Arbitrator notes that Respondent's decision to deny TTD and medical benefits in this case was made in reliance on the opinion of its third §12 examiner, Dr. Vender, who opined that while Petitioner's initial wrist surgery and postoperative treatment were related to his work accident but that the further treatment prescribed by Dr. Derman was not. Reliance on a medical opinion is generally taken as evidence of a good-faith dispute. This is true only if the employer's reliance on its §12 report is "reasonable" under the circumstances.

While the Arbitrator did find that Dr. Vender's opinions were not persuasive, it was not unreasonable for Respondent to rely on Dr. Vender's opinions. Even though Dr. Vender did not have as broad a view of Petitioner's medical condition his opinions were based on the history of injury provided by Petitioner and a clinical examination. Accordingly, the Arbitrator denies Petitioner's Petitioner for Penalties and Fees.

CONCLUSIONS OF LAW

12 WC 21580 (DOI 6/19/2012, foot & ankle):

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

There was no genuine dispute that Petitioner sustained an injury of some sort to his right foot and ankle at work on June 19, 2012. The parties stipulated to an accident on June 19, 2012 that arose out of and in the course of Petitioner's employment. What

is disputed is whether Petitioner sustained a contusion and sprain, as opined by Respondent's §12 examiner, Dr. Kodros, or a peroneal tendon tear and tendinosis, as diagnosed by Drs. Lee and Kadakia. The evidence was clear the Petitioner had no prior problems with his right foot and ankle before a cart ran over the lateral part of his foot at work. It is disputed whether Petitioner's current condition is something more that the sprain and contusion diagnosed by Dr. Kodros. After considering all the evidence the Arbitrator finds that Petitioner proved that his current condition of ill-being in his right foot and ankle is causally related to the June 19, 2012 work accident.

The evidence is quite clear that every physician who examined Petitioner's right foot and ankle after his work accident opined that he sustained an injury from that accident. Petitioner was initially diagnosed with an ankle sprain and peroneal tendinitis at Rush Family Physicians on June 19 and June 25, 2012. Dr. Simon Lee at Midwest Orthopedics at RUSH initially diagnosed an ankle contusion and sprain and then tendinitis with synovitis and then severe peroneal tendonitis with possible instability. Dr. Lee noted peroneal tendon snapping and popping during clinical exams. In addition, Dr. Lee administered a diagnostic injection of Petitioner's ankle. An MRI on June 29, 2012 showed abnormal peroneal tendons and a possible tear of the peroneus brevis. Respondent's §12 examining physician, Dr. Steven Kodros, diagnosed an ankle sprain and contusion. Dr. Allan Shoelson diagnosed chronic tendonitis with subluxation. Dr. Anish Kadakia, Respondent's §12 examiner and then Petitioner treater, diagnosed peroneal tendinitis vs. tendinosis with subluxation. Dr. Kadakia also felt and heard peroneal tendon snapping.

The Arbitrator takes note that Drs. Lee and Kodros observed subjective complaints they felt were inconsistent with Petitioner's objective findings. However, Dr. Kadakia specifically noted that absence of symptom magnification. Dr. Shoelson made no comment questioning the validity of Petitioner's subjective complaints. The Arbitrator notes that pain is subjective with no accepted clinical means to objectively measure pain in another. The Arbitrator does not find this to be helpful in assessing Petitioner's credibility or whether Petitioner's current condition of ill-being is causally connected to the accident.

Drs. Lee, Shoelson and Kadakia all diagnosed an injury to Petitioner's right peroneal tendon. Dr. Kodros, on the other hand, diagnosed only an ankle sprain and contusion. The opinions of Respondent's §12 examiner, Dr. Kodros, were based on incomplete records and a brief clinical examination. Petitioner testified that Dr. Kodros did manipulate his ankle during the exam. Dr. Kodros did not review the ultrasound report, or subsequent physical examination findings, or the positive results of the diagnostic injection that were available. Opinions regarding causation based on incomplete evidence cannot be reliable. The Arbitrator therefore finds Dr. Kodros'

opinions to be unpersuasive.

In addition, even though Dr. Lee eventually abandoned his opinion that Petitioner may require surgery, he did not abandon his diagnosis, in fact in fact noting continued symptoms on his last consultation of Petitioner.

The Arbitrator also finds the opinions of Dr. Lee to be unpersuasive. Dr. Lee had variously diagnosed instability, severe right peroneal tendonitis and tenosynovitis, and peroneal tendinosis. He documented crepitus and tendon popping on manipulation. On August 28, 2012 and August 30, 2012 Dr. Lee recommended surgery. Upon learning that surgery was not approved, on September 24, 2012 Dr. Lee then opined that surgery was no longer necessary, despite Petitioner still presenting objective symptoms and administering an injection.

For similar reasons, the full-duty release issued by Dr. Lee subsequent to Respondent's refusal to authorize surgery is questionable. Dr. Lee's records indicate that he reviewed Dr. Kodros' IME report. After this review and in the absence of any new physical findings or diagnostic studies, Dr. Lee reversed his earlier opinions and retracted his surgical recommendation made on August 28 and August 30, 2012. However, Dr. Lee apparently failed to note Dr. Kodros' lack of access to the crucial evidence detailed above, on which he himself had relied in prescribing surgery. In addition, Dr. Lee's letter to Respondent's adjuster fails to explain how the clinical findings cited in his August 30, 2012 prescription for surgery became a lack of "any type of objective findings or studies" by September 24, 2012. Nor does he explain why the same ultrasound report he noted as showing "severe tendonitis" in August 2012 had become "normal" two months later. Dr. Lee's altered opinion and his full-duty release are also inconsistent with his own documentation of Petitioner's continuing symptoms. Dr. Kadakia testified in detail that the diagnostic process which resulted in Dr. Lee's original recommendation for surgery was the same standard process he or any other surgeon would follow. The only logical diagnosis, he emphasized, was a peroneal tendon injury, and surgery was the only logical solution. Therefore, the Arbitrator finds Dr. Lee's apparent opinion of MMI is not persuasive.

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, there are three diagnoses of peroneal tendon injury versus a diagnosis of ankle sprain. The Arbitrator therefore adopts the causation opinions of Drs. Shoelson and Kadakia, particularly including Dr. Kadakia's confirmation of Dr. Lee's original diagnosis and surgical prescription, as credible and consistent with the medical evidence. The Arbitrator concludes that Petitioner proved that his current condition of

ill-being in his right ankle and foot is causally connected to his work accident of June 19, 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?

Having found causal connection, and further adopting Dr. Kadakia's opinions as persuasive and consistent with the weight of the medical evidence, the Arbitrator finds all the medical bills submitted in Petitioner's Exhibit #8, totaling $24,403.75, to represent reasonable, necessary, and related care for Petitioner's work accident of June 19, 2012. These medical charges are Respondent's liability, subject to adjustment in accord with the medical fee schedule provided by §8.2 of the Act.

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

The Arbitrator finds that Petitioner proved that he is entitled to the prospective medical care recommended by Dr. Kadakia. In order to come to this finding the Arbitrator weighed the conflicting opinions of Respondent's §12 examiner, Dr. Kodros, and Petitioner's treating physicians, Drs. Lee and Kadakia.

The Arbitrator previously found that Dr. Kodros' opinion regarding causation to be unpersuasive. Dr. Kodros' opinion, as his lack of causation opinion, was based on a cursory clinical exam and a review of incomplete clinical records of Petitioner's history. As such, the Arbitrator does not accept an opinion based on less than all available information.

The Arbitrator also does not find Dr. Lee's opinion that Petitioner does not require surgery to be persuasive either. Dr. Lee noted several different opinions and findings over the course of his care of Petitioner. He initially diagnosed sprain and contusion but then diagnosed instability, severe right peroneal tendonitis and tenosynovitis, and peroneal tendinosis. He documented crepitus and tendon popping on manipulation. He twice recommended surgery but then abandoned that recommendation while Petitioner was still symptomatic and without abandoning his diagnosis of peroneal tendon injury. In his report to Respondent's claim's adjuster he did not state his reasoning for withdrawing his previous recommendation for surgery. Based on the shifting nature of Dr. Lee's approach the Arbitrator does find Dr. Lee's opinion that Petitioner does not require surgery is unreliable.

The Arbitrator finds the opinion of Dr. Kadakia reasoned and persuasive. Dr. Kadakia originally examined Petitioner at Respondent's request pursuant to §12 of the

Act. Dr. Kadakia examined Petitioner as well as reviewed a greater body of Petitioner's medical records than did Dr. Kodros. Dr. Kadakia then assumed medical care for Petitioner's foot and ankle injury. Dr. Kadakia had a broader understanding of Petitioner's medical case than did Dr. Kodros.

Therefore, the Arbitrator accepts and adopts Dr. Kodros' opinion that Petitioner requires surgery to cure or relieve that effects of his June 19, 2012 work injury to his right foot and ankle. The Arbitrator orders Respondent to authorize and pay for the surgery recommended by Dr. Kodros, as well as all reasonable and necessary pre-operative care and post-operative rehabilitation.

L: What temporary benefits are in dispute? TTD

A claimant is temporarily totally disabled from the time an injury incapacitates him from work until such time as his condition has stabilized. In other words, has the claimant reached MMI.

Having found causal connection between Petitioner's June 19, 2012 accident and his ongoing symptoms through the date of trial, the Arbitrator finds that Petitioner remains entitled either to TTD or to light duty work within his restrictions. Dr. Kadakia's causal opinion and surgical recommendation, along with the overwhelming weight of the treating records and Petitioner's own credible testimony, establish that he is still in need of medical treatment and has not reached MMI. The evidence also established that at the time of his termination for "attendance policy violations," he was still under medical restrictions which Respondent refused to accommodate.

Petitioner's inability to tolerate standing duty or the wearing of heavy steel-toed work boots was documented by his treating and examining physicians, and Respondent produced no evidence that the light duty it provided Petitioner, which required prolonged standing and walking including in outdoor environments, was within those restrictions. Respondent's levying of "attendance" points for Petitioner's inability to exceed his work-related restrictions was thus not a termination for cause, but a simple refusal on its part to provide appropriate light-duty work.

Because Petitioner is not at MMI and continues to seek recommended surgical treatment for his foot injuries, his "failure" to look for work after his termination by Respondent is irrelevant to his ongoing entitlement to TTD. It is only once a claimant has reached MMI that the burden falls on him to look for work or to demonstrate that he was incapable of any paid employment.

Accordingly, the Arbitrator finds that Respondent liable for TTD through the date

of trial, and awards TTD as follows: from June 20, 2012 through May 27, 2013 and from May 30, 2013 through March 23, 2016, for a total of 198 & 6/7 weeks. This award subsumes TTD and maintenance otherwise owed to Petitioner in the consolidated case (12WC 09727) regarding Petitioner's left upper extremity injuries, as explained in the Arbitrator's separate decision.

M: Should penalties be imposed upon Respondent?

Petitioner filed a motion for fees and penalties in this case on April 4, 2014 (PX #13). The Arbitrator notes that Respondent's decision to deny TTD, medical benefits, and prospective medical care in this case was made in reliance on the opinions of its §12 examiner, Dr. Kodros, who opined that Petitioner's sustained only an ankle sprain and contusion and that Petitioner did not require surgery. Reliance on a medical opinion is generally taken as evidence of a good-faith dispute. This is true only if the employer's reliance on its §12 report is "reasonable" under the circumstances.

While the Arbitrator did find that Dr. Kodros' opinions were not persuasive, it was not unreasonable for Respondent to rely on Dr. Kodros' opinions. Even though Dr. Kodros did not have as broad a view of Petitioner's medical condition his opinions were based on the history of injury provided by Petitioner, review of some medical records, and a clinical examination. Accordingly, the Arbitrator denies Petitioner's Petitioner for Penalties and Fees.

Steven J. Fruth, Arbitrator

May 2, 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

Lee Skeins Jr,
Petitioner,
vs.

NO: 12 WC 09727

Jernberg Industries Inc,
Respondent,

18IWCC0012

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 8, 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 $16,400.00. 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.

JAN 5 - 2018

DATED:
o110917
DLG/mw
045

David L. Gore

L.Elizabeth Coppoletti

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SKEINS JR, LEE
Employee/Petitioner

Case# **12WC009727**

12WC021580

JERNBERG INDUSTRIES INC
Employer/Respondent

18IWCC0012

On 5/8/2017, 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 0.97% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0307 ELFENBAUM EVERS & AMARILIO
JOSEPH D AMARILIO
940 W ADAMS ST SUITE 300
CHICAGO, IL 60607

0532 HOLECEK & ASSOCIATES
JEFF C GOLDBERG
161 N CLARK ST SUITE 800
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Lee Skeins, Jr.
Employee/Petitioner

v.

Jernberg Industries Inc.
Employer/Respondent

Case # **12 WC 9727**

Consolidated cases: **12 WC 21580**

18IWCC0012

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 **3/23/2016**. 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 2, 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 **$28,354.56**; the average weekly wage was **$545.28**.

On the date of accident, Petitioner was **28** 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 **$4,725.76** 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 Petitioner temporary total disability benefits of **$363.52** per week for **13** weeks, for the period commencing **March 21, 2012** through **June 19, 2012**, totaling **$4,725.76**, as provided in §8(b) of the Act. The balance of TTD and/or maintenance otherwise owing in this case has been awarded in the companion case, 12WC 21580.

Respondent shall pay Petitioner's claim-related medical bills for care and treatment for Petitioner's injuries to the right upper extremity, from the date of accident, March 2, 2012, through March 23, 2016, including outstanding medical bills totaling **$16,333.66**, pursuant to §8(a) of the Act and adjusted in accord with the medical fee schedule provided in §8.2 of the Act.

Respondent shall pay Petitioner benefits that have accrued from March 2, 2012 through March 23, 2016 and shall pay the remainder of the award, if any, in weekly payments.

Petitioner failed to prove that he is entitled to penalties and attorney's fees.

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

May 2, 2017
Date

ICArbDec19(b)

MAY 8 - 2017

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

Gregory Boens,
Petitioner,
vs.

NO: 11 WC 46135

Yellow Roadway Corp,
Respondent,

18IWCC0013

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, causal connection, prospective medical 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 23, 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 $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: JAN 5 - 2018
o120717
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

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

BOENS, GREGORY
Employee/Petitioner

Case# **11WC046135**

YRC INC
Employer/Respondent

18IWCC0013

On 12/23/2016, 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 0.64% 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:

0692 HOPKINS & HUEBNER
PAUL SALABERT
100 E KIMBERLY RD SUITE 400
DAVENPORT, IA 52806

2904 HENNESSY & ROACH PC
PAUL NBERARD
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

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)/8(a)

GREGORY BOENS,
Employee/Petitioner

v.

YRC, INC.,
Employer/Respondent

Case # 11 WC 46135

Consolidated cases: _____

18IWCC0013

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 **Rock Island**, on **12/6/16**. 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 _____

18IWCC0013

FINDINGS

On the date of accident, **6/30/11**, 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 **$58,872.78**; the average weekly wage was **$1,132.17**.

On the date of accident, Petitioner was **55** years of age, *married* with **1** dependent children.

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

Respondent shall be given a credit of **$00.00** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$00.00** for other benefits, for a total credit of **$00.00**.

Respondent is entitled to a credit of **$103.50** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services associated with the total shoulder arthroplasty recommended by Dr. Stewart, 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.

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

12/21/16
Date

ICArbDec19(b)

DEC 23 2016

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 55 year old driver/dock worker, sustained an accidental injury to his right shoulder that arose out of and in the course of his employment by respondent on 6/30/11. On 7/28/14 this matter came on for hearing before Arbitrator Erbacci pursuant to Section 19(b) of the Act. The issues in dispute were accident, causal connection, and prospective medical expenses. Arbitrator Erbacci issued his decision on 9/2/14. He found that petitioner sustained an accidental injury to his right shoulder that arose out of and in the course of his employment by respondent on 6/30/11; that petitioner's current condition of ill-being as it relates to his right shoulder was causally related to the injury he sustained on 6/30/11; and that respondent shall authorize and pay the reasonable and necessary medical expenses associated with the right shoulder arthroscopy prescribed by Dr. Stewart, as provided in Sections 8(a) and 8.2 of the Act. Arbitrator Erbacci, in his Conclusions of Law, held that petitioner had been diagnosed with degenerative joint disease and arthritis, as well as a probable posterior labral tear in his right shoulder by his treating physician, Dr. Stewart, and the respondent's examining physician, Dr. Papierski. Arbitrator Erbacci further held that petitioner had not reached maximum medical improvement and respondent was responsible for providing the prospective arthroscopic procedure prescribed for petitioner by Dr. Stewart.

Respondent appealed the Arbitrator's Decision, and on 5/13/15 issued its Decision and Opinion on Review affirming and adopting the Decision of the Arbitrator. No further appeals were taken.

Following the hearing on 7/28/14 petitioner continued working for respondent doing his regular duty job. Petitioner testified that he is working full duty. His duties include loading his own freight, going out and making deliveries and pickups, and unloading the trailer and loading different trailers after returning to respondent after his route. Petitioner has a city route and drives 150-200 miles per day. At times petitioner's trailer is loaded for him, but most often he loads it himself using a forklift or pallet jack. Some items must be loaded or unloaded by hand.

Following the Commission's Decision and Opinion on Review on 5/13/15, petitioner attempted to return to Dr. Stewart. Due to some miscommunications with Dr. Stewart's office petitioner did not get back in to see Dr. Stewart until 10/8/15. Petitioner did not see Dr. Stewart between 7/28/14 and 5/13/15 because Dr. Stewart told him not to return until he had authorization for the recommended surgery.

On 10/8/15 petitioner returned to Dr. Stewart for a recheck of his right shoulder. When petitioner had seen Dr. Stewart on 12/6/11, Dr. Stewart recommended an arthroscopy of the right shoulder with debridement versus repair of the labral tear, and correction of the bony and soft tissues as indicated. Between 12/6/11 and 5/13/15 petitioner had been unable to receive authorization from respondent for this recommended surgery.

Petitioner's complaints on 10/8/15 included right shoulder pain that Dr. Stewart noted was first diagnosed in 2011. Dr. Stewart noted that petitioner was getting worse. Petitioner complained of pain, numbness, stabbing, and sharp pain, constant in nature. He reported that it radiates up and down his arm. Dr. Stewart examined petitioner and noted 10-15 degrees of full motion in the right shoulder. X-rays were taken of the right shoulder that showed endstage primary osteoarthritis, osteophytes and bony spurs, and loss of joint space. Dr. Stewart explained to petitioner that the arthroscopy he recommended 4 years ago would not help him now. He was of the opinion that it would most likely result in more pain and that his real predictable solution was a total shoulder arthroplasty.

On 2/5/16 petitioner was reexamined by Dr. Papierski, at the request of the respondent. Dr. Papierski performed an examination and reviewed some medical records, including Dr. Stewart's report of 10/8/15. He diagnosed right glenohumeral joint osteoarthritis. Dr. Papierski agreed that petitioner needs a right total shoulder arthroplasty. Dr. Papierski opined that the recommended right shoulder arthroplasty is not causally related to the Commission's award of the right shoulder arthroscopy. He further opined that the osteoarthritis of the glenohumeral joint with ostephyte formation and loss of joint space as is reported in Dr. Stewart's October 2010 note is degenerative in nature and not as a result of this individual's work activities.

On 4/21/16 Dr. Stewart drafted a letter to petitioner's attorney, Paul Salabert. Dr. Stewart opined that in 2011 he opined a causal connection between petitioner's right shoulder condition and his work activities, and recommended a shoulder arthroscopy and labral tear. He noted that more recently Dr. Papierski examined petitioner and was of the opinion that petitioner also needed a total shoulder arthroplasty, but that there was no causal connection between the osteoarthritis and his work activities. Dr. Stewart disagreed with Dr. Papierski's opinions and was of the opinion that petitioner's work activities still bother his right shoulder. He noted that petitioner does activities which produce pain in his shoulder as well as decreased function and use. Dr. Stewart noted that Dr. Papierski was of the opinion that petitioner's shoulder pain is the direct result of degenerative osteoarthritis of the shoulder and not related to his work activities. Dr. Stewart was of the opinion that while there can be a portion of petitioner's right shoulder being a degenerative labral tear, the instability of his shoulder due to his labral tear could also produce this type of a change in his shoulder. Dr. Stewart opined that petitioner should undergo a total shoulder arthroplasty to correct his shoulder pain and dysfunction.

On 9/22/16 the evidence deposition of Dr. Stewart was taken on behalf of the petitioner. Dr. Stewart opined that while petitioner's osteoarthritis of his right shoulder was not a direct result of an injury to his right shoulder at work, that the repetitive use of his shoulder continued to advance the osteoarthritis, causing pain with his work activities. Dr. Stewart testified that during his final exam in May of 2013, before he saw him on

10/8/15, he did not diagnose him with osteoarthritis in his shoulder. Dr. Stewart described end stage osteoarthritis as being at the point where there is lost cartilage surface and joint space, starting to develop bony spurs and changes in the humeral head, and to some extent, the glenoid. Dr. Stewart was of the opinion that the chondromalacia of the shoulder noted on the MRI before 2013, represented early degenerative changes in his shoulder, but the majority of his osteoarthritic complaints developed sometime between 2013 and 2015. Dr. Stewart was of the opinion that if he had done the labral resection or repair when recommended, it is unknown if he would need an arthroplasty now. He stated that it depends on the type of tear and its condition, which he would only determine during surgery.

On 10/7/16 the evidence deposition of Dr. Papierski was taken on behalf of the respondent. Dr. Papierski reiterated his causal connection opinion that he previously provided prior to the first 19(b) hearing on 7/28/14, that petitioner's work activities for respondent would not be a cause or aggravation of the arthritis of the right shoulder. Dr. Papierski testified that he did diagnose or find osteoarthritis in petitioner's right shoulder during his IME in 2012.

Petitioner testified that between 7/28/14 and 10/8/15 he continued working his regular duty job and his right shoulder continued to get worse. He stated that it is still getting worse and he has less movement, especially overhead. Petitioner testified that he manages okay except for overhead work. Petitioner denied any new injuries and/or accidents since the injury on 6/30/11. Petitioner testified that everything is hard to do and difficult. Petitioner takes 2 Excedrin, 4 times a day for pain. Petitioner testified that he wants to undergo the right total shoulder arthroplasty recommended by Dr. Stewart on 10/8/15.

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

On 9/2/14 Arbitrator Erbacci held that petitioner sustained an accidental injury to his right shoulder that arose out of and in the course of his employment by respondent on 6/30/11, and that petitioner's current condition of ill-being as it relates to his right shoulder is causally related to the injury he sustained on 6/30/11. Arbitrator Erbacci further held that petitioner had been diagnosed with degenerative joint disease and arthritis, as well as a probable posterior labral tear in his right shoulder by his treating physician, Dr. Stewart, as well as, respondent's examining physician Dr. Papierski. In reaching his finding that petitioner's current condition of ill-being as it relates to his right shoulder is causally related to the injury he sustained on 6/30/11, Arbitrator Erbacci, adopted the causal connection opinion of Dr. Stewart over that of Dr. Papierski. Arbitrator Erbacci's Decision was affirmed and adopted by the Commission in the Decision and Opinion on Review issued on 5/13/15.

Although petitioner did not follow-up with Dr. Stewart or anyone else between 7/28/14 and 5/13/15 due to respondent's refusal to authorize the surgery recommended by Dr. Stewart in 2011, petitioner continued working for respondent doing his regular duty job. Petitioner would load and unload trucks primarily with a forklift or pallet jack and drive 150-200 miles a day. While performing these duties for respondent during this time petitioner's right shoulder condition continued to worsen.

When petitioner finally got in to see Dr. Stewart on 10/8/15 to proceed with the surgery he had recommended in 2011, Dr. Stewart explained to petitioner that the arthroscopy he recommended 4 years ago would not help him now. He recommended a total right shoulder arthroscopy. Petitioner denied any new injuries or accidents between 7/28/14 and 10/8/15. Dr. Stewart was of the opinion that petitioner's work activities still bother petitioner's right shoulder. He opined that while petitioner's osteoarthritis of his right shoulder was not a direct result of an injury to his right shoulder at work, that the repetitive use of his shoulder while continuing to work for respondent for nearly 4 years while awaiting authorization for the arthroscopic surgery recommended by him in 2011, continued to advance the osteoarthritis, causing pain with his work activities. Dr. Stewart was of the opinion that the chondromalacia of the right shoulder noted on the MRI before 2013 represented early degenerative changes in his right shoulder, but the majority of the osteoarthritic changes occurred between 2013 and 2015, while petitioner continued to work for respondent and await authorization for the recommended arthroscopy. Dr. Stewart was of the opinion that if he had performed the labral resection or repair when recommended, it is unknown if petitioner would need a total arthroplasty now. He stated that it depends on the type of labral tear and its condition, which he could only determine by performing the recommended surgery.

Dr. Papierski opined prior to the first 19(b) hearing that petitioner's current condition of ill-being as it relates to his right shoulder was not casually related to the injury petitioner sustained to his right shoulder on 6/30/11. Arbitrator Erbacci, did not find this opinion persuasive, and instead adopted Dr. Stewart's opinion that petitioner's current condition of ill-being as it relates to his right shoulder is causally related to the injury he sustained to his right shoulder on 6/30/11.

Following the recommendation for a total right shoulder arthroplasty by Dr. Stewart, respondent had petitioner reexamined by Dr. Papierski. Dr. Papierski again reiterated the same causal connection opinion that he offered prior to the first 19(b) hearing on 7/28/14, that being that petitioner's current condition of ill-being is as it relates to his right shoulder is not causally related to the injury he sustained to his right shoulder on 6/30/11. He reiterated that petitioner's work activities for respondent would not be a cause or aggravation of the arthritis of the right shoulder.

Based on the above, as well as the credible record, the arbitrator finds the petitioner's current condition of ill-being as it relates to his right shoulder is causally related to the injury petitioner sustained on 6/30/11. The arbitrator bases this finding on the fact that Arbitrator Erbacci made this finding in his Arbitrator Decision on 9/2/14; that the Arbitrator's Decision was affirmed and adopted by the Commission in their Decision and Opinion on Review on 5/13/15; that petitioner sustained no new injuries to his right shoulder between 7/28/14 and 10/8/15, when Dr. Stewart recommended the total right shoulder arthroplasty; that Dr. Papierski's reiteration of his causal connection opinion had already been found not persuasive by Arbitrator Erbacci in his Arbitrator's Decision dated 9/2/14, when he adopted Dr. Stewart's casual connection opinion over that of Dr. Papierski; that petitioner had osteoarthritis in his right shoulder in 2012; and that petitioner's osteoarthritis in his right shoulder worsened from 2012 through 2015 while he continued to work for respondent and await authorization for the surgery recommended by Dr. Stewart 2011, to the point that by 2015 the right shoulder arthroscopy recommended in 2015 would no longer correct petitioner's right shoulder condition.

K. IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE?

Having found petitioner's current condition of ill-being as it relates to his right shoulder is causally related to the injury petitioner sustained to his right shoulder on 6/30/11, and the fact that both Dr. Stewart and Dr. Papierski are of the opinion that petitioner now needs a right total shoulder arthroplasty, the arbitrator finds the respondent shall pay all reasonable and necessary medical expenses pursuant to Sections 8(a) and 8.2 for the total right shoulder arthroplasty recommended by Dr. Stewart on 10/8/15.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert Wolnik,
Petitioner,

vs. NO: 98 WC 68392

Die-Tech Industries, Inc.,
Respondent.

ORDER

Petition for Attorneys' Fees and Costs having been filed by Petitioner's Law firm herein and due notice given this matter came on for hearing before the Illinois Workers' Compensation Commission on March 31, 2016 in Chicago, Illinois.

Upon consideration of said Petition and the Commission's independent review of the record and file, the Commission is of the belief that the Petition for Attorneys' Fees and Costs should be granted.

The Commission finds on August 21, 2014 an Arbitration hearing was held before Arbitrator Williams. On September 29, 2014, Arbitrator Williams entered a decision and awarded 20% man as a whole under Section 8(d)2 of the Act which totaled $120,000.00, $19,473.91 net in temporary total disability benefits ($40,952.59-a credit of $21,478.68) under Section 8(b) of the Act and $2,984.62 in medical expenses under Section 8(a) of the Act. Petitioner appealed the Arbitrator's decision. On June 4, 2015, the Commission affirmed and expanded on the Arbitrator's decision. Petitioner appealed the Commission decision to Cook County Circuit Court. On November 6, 2015, Petitioner's attorneys' filed a Petition for Attorneys' Fees in the amount of $28, 491.04 and costs in the amount of $8,423.11. On November 15, 2015 the Circuit Court granted Petitioner's attorneys' motion to withdraw as Petitioner's attorney. On January 16, 2016, the Cook County Circuit Court dismissed Petitioner's appeal for want of prosecution and at this time the Commission decision became final. As a result, Petitioner's attorneys' are seeking payment of attorneys' fees and costs and are requesting that Respondent not issue the payment of the Commission decision until such time that the Commission rules on Petitioner's Attorneys Petition for attorneys' fees and costs.

Having reviewed the entire record, the Commission finds Petitioner's former attorneys are entitled to $28, 491.04 in attorneys' fees and $8,423.11 in costs related to the prosecution of the above captioned claim. The Commission further finds that Respondent is ordered to pay Petitioner's former attorneys said attorneys' fees and costs and to pay the remaining of the award to the Petitioner in the above captioned claim.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent is to pay Petitioner's former attorneys $28, 491.04 in attorneys' fees and $8,423.11 in costs related to the prosecution of the above captioned claim and to additionally pay the remaining of the award to the Petitioner in the above captioned claim.

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

DATED: MAY 2 0 2016

MB/jm

R: 3/31/16

43

Mario Basurto

David L. Gore

Stephen Mathis

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

Robert Wolnik,
Petitioner,
vs.

NO: 98 WC 68392

Die-Tech Industries,
Respondent.

15IWCC0533

DECISION AND OPINION ON REVIEW

Petitioner appeals the decision of Arbitrator Williams finding that Petitioner sustained an accidental injury on February 26, 1998. As a result Petitioner proved a causal relationship existed through May 9, 2003 but failed to prove a causal relationship thereafter. The Arbitrator found Petitioner was temporarily totally disabled from February 29, 1998 through November 13, 1998 and November 12, 2002 through May 1, 2003 for 61-3/7 weeks, is entitled to medical expenses through May 9, 2003 and is not entitled to vocational rehabilitation. Furthermore, Petitioner is permanently partially disabled to the extent of 40% man as a whole under Section 8(d)2 of the Illinois Workers' Compensation Act. The issues on Review are whether a causal relationship exists between Petitioner's present condition of ill-being and the February 26, 1998 work accident and/or need for medical services, the extent of Petitioner's temporary total disability, the nature and extent of Petitioner's permanent disability, the amount of reasonable and necessary medical expenses and whether Petitioner is entitled to additional compensation under Sections 19(l) and 19 (k) of the Act and attorneys' fees under Section 16 of the Act. The Commission, after reviewing the entire record, affirms and expands the Arbitrator's decision as set forth below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner, a tool and die maker, underwent surgery on April 13, 1987 which consisted of a lumbar hemilaminectomy at the L4-5 level on the right. After the surgery, he returned to full duty work. Petitioner testified that he did not undergo any medical treatment for his back after his release to return to work in 1987 through 1998.

15IWCC0533

2. On February 26, 1998, Petitioner was a vice president/co-owner of Respondent's company. He was a working officer/partner of a company and performed tool and die duties.

3. Petitioner testified that on February 26, 1998 he was transferring 200-300 steel plates which weighted 15-20 pounds from one skid to another when he noticed a pain in his back. Petitioner said a few days later the pain radiated down his left leg and into his calf. Petitioner remained off of work from February 29, 1998 through November 13, 1998.

4. On April 10, 1998 Petitioner underwent a lumbar MRI which showed left paracentral extrusion of L5-S1 disc measuring 1 cm with impingement of the left S1 nerve root, a mild posterior bulging of L3-4 and L4-5 discs with borderline spinal stenosis of the dural sac measuring 8mm, minimal peridural scar at the L4-5 level on the left and minimal scar or small annular tear at the L3-4 level. On June 1, 1998 Petitioner underwent surgery consisting of a lumbar hemilaminectomy at L5-S1 on the left.

5. Petitioner testified he left Respondent in November of 1998 because he was not getting along with his partner and he opened RMB Precision Tools, his own company, which did the same type of work. He had part-time help which consisted of two to three employees and an apprentice. Between November 13, 1998 and November 2002, he worked at RMB. He was performing the same responsibilities he had at Respondent's company. He saw customers, performed sales and he worked production.

6. On March 4, 1999 Petitioner underwent a lumbar MRI which showed degenerative and post-operative changes, but no focal disc herniation.

7. Petitioner said when he worked at RMB from 1998 through 2003 he worked his own hours and he work on a limited basis. He worked in 2 hour increments and then he would go to his house six blocks away and lay down. Periodically, after lunch, he would go back to work and work until about 4:00 p.m.; he would then go home and return again to the shop and work until 6:00 before going home. If he had more work, he would go back again to the shop and work until 10-11:00 p.m. When he drove to see customers he was able to sit and stand as needed.

8. On March 28, 2002 Petitioner underwent a lumbar MRI which showed that Petitioner had previously undergone a left side L5 laminectomy and it showed he had soft tissue thickening encasing the left S1 nerve root which showed an enhancement consistent with scar formation. The L4-5 level showed a posterior central bulging with moderate spinal stenosis and no evidence of scar formation. The L3-4 disc show posterior central bulge with mild spinal stenosis and small amount of granulation tissue. There was also a minimal posterior central bulging of the T11-T12 level. On November 12, 2002 Petitioner underwent surgery consisting of a lumbar hemilaminectomy and a

decompression at the L5-S1 level. Petitioner was off of work from November 12, 2002 through May 1, 2003.

9. On April 10, 2003, Dr. Kranzler recommended that Petitioner return to work in a gradual fashion. Petitioner testified that after he returned to work he found it was difficult to work prolonged hours. He further said that after working an hour and a half he would go home and lay down because the pain was too severe and he could not function. He experienced pain down his hip, through his thigh and down his left calf.

10. On May 9, 2003 Petitioner was evaluated by Dr. Zelby. At that time Petitioner reported he continues to improve and has more good days than bad days with no complaints of low back pain. He did have intermittent numbness and tingling in the left anterolateral foreleg and foot with an occasional left leg weakness. He reported standing is his worse position. His examination revealed diminished sensation in the left L5 distribution at the foot and diminished muscle reflexes at the knees and both ankles. Dr. Zelby opined that Petitioner's recent surgery was not appropriate. Dr. Zelby acknowledged that Petitioner had returned to work part time and he felt that Petitioner had reached maximum medical improvement and Petitioner could resume all vocational and avocational activities without any restriction. He did not recommend a functional capacity evaluation based on the fact that Petitioner was performing his regular job duties, albeit only two hours a day.

11. On June 5, 2003, Petitioner followed up with Dr. Kranzler. Petitioner reported that his left foot was partially numb and this occurs off and on. He also experiences left ankle and leg pain off and on, but it was not present that day. Dr. Kranzler noted that Petitioner works approximately two hours a day. Petitioner reports he is unable to stand for more than one hour at a time. Dr. Kranzler noted that although he still has some symptoms from time to time it was his impression that Petitioner was doing much better. He instructed Petitioner to return to work in a graduated fashion and to continue to take Vicodin. From June 6, 2003 through August 26, 2010, a seven year period, Petitioner testified he did not receive any treatment for his low back.

12. Petitioner testified he stopped working in July of 2003 because he could not honor his commitments; he could not work and he could not function. He said he was the main worker and was working 12-14 hours a day with a few part-time employees. He could not work for more than a couple of hours. RMB closed when he decided he could not work anymore. Petitioner agreed that none of his doctors said he could not work at that time.

13. In 2005 and at his attorney's request, Petitioner said he was evaluated by Dr. Blonsky. Dr. Blonsky noted that Petitioner had a second surgery on November 11, 2002 to remove scar tissue, but the Petitioner did not experience any relief of his symptoms after the second surgery. Initially, he felt some slight improvement, but it took him about five months to return to work. Following that time his pain progressed and he was unable to continue working. He had returned to tool and die making but he was only able to work 3

to 4 hours at a time and then he would have to go home and lie down. He owned his own shop so he was able to set his own hours. He eventually closed down his business because of his inability to perform the functions of a tool and die maker. A functional capacity evaluation was recommended but it has not yet been approved. Currently, Petitioner reports occasional pain in the left sacroiliac joint area but the pain is mainly in the center of the left buttock. He reports that all activities increase his pain. He experiences a cramping sensation in the back of his thigh. His calf pain is dull and his muscles spasm. He also feels spasms and twitching in his heel tendon and his foot is numb. He reports that if he is on his feet for more than three hours, the pain worsens and he had to sit or lie down. If he sits, the pain is constantly present. It is not as intense as when he stands. Petitioner reports he spends a great deal of time in a hot whirlpool at home. When he lays down it also helps. He reports his left leg feels weak and he often trips when he walks upstairs. He reports he can no longer ride a bike, ski or play baseball. In the past, he has been diagnosed as being depressed and he had received medication from his primary physician. He reports he is also a recovering alcoholic and he attends AA meeting twice a week. He reports he relapsed after the first surgery but he has been sober since. He is currently taking Vicodin. Dr. Blonsky opined that Petitioner's history and current physical evaluation are consistent with a left S1 radiculopathy with a possible L5 involvement which is most likely secondary to post-operative fibrosis. In addition, there are findings consistent with a myofascial pain syndrome involving the left hip girdle muscles, most prominently the piriformis and to a lesser extent the gluteus maximum. Dr. Blonsky testified that he has reviewed Petitioner's numerous medical records and he believes Petitioner's current condition is directly related to the February 26, 1998 injury. Dr. Blonsky further opined that because of the nature of his work, which requires him to stand at a press and/or other machines all day, he is significantly disabled and his current condition will prevent him from doing so. Dr. Blonsky testified that Petitioner could possibly perform sedentary work activities so long as he is given the option to change positions periodically. He recommended that Petitioner be enrolled in an inter-disciplinary chronic pain management program with the goal being that Petitioner would to be able to return to some type of gainful employment which is not as physically demanding as that of a tool and die maker.

14. On September 11, 2006 Petitioner saw Dr. Lofland a psychologist. During the interview, Petitioner ranked his pain as being a 6 out of 10 with the worse being 6 and best being 2. He stated he is only able to sit comfortably for 20 minutes before his pain becomes intolerable. However, he is able to drive for a couple of hours. He was unable to answer how long he is able to stand and initially responded that he does not walk but then stated he can walk for 10-15 minutes before becoming overwhelmed with pain. He reports problematic sleep patterns. He stays in bed for 17 hours per day on average but while asleep he wakes every hour. He cites depression and his physical limitations as reasons for his hypersomnolence. He states that sitting, laying down and activities increase his pain while sitting in a whirlpool, swimming or stretching improves his pain. He reports the surgery after his 1998 injury was unsuccessful and that the corrective surgery for scar

tissue was delayed so long his doctors believe it caused his permanent nerve damage. He is not currently on any medication because he does not have insurance or financial means to pay for doctors' appointments. He expressed frustration and said he has no life and cannot do anything. He sleeps all day and night having to awaken every 2 hours to stretch his back out and to avoid unbearable pain. He attempted to return to work after his injury and surgery but he has become increasingly unable to honor his commitments due to his limited physical functioning. Current psychological tests reveal he is mildly to moderately depressed. He rates his area of occupational and physical activity as 10/10 indicating he perceives complete disability in those areas. Based on this assessment, it is felt that Petitioner is experiencing at least a moderate degree of depressive symptomatology and that he would benefit from mental health services as soon as possible. He would also benefit from an interdisciplinary chronic pain management program.

15. On December 4, 2006 Petitioner reported to Dr. Blonsky that his back pain is getting worse. He reported experiencing a flare up of sciatic pain a week or so ago. He does very little in the way of activity. He reported that if he does anything physical the pain increases the next day. Dr. Blonsky noted that it has been recommended that Petitioner be in a chronic pain management program for his emotional and physical problems. Dr. Blonsky opined that Petitioner is not currently employable in any capacity. Although he suggested last year that Petitioner could possibly work in a sedentary capacity for up to three hours, he no longer believes Petitioner could sustain even this short period of activity. He strongly recommended that Petitioner be enabled to enroll in a multidisciplinary intensive chronic pain program as soon as possible.

16. On April 24, 2007, Petitioner treated with Dr. Newman after he fell and sustained a fracture of the distal fibula of his right foot. The week after Petitioner treated with Dr. Newman, Petitioner saw Dr. Surath for chronic back issues consisting of a herniated disc and sciatic nerve which are both cause his pain to worsen. Petitioner reported he is not currently taking any medication and occasionally a friend gives him Methadone to help him sleep. Dr. Surath prescribed Trazadone, Vicodin and Tylenol. On December 4, 2007 Dr. Surath noted Petitioner was addicted to cocaine and alcohol over 15 years ago. During the past 5-6 years, Petitioner has started drinking and this may be affecting his sleep. Petitioner has chronic back pain from a work injury. He reports that three years ago he started using cocaine occasionally with friends but he has stopped. Five years ago, after his wife left him and he lost his business, he started drinking a 6 pack a day. He reports his last use of alcohol was earlier today. On January 10, 2008, Dr. Surath noted that Petitioner is restless while sitting in the chairs. He is sucking on multiple lifesavers and smells slightly of possible ETOH, but he denies drinking any ETOH today. Petitioner reports drinking three beers since his last visit with psychologist in December and he reports he is not going to AA. He states that he has not had any recent falls. Lastly, he reports he feels alive again after his Trazodone dose was increased and now he sleeps 8 hours a night. On March 26, 2008, Dr. Surath noted that Petitioner has requested Tyco

No. 4 and Flexiril refills. Both medicines were given as a 15 day supply at the last visit. The Petitioner's request has been denied and he was counseled that if he needs refill of Narcotic or Flexiril he needs to see doctor first. It was further noted that Petitioner has been counseled on this topic repeatedly.

17. On April 18, 2008 Petitioner was evaluated by Dr. Ghanayem. He noted that Petitioner last worked in 2003 and stopped working because he was in too much pain. On physical examination, there is a strong smell of both cigarette smoke and alcohol on Petitioner's breath. Dr. Ghanayem states that a L4-5 disc herniation typically involves the L5 nerve root and on occasion can interfere with the S1 nerve root as well. Dr. Ghanayem noted that Petitioner has subjective complaints of left sided pain which is in multiple areas of distribution and which do not fit the anatomic pattern of the residuals pain resulting from an L4-5 discectomy or scar removal. He had problems in the L3, L4, L5 & S1 dermatomes. In addition, he currently has bilateral symptoms, but he only had one sided pain after his 1998 work injury. Dr. Ghanayem stated that if Petitioner was fine after the first surgery, he should have no basis for any bilateral symptoms at this time. Therefore, he opined that Petitioner has articulated significant subjective complaints which are not substantiated with a presumed lumbar disc that may have occurred in 1998. Dr. Ghanayem opined that there is a component of non-organic pain behavior in this case. He opined that Petitioner has reached maximum medical improvement and a chronic pain program this late after an allege work injury simply has no chance of providing Petitioner with any demonstrable benefit. Assuming he did sustain a second lumbar disc herniation in 1998, Petitioner should be able to function at least at the light to light-medium work capability. If necessary a functional capacity evaluation should be obtained.

18. On August 9, 2008 Dr. Blonsky issued a letter to Petitioner's attorney in which he stated that he disagreed with Dr. Ghanayem and opined that perhaps Dr. Ghanayem does not truly understand the nature of chronic pain management program. He further stated that it continues to be his opinion that Petitioner would benefit from psychological services and an interdisciplinary chronic pain management program.

19. On April 5, 2009, Dr. Blonsky again saw Petitioner. Petitioner reported recently his left knee buckled and he fell down some stairs and injured to his right elbow. About two years ago, he fell and fractured his right ankle. At this time, Petitioner continues to experience pain in his left buttock which radiates down the back of his thigh to his lateral calf and the ankle. His left foot is numb. He wakens with pain and it is present constantly. He leg feels irritated lying in bed and he constantly has to shift around to try to get comfortable. Petitioner reports he is no longer able to walk the dog and because the dog is too big and strong he pulls him. He is getting about ten hours of sleep throughout the day and night but it is interrupted. He feels constantly fatigued. He experiences more pain in his legs at night and wakes frequently with pain in the calves. He gets cramps and spasms in his calves. His hips are also painful, especially on the left side. His left knee gave out abruptly about two years ago resulting in a fracture of his right ankle. This

occurred again a week before the exam when he fell on some steps. It was his perception that he has a meniscal injury that required an arthroscopy of his right knee. Dr. Newman suggested a possible total knee replacement but he declined that surgery. He has a lot of pain in his left knee but he is holding off treating it at this time. The pain has eased since his right knee surgery. He was recently hospitalized for COPD. He has developed cellulitis of his foot from where they casted his ankle. He is depressed over the death of his mother. He is taking medication for his high blood pressure, has COPD and has trouble sleeping. He states he gave up smoking and has not had alcohol for four months. Dr. Blonsky noted that the findings on the physical examination are similar to those that have been noted previously. One of the unfortunate consequence of his lack of care is that he resumed drinking after being sober for several years. Dr. Blonsky opined that Petitioner's current complaints result directly or indirectly from the February 26, 1998 work injury. He further stated that Petitioner's ability to work is unchanged from his December 4, 2006 opinion. It is his opinion that Petitioner's current condition is permanent in nature and it will not allow him to function at more than a sedentary level of physical activity.

20. On June 4, 2010 Petitioner was evaluated by Dr. Obolsky, a psychiatrist. The doctor noted that Petitioner exhibits the following psychiatric conditions: alcohol dependence, cannabis abuse, cocaine dependence, hallucinogen abuse, substance induced mood disorder with anxiety and sleep dysfunction and substance related disorder. Dr. Obolsky opined that the above conditions are not causally related to the February 26, 1998 work event. In his opinion, Petitioner does not now exhibit any mental, emotional or cognitive impairment that prevents him from gainful employment. Petitioner reported 12 years of sobriety, but since the age of 50 he has been drinking off and on. Additionally, his reported history of 12 years of sobriety is contradicted by the medical records from St. Joseph that indicated he reported he stopped using alcohol in November of 1997. In addition to alcohol, Petitioner reported using LSD, other hallucinogens including marijuana and mushrooms. He also regularly used cocaine and pills, including both uppers and downers. According to the Resurrection Hospital's records, Petitioner reported a history of intravenous drug abuse. He reported alcohol and drug rehabilitation treatments and participating in AA. He reports he has seen six psychiatrists throughout his life which is contradicted by his history to Dr. Blonsky that he said he never saw a psychiatrist or psychologist. Petitioner reports he developed depression in his thirties. Although Petitioner reported current alcohol use and he denied use of other substances, this examiner cannot take his statement at face value. Dr. Obolsky opined that Petitioner is not mentally impaired from gainful activities consistent with his education, training experience and skills. Petitioner has indicated that his physical limitations have affected him emotionally and that is why he is on an anti-depressant. He reported that he does drive but not very often. He reports he has seen approximately six psychiatrists over the years. He also reports his company is no longer active and he basically gave everything up. He stopped paying rent on the building around 2003 when he finally realized he could not do it anymore because of the pain.

21. In a June 30, 2010 vocational rehabilitation report from Mr. Rascati, Petitioner reports his overall condition is poor. His left leg is "dead" to his foot. He must change positions approximately every 10-15 minutes. He explained that he is disillusioned about his condition and about working, noting that his overall condition is poor. During the evaluation, Petitioner took frequent breaks approximately every 15 minutes. He appeared to be easily distracted and had difficulty concentrating and had to be redirected throughout the meeting. The consultant repeatedly had to repeat questions because it appeared he was having difficulty processing and/or concentrating on the questions. Petitioner reports he uses a cane on occasions. He is taking Trazodone. He reported that as a result of the weakness in his leg, he fell and broke his right ankle approximately three years ago. He reported his back injury led to two knee surgeries and now he needs a third. He reported he is unstable in the shower and he uses a whirlpool and massage chair frequently. He does what he can, but he must take frequent breaks approximately every five minutes. He reports he can walk about 4 blocks, but he can stretch it to 6 blocks. He can sit and stand for 10-15 minutes before he has to change positions. Dr. Blonsky's December 4, 2006 and April 5, 2009 reports indicates Petitioner is not currently employable in any capacity. In the second report Dr. Blonsky also said that Petitioner's physical limitations are permanent and he will not allow Petitioner to function in more than a sedentary level. Petitioner reported he does not have an Illinois driver's license as it expired four years ago. He denies presently drinking alcohol. He has a high school education and completed a four year vocational program. Petitioner does not have a computer and does not know how to use one. He loved his job tremendously. He reads blueprints in order to manufacture dies. He worked in sales and has trained employees in this position. He worked his entire adult career as a tool and die maker. He would be classified as a highly skilled employee with 4 to 10 years of specialized training. It can be expected that his reasoning, math, language abilities would fall at the 9-12 grade level. In terms of his physical labor, he would be classified as at a medium level. Based on his work history, Petitioner would present the following transferable skills: performing a variety of duties, attaining precise limits and tolerances, making judgments and decision, analyzing data, speaking and signaling and setting up. Petitioner reported he was very disturbed about the process of not being able to return to his former work. He states he would love to work but cannot imagine functioning in any employment where he needs to sit or stand in one position for any length of time. He stated he feels frustrated and he spends most of his day watching T.V. and pacing around his apartment. He adds that he is pretty much homebound as he does not drive and can only walk a few blocks. He tried to use public transportation but he had difficulties doing so as a result of his current physical state. Petitioner presented a solid and consistent work history but it is also a singular work history having worked solely in the tool and die industry. Thus, Petitioner presents minimal transferable skills. According to Dr. Blonsky, Petitioner is incapable of working and he cannot function at more than a sedentary level. From a vocational standpoint when looking at Petitioner's singular work history, minimal transferable skills and overall presentation along with the fact that he does not drive, had difficulty

ambulating greater than 4-6 blocks, has limited lifting tolerance, had very limited sitting/standing tolerance of 10-15 minutes and appears to have significant difficulty concentrating, it is this consultant's opinion that he is not a candidate for vocational rehabilitation and is not employable.

22. On July 21, 2010, Dr. Kranzler completes a disability certificate for a parking placard. He diagnosed Petitioner as being permanent disabled due to back surgery and he checked a box which stated that there are severe limitations in this person's ability to walk due to an arthritic, neurological or orthopedic condition. On August 26, 2010, Dr. Kranzler noted Petitioner reported his left leg buckled and he broke his right ankle. He ordered studies of the lower extremity. The August 31, 2010 clinical dermatomal and mixed nerve testing of Petitioner's lower extremity showed evidence of the S1 left 1.3 sd//right 1.0 sd. The September 27, 2010 lumbar MRI ordered by Dr. Kransler showed Petitioner's back condition is post laminectomy at L4-5 and L5-S1 on the left. There is a minimal enhancing anterior epidural scar at these two levels. There is a posterior bulging disc with moderate spinal stenosis at L3-4 and mild spinal stenosis at L4-5 level. There are foraminal stenosis bilateral bulging discs at multiple levels with mild foraminal stenosis. The findings are worse at L5-S1 on the left with compromise of exiting left L5 nerve root.

23. Mr. Rascati, a certified rehabilitation consultant, was deposed on February 16, 2011. He testified he was provided the medical reports from Drs. Blonsky and Lofland and referenced her doctors as well. According to Dr. Blonsky, Petitioner is not currently employable in any capacity. He opined that Petitioner is not a vocational rehabilitation candidate based on his medical information, his overall presentation and his lack of concentration. Mr. Racati opined that Petitioner is not employable based on a lack of a return to work release, his minimal transferable skills, his lack of a driver's license and his overall presentation as someone who sees himself as being disabled. On cross-examination, Mr. Rascati stated he does not know how long Petitioner owned his own company after February 26, 1998. His file consists mainly of reports from Dr. Blonsky. He agreed that other than the antidepressant that Petitioner takes Petitioner was not under any treatment from any other doctor for his back. Mr. Rascati testified he was not aware of the fact that Dr. Obulsky determined that Petitioner had alcohol dependence, that he has a history of marijuana abuse, cocaine dependency, hallucinogen abuse, substance induced dysfunction. Petitioner did not tell him he was participating in AA. He does not know if Petitioner's difficulty in concentrating was related to his work accident. He does not have an opinion as to whether Petitioner's problems resulted from his 1998 work accident. He would agree that parts of Petitioner's present vocational problems are the result of his mental or emotional state. He does not have an opinion as to whether or not Petitioner's mental or emotional states are related to his work accident. He is unaware of the fact that Petitioner left Respondent and starting his own business. Petitioner gave him no history of looking for work. He did not know that Dr. Ghanayem found Petitioner could return to work at the light/medium work level.

24. Sharon Babat, a certified vocational rehabilitation counselor was deposed on March 9, 2011. She interviewed Petitioner on November 18, 2010 and was asked to complete a vocational assessment. She had Dr. Blonsky's April 8, 2008 evaluation in which he indicated Petitioner could return to sedentary work. She knew that Dr. Kranzler recommended light duty work while Dr. Obolski on June 4, 2010 stated Petitioner could return to work full time. She did not review any other medical records. She opined that Petitioner does not need vocational rehabilitation to return to his last employment, which was at a light to medium range. He could return to his employment as a machine shop owner. She is not aware of Petitioner attempting to find any employment. She opined that Petitioner has not suffered an impairment of earning potential as a result of his low back restrictions and she opined that there are jobs available to Petitioner. She said Petitioner could be a Tool and Die Company owner/supervisor, a die salesperson, a warehouse manager and lathe machine operator. She noted that Petitioner does not have a driver's license but he is not physically restricted from driving. Petitioner did not say he was under active medical treatment for his low back. Petitioner did not give her a history of past or present substance abuse problems, spending any time in jail, seeing a number of psychiatrists or being diagnosed for depression. Petitioner also did not report to her that he was receiving Social Security Disability benefits (SSDI). Based on Drs. Ghanayen and Obolski's opinions, she opined that Petitioner would be capable of full-time employment in his usual and customary field of machine shop manager or owner. She was not asked to perform a labor market survey.

25. A May 22, 2012 lumbar MRI ordered by Dr. Kransler showed moderate spinal stenosis seen at L3-4 and L4-5 with severe bilateral neural foraminal narrowing at L5-S1 level. On October 31, 2012 Petitioner underwent surgery consisting of a lumbar decompression laminectomy on L5 on the left side. On December 18, 2012, Dr. Kranzler indicated Petitioner was last seen on November 13, 2012. At that time, Petitioner reported he occasionally has shooting pain in the back of his legs. He is now six weeks out from the surgery and he is gradually increasing his activity. He is walking two times a day after using a stationary bicycle. On physical examination, his back reveals no spasm. His wound is healed. He walked well, including on his toes and heals. His sciatic notch was not tender. It was his impression that Petitioner was doing as well as could be expected at this point in time.

26. On January 17, 2013 Dr. Kranzler indicated Petitioner reports he feels the same. He has pain in his left hip, ankle and both calves and numbness in the top and bottom of his foot. He can raise his left leg up to 90 degrees. On exam, his back reveals no spasm. He walked with a limp favoring his left leg. It is his impression that Petitioner is recovering but he still needs four Vicodins a day.

27. On February 21, 2013 Dr. Kranzler indicated Petitioner reports pain in left hip, ankle, foot and toes, which causes him to limp on occasion. Petitioner reports he walks the dog

four times a day. He is walking faster and the pain has improved. He can live with this level of discomfort. All in all, he feels improved. On physical examination there are no spasms. He walks well on toes and heels. His wound is healed. Dr. Kranzler noted that it is his impression that Petitioner is still in pain so he prescribed Norco and opined that Petitioner remains totally disabled from work.

28. On June 6, 2013, Dr. Kranzler diagnosed Petitioner as having chronic pain syndrome, cervical degenerative disc disease and cervical radiculopathy. He noted that Petitioner has been complaining of a stiff neck for the last two months along with numbness in the left arm and occasionally the bottom of the left foot. He recommended that Petitioner be seen at the pain clinic.

29. On June 28, 2013 Petitioner saw Dr. Kiokemeister and reported chronic low back pain with radicular pain for many years. Dr. Kiokemeister noted that Petitioner has chronically use narcotic medications and presently he is on Vicodine or Norco. His pain score is 7 out of 10. He denies the use of alcohol. Dr. Kiokemeister prescribed Advinza and Norco.

30. On January 2, 2014 Dr. Kranzler sent Petitioner's attorney a letter in which he opined that Petitioner's June 1, 1998 surgery seemed directly related to his work accident while the November 11, 2002 and October 31, 2012 surgeries were more likely related to the scar tissue.

31. On February 14, 2014, Dr. Kiokemeister prescribed Methadone and Norco for the Petitioner. Dr. Kiokemeister indicated that Petitioner reported he feels he has improved significantly. With the use of medication, he would estimate his improvement as a 40% since his first visit. On April 11, 2014, Dr. Kiokemeister indicated that Petitioner's cervical MRI that shows significant cervical degenerative disc disease with marked spinal stenosis at C3-C7 most severe at C4-5 and C5-6. There was prominent disc bulging as well as disc osteophytes noted throughout those areas. Petitioner was instructed to continue taking the same medication, follow up on physical therapy and to consider cervical epidural steroid injections. On July 7, 2014, Dr. Kiokemeister refilled the prescription for methadone and Norco.

32. Petitioner testified that Dr. Kiokemeister has provides him pain management treatment on a monthly basis since June of 2013. He prescribes Vicodin and Methadone. Petitioner said he also takes Trazodone for his depression. Currently, he is in bed for a considerable amount of time every day. He can only stand for a couple hours before he experiences severe pain and has to go to bed. In a 24 hour period, he spends approximately 20 hours in bed. He can sit for an hour at a time before he has to adjust his position due to pain. He can walk a couple of blocks at a time. He walks his dog 3 to 4 times a day for 10 minutes at a time. After he returns from the walks, he goes back to lie down in bed. He experiences pain in his low back, left leg and right ankle. He experiences back spasms. His left leg still gives out. During an average day, he wakes up at 1:00 or 2:00 p.m. He

sleeps 12 hours at night and gets up 4-5 times a night. The Trazodone does not work as a sedative. It puts him asleep, but it does not keep him asleep. He is constantly repositioning himself due to the pain. He can only lay on his left side with his legs straight out. He gets the majority of his food from Meals on Wheels. His son also takes him grocery shopping and he likes to make spaghetti, barbecue and roasts. Petitioner testified he has a current driver's license, but he does not feel safe driving because his left leg gets numb when he sits and drives. He does do some minimal driving to his AA meeting twice a week. He is currently sober and has been for the last four years. He used cocaine a long time ago and he used to smoke pot. He used to be an avid skier, coach football and baseball, fish, bowl and shoot pool. He cannot do these activities with his five grandsons. He gets aggravated easily due to his current life circumstances. It took him a long time to reach his level of success in business and then it was all taken away after the accident. Since he stopped working he had become severely depressed and he started drinking again. He also got divorced and was self-medicating. He had been sober for twelve years prior to the accident. He attributes his depression to his low back injury. He is presently receiving SSDI benefits. He has not been offered any vocational rehabilitation. He was born on February 6, 1950. His highest level of education is high school. He is not computer literate. He was trained in the tool and die field for over five years. He has not held any other jobs outside the tool and die field in the last 30 years. He used to be proficient in math. He is good at reading blueprints and he had trained people to work in tool and die. He also has experience in sales and tool design. He has not sought any employment or vocational training on his own. Currently, he is "permanently disabled" and he has grown accustom to being in bed for 20 hours a day. Dr. Kranzler has not released him to return to work in any capacity. While he has not been told by any doctor that he has a "dead" leg, Petitioner said his left leg is dead and it has no value for him. While testifying today, he is depressed, aggravated, agitated and irritated. He did not drive himself to the hearing because it would have been irritating and he could not handle it mentally. He did not have any physical concerns about driving. A friend drove him to the hearing. This is the same friend that brings him cigarettes.

Based on the above, the Commission finds that Petitioner is not credible. The Commission finds that the record is replete with numerous inconsistencies between Petitioner's overall testimony and the information he provided to the medical and vocational rehabilitation personnel alike. These inconsistencies all factor into what weight to place on Petitioner's subjective pain complaints and the extent the permanent disability that arose out of the February 26, 1998 work accident. More specifically, Petitioner provides varied information as to whether he is currently capable of driving and/or whether he owns a vehicle. On the one hand, Petitioner tells both vocational rehabilitation personnel that he does not have a current Illinois driver's license and/or car. Yet, he acts in a contradictory manner when he asks Dr. Kranzler, at/around the same time he is interviewed by both the vocational rehabilitation personnel, to complete a disability certificate for a parking placard. When this is viewed along with the fact that he also tells Dr. Obolsky he drives and he testified at Arbitration that he specifically drives

to AA meetings, the Commission had to question the veracity of the statement he provides to the vocational rehabilitation counselors. A similar contradiction arises when Petitioner reports to Dr. Blonsky on April 5, 2009 that he is no longer able to walk his dog but he tells Dr. Kranzler on February 21, 2013 and the Arbitrator on August 21, 2014 that he walks his dog three to four times a day. Obviously, the latter scenario shows that Petitioner is more active than he led some of the doctors to believe and this factors into the issue of permanent disability. Yet, a further contradiction arises when Petitioner tells Dr. Obosky that he has seen six psychiatrists over his life time. However, he tells Dr. Blonsky that he has not seen any psychiatrist/psychologist before. Furthermore, in 2008, both Drs. Surath and Ghanayem notice that Petitioner is using alcohol during their examination/treatment. Yet, Petitioner tells Dr. Obolsky in 2010 that he has been sober for the last 12 years and he tells Dr. Blonsky on April 5, 2009 that he has not used alcohol in the last four months. The earlier statement is questioned by Dr. Obosky at the time he is taking Petitioner's history and he notes that the St. Joseph's Hospital records contract Petitioner's history that he is not abiding in alcoholic beverages. In addition to the contradictions, it appears that Petitioner is overusing prescribed narcotic medication. More specifically, this is noted in the March 26, 2008 entry from Dr. Surath's office when Petitioner requested his medication earlier than usual and it was noted that he has been repeatedly counseled that he cannot have his medication early. The Commission finds that all of these inconsistencies lead the Commission to question Petitioner's credibility as a whole and it requires the Commission to place additional scrutiny on Petitioner's subjective pain complaints in relationship to the extent of Petitioner's permanent disability. Furthermore, Petitioner's inconsistencies require the Commission to take a closer look at the foundation bases for both the doctors' and vocational rehabilitation personnel's causation opinions.

Having reviewed both vocational rehabilitation counselors' reports and depositions, the Commission finds that both reports are lacking vital medical information which is needed to correctly assess Petitioner's current condition. More specifically, Mr. Rascati was only provided with Drs. Blonsky and Loflands records and not Drs. Ghayayem and Obolski records. While Ms. Babat was provided Dr. Blonsky's April 5, 2009 evaluation, she did not indicate she was provided his subsequent December 4, 2006 and April 5, 2009 evaluations where his recommendation changed from Petitioner being able to work sedentary employment to not being able to work at all. Furthermore, a review of Mr. Rascati's cross-x testimony and Ms. Babat's direct testimony demonstrates that they were not given Petitioner's complete medical history and as such their opinions on Petitioner's ability to work/not work are incomplete.

In terms of the doctors themselves, Drs. Blonsky and Lofland find that Petitioner is medically permanently and totally disabled while Drs. Ghayayem and Obolski find that Petitioner is capable of working in some capacity. This case is further complicated by the fact that Petitioner owned his own business and he voluntarily removes himself from the job market by quitting/ceasing the operating his business. On or about that time, in

addition to closing down his business, Petitioner was dealing with personal matters such as his divorce and he became depressed and started drinking again. The Commission notes that after May/June of 2003 Petitioner does not receive treatment, other than prescription drugs, for his low back again for an additional period of 7 years. While Petitioner treats with Dr. Surath some time on/around April of 2007 and Dr. Surath notes Petitioner has a chronic back issue. Dr. Surath's treatments consist solely of prescribing Trazadone, Vicodin and Tylenol. When Petitioner receives back treatment again he does so at the behest of his attorney some seven years removed from his last treatment. Additionally, while Petitioner has yet another surgery in 2012, post-surgery Petitioner still has the same complaints and is provided the same treatment he had prior to the latest surgery. Additionally, while the origination date was not specified, it is also clear that at some point on/around 2010 Petitioner starts receiving SSDI and as such he further removed himself for the job market. Given Petitioner's addictive personality, the fact that his treatment is based solely on his subjective pain complaints, his general lack of veracity as evidenced by the facts in this case, the lack of treatment for seven year period and failure of any additional treatment to alleviate Petitioner of his pain complaints, the Commission finds that the chain of events does not support Petitioner's claim that his subjective low back/leg pain complaints are sufficient to support the claim that his current condition is causally related to the February 26, 1998 accident. The Commission combines all of these findings to the previous findings of the Arbitrator and affirms the Arbitrator's decision.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $666.67 per week for a period of 61-3/7 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 $600.00 per week for a period of 200 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 40% loss of a man as a whole.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for $21,478.68 paid to or on behalf of Petitioner on account of said accidental injury.

15IWCC0533

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: JUL 15 2015

Mario Basurto

MB/jm

David L. Gore

O: 6/4/15

Stephen Mathis

43

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ILLINOIS WORKERS' COMPENSATION COMMISSION
INSURANCE COMPLIANCE DIVISION,

Petitioner,

18IWCC0014

vs.

NO. 12 INC 643

ADAM PUROL, INDIVIDUALLY & AS PRESIDENT OF
A & E ROOFING and A & E ROOFING,

Respondents.

DECISION AND OPINION ON COMPLAINT FOR INSURANCE NON-COMPLIANCE

This matter comes before the Commission on an action by the Illinois Workers' Compensation Commission Insurance Compliance Division. A hearing was held in Chicago before Commissioner Simpson on August 29, 2017. Petitioner was represented by the Office of the Illinois Attorney General and Respondent was appeared *pro se* with the benefit of an interpreter. Mr. Purol was allowed to represent himself but as a non-attorney he could not represent A & E Roofing. A record was taken.

Findings of Fact & Conclusions of Law

1. Don Johnson testified he has been Lead Investigator for the Illinois Workers' Compensation Commission Insurance Compliance unit for about 9 years, investigating whether businesses carry workers' compensation insurance. In his investigations, Mr. Johnson uses numerous tools, including data from the National Council on Compensation Insurance ("NCCI"). He has used that resource hundreds of times in his job.

2. Mr. Johnson also testified he was assigned to investigate the circumstances of a claim filed by Jan Duda against A & E Roofing, which is owned by Respondent Purol. The date of that accident was March 17, 2007. The Illinois Injured Workers' Benefit Fund paid $65,352.52 on that claim. The total award was actually $233,500.00.

3. In his investigation, the witness obtained a certification from the Workers' Compensation Self-Insurance Division indicating neither A & E Roofing nor Mr. Purol was a registered self-insured entity at the time of Mr. Duda's accident. Mr. Johnson then inquired about insurance coverage through NCCI. Mr. Johnson determined that Respondents had workers' compensation insurance from September 18, 2004 to September 18, 2005 and then purchased insurance effective from March 21, 2010 to March 21, 2011. However, that policy was cancelled on the day it was to become effective. Respondents also did not have workers' compensation insurance from September 19, 2006 through March 20, 2007. Respondents' insurance was also cancelled on September 18, 2005 for non-payment of premium. In addition, as of July 30, 2014, "Mr. Purol was claiming carpentry class of employees with the construction of residential dwelling not exceeding three-stories in height." The premium for that standard policy was $730.00 annually.

4. Mr. Johnson's office sent Mr. Purol a notice of non-compliance dated May 21, 2008. There was also notice for Mr. Purol to attend an informal insurance non-compliance hearing. No settlement was reached at the informal hearing.

5. On cross examination by Mr. Purol through the interpreter, Mr. Johnson was asked whether he knew one is required to have two types of insurance in order to obtain a roofing contractor license in the State of Illinois. Mr. Johnson testified he did not know of insurance requirements for roofing contractors other than the requirement that they have workers' compensation insurance.

6. Mr. Purol testified in a narrative manner through the interpreter. He has worked as a contractor for 32 years and as a licensed roofing contractor for 30 years. He never had any problems until the alleged work accident. He acknowledged "that there have been some issues of nonpayment" but that was due to his insurance carrier, Omega not providing proper notice that payment was due. He tried to work within the law and believed he "has always done honest work."

7. On cross examination, Mr. Purol agreed that he was experienced in roofing and was a businessman. He did not have proof about Omega not providing proper notice, because there was a fire at his home in 2009. He inquired about obtaining information but learned that Omega was out of business. He also acknowledged that at the time of Mr. Duda's accident he did not have workers' compensation insurance, but he thought he had insurance at the time. He knew that roofers needed such insurance. Roofers also need liability insurance.

8. Mr. Purol also testified that Mr. Duda worked for him on some jobs for about two years prior to his accident, but he also did other side jobs. Mr. Purol taught him how to pull off and install shingles. He checked Mr. Duda's work to make sure the work was done correctly.

9. Petitioner submitted into evidence documentation verifying the testimony of Mr. Johnson.

The Commission finds that Petitioner proved that Respondent Adam Purol, individually and as President of A & E Roofing, knowingly and intentionally operated his business without workers' compensation insurance, as required by the Act. Mr. Purol admitted that he knew he needed workers' compensation insurance and that he did not have such insurance when his employee, Jan Duda, sustained a work-related accident and serious injuries therefrom. It appears that Mr. Purol intentionally manipulated the system by obtaining workers' compensation insurance simply to renew his license and then cancelled it the same day. By circumventing the workers' compensation insurance for several years, Mr. Purol obtained an unfair competitive advantage against other roofing companies that complied with the law. Mr. Purol's lack of insurance resulted in substantial liability for the State of Illinois Injured Workers' Benefit Fund, reduction of benefits to other recipients of awards paid by the Fund, and the substantial likelihood that Mr. Duda will never be fully compensated for his accident and injuries.

The Commission notes that Petitioner's business was roofing, a business involved in construction/remodeling/demolition, which are categories the Act delineates as "extra hazardous" for which workers' compensation insurance is "automatically" mandated. 820 ILCS 305/3. This is not a situation in which the respondent was operating a service-oriented business such as an accounting firm *etc.*, in which one would not necessarily expect a multitude of injuries and the need for such insurance may not be as obvious. The Act provides for a fine of up to $500 a day for not having required insurance. Because Respondent intentionally and knowingly failed to maintain workers' compensation insurance for many years, because he apparently flagrantly manipulated the process to maintain his license, because he operated for years with a competitive advantage in the profession by operating without incurring the expense of insurance, because of the inherently dangerous nature of his business, and because Mr. Purol's failure to maintain insurance, resulted in substantial harm to his prior employee, the Fund, and the other recipients of benefits from the Fund, the Commission finds no reason to assess less than the fine specified in the Act.

The Commission finds that Petitioner proved that Respondent intentionally and knowingly operated without the required workers' compensation insurance for 1,279 days, from September 19, 2006 through March 20, 2011. Pursuant to Section 4(d) of the Act, the Commission imposes a fine of $639,500.00. In addition, the Fund seeks reimbursement of $65,353.52 it paid pursuant to the award to Mr. Duda for the injuries he sustained while employed by Respondent and A & E Roofing under 07 WC 13540/13 I.W.C.C. 552. The Act provides that "the Commission shall have the right to obtain reimbursement from the employer for compensation obligations paid by the Injured Workers' Benefit Fund." 805 ILCS 305/4(d). Therefore, the Fund is entitled to an order of reimbursement.

IT IS THEREFORE ORDERED BY THE COMMISSION Petitioner's request for fines is hereby granted.

IT IS FURTHER ORDERED BY THE COMMISSION, that Respondent, Adam Purol, individually and as President of A & E Roofing and A & E Roofing as a separate entity, pay to the Commission $639,500.00 for knowingly and intentionally failing to maintain workers' compensation insurance for 1,279 days, pursuant to §4(d) of the Act.

18IWCC0014

IT IS FURTHER ORDERED BY THE COMMISSION, that Respondent, Adam Purol, individually and as President of A & E Roofing and A & E Roofing as a separate entity, reimburse to the Injured Workers' Benefit Fund $65,353.52 it paid pursuant to the award to Mr. Duda under 07 WC 13540/13 I.W.C.C. 552 for the injuries he sustained while employed by Respondent and A & E Roofing.

Bond for the removal of this cause to the Circuit Court by Respondents is hereby fixed at the sum of $75,000.00. The party commencing the 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: JAN 5 - 2018

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

DLS/dw
O-12/14/17
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	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOHNNY BAGGETT,

Petitioner,

vs. NO: 12 WC 43173

II in ONE CONTRACTORS,

18IWCC0015

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 temporary total disability, nature and extent, and penalties, 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.

This matter came up for hearing on November 17, 2016 and December 16, 2016. The Request for Hearing form reflects that the parties stipulated to temporary total disability benefits commencing December 7, 2012 through April 23, 2015, representing 123 6/7 weeks at $1,166.67 per week. The Decision by the Arbitrator gave a credit of $144,500.43 to Respondent but failed to award the temporary total disability benefits stipulated to by the parties. The Commission hereby modifies the Decision to reflect the stipulation regarding temporary total disability benefits.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,166.67 per week for a period of 123 6/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $695.78 per week for a period of 175 weeks, as provided in §8(d)2 of the Act, for the

18IWCC0015

reason that the injuries sustained caused the loss of use of 35% of the person as a whole.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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: JAN 5 - 2018
o: 11/9/17
SM/msb
44

Stephen Mathis

Deborah Simpson

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BAGGETT, JOHNNY
Employee/Petitioner

Case# **12WC043173**

II IN ONE CONTRACTORS
Employer/Respondent

18IWCC0015

On 3/10/2017, 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 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:

0274 HORWITZ HORWITZ & ASSOC
MITCHELL W HORWITZ
25 E WASHINGTONST SUITE 900
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
TAMMY PAQUETTE
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

18IWCC0015

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 Baggett
Employee/Petitioner

v.

Il in One Contractors
Employer/Respondent

Case # **12 WC 43173**

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 Milton Black, Arbitrator of the Commission, in the city of **Chicago,** on **November 17, 2016 and December 16, 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: **8(d)(1) benefits from April 24, 2015 through November 17, 2016**

FINDINGS

On **November 12, 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $91,000.00; the average weekly wage was $1,750.00.

On the date of accident, Petitioner was **54** years of age, ***single*** with **2** dependent children.

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

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

Respondent shall be given a credit of **$144,500.43** 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 be given a credit of $144,500.43 for temporary total disability benefits that have been paid.

Petitioner failed to establish an entitlement to any 8(d) (1) benefits; therefore those benefits are hereby denied.

Respondent shall pay Petitioner permanent partial disability benefits of $695.78/week for 175 weeks, because the injuries sustained caused the 35% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Petitioner's claims for penalties and attorneys' fees 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.

Walter Black

Signature of Arbitrator

March 10, 2017

Date

MAR 10 2017

FACTS

At the time of this accident, Petitioner was a cement finisher for the Respondent. He testified that while working a buffer machine, it struck a pipe on a floor and he was then struck in the abdomen and pinned against a wall.

Petitioner was initially seen at Associated Medical Center of Illinois on December 7, 2012. Petitioner was voicing pain complaints in the low back, right arm tingling and right lower extremity numbness. Petitioner' had tenderness and increased tone through the lumbar spine but range of motion was full with pain. The impression was cervical radiculopathy, acute lumbar strain and lumbar radiculopathy. Petitioner was taken off work at that time. (PX 9)

Petitioner continued to voice pain complaints and followed up with Dr. Foreman. On January 7, 2012, he recommended that Petitioner undergo an MRI of the cervical and lumbar spine and progress to a more active physical therapy program. (PX 9)

An MRI of lumbar spine was performed on February 6, 2013 and revealed no frank disc herniations and degenerative changes from L3-S1. (PX 1) Petitioner continued physical therapy and massage therapy through February 14, 2013. On February 18, 2013, Petitioner was referred to a pain specialist for possible injections. Therapy then continued through Dr. Foreman's facility until March 25, 2013 at which point a functional capacity evaluation was ordered. (PX 9)

Petitioner underwent an MRI of the cervical spine at Preferred Open MRI on February 13, 2013, which revealed no herniations but stenosis and a protrusion at C6-C7. (RX 7)

Petitioner underwent a right paramedian interlaminar lumbar epidural steroid injection at L4-L5 on February 28, 2013, administered by Dr. Marsiglia. (PX 6)

On March 14, 2013 Petitioner underwent a midline interlaminar epidural steroid injection at L3-L4 administered by Dr. Marsiglia. (PX6)

Petitioner underwent a functional capacity evaluation at AMCI on March 29, 2013 which placed him at a medium-heavy capacity. (PX 9)

On March 28, 2013, Petitioner underwent a right paramedian interlaminar cervical epidural steroid injection at C7-T1 performed by Dr. Marsiglia. (PX 6)

On April 2, 2013, Petitioner underwent a work conditioning evaluation at AMCI. It then was recommended that he undergo work conditioning 3 times a week for 3 weeks. (PX 9)

Petitioner continued with work conditioning until he was found to have plateaued with conservative treatment on April 22, 2013, and he was released from Dr. Foreman's care. (PX 9)

Petitioner was seen by Dr. Sokolowski on April 24, 2013. Petitioner was complaining of neck pain with radiation to the bilateral periscapular regions, lumbar pain with radiation to the right buttock and right lower extremity, burning an paresthesias along with shoulder pain, all subsequent to a work

related accident. Petitioner was diagnosed with cervical pain, cervical radiculopathy at C7 and C8 nerve roots, lumbar pain, lumbar radiculopathy and bony contusion identified on MRI in the pedicle of L3-5. It was recommended that he undergo a functional capacity evaluation to determine treatment options. (PX 3)

On May 6, 2013, Petitioner underwent a functional capacity evaluation at AMCI, which placed him at a light-medium demand level. (PX 9)

Dr. Singh examined Petitioner on May 20, 2013. Petitioner was complaining of neck pain and lower back pain. Based on his evaluation and review of the scans, Dr. Singh found that Petitioner had sustained a cervical strain, had sustained a muscle strain, and had pre-existing degenerative disc disease at L5-S1. (RX 1)

Petitioner commenced work conditioning at Accelerated Rehabilitation on June 4, 2013. At the time of his initial evaluation he was able to perform 77.8% of his job duties as a cement mason. Petitioner continued work conditioning through July 3, 2013 at which point he was discharged at the direction of his doctor. (PX 8)

Petitioner returned to Dr. Sokolowski on June 12, 2013. At that time he was continuing with pain complaints and indicating that the pain was adversely affecting his quality of life. He was advised to remain off work and continue with work conditioning. (PX 1)

On July 15, 2013, Petitioner returned to Dr. Marsiglia with continued complaints of pain in the neck and low back. Petitioner was given permanent restrictions at a light physical demand level and released from care. (PX 6)

Dr. Singh examined Petitioner a second time on August 5, 2013. Petitioner was continuing to voice complaints of pain throughout his back. (RX 1, p. 15-16) Dr. Singh opined that Petitioner required work conditioning to allow a full duty return to work and that he did not see any reason for restrictions. (RX 1)

Dr. Singh authored a third report dated January 26, 2015, after reviewing video surveillance. The surveillance depicted Petitioner entering and exiting his truck, carrying bags from a grocery store, and lifting cases of beer into a grocery cart. Dr. Singh opined that the surveillance affirmed his opinions regarding Petitioner's pain complaints and validity of Petitioner's efforts during exams. Dr. Singh further opined that Petitioner could return to work in a full duty capacity. (RX 1)

Based on Dr. Singh's opinion, benefits were terminated as of April 23, 2015.

Petitioner was examined by Dr. Sokolowski on September 1, 2015. He also reviewed the video surveillance. Dr. Sokolowsi opined that the surveillance did not change his opinion regarding Petitioner's abilities to return to work. (PX 3)

Dr. Sokolowski's deposition took place on October 22, 2015. He testified that while Petitioner may have had the changes within his spine prior to the accident, those were rendered symptomatic by the work injury and that Petitioner did continue to require permanent restrictions. Dr. Sokolowski testified that the fact that Petitioner continued to have the same complaints and objective findings

along with the fact that he was asymptomatic prior to the alleged work injury all led him to conclude that Petitioner's condition and his need for restrictions were in fact related to the alleged work injury. Dr. Sokolowski testified that Petitioner would be capable of doing some sort of work. (PX 3)

The deposition of Dr. Kern Singh was taken on December 17, 2015 and he testified that in his opinion Petitioner could return to work in a full duty capacity. (RX 1)

CAUSATION

Petitioner has had continued complaints, albeit embellished, since his work accident. The sequence of events is consistent. The medical records are corroborative. Dr. Sokolowski's testimonial opinions are persuasive.

Therefore, the Arbitrator finds that Petitioner's alleged current condition of ill-being is causally related to the work injury of November 12, 2012.

NATURE AND EXTENT

Petitioner has sustained a career ending injury. However, he has embellished his symptoms. His claim of entitlement to wage differential benefits must be based upon credible testimony of actual physical limitations. Such actual physical limitations cannot be determined in the absence of reliable testimony.

Therefore, the Arbitrator finds that Petitioner's claims for any wage differential benefits are denied.

The Arbitrator further finds that Petitioner is entitled to be compensated for a loss of trade.

Based upon the foregoing, the Arbitrator finds that Petitioner has sustained the 35% loss use of the person as a whole.

PENALTIES

Based upon the preceding analyses, the Arbitrator finds that Petitioner's claims for penalties and attorneys' fees are 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 Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jorge D. Moran,

Petitioner,

vs. No. 14 WC 16477

18IWCC0016

Chicago Custom Home Builders, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, prospective medical care and temporary 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, medical benefits or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327 (1980).

The Arbitrator found that both the left wrist and right shoulder conditions of ill-being are causally connected to the work accident. For the reasons that follow, the Commission disagrees that Petitioner proved his right shoulder condition is causally connected to the accident.

Petitioner testified that on April 10, 2014, he injured his left wrist and felt pain in the right shoulder when he stepped/fell into a trench while carrying a heavy window. Petitioner's witnesses, Christian Calderon and Eduardo Garcia, testified that Petitioner fell while carrying a window. Neil Regan, Respondent's president, testified that Petitioner complained of soreness in his hand. Mr. Regan did not witness the accident. Petitioner in his testimony admitted a prior

injury to the right shoulder. He testified the shoulder injury was work-related and he had not received any treatment for it.

The medical records in evidence show that on April 26, 2014, Petitioner sought treatment at Nuestra Clinica "due to a work injury that occurred on 3/26/2014. The injury occurred while he was *** at work, pt and a co-worker lifted a long beam about 22 ft long weighing approx 230 lbs, upon entering the doorway the coworker dropped his end and the beam fell on pt's Rt shoulder. Pt felt pain of the shoulder and informed his manager/Ricardo, this occurred on 3/26/14. On 4/10/2014, pt and a coworker was carrying a window weighing approx 180-200 lbs, pt and coworker entered the doorway and ground gave in and pt fell toward the Lt side and struck the shoulder and hurt his Lt wrist. Pt was able to hold on to the window with his coworker while at his job." Petitioner complained of pain in the right shoulder and left wrist.

On May 30, 2014, Petitioner consulted Dr. Sclamberg, an orthopedic surgeon. Dr. Sclamberg noted a history of right shoulder injury on March 10, 2014, and a left wrist injury with a right shoulder reinjury in April of 2014. Dr. Sclamberg noted the following mechanisms of injury: "In March of this year, [the patient] was carrying a 200-pound beam with a supervisor and the supervisor went to throw the beam and the patient took all the weight on his right-dominant side, felt a pop in his right shoulder with pain;" and "In April 2014, he was carrying a 30-pound window, walking on loose ground, and fell on his outstretched left wrist and hand." An MRI of the right shoulder performed May 31, 2014, showed acromioclavicular joint hypertrophy. An MRI arthrogram performed November 4, 2014, showed "[m]ild changes of acromioclavicular arthropathy."

Having carefully considered the evidence before us, the Commission finds Petitioner failed to prove his right shoulder condition is causally connected to the work accident on April 10, 2014. Petitioner alleges injuring his right shoulder on March 26, 2014, but such claim is not before this Commission. The mechanism of injury and resulting medical treatment is inconsistent with an injury occurring regarding Petitioner's right shoulder. Accordingly, the Commission denies the medical bills Petitioner incurred relative to the right shoulder condition. All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 17, 2015, 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 $400.00 per week for a period of 33 6/7 weeks, from June 4, 2014, through January 27, 2015, 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, medical benefits or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the medical bills in evidence that are related to the left wrist injury, pursuant to §§8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall provide prospective medical care recommended by Dr. Irvin Wiesman consisting of left wrist surgery and necessary follow-up care, 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.

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: JAN 5 - 2018
o-11/09/2017
SM/sk
44

Stephen Mathis

L. Elizabeth Coppoletti

David L. Gore

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

MORAN, JORGE D
Employee/Petitioner

Case# **14WC016477**

CHICAGO CUSTOM HOME BUILDERS INC
Employer/Respondent

18IWCC0016

On 3/17/2015, 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 0.14% 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:

0147 CULLEN HASKINS NICHOLSON ET AL
JOSE M RIVERO
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

1120 BRADY CONNOLLY & MASUDA
MATTHEW P SHERIFF
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

18IWCC0016

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)

Jorge D. Moran
Employee/Petitioner

v.

Chicago Custom Home Builders, Inc.
Employer/Respondent

Case # 14 WC 16477

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 **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **January 27, 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 _____

18IWCC0016

FINDINGS

On the date of accident, **April 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 **$31,200.00**; the average weekly wage was **$400.00**.

On the date of accident, Petitioner was **33** 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 **$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 for the reasonable and necessary medical services, pursuant to the medical fee schedule, of $14,385.41 to Nuestra Clinica, $1,158.24 to Chicago Pain & Orthopedic Institute, $3,000.00 to Buck town Open MRI, $200.00 to Grey Medical, $4,162.12 to RX Development, Archer MRI in the amount of $1,500.000, and $345.38 to Illinois Orthopedic Network, pursuant to the medical fee schedule or by prior agreement, whichever is less, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $400.00/week for 33-6/7 weeks, commencing 6/4/2014 through 1/27/2015 as provided in Section 8(b) of the Act.

Respondent shall authorize and pay for the prospective medical care recommended by Dr. Irvin Weisman consisting of the surgery and any necessary follow-up care including 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.

Deborah L. Simpson
Signature of Arbitrator

March 16, 2015
Date

ICArbDec19(b)

MAR 17 2015

18IWCC0016

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jorge D. Moran,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 14 WC 16477**
	)	
Chicago Custom Home Builders, Inc.,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on April 10, 2014, 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.

At issue in this hearing is as follows: (1) Did the Petitioner sustain accidental injuries or was she last exposed to an occupational disease that arose out of and in the course of employment; (2) Was Respondent given notice of the accident within the time limits stated in the Act; (3) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (4) What were the Petitioner's earnings during the year preceding the injury and what was his average weekly wage, calculated pursuant to Section 10 of the Act; (5) Is the Respondent liable for the unpaid medical bills to Nuestra Clinica ($14,385.41) Chicago Pain and Ortho ($1,158.24), Bucktown Open MRI ($3,000.00), Gray Medical ($200.00), RX Development ($4,162,12), Archer Open MRI ($1,500.00) and ION ($345.38); and (6) Is Petitioner entitled to TTD from June 4, 2014 through January 27, 2015.

The Petitioner testified with the assistance of Mr. Joseph Bonura, a certified interpreter, who was duly qualified under oath and accepted by the Arbitrator and the Attorneys for both parties.

STATEMENT OF FACTS

On April 10, 2014, the petitioner was working as a general laborer for the respondent, Chicago Custom Home Builders. The petitioner testified that he started in late August of 2013, and had been working for the respondent since that time.

The Petitioner worked as a laborer for Chicago Custom Home Builders, the Respondent, for about eight months prior April 10, 2014. The Petitioner testified that he did demolition work, cleaning up, putting garbage in dumpsters, putting materials in homes and painting. Petitioner testified that sometimes he did repairs as well. Petitioner testified that on April 10 2014, he was working at a home located at 1820 N. Hudson. There he was helping install new windows. He

testified that that he and his co-worker, Christian Calderon, were carrying the windows that had been delivered and left near the sidewalk of the home to the house. Petitioner testified that the yard was fenced in and there was a gate from which he would have to enter to get to the houses main entrance.

Petitioner also testified that in the yard and near the pathway to the main entrance there was a trench that he had dug earlier. Petitioner testified that the trench was about ten feet long, 2 feet wide and four feet deep. Petitioner testified that he was carrying one of the heavier windows weighing approximately 200 pounds along with Christian when he stepped on loose dirt causing him to partially fall into the trench. Petitioner testified that he did not let go of the window but rather he tried to sustain his grip as the window fell and his right leg fell into the trench. His left hand was pinned between the window and a temporary wall that had been built there for purposes of the construction being done. Petitioner testified that he immediately noticed pain from the pressure in his left hand and pain in his right shoulder, he could not move because of the position he was in. Petitioner testified that an electrician that was nearby, named Eduardo, helped him get out of the hole.

The Petitioner attempted to describe the scene and the surroundings. Eventually a drawing was rendered by the Petitioner's own hand, and admitted into evidence as Joint Trial Ex. 1. This exhibit demonstrated the location of the front door of the house, where the windows were placed on the street, as well as the path the Petitioner took attempting to take the windows from the street to the front door.

Petitioner testified that his employer, Neil Regan was present at the site that day. Petitioner testified that he continued to work that day despite his hand pain. At the end of the day, he notified Neil Regan about the accident that had occurred that day. Petitioner testified that Mr. Regan suggested that he seek medical care with an acupuncturist, which would cost about $40.00. Petitioner testified that he did not go because he was afraid of needles.

Petitioner testified that he had previously injured his right arm at work on or about March 26, 2014 but sought no treatment for the injury. He did not lose time from work for the injury either.

Petitioner continued to work for Respondent for the following two weeks until he sought medical care with Dr. Joseph Santiago of Nuestra Clinica of Chicago on April 26, 2014. There, a history was recorded indicating that "on April 10, 2014, patient and co-worker was carrying a window weighing approximately 180 to 200 pounds, patient and co-worker entered the doorway and ground gave in and patient fell forward, the left side struck the shoulder and it hurt his left wrist". (PX. 2, pg. 70). The Petitioner was placed on light duty with restrictions for use of his left hand.

Petitioner's last day of work for the Respondent was April 25, 2014. Respondent was not able to accommodate the restrictions; Petitioner testified that thereafter he worked for Collin's Construction in a light duty capacity through June 3, 2014. During this time he continued to receive physical therapy from Dr. Santiago at Nuestra Clinica (PX. 2).

On May 30, 2014, Petitioner saw Dr. Steven Sclamberg of Chicago Pain & Orthopedic Institute upon the referral of Dr. Santiago. (PX.3, pg. 3). On that day, Dr. Sclamberg diagnosed

Petitioner with left scaphoid wrist fracture and right shoulder pain and recommended he have MRI's of both body parts. (PX.3, pg. 4).

MRI's were performed on August 31, 2014. The MRI of the left wrist revealed a minimally displaced complete acute fracture of the scaphoid bone. (PX.3, pg. 24). The MRI of the right shoulder was essentially normal.

Petitioner followed up with Dr. Sclamberg on June 20, 2014, upon review of the MRI's Dr. Sclamberg diagnosed Petitioner with right shoulder impingement and a left wrist scaphoid fracture. He recommended Petitioner continue physical therapy and wear a brace for the left wrist.

On August 15, 2014, Dr. Sclamberg recommended that Petitioner undergo a CT scan of the left wrist and on September 16, 2014 he reviewed those results. (PX. 3, pgs. 8 & 10). He went on to recommend Petitioner undergo hand surgery for further evaluation of his right wrist and provided Petitioner with an injection to the wrist to relieve him of his continued pain. (PX. 3, pg. 11).

On October 24, 2014, Dr. Sclamberg noted continued pain in the right shoulder and recommended Petitioner undergo an arthrogram with the right shoulder. (PX. 3, pg 13). He also suggested a referral for possible open reduction internal fixation of the right wrist. Petitioner underwent the right shoulder arthrogram on November 4, 2014, which revealed mild changes of acromioclavicular arthropathy. (PX. 3, pg. 19).

On December 1, 2014, Petitioner was evaluated by Dr. Irvin Weisman a Hand Specialist with the Illinois Orthopedic Network. (PX. 8, pg. 4). Dr. Weisman diagnosed Petitioner with painful non-union of the left scaphoid fractured at the wrist. Dr. Weisman recommended he undergo a percutaneous pinning of the scaphoid. (PX. 8, pg. 4). At hearing, Petitioner testified that he has opted to undergo this procedure. Petitioner has not worked since June 3, 2014.

Petitioner testified that he was earning $15.00 an hour for wages, and was paid by a check, some of which was introduced into evidence (Pet. Ex. 10). Petitioner testified that he was paid for forty hours per week. He testified further that he usually worked between 55 and 60 hours per week but was not paid overtime for the additional hours that he worked. Respondent also presented a wage statement which indicated Petitioner's wages earned from August 7th start date to his last day worked of April 25, 2014. (Resp. Ex. 1).

The checks presented also reflected money that the Petitioner was purportedly paid to reimburse him for materials he may have purchased for various jobsites on various days covering certain time periods, and the amounts were not delineated on the checks presented as evidence. The Respondent's wage statement introduced into evidence indicated the gross amount paid to the Petitioner throughout the time that he worked for the Respondent, and indicated a grand total of $20,114.00. (Res. Ex. 1).

On cross-examination Petitioner testified that Christian Calderon is a friend of his that he has known for 7 years and they met through his uncle.

In Rebuttal the Petitioner offered the testimony of Christian Calderon who testified that he recalled Petitioner injuring himself while carrying a window on April 10, 2014. Mr. Calderon believed that the window weighed approximately 200 pounds and that as they were approaching

the main entrance the Petitioner slipped and fell and injured himself. Mr. Calderon did not recall a wall being near the pathway nor could he recall how he or the Petitioner were holding the window as they were carrying it.

Eduardo Garcia also testified on behalf of the Petitioner, in rebuttal. Mr. Garcia testified that he was present on April 10, 2014 and that he saw Petitioner fall into the trench. He testified that he helped the Petitioner get out of the trench by helping him grab the window. Mr. Garcia testified that he worked for an independent electrician on that site and did not work for the Respondent. Mr. Garcia indicated that he is not a friend of the Petitioner but knew him from other job sites.

Neil Regan, Owner of Chicago Custom Home Builders testified at the hearing on behalf of the Respondent. Mr. Regan testified that on April 10, 2014 he was present in and out at the construction site at 1820 N. Hudson. He testified that he was circulating between at least three job sites that day. Mr. Regan testified that he was on the jobsite that morning, noticed that the windows had been delivered, and instructed the workers regarding bringing the windows into the home and then installation of the windows. Mr. Regan testified that he did not witness any accident of the Petitioner, as he was only at the site for a short period of time before he left to visit the other jobsites he had working currently at that same time period.

Mr. Regan testified that he returned to the jobsite later in the day, and was not advised by anyone that any injury had been suffered. He denied ever having witnessed an accident by Petitioner and denied ever having received any notice from Petitioner of such an accident. Mr. Regan testified that Petitioner did approach him at the end of the day on April 10, 2014 complaining of hand pain. Mr. Regan indicated that he recommended that Petitioner go see an acupuncturist. On cross-examination Mr. Regan admitted that although he was disputing the causal connection of Petitioner's condition to his accident, he did not seek second opinion from another doctor through Section 12 or Utilization Review.

Mr. Regan testified that Petitioner was only to work 40 hours per week and that although the time sheets offered into evidence by Petitioner showed that Petitioner regularly worked beyond 40 hours, he did not pay Petitioner for any hours beyond 40. Mr. Regan admitted that he did not pay Petitioner at all beyond 40 hours and that he did not pay time and one half for any hours worked over 40 hours during the work week. Mr. Regan also admitted to having made illegal deductions from Petitioner's paycheck for repayment of a loan for a pick-up truck that Mr. Regan purchased for the Petitioner. Mr. Regan stated that he did not pay overtime because Petitioner was an independent contractor. However, he admitted that after a week or so of working he converted the Petitioner into an employee of Respondent.

Although Mr. Regan denied that the Petitioner told him about the accident on April 10, 2014, when Petitioner was complaining of pain in his hand, Mr. Regan admitted that he did receive notice of the claim which according to Commission records was filed within the 45 days statutory period.

CONCLUSIONS OF LAW

An injury is accidental within the meaning of the Worker's Compensation Act when it is traceable to a definite time, place and cause and occurs in the course of the employment

unexpectedly and without affirmative act or design of the employee. *Matthiessen & Hegeler Zinc Co. v Industrial Board,* 284 Ill. 378, 120 N.E. 2d 249, 251 (1918)

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 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).

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)

With respect to issue (C) whether Petitioner sustained an accident that arose out of in the course of Petitioner's employment by Respondent, the Arbitrator finds as follows:

The Petitioner credibly testified that he fell into a trench that was located along the pathway where he and a co-worker, Christian Calderon were carrying a heavy window from the street where it was delivered into the house it was going to be installed in. Petitioner testified that the fall caused the window to pin his left hand causing him pain in his left wrist, and pain in his right shoulder.

Petitioner's account of the accident was corroborated by two witnesses, Christian Calderon and Eduardo Garcia. Mr. Regan did not witness the alleged accident and therefore could not and did not directly refute its occurrence. Mr. Regan admitted he was not at the jobsite the entire day and did not know what happened when he was gone. Accordingly, the Arbitrator finds that Petitioner sustained an accident that arose out of and in the course of his employment with Respondent.

With respect to issue (E) whether timely notice was given to the Respondent, the Arbitrator finds as follows:

Petitioner testified that he notified the Respondent the day of the accident of his injury to his left wrist and right arm.

Mr. Regan denied having received such a notice but did admit that Petitioner approached him on that day complaining of left wrist pain. According to Mr. Regan he was at the jobsite in the morning instructing the workers what to do with the windows and how to install them, he then left to go to other jobsites that were being worked that day. He testified that he did return to

the jobsite at 1820 North Hudson where Petitioner was working. Even assuming Respondent's version of the events, Respondent received adequate statutory notice as Petitioner filed his Application for Adjustment of Claim on May 14th within the 45 day period statutory.

Mr. Regan testified that he received noticed of the Application for Adjustment of Claim via mail. Accordingly the Arbitrator finds that Petitioner provided adequate proper notice to Respondent of his accident.

With respect to issue (F) whether Petitioner's current ill-being is related to the injury, the Arbitrator finds as follows:

The chain of events reveal that Petitioner was working on April 10, 2014, sustained an accident to the left wrist and right shoulder and continued to work albeit with pain for two weeks before he sought medical care with Dr. Santiago.

Dr. Santiago immediately commenced treatment on Petitioner's left wrist and right shoulder and eventually referred Petitioner to an orthopedic specialist who discovered a fracture to Petitioner's right wrist which requires surgical intervention. Dr. Sclamberg noted that Petitioner experienced no previous history of problems involving his shoulder or wrist. (PX.3 , pg.3). Given that Petitioner did not have any prior problems involving his left wrist, and that his prior issue with respect to his right arm required no medical attention or lost time, he experienced an onset of symptoms following his injury of April 10, 2014 and sought medical care thereafter. The chain of events and the medical records support a finding of causal connection. Respondent offered no medical testimony to the contrary.

With respect to issue (G), what were Petitioner's earnings, the Arbitrator finds as follows:

Respondent offered into evidence a wage statement which it purports to illustrate Petitioner's earnings for the 52-weeks prior to his accident. However, the reliability of this document is put into question as the hours reported by Respondent contradict the hours reported on Petitioner's timesheets (PX. 9). For example, according to the timesheets provided by Petitioner, he worked a total of 114.5 hours for the pay period from April 16, 2014 through April 25, 2014. However, the Respondent's wage statement states Petitioner only worked 63 hours for that period. According to the timesheets, Petitioner regularly worked overtime, but Respondent reports that no overtime was worked on the wage statement.

At the hearing Respondent admitted that Petitioner did work overtime hours, and that he never paid Petitioner for any hours worked beyond 40.

Given the unreliability of Respondent's evidence regarding wages, the Arbitrator finds Petitioner's average weekly wage to consist of $600.00, representing the $15.00 per hour pay rate at 40 hours per week.

With respect to issue (J), were the medical services provided to Petitioner reasonable and necessary, the Arbitrator finds the following facts:

Petitioner underwent physical therapy with Dr. Joseph Santiago from April 26 through November 10, 2014. Petitioner underwent an injection and orthopedic consultation by Dr. Sclamberg and Dr. Weisman. Furthermore, he underwent MRI's and CT scans to diagnose his condition. Respondent offered no Utilization Review challenging the reasonable and necessity of the care provided to Petitioner.

Accordingly the Arbitrator find that the entire treatment rendered to Petitioner was reasonable and necessary and Respondent is liable for the expenses consisting of $14,385.41 to Nuestra Clinica, $1,158.24 to Chicago Pain & Orthopedic Institute, $3,000.00 to Bucktown Open MRI, $200.00 to Gray Medical, $4,162.12 to RX Development, Archer MRI in the amount of $1,500.000, and $345.38 to Illinois Orthopedic Network at a rate consistent with the Fee schedule as provided in the Act.

With respect to issue (K), whether Petitioner is owed temporary total disability benefits, the Arbitrator finds the following facts:

Petitioner testified that following his injury he continued to work for Respondent for approximately two weeks. Thereafter, Respondent indicated to him that he no further work for him. Petitioner worked in a light duty capacity for another construction company through June 3, 2014. Since then, Petitioner has not returned to work. His medical providers placed him off work and he continues to remain off work pending the surgery recommended by Dr. Weisman. Respondent offered no evidence to the contrary. Accordingly, Petitioner is entitled to temporary total disability benefits from June 3, 2014, through January 27, 2015, the date of hearing.

With respect to issue (O), whether Petitioner is entitled to perspective medical care, the Arbitrator finds the following facts:

Given the Arbitrator's finding with respect to accident and causation, the Arbitrator further finds that Respondent is liable to Petitioner for the cost of perspective medical care, mainly the surgery recommended by Dr. Irvin Weisman for Petitioner's left wrist and any physical therapy or other treatment that stems from the surgery. Arbitrator notes that Respondent offered no medical testimony to refute to the recommendation by Dr. Weisman.

ORDER OF THE ARBITRATOR

Respondent shall pay for the reasonable and necessary medical services, pursuant to the medical fee schedule, of $14,385.41 to Nuestra Clinica, $1,158.24 to Chicago Pain & Orthopedic Institute, $3,000.00 to Buck town Open MRI, $200.00 to Grey Medical, $4,162.12 to RX Development, Archer MRI in the amount of $1,500.000, and $345.38 to Illinois Orthopedic Network, pursuant to the medical fee schedule or by prior agreement, whichever is less, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $400.00/week for 33-6/7 weeks, commencing 6/4/2014 through 1/27/2015 as provided in Section 8(b) of the Act.

Respondent shall authorize and pay for the prospective medical care recommended by Dr. Irvin Weisman consisting of the surgery and any necessary follow-up care including physical therapy.

Richard L. Simpson
Signature of Arbitrator

March 16, 2015
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

JOANNE SIMS,

Petitioner,

vs. NO: 11 WC 006503

UNIVERSITY OF ILLINOIS,

Respondent.

18IWCC0017

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the parties herein and notice given to all parties, the Commission, after considering the issues of medical expenses, permanent disability, 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.

The Commission finds Respondent's application of Section 8.2(e) of the Act to be misapplied. Respondent correctly cited Section 8.2(e) of the Act as "a provider shall not hold an employee liable for costs related to a non-disputed procedure, treatment, or service rendered in connection with a compensable injury." In this instant matter, however, medical services were disputed and, therefore, leaving Petitioner potentially liable for some or all of the costs of her treatment.

Respondent, in its Statement of Exceptions and Supporting Brief, indicated Petitioner's medical services were paid for through its group carrier. Any amount that remained unpaid after the payment through the group carrier would be borne by Petitioner as the facts of this case place it outside Section 8.2(e) of the Act. Petitioner was found to have paid the balance of the charges not paid by the group carrier for the medical services that were found compensable. Petitioner is entitled to be reimbursed for her out-of-pocket expenses in the amount of $188.48.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the

18IWCC0017

Arbitrator filed February 29, 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 $2,100.00. 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.

JAN 8 - 2018

DATED:
KWL/mav
O: 11/07/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SIMS, JOANNE
Employee/Petitioner

Case# **11WC006503**

UNIVERSITY OF ILLINOIS
Employer/Respondent

18IWCC0017

On 2/29/2016, 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 0.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5181 CANDIANO LAW OFFICE
CHARLES J CANDIANO
53 W JACKSON BLVD SUITE 1337
CHICAGO, IL 60604

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

1408 HEYL ROYSTER VOELKER & ALLEN
LYNSEY WELCH
120 W STATE ST 2ND FL
ROCKFORD, IL 61101

0902 UNIVERSITY OF IL/CLAIMS MGMT
ATTN: CHUCK HUTCHISON
1737 W POLK ST M/C 940 STE B9
CHICAGO, IL 60612

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

FEB 29 2016

RALD A. RASSIA, Acting Secretary
Illinois Workers' Compensation Commission

J. Sims v. U of I , 11 WC 6503

18IWCC0017

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

JOANNE SIMS
Employee/Petitioner
v.
UNIVERSITY OF ILLINOIS
Employer/Respondent

Case # 11 WC 006503

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 **12/09/15**. 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [x] Should penalties or fees be imposed upon Respondent?
N. [x] Is Respondent due any credit?
O. [ ] Other _____

18IWCC0017

FINDINGS

On **1/04/11**, 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 ***in regards to the left middle and left ring finger is*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$87,138.48**; the average weekly wage was **$1,675.74**.

On the date of accident, Petitioner was **61** 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 under Section 8(j) of the Act, as is set forth below.

ORDER

Respondent shall be given a credit for the actual amounts of 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 **$188.48** for reimbursement of Petitioner's **out of pocket payments** to Loyola for treatment in January of 2011.

Respondent shall pay Petitioner **permanent partial disability benefits** of **$669.64/week for 2.7 weeks**, because the injuries sustained caused the **10 % loss of use of the left ring finger**, as provided in Section 8(e) of the Act.

Petitioner's claim for Penalties and Attorney's Fees is denied.
Respondent shall pay Petitioner all compensation benefits that have accrued from 1/4/2011 through 12/9/2015 in a lump sum and shall pay the remainder of the award, if any, in weekly benefits.

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

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

Signature of Arbitrator

February 29, 2016
Date

FEB 29 2016

18IWCC0017

FINDINGS OF FACT

Petitioner was employed by Respondent as a Fiscal Administrator in the College of Urban Planning and Public Affairs. Petitioner worked for Respondent for over 36 years. Petitioner is right handed.

On January 4, 2011, she was involved in an altercation with an intruder in her office space who was attempting to steal her purse. She fell against the doorframe of her office, impacting her left hand and left forearm. Following the initial impact, Petitioner experienced excrutiating pain in her fingers in her left hand. She did continue to attempt to restrain the intruder, using her right hand, wrestling with him and holding on to his hooded sweatshirt. The intruder got out of the hoodie and made his getaway. The incident took about 5 minutes. Petitioner noticed that her left hand was throbbing.

Petitioner received treatment at the emergency department at the University of Illinois Medical Center on January 4, 2011. She was diagnosed with a small closed nondisplaced interarticular fracture of the left ring finger and a soft-tissue injury to the left middle finger. The left ring finger was placed in a splint. Petitioner never mentioned any injury to or complaints regarding her left shoulder or cervical spine at the ED. The physical exam, other than the left 3rd and 4th fingers, was benign. Dr. Elizabeth Orsay performed a thorough examination of the Petitioner and specifically noted: "No other injuries sustained." Petitioner was released to return back to work with limited use of her left hand. Petitioner testified that she did not miss any time from work. She was advised to follow up with an orthopedic physician in the next five to seven days. (RX#2)

On January 4, 2011, Petitioner completed two First Reports of Injury in regards to this event. Both reports indicated that she suffered only an injury to her left middle finger and left ring finger. There was no mention of any injury to her shoulder or neck at that time. (RX#'s 3 & 4)

On January 5, 2011, Petitioner was seen at U of I Health Services for follow-up on a work related injury. She injured her left 3rd and 4th fingers attempting to prevent an intruder from stealing her purse. The diagnosis was fracture of the 4th finger and soft tissue injury to the 3rd finger. There is no mention of a cervical spine or left shoulder injury or complaints. (RX#1)

Petitioner chose to see Dr. Michael Bednar of Loyola University Medical Center for a follow-up regarding her fractured ring finger. She was first examined on January 11, 2011. The physical examination revealed full range of motion of the elbow, forearm, wrist, and fingers with exception to the left ring finger. An X-ray showed a fracture at the distal end of the middle phalanx into the region of the DIP joint of the left ring finger. There was no treatment provided for the left middle finger. Petitioner made no complaints at that time regarding her left shoulder or cervical spine. She was again provided an extension splint, but she was advised that she was allowed to remove it for range of motion. She was requested to return back in two weeks. Petitioner characterized her pain complaints at that time as a 1 out of 10. (PX#9)

Petitioner returned to Dr. Bednar on January 25, 2011. At that time, she reported her pain complaints as decreasing in the finger. It was noted that she had good range of motion in both the PIP and the DIP joints. She was advised to remove her splint with increasing motion of the digit. Petitioner was advised to only return back on an as-needed basis. Again, there was no mention of any shoulder complaints or cervical spine complaints. (PX#9)

Petitioner returned to Dr. Bednar on February 22, 2011. She stated that she was experiencing pain and numbness radiating from her wrist to her elbow. No further treatment was recommended at that time. In fact, she was released to return back to work full duty. There were no further visits with Dr. Bednar. (PX#9)

Next, on a referral from her attorney, Petitioner began treatment with Dr. Scott Rubinstein. She was first examined on March 14, 2011. At the first visit, Petitioner gave a history of an injury to her left hand as a result of an assault. She was slammed against the door frame and had trauma to her left upper extremity. She tussled with the intruder. "She was noted to have fractures of the middle and ring fingers" – these appear to have healed. Her main complaints were of a stocking/glove type of distribution numbness throughout her arm from about her mid upper arm just above the elbow all the way down to the fingers and this encompasses circumferential and total sensory loss in the above-mentioned areas. She reported no pain or discomfort with any motion of the neck, including tilting and turning to the side. She had full range of motion of her arm. Dr.

Rubinstein thought that the patient "may have some neurologic things going on (possibly a stretch of the brachial plexus or one of the cervical nerve roots. An EMG was ordered. (PX#4)

The EMG/NCV was completed at Pain Management Services on April 7, 2011. All nerve conduction studies were within normal limits. The EMG findings showed no muscles with evidence of electrical instability. (RX#10)

Petitioner returned to Dr. Rubinstein on April 27, 2011 and he charted that the EMG study did not show "much of anything." On that date, Petitioner's pain complaints moved to include vague numbness in her upper extremity that appeared to be coming from a "more central location." She was noted to still have full range of motion of her shoulder. (RX#11)

Petitioner returned to Dr. Rubinstein on May 18, 2011, complaining of numbness radiating down her arm. Dr. Rubinstein noted that this was not in a specific anatomic distribution and covers both the anterior and posterior portions of the arm and forearm. Dr. Rubinstein noted that while she does appear to have neurological findings, they do not fit a particular syndrome. There was the possibility of posttraumatic thoracic outlet syndrome. Dr. Rubinstein charted that the patient "wrenched her neck at the time of the initial injury." He ordered an MRI of her cervical spine. The MRI showed multilevel degenerative disc disease from C3- C4 down to C6 -C7 levels, with pre-existing osteophytes and joint hypertrophy. There was also some central and foraminal stenosis. Physical therapy was recommended at that time. (PX#4)

On June 5, 2011, Petitioner presented to Dr. Maureen Fearon, her primary care physician. She reported she did not have any left arm pain until one month after the January 4, 2011, work injury. (PX#6)

Petitioner participated in a course of physical therapy. On August 3, 2011, Petitioner returned to Dr. Scott Rubenstein complaining of paresthesia down her left upper extremity when she tilted her head to the left. She was prescribed a Medrol Dosepak and advised to continue with physical therapy. (RX#11)

Petitioner returned to Dr. Rubinstein on October 3, 2011, complaining that the physical therapy was not giving her much benefit. An MRI of the left shoulder was ordered at that time. The shoulder MRI took place

on November 23, 2011, at Chicago Northside MRI Center. It showed no evidence of fracture or AC separation. There was no tear to the rotator cuff, although tendinitis was noted. (RX#11)

Petitioner was last seen by Dr. Rubinstein on March 21, 2012. He felt that the Petitioner was getting close to a "static state," as she did not want to proceed with any more aggressive treatment. She continued to complain of pain and discomfort in the neck and difficulty moving her neck from side to side to some degree, although it was not as bad as it had been. Petitioner's problems were multifactorial (shoulder and neck?) It was noted at that time that the Petitioner had retired from her work duties at the University of Illinois. (PX#4)

Petitioner was examined by Dr. Gunnar Andersson, pursuant to Section 12, on December 6, 2011. Dr. Andersson performed a physical examination of the Petitioner and reviewed some of her medical records. He found no causal connection between her neck complaints and the work injury. He deferred to a shoulder specialist regarding any left shoulder diagnosis. Her current complaints were not likely neck related, probably. The patient's symptoms began at the time of the injury. (RX#5)

Petitioner's left shoulder complaints were evaluated by Dr. Allan Michael Brecher, via a records review. His report dated November 7, 2014, found no causal connection between Petitioner's neck and shoulder complaints and the work injury. There was no clear temporal relationship between the 1/4/2011 work related finger injury and Petitioner's neck and shoulder problems. ODG guidelines for causation do not support in such a case. Dr. Brecher's clinical summary is deficient. He may be board certified in orthopedic surgery, but he is non-certified in proofreading, eg: "second glove-like numbness in left hand", "he thought she might have a rectal plexus cervical nerve root injury."

At trial, the Petitioner testified she has pain and numbness in the left hand and arm up to the base of her neck. Light touch causes excruciating pain. She has back pain. The tingling and numbness is constant. She limits here activities. She drops objects weighing four pounds. Sitting hurts when she leans to the left. She has difficulty driving and turning her head to the left. She never experienced these problems before the accident.

Petitioner testified that she was honest and truthful with all medical providers. The last visit with Dr. Rubinstein was December 27, 2013. Petitioner is now retired and not working. She has no current recommendations for treatment and no current prescriptions for medications. Group paid Petitioner's medical bills and she paid some out of pocket expenses. Petitioner's physicians have told her that there are no more treatment options for her. She would seek more treatment if her physicians would say that she would get better.

There was no compensable lost time. Petitioner continued to work her regular job until she retired.

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 relating to (C), did an accident occur that arose out of and in the course of Petitioner' employment by Respondent, the Arbitrator finds the following facts:

The Arbitrator heard Petitioner's testimony and reviewed all the evidence and finds that Petitioner sustained accidental injuries that arose out of and in the course of her employment by Respondent on January 4, 2011.

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 the following facts:

The Arbitrator finds that Petitioner's current condition of ill-being regarding her left third and fourth finger (status post soft tissue contusion with no residual complaints and status post interarticular fracture at the distal end of the middle phalanx into the region of the DIP joint, respectively) is causally connected to the injury. Petitioner has failed to prove that her current condition of ill-being regarding her cervical spine and left shoulder is causally related to the alleged injury.

The accident reports completed by the Petitioner on January 4, 2011, do not mention any left shoulder or cervical spine injury. (RX#'s 3&4) Her body part injured was reported as the left middle and left ring fingers. *I*

Petitioner was examined and evaluated at the emergency department at University of Illinois Medical Center on January 4, 2011. There is no mention of an injury to her left wrist, elbow, shoulder, or cervical spine. There are no pain complaints or findings regarding the left arm or cervical spine. (RX#2)

Thereafter, Petitioner presented to University of Illinois Health Services on January 5, 2011. At that time, she reported her pain complaints as only involving the left ring and left middle finger. There was no mention of any injury to any other part of her left upper extremity or cervical spine. (RX#1)

Petitioner then had significant treatment with Dr. Michael Bednar at Loyola University Medical Center, beginning January 11, 2011. There is no mention of any pain complaints regarding the shoulder or cervical spine in any of his treatment notes. (PX#6)

The Arbitrator places great weight on the lack of shoulder and neck complaints in the initial records. The absence of same convince the Arbitrator that Petitioner's condition of ill being regarding her left shoulder, arm, elbow, and cervical spine is not causally connected to the injury. The opinions of Dr. Andersson and Dr. Brechar are persuasive on this issue and provide support for the finding of no causal set forth above.

In support of the Arbitrator's decision relating to (J), were the medical services that were provided to Petitioner reasonable and necessary, and has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following facts:

Based upon the Arbitrator's finding regarding causal connection, all claimed bills for services rendered after the last visit with Dr. Bednar on February 22, 2011 are denied, as they are not causally related to the injury.

Petitioner is claiming $188.48 in out-of-pocket expenses paid to Loyola. Respondent is claiming a §8(j) credit for bills paid by group. Respondent should be responsible for reimbursement to Petitioner of the OOP

expenses set forth in Petitioner's Exhibit 7. Respondent is obviously obtaining a benefit in not having to pay Loyola at the Fee Schedule rate. The claim for $188.48 in medical expenses is allowed.

In support of the Arbitrator's decision relating to (L), what is the nature and extent of the injury, the Arbitrator finds the following facts:

Only Petitioner's left middle and left ring finger injuries are causally related to the accident.

With respect to her left middle finger, Petitioner's only treatment was on the date of her alleged injury on January 4, 2011, at the emergency department at University of Illinois Medical Center. She was diagnosed with nothing more than a soft-tissue injury. The injury required no treatment. Petitioner was noted to be back to full function without any difficulty in regards to the left middle finger. There is no permanency awarded for the left middle finger pursuant to Section 8(e).

With respect to the left ring finger, the Petitioner was diagnosed with a closed "nondisplaced interarticular fracture." Her treatment was limited to a splint. She was released to return back to work full duty on February 22, 2011. She missed no time from work. Petitioner has no follow-up appointments scheduled with any physician. She is not taking any prescribed pain medication. Dr. Bednar noted that she had good range of motion in both joints of the finger. Based upon the entire Record, the Arbitrator finds that the injuries sustained caused the 10% loss of use of Petitioner's left ring finger.

In support of the Arbitrator's decision relating to (M), should penalties and fees be imposed upon Respondent, the Arbitrator finds the following facts:

Petitioner's claim for Penalties and Attorney's Fees is denied. The Arbitrator does not find Respondent's actions to be unreasonable or vexatious.

In support of the Arbitrator's decision relating to (N), is Respondent due any credit, the Arbitrator finds the following facts:

Pursuant to the Respondent's Exhibit Nos. 6 and 9, the Respondent and the group carrier paid medical benefits. The Respondent is entitled to a total credit of amounts paid pursuant to the Respondent's Exhibit Nos. 6 and 9.

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

VIRGINIA DUBOISE,

Petitioner,

vs.

NO: 14 WC 31482

CHICAGO COMMONS,

18IWCC0019

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b) of the Act 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), and prospective medical, 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 the testimony, exhibits, pleadings, and arguments submitted by the parties.

In this claim, the parties stipulated that on November 12, 2013, Petitioner sustained an accidental injury that arose out of and in the course of her employment. By their respective briefs, the parties are not disputing causal connection for Petitioner's back injury, but Respondent does contest causal connection relative to Petitioner's left shoulder and right hip conditions and the need for additional treatment, including surgery.

The Arbitrator did not find causal connection for Petitioner's left shoulder, and indicated that Petitioner reached maximum medical improvement (MMI) for her shoulder on October 12,

18IWCC0019

2015. The Arbitrator took notice of an intervening injury to Petitioner's left shoulder in January 2015 as a basis for her Decision. As to this intervening injury, the medical records indicated that Petitioner had aggravated her shoulder condition in January 2015, when her right leg gave way and she extended both arms to prevent herself from falling. (PX3; PX11, pg. 20).

As to intervening injuries, *Int'l Harvester Co. v. Indus. Comm'n* instructs as follows:

> An "independent intervening cause" has been held to be one which breaks the chain of causation between a work-related injury and an ensuing disability or injury. [Citation]. Where the work injury itself causes a subsequent injury, however, the chain of causation is not broken. [Citation]. In this context, the cases have applied a "but for" test, basing compensability for an ultimate injury or disability upon a finding that it was caused by an *event* which would not have occurred had it not been for the original injury. 46 Ill. 2d 238, 245 (1970).

The Commission finds that the record in this case demonstrates a "but for" relationship between Petitioner's original, undisputed injury to her lumbar spine and her current left rotator cuff injury. The evidence indicates that Petitioner saw Dr. Richard Lim, an orthopedic surgeon at Midwest Orthopedic Consultants, on January 9, 2015 with complaints of back and leg pain, and stated that her ability to ambulate was significantly limited. Dr. Lim indicated that Petitioner had positive right-sided straight leg raise as well as objective signs of weakness. These symptoms were consistent with lumbar radiculopathy. X-rays and the January 21, 2015 MRI of the lumbar spine confirmed his diagnosis. (PX7). These findings correspond with Petitioner's claim that around January 12, 2015, her right leg gave way and she re-injured her left shoulder. Thus, the Arbitrator's finding and Respondent's position that there was no evidence in the medical records that Petitioner had any such leg weakness, and there was no reference to radiating pain or either leg giving way near the time of the intervening injury, is erroneous. (Respondent's Brief, pg. 12).

Respondent further argues that the January 2015 accident resulted in a new injury to Petitioner's left shoulder because Petitioner had stopped treating for her left shoulder until the intervening event. (Respondent's Brief, pg. 12). The Commission finds that Respondent indeed is correct in its claim that following the January 2015 intervening injury, Petitioner's treatment to the left shoulder resumed, and included a new MRI ordered by Dr. Robert Strugala to evaluate the "new injury." (PX3). Petitioner even reported to Respondent's Section 12 examiner, Dr. Daniel Troy, on December 11, 2014, that her shoulder condition had improved and she had full range of motion in her left shoulder. (Respondent's Brief, pg. 12; RX2). However, these facts do not change the fact that but for Petitioner's low back injury that she sustained in the November 12, 2013 accident, her right leg would not have given way and she would not have re-injured her left shoulder. Therefore, the Commission finds that Petitioner's left shoulder condition is causally related to the November 12, 2013 accident.

As to the issue of causal connection for Petitioner's right hip condition, the Commission agrees with the Arbitrator's Decision in this regard, and finds equally important the distinct lack of complaints, diagnostic tests, and treatment for the right hip until July 2014 when Petitioner

underwent an MRI of the right hip. Formal treatment for the right hip commenced thereafter. (PX3; PX4). Petitioner's own, long-time treater, Dr. Strugala, also could not directly link Petitioner's right hip pain to the November 12, 2013 accident as there were no hip complaints at the onset. (PX11, pgs. 29-30). During Petitioner's final Section 12 examination with Dr. Troy, on October 12, 2015, he opined similarly to Dr. Strugala, that Petitioner's complaints of right hip and right groin pain were not related to the November 12, 2013 accident. He found that Petitioner was morbidly obese which contributed to degenerative and secondary changes to her bilateral hips. (RX3). Therefore, the Commission finds that Petitioner has failed to prove a causal relationship exists between the accident of November 12, 2013 and her current condition of ill-being to her right hip; thus, her claim for compensation relative to the right hip is denied.

In light of the foregoing, and based on the totality of the evidence, the Commission finds that Petitioner is entitled to reasonable, necessary, and related medical expenses and TTD through December 22, 2016, the date of hearing, for the left shoulder, but not the right hip. Petitioner is also entitled to prospective medical care for the left shoulder as recommended by Dr. Michael Maday.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed February 24, 2017, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner reasonable and necessary medical services, pursuant to Sections 8(a) and 8.2 of the Act as contained in Petitioner's Exhibit 1. Respondent is not liable for any unpaid medical bills related to treatment for Petitioner's right hip; this includes any outstanding amount due to Dr. Shane Nho of Midwest Orthopedics at Rush.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $319.00 per week, for a period of 153 1/7 weeks, commencing January 16, 2014 through December 22, 2016, that being the period of temporary total incapacity from work under Section 8(b) of the Act, and that as provided in Sections 19(b) and 19(b)1 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 shall be given a credit of $24,900.51 for temporary total disability benefits previously paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to prospective medical care as recommended by Dr. Michael Maday for the left shoulder only.

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

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





Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $34,400.00. 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 the Circuit Court.

DATED: JAN 9 - 2018
MJB/pm
12-12-17
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

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

DUBOISE, VIRGINIA
Employee/Petitioner

Case# **14WC031482**

CHICAGO COMMONS
Employer/Respondent

18IWCC0019

On 2/24/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.67% 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:

1747 SEIDMAN MARGULIS & FAIRMAN LLP
STEN J SEIDMAN
20 S CLARK ST SUITE 700
CHICAGO, IL 60603

1604 STELLATO & SCHWARTZ
BRUCE ORGON
120 N LASALLE ST 34TH FL
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF CCOK)

☐ 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)

VIRGINIA DUBOISE
Employee/Petitioner

v.

CHICAGO COMMONS
Employer/Respondent

Case # **14** WC **31482**

Consolidated cases: _____

18IWCC0019

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 **Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **December 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, **November 12, 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 entirely*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$21,163.48**; the average weekly wage was **$406.99**.

On the date of accident, Petitioner was **49** 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 **$24,900.51** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$24,900.51**.

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 $319.00/week for $90^{4}/_{7}$ weeks, commencing January 16, 2014 ending October 12, 2015, as provided in Section 8(b) of the Act. Petitioner is owed $4,004.04 in underpayment of benefits ($99/week from 1/16/14-10/15/14 = $3,861.00 and $47.68/week from 5/16/15-6/5/15 = $143.04).

Respondent shall be given a credit of $24,900.51 for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary services, pursuant to Sections 8(a) and 8.2 of the Act, for treatment incurred up to October 12, 2015. Respondent shall be given a credit for all medical benefits that have been paid.

Petitioner has not proven, by a preponderance of the evidence that her current condition of ill-being regarding her left shoulder and right hip is causally related to the accident therefore, Petitioner has not proven that she is entitled to prospective medical care and treatment for these areas. The request for prospective medical care is denied.

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

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

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

FINDINGS OF FACT

On December 22, 2016, the parties proceeded to hearing with the following issues in dispute: 1) causal connection; 2) medical bills; 3) temporary total disability; and 4) prospective medical care/treatment regarding petitioner's left shoulder and right hip. *See,* AX1.

Mrs. Virginia DuBoise, ("Petitioner") was employed as a health aide for Chicago Commons ("Respondent"). In that capacity, she assisted clients with activities of daily living. On November 12, 2013, Petitioner was walking a client to the bathroom when the client began to have a seizure, falling and landing on top of the petitioner. Petitioner testified that she, with the petitioner's weight, fell onto her lower back and left side, hitting her whole body. At trial, she testified that she was "in shock" after the fall, but admitted she was not cut or bleeding and did not lose consciousness.

Petitioner testified that the next day she began to experience pain in her lower back and left shoulder. However, despite these complaints, she did not seek treatment for any claimed injuries until December 12, 2013 when she was seen at Union Health Service. There, she presented with complaints of left shoulder/arm and left hip/leg pain. She denied head trauma and any other complaints. Petitioner returned to that clinic for several follow-up visits through February 26, 2014. PX2.

On February 10, 2014, Petitioner was seen by Dr. Robert Strugala of Midland Orthopedic Associates for an evaluation of left shoulder, low back and left hip pain. Following his examination, Dr. Strugala, indicated he was concerned about a possible rotator cuff injury and suspected petitioner's left hip symptoms were emanating from her lumbar spine. PX3.

On February 12, 2014, Petitioner underwent MRIs of her left hip, left shoulder and lumbar spine. The left hip MRI was essentially unremarkable, the left shoulder scan revealed a partial-thickness undersurface tear of the distal supraspinatus; and the lumbar spine scan noted chronic degenerative disc and facet changes at the L5-S1 level. PXs 2 & 3.

On May 9, 2014, Petitioner was seen by Dr. Daniel Troy at Respondent's request, under Section 12 of the Act. Following his examination, Dr. Troy diagnosed left shoulder impingement, markedly improved with a resolving left shoulder strain; and a lumbosacral strain with associated aggravation or subsequent cause of a centralized L5-S1 herniated nucleus pulposus. Dr. Troy opined these described conditions were causally related to the work accident. Dr. Troy recommended that the petitioner receive an additional four (4) weeks of physical therapy for both conditions, followed by a home exercise program. RX1.

Petitioner continued seeing Dr. Strugala through July 7, 2014, during which time she received physical therapy for her left shoulder and lumbar spine. By that date, the doctor noted that the petitioner's shoulder and low back symptoms had improved. However, as the petitioner was now

experiencing increasing pain in her right groin and was also making complaints of increasing right hip symptoms. Dr. Strugala ordered an MRI of her right hip. PX3.

On July 30, 2014, Petitioner underwent the recommended MRI of her right hip. According to the radiologist who reviewed the scan, the labrum was intact and demonstrated a normal signal. A possible paralabral cyst and mild osteoarthritic changes of the bilateral hip joints were noted.

On August 4, 2014, Petitioner returned to see Dr. Strugala with her chief complaint being ongoing right groin pain. Dr. Strugala noted the MRI revealed a probable cyst as well as some degenerative change in each hip joint. Dr. Strugala felt that finding the cyst might indicate the presence of an underlying acetabular tear and referred the petitioner to Dr. Shane Nho for a consultation.

On September 9, 2014, the petitioner was examined by Dr. Nho who examined her right hip. Dr. Nho confirmed the findings of the radiologist who reviewed the MRI scan of the right hip, noting that it only revealed mild osteoarthritic changes in bilateral hip joints as well as a small fluid collection in the area of the anterior superior labrum, which may represent a paralabral cyst. Based on the objective findings and Petitioner's subjective complaints, Dr. Nho recommended a cortisone injection. PX5.

Petitioner returned to see Dr. Strugala on October 20, 2014, ten days after undergoing the recommended injection and advised she was no longer experiencing significant right groin pain. On that day, Petitioner complained primarily of low back pain extending into her right leg, with numbness in her right foot. Based on continued complaints of low back pain, the petitioner was referred to Dr. Richard Lim for a surgical consultation. PX3.

Petitioner was seen for a second Section 12 examination with Dr. Troy on December 11, 2014. Dr. Troy reviewed the MRI of Petitioner's right hip and noted that it demonstrated mild osteoarthritic changes of the bilateral hip joints. There was also a small, well-defined lobulated high STIR/PD-FSE fat sat and low T1 signal abnormality, measuring approximately 2.1 x 1.9 cm, adjacent to the superior pillar of the right acetabulum; which possibly represented a paralabral cyst.

Following his examination, Dr. Troy opined petitioner's left shoulder condition had resolved and she was at maximum medical improvement ("MMI") for that body part. With respect to her low back condition, Dr. Troy believed Petitioner was suffering from an aggravation of pre-existing degenerative changes or a questionable new onset of a disc herniation at L5-S1. He recommended she be seen by a spine specialist. RX2.

On January 21, 2015, Petitioner underwent an MRI of her lumbar spine. The unsigned report indicates the findings of a prominent posterior disc protrusion at L5-S1, which had increased in size.

Petitioner returned to see Dr. Strugala on January 26, 2015. That day, she reported having stumbled two weeks earlier. She stated that she extended both arms to prevent herself from falling and jarred

her left shoulder in the process. She reported increased pain in the left shoulder as a result of this incident.
On September 1, 2015, Petitioner saw Dr. Nho for a second time. During that visit, the doctor again reviewed the MRI taken of her right hip on July 30, 2014. He then, without explanation or elaboration, changed his opinion by indicating the scan revealed evidence of a small tear with a paralabral cyst. PX5.

Petitioner returned for a third examination with Dr. Troy on October 12, 2015. Following this examination and review of additional records, Dr. Troy reiterated that with respect to Petitioner's left shoulder, she was at MMI as of December 11, 2014. He stated that she may have aggravated her symptoms when she fell, but noted there was a discrepancy between the history provided to him, i.e., tripping as she was going upstairs versus the purported history given to Dr. Strugala, i.e., stumbling and extended both arms to break her fall. With respect to Petitioner's right hip, Dr. Troy opined that she was at MMI. RX3.

On March 17, 2016, at the request of Petitioner's attorney, Dr. Strugala prepared a letter addressing causal connection with respect to the petitioner's left shoulder. In the letter, Dr. Strugala provided that Petitioner "suffered an event in January of 2015 at which time her right leg gave way causing her to stumble." He added, "it should be noted that the cause of the stumble was the right leg giving way, which was a consequence of her ongoing lumbar spine issue that ultimately required spine surgery. He further opined, "I think the stumble further aggravated her condition."

Deposition of Dr. Shane Nho dated May 16, 2016
Dr. Nho testified by way of deposition on May 16, 2016. He stated that he examined the petitioner's right hip on September 9, 2014 and that she "did have weakness with hip flexion." And "pain with hip provocation maneuvers which included flexion, adduction, internal rotation or also known as the impingement test; and flexion, abduction, external rotation also known as iliopsas impingement test." He opined that the petitioner "had hip pain consistent with femoroacetabular impingement and a hip labral tear". In addition, these injuries were caused by the accident of November 12, 2013.

The doctor was asked, "Could you tell us what, if anything significant did you note from the imaging of the hip, if anything? To which, the doctor replied, "First she had well-preserved joint space. She had center edge angle of 31 degrees and alpha angle of 56 degrees. Her MRI of July of 2014 showed a labral tear with a pair of labral cysts, with some mild bursitis". PX10.

Deposition of Dr. Robert Strugala dated June 10. 2016
Dr. Strugala testified by way of deposition on June 10, 2016. When asked his opinion on causal connection between the work accident and petitioner's right hip symptoms, the doctor indicated he could not directly link the two. He explained that he "did not see indication of initial right hip pain by report nor [sic] our initial clinical exam." Dr. Strugala also confirmed he did not address a causal relationship between the work accident and petitioner's left shoulder injury until he prepared his

narrative report at the request of petitioner's attorney. Additionally, Dr. Strugala maintained the letter he received from Petitioner's attorney is contained in his chart. PX11 pp. 29-36.

CONCLUSIONS OF LAW

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

A decision by the Commission cannot be based upon speculation or conjecture. *Deere and Company v. Industrial Commission*, 47 Ill.2d 144, 265 N.E. 2d 129 (1970). A petitioner seeking an award before the Commission must prove by a preponderance of credible evidence each element of the claim. *Illinois Institute of Technology v. Industrial Commission*, 68 Ill.2d 236, 369 N.E.2d 853 (1977). Where a petitioner fails to prove by a preponderance of the evidence that there exists a causal connection between work and the alleged condition of ill-being, compensation is to be denied. Id. The facts of each case must be closely analyzed to be fair to the employee, the employer, and to the employer's workers' compensation carrier. *Three "D" Discount Store v. Industrial Commission*, 198 Ill.App. 3d 43, 556 N.E.2d 261, 144 Ill.Dec. 794 (4th Dist. 1989).

The burden is on the Petitioner seeking an award to prove by a preponderance of credible evidence all the elements of his claim, including the requirement that the injury complained of arose out of and in the course of his or her employment. *Martin vs. Industrial Commission*, 91 Ill.2d 288, 63 Ill.Dec. 1, 437 N.E.2d 650 (1982). The mere existence of testimony does not require its acceptance. *Smith v. Industrial Commission*, 98 Ill.2d 20, 455 N.E.2d 86 (1983). To argue to the contrary would require that an award be entered or affirmed whenever a claimant testified to an injury no matter how much his testimony might be contradicted by the evidence, or how evident it might be that his story is a fabricated afterthought. *U.S. Steel v. Industrial Commission*, 8 Ill.2d 407, 134 N.E. 2d 307 (1956).
It is not enough that the petitioner is working when an injury is realized. The petitioner must show that the injury was due to some cause connected with the employment. *Board of Trustees of the University of Illinois v. Industrial Commission*, 44 Ill.2d 207, 214, 254 N.E.2d 522 (1969); *see also Hansel & Gretel Day Care Center v. Industrial Commission*, 215 Ill.App.3d 284, 574 N.E.2d 1244 (1991).
Concerning petitioner's left shoulder and right hip complaints, the Arbitrator finds the opinions of Dr. Daniel Troy to be more persuasive than those of Drs. Nho and Strugala. With respect to the petitioner's right hip, the Arbitrator notes that Petitioner did not begin complaining of pain in that area until approximately nine (9) months after the work accident. Further, the MRI performed on July 30, 2014 revealed an intact labrum with a normal signal. Significantly, that finding was confirmed by Dr. Nho when he first saw petitioner for a consultation on September 9, 2014. Another year had passed before Dr. Nho looked at the same MRI scan and indicated he then felt there was a small tear in the labrum. However, when Dr. Nho later testified he offered no explanation as to why he changed his opinion regarding the findings of the MRI.

With respect to Petitioner's left shoulder, the Arbitrator believes Petitioner's fall in January 2015 was an intervening event which broke the chain of causation. It is significant that Dr. Strugala provided a

causation opinion, suggesting a weakened condition in petitioner's leg, only after an opinion was requested by Petitioner's attorney. Further, despite the fact that Dr. Strugala indicated the letter from the attorney requesting the narrative report was in his chart, the Arbitrator cannot find it submitted as part of any group exhibit. Significantly, Dr. Strugala's opinion that the fall was due to a weakened condition in petitioner's leg is not contained anywhere in his earlier records or reports and does not appear until after he received the letter requesting his opinion on causation. In addition, the Arbitrator relies on the well-reasoned, cogent reports of Dr. Troy as he documents the petitioner's progress through her treatment.

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?

In relying on the findings and opinions of Dr. Troy, the Arbitrator finds Petitioner attained MMI for all claimed injuries sustained in the work accident by October 12, 2015; and any treatment provided to any body part after that date is deemed unreasonable and unnecessary. Therefore, Respondent is obligated to pay only for treatment provided prior to October 12, 2015 and any such unpaid charges are to be paid per the medical fee schedule.

K. Is Petitioner entitled to prospective medical care?

As indicated, the Arbitrator relies on the findings and opinions of Dr. Daniel Troy on the issue of causal connection. In so doing, the Arbitrator adopts Dr. Troy's opinion that Petitioner is at MMI with respect to her right hip and that her current condition of ill-being in her left shoulder is unrelated to the injuries sustained in the work accident. Thus, the Arbitrator finds that the petitioner has not proven, by a preponderance of the evidence, that she is entitled to prospective medical care for either body part.

L. What temporary benefits are in dispute?

In relying on the findings and opinions of Dr. Troy, the Arbitrator believes Petitioner was capable of returning to full duty work form the related injuries, as of October 12, 2015, the day of the third examination. Therefore, the Arbitrator finds that Petitioner has not proven by a preponderance of the evidence that she is entitled to any temporary total disability benefits beyond that date. The Arbitrator further finds Petitioner is owed $4,004.04 in underpayment of benefits ($99/week from 1/16/14 – 10/15/14 = $3,861.00 and $47.68/week from 5/16/15 -6/5/15 = $143.04).

18IWCC0019

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
14WC31482
SIGNATURE PAGE

Signature of Arbitrator

February 24, 2017
Date of Decision

FEB 24 2017

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 up	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

COSIMO BARABBA,
Petitioner,

vs. NO: 10 WC 35356

PINE LANDSCAPING, INC.,
Respondent.

18IWCC0018

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 reasonableness and necessity of medical expenses and prospective medical, causal connection, temporary total 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. 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).

Findings of Fact and Conclusions of Law

The Commission adopts the Arbitrator's Findings of Fact. The Commission affirms and adopts the Arbitrator's Decision with respect to issue (C) "Did an accident occur that arouse out of and in the course of Petitioner's employment by Respondent?", however, disagrees with the Arbitrator's Conclusions of Law with respect to (F) "Is Petitioner's current condition of ill-being causally related to the injury?" for the reasons stated herein.

18IWCC0018

The Arbitrator found Petitioner not credible. The Commission disagrees. When Petitioner returned to his then treating dentist, Dr. Romano on July 3, 2009 and July 7, 2009 the short-handwritten notes do not appear to reflect Petitioner reported the accident, however, Petitioner saw a second dentist, Dr. Glenn Scheive within two weeks and reported the work accident. Dr. Scheive wrote a letter on October 12, 2009 thanking Dr. Romano for referring Petitioner to his office for his oral surgery needs.

The Commission finds Dr. Antonino Romano was Petitioner's first choice of medical provider for his work injury on July 15, 2009. Although not dated, Dr. Romano also authored a handwritten letter addressed to Dr. Scheive asking him to evaluate Mr. Barabba for the possibility of Eagle's Syndrome encroachment of the styloid process. Dr. Scheive then referred Petitioner to Dr. Evan Rumack.

Dr. Rumack's history documented a fall on "7/1 or 7/2/09" and Petitioner "fell forward and hit (illegible) on the top of door - couldn't open mouth. Dr. Romano gave Flexeril--saw Dr. Scheive" and "he can open now." Therefore, Petitioner reported to Dr. Rumack he had seen both Dr. Romano and Scheive. On August 10, 2009 Dr. Rumack's notes confirm Petitioner had an appointment with Dr. Victor Mokarry, an ears, nose and throat specialist (ENT). The Commission notes Dr. Mokarry was referred by Dr. Romano according to the Patient History. Dr. Romano also referred Petitioner to an endodontist specialist, Dr. Jeffery Linden who referred Petitioner to a neurologist. Petitioner saw neurologist Dr. Daniel Cacioppo on September 15, 2009 and was referred for an MRI of his brain and a CT of the neck.

Dr. Romano referred Petitioner for physical therapy between October 8, 2009 and November 20, 2009. Petitioner then went to UIC at Chicago and saw Dr. Klasser on December 4, 2009. Next the Petitioner saw Dr. Mark Steinberg on referral from Dr. Romano. Dr. Steinberg recommended a second endodontic evaluation and Petitioner saw Dr. Gary Morris. Dr. Steinberg and Dr. Morris communicated regarding Petitioner's treatment. On August 27, 2010, Dr. Steinberg Noted Petitioner was still seeing Dr. Romano.

The Arbitrator correctly noted Petitioner had complaints of pain on the right side of his body on September 15, 2009, and complained of right arm radicular pain to Dr. Mokarry on November 13, 2009, symptoms consistent with a history of falling on his right side on July 2, 2009. Therefore, the Commission finds Petitioner's condition of ill-being with respect to his face, neck, right shoulder and right arm are causally related to the accident of July 2, 2009. Therefore, the Commission awards the medical treatment recommended by Dr. Romano as articulated in his letter dated March 8, 2011 for extract of symptomatic teeth numbers 4 and 5, replacement with implants and bone augmentation, and final restorations, within the strictures of §8(a) and §8.2.

The Commission finds Petitioner's treatment with multiple providers including Dr. Cinto, Dr. Klasser, Dr. Dallas-Prunskis, Dr. Lubenow, and Dr. LaVacca and respective referrals to chiropractor Sierszulski and Dr. Petruzzelli outside the chain of referrals from either Dr. Scheive or Dr. Romano and the Commission is compelled to deny these medical expenses based on the plain language of §8(a) of the Act.

18IWCC0018

The Commission finds Petitioner saw Dr. Cacioppo December 14, 2009 and a Plan was devised for treatment over the next three or four months. Petitioner saw Dr. Steinberg on December 21, 2009 and his letter to Dr. Romano documents the Petitioner had a negative workup including brain MRI, maxillofacial and neck CT Scans. Dr. Steinberg recommended an endodontic evaluation for what he described as chronic facial pain of unknown etiology. The next day (and eight days after last seen) Petitioner called Dr. Cacioppo's office with severe pain complaints and was referred to the emergency room at Alexian Brothers. The Petitioner appears to have requested out-patient treatment with Dr. DiGianfilippo, and Petitioner saw Dr. DiGianfilippo one time five months later on May 3, 2010 and had two follow-up phone calls. The Commission finds this treatment is not reasonable or necessary treatment noting that Dr. DiGianfilippo referenced the fact Petitioner had an MRI brain scan and cervicolumbar films that are unremarkable and "Those go back to 2008" predating the Petitioner's subject accident. Dr. DiGianfilippo also reviewed other medical records noting that in the past multiple sclerosis had been a differential diagnosis and that appears to have been ruled out. Petitioner was also seeing Dr. Stefoski and Dr. Echiverri in the past according to Dr. DiGianfilippo's records. The May 26, 2010 phone call note also documents Petitioner inquired about a certain drug and Dr. DiGianfilippo referred Petitioner back to Dr. Lagattuta, Petitioner's "medical physician." Dr. DiGianfilippo stated Dr. Echiverri is the neurologist Petitioner saw in the past "but that was some time ago."

The Commission finds treatment at Central DuPage Hospital and with Dr. Lagatutta is unrelated to Petitioner's condition of ill-being from the subject work accident.

The Commission also considered the issue of the Arbitrator's rejection of Respondent's Exhibit No. 18, the second deposition of the examining dentist Dr. DiVerde taken on September 9, 2014. The Commission overrules the Arbitrator's decision to reject the exhibit, however, after considering Dr. DiVerde's evidence deposition testimony finds his opinion was not critical to the Commission's Decision and the Arbitrator's rejection of Respondent's Exhibit No. 18 was harmless error.

The Commission finds the Petitioner's average weekly wage rate is $1,845.92. The Commission also finds Petitioner is entitled to 1-2/7 weeks temporary total disability for the period from January 17, 2011 to January 26, 2011.

IT IS THEREFORE ORDERED BY THE COMMISSION that the §19(b) Decision of the Arbitrator, filed July 15, 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 $1,230.62 per week for a period of 1-2/7 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.

18IWCC0018

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the medical expenses from Dr. Romano, Dr. Scheive, Dr. Mokarry, Dr. Cacioppo, Dr. Steinberg, and Dr. Gary Morris, for the reasonable related and necessary treatment provided to Petitioner between July 2, 2009 through August 20, 2015 and ATI physical therapy for the period between October 8, 2009 through November 20, 2009, and Alexian Brothers for the emergency visit on December 22, 2009 pursuant to §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the prospective medical expenses as recommended by Dr. Romano in his letter dated March 8, 2011 for extract of symptomatic teeth numbers 4 and 5, replace with implants and bone augmentation, and final restorations.

IT IS FURTHER ORDERED BY THE COMMISSION Respondent shall be given credit for medical benefits that have been paid and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in §8(j) of the Act, if applicable.

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 $1,400.00. 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: JAN 8 - 2018

kwl/bsd
o-11/07/17
42

Thomas J. Tyrrell

Michael J. Brennan

18IWCC0018

DISSENT

I respectfully dissent from the decision of the majority. Arbitrator Cronin's decision is thorough, well-reasoned, and grounded in the evidence. I would affirm and adopt it in its entirety.

Kevin W. Lamborn

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

BARABBA, COSIMO
Employee/Petitioner

Case# **10WC035356**

PINE LANDSCAPING INC
Employer/Respondent

18IWCC0018

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:

5669 ALEKSY BELCHER
RICHARD E ALEKSY
350 N LASALLE ST SUITE 750
CHICAGO, JL 60654

1408 HEYL ROYSTER VOELKER & ALLEN
LYNSEY WELCH
120 W STATE ST PO BOX 1288
ROCKFORD, IL 61105-0399

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPage)

☐ 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)

Cosimo Barabba
Employee/Petitioner

v.

Pine Landscaping, Inc.
Employer/Respondent

Case # **10** WC **35356**

Consolidated cases: _____

18IWCC0018

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 **Elgin** and **Chicago** on **8/11/15** and **8/20/15**, 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. X Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. X Was timely notice of the accident given to Respondent?
F. X Is Petitioner's current condition of ill-being causally related to the injury?
G. X What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. X Is Petitioner entitled to any prospective medical care?
L. X What temporary benefits are in dispute?
X TPD ☐ Maintenance X TTD
M. X Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. Other: **Violations of two doctor rule**

FINDINGS

On **7/2/09**, 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.

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

On the date of accident, Petitioner was **38** years of age, ***married*** with **2** dependent children.

ORDER

Compensation is hereby denied as Petitioner failed to prove that his current conditions of ill-being of his face, head, neck, right shoulder and right arm are causally related to the accident of July 2, 2009. The Arbitrator has found for Petitioner on the issue of accident, but has denied causal connection. Therefore, all other issues have been rendered 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.

Brian T. Cronin

Signature of Arbitrator

7/14/2016

Date

JUL 15 2016

18IWCC0018

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Cosimo Barabba v. Pine Landscaping, Inc
10 WC 35356

Findings of Fact

Petitioner's Testimony:

On July 2, 2009, Cosimo Barabba ("Petitioner") was employed by Pine Landscaping ("Respondent") as a salesman and foreman. Petitioner testified that he has worked for Respondent since 1990.

On July 2, 2009, Petitioner was working and was on his way to give an estimate. Petitioner testified that as he was stepping out of the truck that morning, he missed a step and hit the right side of his face. He testified that after he struck his face, he was a little dizzy and then, hours later, he felt a lot of pain come on to him. Between July 2, 2009 and July 15, 2009, he noticed a lot of pain "always" to the right side of his face. Petitioner testified that he reported the July 2, 2009 right facial injury to Anthony Barabba, Respondent's owner, on the same day that it happened. Petitioner testified that during the days that followed, he spoke with Mr. Barabba about his condition.

Petitioner first sought medical attention for this problem with Dr. Glenn Scheive on July 15, 2009. When Dr. Scheive saw him on July 15, 2009, he examined Petitioner's face, his mouth and the right side of Petitioner's body. Petitioner sought other dental opinions and the diagnoses included neuralgia, TMJ, and that his bite was off. Petitioner underwent an MRI, a CT, and an EMG. His odyssey of visits to various dentists, medical doctors, a chiropractor, and a physical therapist, began at that time and included Dr. Evan Rumack and Dr. Victor Mokarry, Dr. Antonio Romano, Dr. David Cinto, Dr. Jeffrey Linden, Dr. Daniel B. Cacioppo, Dr. Gary Klasser, Dr. Mark Steinberg, Dr. Terry Dallas-Prunskis, Dr. Gary Morris, Dr. Anthony

DiGianfilippo, Dr. Guy Petruzzelli, Dr. Robert Sierszulski, Dr. Timothy Lubenow and Dr. Anthony LaVacca. Petitioner participated in physical therapy at ATI, and received medical treatment at Alexian Brothers emergency room and Central DuPage Hospital. Petition testified that he also saw Dr. Kurt Bruksch at the request of the insurance company.

Petitioner testified that he has reviewed the payroll records that cover the period from July 7, 2008 through June 29, 2009, and that he earned $95,988.00 during this period, that he worked a whole 52 weeks and that that is an average of $1,845.92 per week

Petitioner wishes to receive the treatment that Dr. LaVacca and Dr. Lubenow have recommended. He is also seeking payment of TTD benefits, TPD benefits and outstanding medical bills. (Ax.1) Petitioner testified that he understands that there is a two-doctor rule in the state of Illinois. He is seeking reimbursement of out-of-pocket expenses and unpaid medical bills he has incurred that are covered under the Workers' Compensation Act. Petitioner testified that to the best of his knowledge, the total amount of the medical bills is $92,486.62, that workers' compensation insurance paid $26,726.12 and that the health insurance provided by his employer paid some of the bills. Adjustments, or discounts, were made to the bills. Petitioner further testified that he paid out-of-pocket charges of $7,781.63, which includes the charges from Connie McKeogh. Petitioner testified that, therefore, he is seeking reimbursement of the out-of-pocket charges in the amount of $7,781.63, as well as the unpaid balances, which would exclude Ms. McKeogh's bill of $6,450.30.

On cross-examination, Petitioner testified that there were no witnesses to his July 2, 2009 fall. The fall happened in the morning between 8:00 and 10:00 a.m. As Petitioner recalled, he thought the fall occurred at his second estimate. Petitioner usually started his workday at around 5:30 a.m. On the day of his fall, July 2, 2009, Petitioner did not see his primary care physician and did not present to any emergency room. Petitioner testified that his primary

dentist at the time of his alleged incident was Dr. Anthony Romano. Petitioner testified that he is honest and truthful with his treating physicians, dental health professionals, chiropractors and physical therapists. When he saw these medical professionals, Petitioner continued, he gave accurate histories of the pain and complaints that he endured with the fall. Petitioner testified that prior to July 2, 2009, he had missing teeth, fillings to his teeth, crowns and root canals on the left side. Petitioner testified that Dr. Lubenow prescribed Lyrica for nerve pain, which he takes. Currently, Petitioner does not have any work restrictions from any physician.

Contemporaneous Medical Records:

On June 26, 2009, Petitioner received treatment from his dentist, Antonio Romano, D.D.S. On that date, Dr. Romano handwrote the following:

> "persistent pain UR [upper right quadrant] pt saw
> Dr. Pison he finds nothing wrong w/RCT [root canal
> treatment] #2, 31, gave pt night guard removed post/
> CR #31 Porcpost building w/finger adj occl. [occlusion] 0/0
> pl very painful UR [upper right quadrant] @ TMJ. cause?
> will re eval if persistence ext [extract] 2 ? pt to advise"
> (Words in brackets added) (Rx.13)

On June 29, 2009, Petitioner sought treatment at Alexian Brothers Medical Center. His chief complaint was chest pain. The triage narrative notes indicate:

"PT REPORTS LEFT ARM PAIN AND NUMBNESS AND HE STATES HIS LEFT ARM FEELS LIKE DEAD WEIGHT WITH BURNING AND PINS AND NEEDLES. HE STATES THAT THE PAIN READATES (sic) TO THE LEFT CHEST AND THE BACK OF HIS NECK AND BEHIND HIS HEAD AND PRESSURE IN HIS EARS." (Rx.17)

The notes at the end of the NURSING SYSTEMS REVIEW section in the June 29, 2009 Alexian Brothers Medical Center records state:

"Patient presents to the ER Today because he states that for the past 4 days he has had left arm pain and that it states (sic) that it feels like pins and needles. Patient also complains of neck pain and a headaches the (sic) "feels like a brain freeze." Patient states that the tingling in him (sic) left arms (sic) starts at his shoulder and works its way down to his fingers. Patient states the headache a 8/10. (sic)" (Px.17)

The notes at the end of the HISTORY OF PRESENT ILLNESS section in the June 29, 2009 Alexian Brothers Medical Center records state:

"HPI text: 38 yo male presents here with left arm pain. Pt reports symptoms started 4 days ago with tingling in the left lower arm and hand, neck pain. Left arm started feel-

ing heavy but no weakness. Neck pain posterior bilateral, worse with movement, radiates up to base of head in back and scalp and down left shoulder to arm. Today while at work at rest, not exerting himself, pain was worse, right side of face also felt tingling and had 5 minutes of left sided chest pain. No chest pain now except if touching left ribs. Pt works construction, no known cervical disc pathology. No numbness or weakness of arms or legs." (Rx.17)

Petitioner's workup included a CT scan of the head due to dizziness, x-rays of the cervical spine, x-rays of the chest, EKG and blood work. (Rx.17)

The primary diagnosis was chest wall pain, radiculopathy and arm pain. (Rx.17)

On June 30, 2009, Petitioner returned to his dentist, Dr. Romano. At that time, Dr. Romano handwrote the following:

"2 > 31 ext [extract] due to persistant [sic] pain

20 - 10 m WN implant placed

3 carp C de 2 4 1 1 0 0 1" (Words in brackets added) (Rx.13)

On July 2, 2009, Petitioner returned to his dentist, Dr. Romano. At that time, Dr. Romano handwrote the following:

"#13 RCT [root canal treatment] after CN prep

due to pain after CN perp [sic] on 6/30/09

imp [impression] had been taken."

(Words in brackets added) (Rx.13)

On July 3, 2009, Petitioner returned to his dentist, Dr. Romano. At that time, Dr. Romano handwrote the following:

"ext [extract] 13 Z Pack 500 mg ... implant ... U-WN placed ↓ ..."

(Word in brackets added) (Rx.13)

On July 7, 2009, Petitioner returned to his dentist, Dr. Romano. At that time, Dr. Romano handwrote the following:

"PO [by mouth] hi g slow - smoker (R) TMJ pain cause?"

(Words in brackets added) (Rx.13)

On July 15, 2009, Petitioner sought treatment from Glenn Scheive, D.D.S. The handwritten notes in Dr Scheive's records of that date state:

"DDS Consult on his chin & right jaw joint
July 2nd he fell out of his truck and hurt
his chin on the door. Since then his jaw
joint hurts a lot mostly on his right jaw
joint, earaches, back of his head. He feels
like he loss (sic) balance. He started having
the clicking and popping on the right side
but it went away. He's on Flexeril and Vico-
profen. Smokes (+) 1 pack a day Ortho (-)
Anesthesia (+) no problems

c/o R side ache c̄ click but click has

resolved. Pt using Vicoprofen x 2 daily

More problems on opening 40 mm c

1 mm lateral shift (R) lat pterygoid pain

lat ached on on (R) side cause R pre auricular

pain (R) ear hear problems

(B) distal dysplasia" (Px.2)

Dr. Scheive then prescribed Flexeril and Lodine. (Px.2)

In a handwritten, undated letter from Tony Romano to Dr. Scheive, he wrote:

"Please evaluate Mr. Barabba for the possibility of Eagle's Syndrome encroachment of the styloid process." (Px.2)

In a handwritten, undated letter from Antonio Romano, D.D.S., to Dr. Steinberg, he wrote:

"I am referring Cosimo Barabba to you for evaluation and possible treatment of generalized chronic right facial pain with acute dental manifestation. Recent history include: trauma to face, dental restorations, root canals, extractions and dental implants. Right TMD is suspected. Please evaluate and advise. Please contact me should I be of any help. (Rx.13)

CONCLUSIONS OF LAW

The Arbitrator adopts the above findings of material facts in support of the following conclusions of law:

In support of his decision 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 testified that on July 2, 2009, between 8:00 a.m. and 10:00 a.m., as he was stepping out of the truck to give an estimate, he missed a step and hit the right side of his face.

The following are histories of accident provided by Petitioner and recorded by the various dentists, doctors and a physical therapist from the date of accident until the end of 2009:

Dr. Scheive's July 15, 2009 chart notes indicate that on "July 2nd he fell out of his truck and hurt his chin on the door." (Px.2)

On July 27, 2009, Petitioner began treating with Dr. Rumack. On that date, Dr. Rumack recorded that Petitioner "fell 7/1 or 7/2 – fell forward + hit Q on top of door couldn't open mouth." (Px.3)

On August 12, 2009, Petitioner saw Victor P. Mokarry, M.D., an ear, nose and throat specialist who is associated with Northwest ENT Associates, S.C. Dr. Mokarry wrote: "This started in July following a fall where the patient struck the right side of his face and under his jaw." (Px.4)

On August 17, 2009, Petitioner saw David A. Cinto, D.D.S., whose office is located in Oswego, Illinois. Dr. Cinto wrote: "Accident July 2, '09: missed step on truck; crashed into door with right side of head." (Px.5)

On August 27, 2009, Petitioner saw Jeffrey J. Linden, D.D.S, an endodontist who is associated with Advanced Endodontic Specialists. Dr. Linden wrote: "Pt. had fall in July and

hit is (sic) face on the car door. Pt. said he clinched (sic) his teeth together really hard when the accident occurred." (Px.6)

On September 15, 2009, Petitioner saw Daniel B. Cacioppo, M.D., a neurologist who is associated with Suburban Neurologists, S.C. Dr. Cacioppo wrote: "For the last two months he has complained of headache and facial pain ever since he allegedly fell out of his own work truck. He fell and hit the right side of his face and head." (Px.8)

Petitioner started a course of physical therapy at ATI Physical Therapy on October 8, 2009. The physical therapist recorded the following mechanism of injury ("MOI"): "Fall out of truck. Hit face on truck." (Px.9)

In handwritten letters authored by Antonio Romano, D.D.S.,one undated and directed to Dr. Steinberg and one dated October 13, 2009 and directed to "Colleague," Dr. Romano wrote that recent history includes trauma to face and history of trauma to face (7/09), respectively. (Rx.13)

On December 4, 2009, Petitioner saw Gary Klasser, D.M.D., who is associated with the UIC College of Dentistry. Dr. Klasser wrote: "He indicated his chief complaints commenced on July 2/2009 after falling out of a truck and as a result of this, receiving subsequent trauma to the right side of his face, neck and shoulder regions." (Px.11)

On December 21, 2009, Petitioner saw Mark J. Steinberg, D.D.S., M.D., who is associated with North Suburban Center for Oral and Facial Surgery. Dr. Steinberg wrote: "In July 2009, Mr. Barabba fell out of his truck. At that time, he hit the right side of his face on the truck door."

Petitioner testified that on July 2, 2009, following his unwitnessed work injury, he did not seek medical treatment for his face/jaw at the emergency room or with his primary care

physician. Petitioner testified that he first sought medical care for this accidental injury with Glenn Scheive, D.D.S., 13 days later.

Rx.13 indicates that Petitioner treated with his dentist, Antonio Romano, D.D.S., on July 2nd, 3rd and 7th, 2009. Nowhere in those 3 days of chart notes is there a history of traumatic injury to the right side of Petitioner's face/chin, although part of the chart note of 7/3/09 is difficult to read.

Petitioner testified that he usually started his workday at around 5:30 a.m.

There is no evidence that Petitioner and a co-worker drove to his second estimate.

Therefore, the Arbitrator reasonably infers that on the morning of July 2, 2009, Petitioner was exiting his truck on the driver's side when he missed a step. Petitioner later indicated to Dr. Lubenow that he fell on his outstretched right arm/hand. So, Petitioner claims that as he was exiting his truck on the *left* side, he missed a step and struck the *right* side of his face on the truck door and then proceeded to fall to the ground on his outstretched *right* arm.

There is no evidence as to the type of truck Petitioner drove that morning, or how many steps there were.

There is no evidence that Anthony Barabba or any other manager or supervisor completed an accident report for Petitioner's July 2, 2009 work injury.

Nevertheless, Petitioner, Cosimo Barabba, provided unrebutted testimony that he reported the July 2, 2009 right facial injury to Anthony Barabba, Respondent's owner, on the same day that it happened. Petitioner further testified that during the days that followed, he spoke with Mr. Barabba about his condition.

Anthony Barabba was not called to testify.

Petitioner testified that he is a salesman and foreman for Pine Landscaping and that on the morning of July 2, 2009, he drove to two prospective customers to give estimates. The

Arbitrator concludes that, given such job description, Petitioner was a traveling employee and the act of getting in and out of a truck would have been reasonable and foreseeable to Respondent.

Therefore, by a preponderance of the weight of the evidence, the Arbitrator finds that on July 2, 2009, Petitioner sustained an accident that arose out of and in the course of his employment by Respondent.

In support of his decision with respect to issue (F) "Is Petitioner's current condition of ill-being causally related to the injury?", the Arbitrator finds as follows:

In his Application for Adjustment of Claim, Petitioner alleges that as a result of his accidental injury of July 2, 2009, he sustained injuries to multiple parts. Petitioner is seeking to have Anthony LaVacca, D.M.D., rehabilitate and restore his dentition and have anesthesiologist Timothy R. Lubenow, M.D., administer additional Botox injections for pain relief.

On October 25, 2012, Dr. Lubenow testified via deposition. Dr. Lubenow first saw Petitioner on November 11, 2010. (Px.21) Dr. Lubenow testified that for Petitioner's facial symptoms, he diagnosed him with glossopharyngeal neuralgia, which is sometimes referred to as Eagle's Syndrome. He also diagnosed Petitioner with cervical radiculopathy. (Px.24, p. 5) Dr. Lubenow testified that there are two elements of Petitioner's history that he thought were important. The first is that he had some trauma to the outside lateral aspect of the face and jaw, and that he also fell forward onto his outstretched hand. As a consequence of that, Dr. Lubenow continued, he developed cervical radiculopathy that was manifested on an EMG and as a consequence of the door, he probably traumatized some of the nerves to the face which include the glossopharyngeal and some of the mandibular nerves that run in close proximity to the jaw. Dr. Lubenow testified that the pain that was most problematic for Petitioner during the

time that he treated him was the pain in the distribution of the glossopharygeal nerve, which is one of the cranial nerves that travels in the lateral aspect of the neck. (Px.24, p. 11) Dr. Lubenow testified, to a reasonable degree of medical certainty, that there is a correlation between the event that Petitioner shared with him, smashing his face into the truck door, and the complaints of ill-being that Petitioner reported to him. (Px.24, pp. 15-16)

On cross-examination, Dr. Lubenow testified that the history of accident that he had was the one that Petitioner rendered on that particular day, which was a synopsis. Dr. Lubenow did not recall Petitioner indicating how far he fell before he hit the truck door or the amount of force with which he struck such door. Petitioner did not indicate to Dr. Lubenow how high he was when he fell to the ground with his arm outstretched. (Px.24, pp. 18-19) Dr. Lubenow testified that the EMG showed impingement on the C7 nerve root, and that Petitioner has chronic C7 radiculopathy. However, there are several causes for such condition. (Px.24, pp. 22-23) Dr. Lubenow testified that the glossopharygeal nerve was where it would have been: in the lateral aspect of the face, jaw line and lateral aspect of the neck. (Px.24, p. 24) Dr. Lubenow testified that he did not recall that Petitioner was undergoing dental treatment at around the time of the accident and afterwards. (Px.24, p. 25)

On October 10, 2013, Dr. LaVacca testified via deposition. Dr. LaVacca testified that when Petitioner first presented to him on April 15, 2011, he told Dr. LaVacca that he experienced a traumatic event when he fell out of his truck and "hit his face on the side of the sidewalk basically." (Px.25, pp. 7-8) When Petitioner first presented to Dr. LaVacca, his chief complaints were: back pain, dizziness, ear and eye congestion, facial pain, headaches, jaw clicking, jaw joint noises, jaw pain, muscle soreness, neck pain, shoulder pain, visual disturbances, ringing ears and pain with chewing. (Px.25, p. 9) Dr. LaVacca testified that after examining Petitioner, he found that he had a "lack of posterior support," and that a lack of

posterior support is related to the absence of any kind of teeth back there. (Px.25, pp. 10-11) Dr. LaVacca explained that if there are no posterior teeth, the head of the condyle has a greater ability to be driven into the base of the skull and that is usually what causes TMJ and pain and discomfort. (Px.25, p. 10) Dr. LaVacca further testified that he understood that Petitioner had some implants removed on the lower right, but he was not sure about the upper right. (Px.25, p. 11) Dr. LaVacca testified that if there was a blow to the jaw, it's going to drive the condyle or head into the base of the skull, which then can cause damage to those structures along with a loss of consciousness. (Px.25, pp. 11-12) Dr. LaVacca did not perform any diagnostic studies to confirm the relationship of the condyle and the resulting TMJ. (Px.25, p. 12) Dr. LaVacca's testified that within a reasonable degree of dental, surgical and his specialty area (sic), that Petitioner's condition of ill-being that Dr. LaVacca discussed during direct examination, could be related to the striking of the right side of his face, based upon the history Petitioner gave him. (Px.25, p. 15) Dr. LaVacca testified to a reasonable degree of his area of expertise that this condition of ill-being and the treatment he is recommending could or might be related to his event of trauma as he detailed it for Dr. LaVacca as occurring on July 2, 2009. (Px.25, pp. 22-23)

On cross-examination, Dr. LaVacca testified that he testified earlier that Dr. Lubenow referred Mr. Barabba to him. Dr. LaVacca testified that if the April of 2011 notes indicate that Mr. Barabba was not sent to him by Dr. Lubenow, those notes would be correct. (Px.25, p. 25) Then, Dr. LaVacca testified that it would be incorrect that Petitioner did not present to him in April of 2011 at the direction of Dr. Lubenow. (Px.25, pp. 26-27) He testified that such visit was at the direction of Dr. Lubenow and that he then asked Dr. Lubenow for a prescription to treat Petitioner as a team approach "and that's when the prescription came according to the timeline after I saw him." (Px.25, p. 27) Dr. LaVacca agreed with Respondent's Counsel that Dr. Lubenow's name is spelled R-u-b-e-n-a-u-g-h. (Px.25, p. 29) Dr. LaVacca testified that in 2009,

he saw Petitioner because Petitioner does some landscaping for him. Dr. LaVacca testified that Petitioner is a business acquaintance of his. (Px.25, p. 30) Dr. LaVacca testified he is basing his opinions solely on the history that Petitioner gave him. (Px.25, p. 31) Dr. LaVacca testified that he has a March 8, 2011 letter in his chart from Dr. Romano, but has no other records in his chart that predate Petitioner's initial treatment with Dr. LaVacca. (Px.25, pp. 31-33) Dr. LaVacca was not aware that Petitioner had previously requested that all of his teeth be pulled. (Px.25, p. 34) Dr. LaVacca testified that Petitioner's condition of ill-being could also be related to the lack of posterior support that he already had in his mouth. (Px.25, p. 37) Dr. Lavacca testified that if somebody falls and doesn't have back teeth and gets hit in the jaw and the jaw bone goes into the base of the skull, "that's where the beginning of his pain started to come from ..." (Px.25, pp. 37-38) Dr. LaVacca testified that the lack of posterior teeth degeneratively could possibly cause such a condition. (Px.25, p. 39) He testified that a blow to the head could have exacerbated the pain. (Id.) He testified that the TMJ overall is coming from objective findings. (Id.) Dr. LaVacca testified that all of the exam findings are based on what Petitioner was telling him. (Px.25, p. 41) Dr. LaVacca testified that Petitioner's jaw pain could be related solely to a degenerative condition in his mouth. (Id.)

On redirect examination, Dr. LaVacca testified that that in the absence of the traumatic event where he smashed his face on July 2, 2009, Petitioner could be fine the rest of his life without posterior teeth. (Px.25, p. 42) Dr. LaVacca testified that he would need a CT scan to get a clear clinical picture of whether or Petitioner's condyle was in any way, shape or form displaced. (Px.25, p. 42) Dr. LaVacca testified: "Any traumatic event with patients without posterior teeth could exacerbate a condition, whether it be there or not be there." (Px.25, p. 43) Dr. LaVacca also testified: "I feel getting smashed in the face and his teeth slamming together

without posterior support can drive the condyle into the base of the skull and cause trauma." (Id.)

On June 20, 2012, Richard L. Noren, M.D., an anesthesiologist, testified via deposition. Dr. Noren performed a Section 12 examination of Petitioner at the request of Respondent on December 13, 2011. (Rx.5, Dep. Ex. 2) Dr. Noren testified that between 5% and 10% of his practice is devoted to conducting independent medical evaluations, and the balance of his practice would involve treating patients and pain management. (Rx.5, p. 6) Petitioner told Dr. Noren at the examination that he was having pain over the right side of his face, including the nose, and that it extended above his eye to include the whole right side of his face as well as the right neck radiating down to his shoulder. He also reported some numbness in his arm involving the fingers and the lateral portion of the hand. (Rx.5) Dr. Noren reviewed a December 2011 letter from the law firm and the medical records from Paul Gruenwald, Daniel Cacioppo, Guy Petruzzelli, ATI Physical Therapy, Rush Pain Center, Dr. Terri Dallas and the Illinois Pain Center, Jeffrey Linden, D.D.S, Robert Sierszulski, Victor Mokarry, M.D., and the following dentists: Gary Morris, Evan Rumack, Glenn Scheive, David Cinto, Anthony LaVacca, as well as some records from Alexian Medical Center and an MRI of the cervical spine also from Alexian Brothers. (Rx.5, pp. 8-9) When Dr. Noren asked Petitioner how he hurt himself, Petitioner reported that he missed a step in July 2009, fell out of his truck, hit his face on the truck door and fell on his right arm. (Id.) Dr. Noren further testified that when he asked Petitioner to give a history of the medical treatment he had received up until the Section 12, exam, Petitioner said he had seen a doctor who had removed his upper and lower molars, he saw Dr. Dallas at the Illinois Pain Institute and was subsequently referred to Timothy Lubenow who administered additional injections. (Rx.5, pp. 9-10) Dr. Noren opined that Petitioner's condition does not fit any clear specific diagnosis; the most likely diagnosis - - his pain symptoms were probably

consistent with something described as Eagle Syndrome. Dr. Eagle, an E.N.T., described patients who had tonsillectomies who then develop a facial pain syndrome that he related to the glossopharyngeal nerve. It can be related to the muscle and to the bone. It can be related to a fracture in that region affecting that specific cranial nerve. (Rx. 5, p. 11) Dr. Noren further testified that this is a poorly defined syndrome, for which there is no specific recognized treatment. (Rx. 5, p. 12) Dr. Noren believed that Eagle Syndrome is synonymous with a condition known as glossopharyngeal neuralgia.

Petitioner also told Dr. Noren that he has constant facial pain, that eating aggravated his symptoms and focusing with his right eye was difficult, that his taste sensation is decreased and he has a metallic taste in mouth but no changes with hot and cold food in his mouth, that opening and closing his mouth sometimes aggravated his symptoms but denied any clicking sensation in his ear with opening and closing his mouth. He denied any nasal problems of which he was aware; he had a CT of his sinuses. He also described a radiating sensation into his fourth and fifth fingers, which he described as tingling and numbness. (Rx.5, pp. 12-13)

Dr. Noren conducted a physical examination of Petitioner and found that Petitioner exhibited decreased sensation in the middle branch of the cranial nerve called the V2 branch of the cranial nerve. That was the only objective or subjective abnormal finding. (Rx.5, pp. 13-14) Dr. Noren explained that facial numbness would not be related to Eagle Syndrome since Eagle Syndrome involves the ninth cranial nerve and the facial nerve is the fifth cranial nerve. (Rx.5, p. 14) Dr. Noren diagnosed Petitioner with atypical facial pain and opined that it is not clear that he has Eagle Syndrome. (Id.) Dr. Noren testified that Petitioner did have some dental procedures that could potentially explain all of this. (Rx.5, p. 15) He testified that Petitioner relates it specifically to the trauma from his date of injury. (Id.) Dr. Noren testified that the causative explanations for Eagle Syndrome are purely hypothetical as Eagle, himself, described

it as related to tonsillectomies. It has been associated with fractures of the stylohyoid bone, which is a bone at the base of the skull and under the jaw, calcification of the ligaments, and calcification of the muscle in that region. (Rx.5, pp. 17-18) Dr. Noren testified, based on a reasonable degree of medical and surgical certainty as to whether Petitioner's condition at the time Dr. Noren saw him would be causally related to his trauma in July of 2009, that there is no evidence to say that a trauma of hitting your face against the side of a door would result in this type of pain syndrome. (Rx.5, p. 18) Dr. Noren opined that the correlation is based on the history that Petitioner provided him. (Rx.5, pp. 18-19)

On cross-examination, Dr. Noren testified that Eagle Syndrome would be and could be on the list of top ten diagnoses for Petitioner. (Rx.5, p. 23) Dr. Noren testified that if there were a contrary history of accident, he would have put it in his report. (Rx.5, p. 24) Dr. Noren testified that he did not believe that Petitioner suffered any structural damage to any part of his teeth or jaw. Dr. Noren reviewed some MRIs, but did not review any EMGs or x-rays. (Rx.5, pp. 25-26) Dr. Noren testified that he did not believe that he was provided with a report by the insurance company of a clinical investigation by Dr. John C. Braun that was put together on March 26, 2011. (Rx.5, p. 26) When asked if he was aware that the impression in such report included fractures of some teeth, some damage in his jaw, and multiple dental procedures with regard to teeth extraction, Dr. Noren testified that Petitioner told him that he had had a bunch of dental extractions. (Id.)

Dr. Noren testified that he does not read the medical diagnoses of others before he takes a history and conducts a physical examination because he does not want to be biased. (Rx.5, pp. 27-28) When Dr. Noren examined Petitioner, he found that Petitioner had no radiculopathy in his neck and going down his arm. He had no sensory findings, weakness or numbness. (Rx.5, p. 31) Dr. Noren testified that he has no basis to think that Petitioner is making up these

symptoms. (Rx.5, p. 37) Dr. Noren testified that he does not recall seeing a report written by Dr. Richrard Diverde, who examined Petitioner at Respondent's request. (Rx.5, p. 39) Dr. Noren testified that when he examined Petitioner, he found that he had normal strength, and there was nothing on his examination, specifically, that would be any contraindication, given his pain phenomena, of him working and performing hands-on physical labor. Dr. Noren testified that pain can be debilitating. (Rx.5, p. 40)

On redirect examination, Dr. Noren testified that it is not correct that there was no mention of Eagle Syndrome in any of the records that he reviewed. (Rx.5, p. 43) He testified that Petitioner told him that he had dental implants done prior to his injury in July of 2009. He further testified that Dr. Eagle described this syndrome in reference to a tonsillectomy and that he is unaware of anything in the literature that specifically causally relates glossopharyngeal neuralgia to facial trauma. (Rx.5, p. 44) Dr. Noren testified that he prepared his Section 12 report contemporaneous with his examination of Petitioner. (Id.)

On recross examination, Dr. Noren testified that he prepared such report some minutes or hours after the examination. (Rx.5, pp. 44-45)

On December 10, 2013, Richard B. DiVerde, D.D.S., testified via deposition. Dr. DiVerde testified that he was asked to review voluminous medical and dental records on Petitioner and to draft a report. (Rx.2, p. 7) The report was dated April 5, 2012. (Rx.2, Dep. Ex. 2) The records he reviewed were those of Paul Gruenwald, M.D., Daniel Cacioppo, M.D., Guy Petruzzelli, M.D., ATI Physical Therapy, Rush Pain Center, Dr. Terri Dallas-Prunskis and the Illinois Pain Center, Jeffrey Linden, D.D.S, Robert Sierszulski, D.C., Victor Mokarry, M.D., Gary Morris, D.D.S., Evan Rumack, D.D.S., Glenn Scheive, D.D.S., David Cinto, D.D.S., Anthony LaVacca, D.M.D., the records from Alexian Medical Center showing the MRI of Petitioner, Mark Steinberg, D.D.S., and Dr. Noren, M.D. (Rx.2, pp. 8-9) Dr. DiVerde testified that from his review

of the records, he noted that Petitioner worked as a landscaping estimator and that while he was exiting his truck, he missed a step and fell, striking his face on the door and his head, shoulder and arm on the ground. (Rx.2, p. 9) Dr. DiVerde noted from his review that there were multiple diagnoses by multiple doctors that he had seen. (Rx.2, p. 10) Dr. DiVerde testified that other than several missing teeth, he did not note any other pre-existing conditions. The missing teeth, Dr. DiVerde opined, could have been a degenerative condition or a traumatic condition. (Rx.2, p. 11)

Dr. DiVerde further opined that there were a lot of redundant examinations and treating physicians. Dr. DiVerde testified that after reading through the notes of each of the treating physicians and dentists, he noted that there was some progress being made in Petitioner's treatment and then somehow he went to another treating physician and began the process all over again. (Rx.2, p. 12) That set him back in diagnosis and treatment. (Id.) Dr. DiVerde testified that he agreed with the diagnosis of atypical odontalgia, and that the pain did not originate in Petitioner's teeth. Dr. DiVerde testified that Petitioner, in the records, reported pain in some teeth and that those teeth were removed. (Rx.2, p. 13) Dr. DiVerde did not have an opinion with regard to appropriate treatment for Petitioner. (Rx.2, p. 16) Yet, he agreed that Petitioner would need to have his posterior teeth on the right side replaced to stabilize chewing function and any kinds of problems that are going to be associated with his jaw joints. (Id.) Anytime you lose your teeth, Dr. DiVerde testified, there are going to be effects on the chewing function and the TMJ joints. (Id.)

Dr. DiVerde testified, to a reasonable degree of medical and dental certainty, that the loss of Petitioner's teeth is related to Petitioner feeling pain in the teeth, and that those teeth needed to be removed for the pain to go away. Dr. DiVerde found it really difficult to say that the loss of Petitioner's teeth is causally related to the fall. Dr. DiVerde testified that he felt Petitioner

could return to work without restriction doing estimates for a landscaping company. (Rx.2, p. 17)

On cross-examination, Petitioner testified that he believed that he did not review any records that were dated prior to the event that troubles Petitioner. (Rx.2, p. 18) Dr. DiVerde testified that Dr. Steinberg, Dr. Morris and Dr. Dallas-Prunskis were making progress during treatment. (Rx.2, p. 19) Dr. DiVerde testified that, as far as he knew, Dr. Scheive never removed those teeth. (Rx.2, p. 22) Dr. DiVerde testified that Dr. Linden, an endodontist, did 4 root canals due to pain emanating from those teeth. (Rx.2, p. 23) Dr. DiVerde testified that if something were not self-evident to various examiners and dental professionals that he saw, he would characterize that as "atypical odontalgia," a catchall. (Rx.2, p. 24)

Dr. DiVerde testified that given the histories in the records that he saw, there was a consistent history of slipping, striking the right side of his face on the door and then falling to the ground. (Rx.2, p. 25) Dr. DiVerde testified that that event would be a factor in causing, aggravating or accelerating any underlying condition that may have been asymptomatic prior to the event. (Rx.2, p. 26) Dr. DiVerde testified that some of Petitioner's posterior teeth were missing before the event, that such teeth were molars and that that would create instability. (Rx.2, p. 27) Dr. DiVerde agreed that Dr. LaVacca's approach would be appropriate. (Rx.2, p. 28) Dr. DiVerde testified that fourteen days before Petitioner saw Dr. Lubenow, Petitioner complained of significant right, atypical facial pain with the worst of his pain in two sites, the angle of the jaw. (Rx.2, p. 34)

Dr. DiVerde testified that he believed that Doctors Morris, Steinberg and Prunskis were eliminating many possible causes of his problem and were treating and relieving his pain relatively, not completely. (Rx.2, pp. 34-35) Dr. DiVerde testified that Dr. Morris stated that Petitioner needs to decide on a treating physician and stay with the program and recommended

that Dr. Romano stop performing procedures so that they can try to figure out where the pain is coming from. (Rx.2, p. 35) Dr. DiVerde testified that he does not have Dr. Romano's records and did not review such records. (Rx.2, p. 37) Dr. DiVerde testified that since DiVerde's report of April 5, 2012, he has not been provided with any additional information regarding Petitioner's condition. (Rx.2, p. 39) Dr. DiVerde agreed with Petitioner's Counsel that in two or three different places in DiVerde's report, DiVerde concluded that Petitioner's problems were related to this episode of trauma that he learned from the records. (Id.) Dr. DiVerde would not disagree with Dr. LaVacca's plan of splinting and stabilization. (Rx.2, p. 40) Dr. DiVerde agreed with Petitioner's Counsel that it would be prudent for the doctor to stabilize that posterior region - - where we do not know whether it was pre-existing or not pre-existing - - but where he had some missing teeth, and that that would be an effective approach for continued stabilization. (Id.)

On redirect examination, Dr. DiVerde testified that the root canals that were performed could be related to a pre-existing condition in Petitioner's mouth. (Rx.2, p. 41)

On recross examination, Dr. DiVerde agreed with Petitioner's Counsel that we have no knowledge as to whether or not Petitioner had any difficulties that would lead to root canals in four separate places. (Rx.2, p. 41) Dr. DiVerde also agreed with Petitioner's Counsel that "given the fact that, as a generally accepted proposition, he was asymptomatic prior to this smash in the face, it is more likely or (sic) not that these conditions were imposed - - or these procedures were imposed for the purpose of relieving the resulting pain from this weird complex of symptoms." (Rx.2, pp. 41-42)

The fact of the matter is, according to Rx.13, Petitioner *was* symptomatic shortly before the date of accident, and actually treated with his primary dentist, Antonio Romano, D.D.S., on the date of accident. Petitioner testified that 13 days post-accident, he first sought treatment *with a different dentist* for a condition that he claimed was related to the accident.

The Arbitrator finds that Petitioner is not credible.

On June 26, 2009, Petitioner complained of persistent pain in the upper right quadrant of his mouth at the TMJ, and Dr. Romano questioned the cause of such pain.

On June 29, 2009, which was 3 days before the accident, Petitioner presented to Alexian Brothers Medical Center. He had various complaints, which included headaches and neck pain, posterior bilateral, as well as pressure in the ears. The diagnostic tests included a CT scan of the head due to dizziness, and x-rays of the cervical spine. Quite significant was the following entry:

> "Today while at work at rest, not exerting himself,
> pain was worse, right side of face also felt tingling ..."

On June 30, 2009, Petitioner returned to Dr. Romano. Dr. Romano wrote:

> "2 > 31 ext [extract] due to persistant [sic] pain
> 20 – 10 m WN implant placed
> 3 carp Gde 2 4 1 1 0 0 1"
>
> (Words in brackets added) (Rx.13)

Petitioner testified that on July 2, 2009, he sustained the accident between 8:00 and 10:00 a.m. at the location of the second estimate. Petitioner usually started his workday at around 5:30 a.m. Petitioner testified that after striking his face that day, he felt "a lot of pain." Yet, he did not present to any emergency room that day or see his primary care physician that day or shortly thereafter. Petitioner neglected to mention at trial that on the same day as the accident, he treated with his dentist, Dr. Romano. At that visit, Dr. Romano made notes that fail to mention any occurrence that day of Petitioner hitting the right side of his face and fail to indicate any contusions, abrasions or bruising on Petitioner's chin or face. The July 2, 2009 entry consists of the following:

> "#13 RCT [root canal treatment] after CN prep
> due to pain after CN perp [sic] on 6/30/09
> imp [impression] had been taken."
>
> (Words in brackets added) (Rx.13)

Petitioner testified that after he struck his face on July 2, 2009, he was a little dizzy and then, hours later, he felt a lot of pain come on to him. When Dr. Steinberg saw Petitioner on December 21, 2009, he recorded a history in which Petitioner suffered a lot of dizziness immediately after the incident. He wrote that Petitioner experienced intense facial pain on the right side of his face. Yet, there is no evidence in Dr. Steinberg's report that the facial pain came on hours after the accident.

On July 3, 2009, Petitioner returned to his dentist, Dr. Romano. At that time, Dr. Romano handwrote the following:

"ext [extract] 13 Z Pack 500 mg ... implant ... U-WN placed ↓ ..."

(Word in brackets added) (Rx.13)

That is, Dr. Romano referred to an extraction of the #13 tooth, gave Petitioner a Z pack antibiotic, and referred to an implant.

On July 7, 2009, Petitioner returned to his dentist, Dr. Romano. At that time, Dr. Romano handwrote the following:

"PO [by mouth] hi g slow - smoker (R) TMJ pain cause?"

(Words in brackets added) (Rx.13)

So, on July 7, 2009, Dr. Romano was still questioning the cause of Petitioner's right TMJ pain.

The Arbitrator makes the reasonable inference that if Petitioner's accident had been a forceful injury, Dr. Romano would have attributed Petitioner's condition, at least in part, to such injury. Instead, 5 days post-accident, Dr. Romano was still questioning the cause of Petitioner's right TMJ pain.

In a handwritten letter dated "10/13/09" from Antonio Romano, D.D.S., to "Colleague," this dentist wrote:

"I am referring Mr. Cosimo Barabba to your clinic for an evaluation and possible treatment of right facial pain and right dentition hypersensitivity. Mr. Barabba has a history of trauma to face (07/09) and subsequent pain in affected area. Please forward me your findings and proposed treatment plan and let me know if I can help in this matter." (Rx.13)

Then, in a typewritten letter dated March 8, 2011 to "Sir or Madam", Antonio Romano, D.D.S., wrote:

> "Following an accident on July 2, 2009, Mr. Cosimo has had a multitude of complex dental problems and subsequent treatment, among which included the need to extract several teeth ..." (Px.23)

The Arbitrator finds that Dr. Romano is not credible as Petitioner clearly experienced right-sided facial pain and dental problems shortly before the accident. Furthermore, Dr. Morris later recommended that Dr. Romano stop performing dental procedures on Petitioner so that they could identify the source of Petitioner's pain.

When Dr. Scheive saw Petitioner on July 15, 2015, he found, *inter alia*, that Petitioner's right-sided clicking had resolved. Dr. Steinberg, on December 21, 2009, could not discern any right-sided clicking.

Dr. LaVacca's understanding of Petitioner's accidental injury was that he fell out of a truck and hit his face "on the side of the sidewalk, basically."

The Arbitrator notes that not one of the 4 doctors/dentists who was deposed reviewed Dr. Romano's handwritten chart notes (Rx.13), and consequently, not one was given a complete medical history. There is no evidence that either Dr. Lubenow or Dr. LaVacca reviewed any Alexian Brothers Medical Center records. It is not clear that either Dr. Noren or Dr. DiVerde reviewed the Alexian Brothers Medical Center record with a June 29, 2009 date of service. Therefore, the Arbitrator finds the opinions regarding causation of all 4 doctors to be defective and gives them little, if any, weight.

The Commission is not required to accept a causal connection opinion when it is based on flawed, inaccurate or incomplete histories. Sorenson v. Industrial Commission, 281 Ill. App.3d 373, 666 N.E.2d 713, 217 Ill. Dec. 44 (1st Dist. 1996)

A finder of fact is not bound by an expert opinion on an ultimate issue, but may look 'behind' the opinion to examine the facts. In re Joseph S., 339 Ill.App.3d 599, 607, 791 N.E.2d 80, 87, 274 Ill. Dec. 284 (2003)

On June 29, 2009, Petitioner was diagnosed with radiculopathy as Petitioner had complaints of pain and numbness, pins and needles and a burning sensation in his left arm, as well as chest pain. The following diagnostic tests were ordered: CT scan of the head due to dizziness, x-rays of the cervical spine, x-rays of the chest, EKG and blood work.

Petitioner complained of pain on the right side of his body on September 15, 2009. Petitioner complained of right arm radicular pain to Dr. Mokarry on November 13, 2009. Petitioner visited the emergency room of Alexian Brothers Medical Center on December 22, 2009, at which time he complained of right arm numbness and chest pain for 2-3 days. He also complained of numbness to his neck and jaw. Petitioner thought these symptoms were related to taking Neurontin. (Px.13)

The Arbitrator notes that it was not until November 11, 2010, when he first visited Dr. Lubenow, that Petitioner gave a history of missing a step, falling, hitting the right side of his face *as well as falling to the concrete on an outstretched right arm* on July 2, 2009. (Px.21, History and Physical, handwritten H.P.I.) Petitioner complained to Dr. Lubenow on November 11, 2010 of right arm pain that began in July 2009, which is a claim that is simply not supported by the medical records.

Therefore, based on the foregoing, the Arbitrator finds that Petitioner failed to prove that the current conditions of ill-being of his face, neck, head, right shoulder or right arm are causally related to the accident of July 2, 2009. Compensation is hereby denied.

Brian Cronin
Arbitrator

7-14-2016
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

Henry Ramos,

Petitioner,

18IWCC0020

vs.

NO: 15 WC 11059

The Malnati Organization,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 10, 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: JAN 10 2018
o12/14/17
DLS/rm
046

David L. Gore

Stephen J. Mathis

DISSENT

I respectfully dissent from the opinion of the majority. I would find that Petitioner failed to prove his current condition of ill-being is causally related to the accident of January 7, 2015. On the date of hearing, Petitioner was 27-years-old and taking care of his 7-month-old child at home. In addition to child care, Petitioner testified that he prepares meals, sweeps, mops, and does the shopping for the household. Petitioner claimed that he could not perform his job duties as a cook for Respondent, however I do not find his testimony to be persuasive. Petitioner continued working after the accident and the records from Concentra show that he reported improvement in physical therapy and he was released at maximum medical improvement for his lumbar contusion at the end of February. In April, Petitioner filed an Application for Adjustment of Claim and was referred for an MRI by his chiropractor at New Life Medical. However, Petitioner failed to offer complete records of New Life Medical into evidence. Petitioner testified that he has had no improvement in his back pain. As the medical records show, the basis for Petitioner's surgical recommendation is Petitioner's subjective complaints, which are not supported by the objective evidence. On the issues of causal connection and Petitioner's need for a lumbar fusion, I would not find the opinions of Dr. Erickson to be more persuasive than those of Dr. Lami. Dr. Erickson was not deposed and there is little evidence of his qualifications in the record. Dr. Lami had the opportunity to see Petitioner over a longer duration than Dr. Erickson, and Dr. Lami had the benefit of examining prior medical records in reaching his conclusions. I am not persuaded by the evidence in this case that Petitioner's lumbar condition and need for the requested lumbar fusion is causally related to the January 7, 2015 accident and therefore I must dissent.

Deborah L. Simpson

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

18IWCC0020

RAMOS, HENRY
Employee/Petitioner

Case# **15WC011059**

THE MALNATI ORGANIZATION
Employer/Respondent

On 5/10/2017, 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 1.01% 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:

0732 CARL H EBERT & ASSOC
REGAN D EBERT
134 N LASALLE ST SUITE 710
CHICAGO, IL 60602

1596 MEACHUM & STARCK
DEBORAH A BENZING
225 W WASHINGTON ST SUITE 500
CHICAGO, IL 60606

18IWCC0020

18IWCC0020

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)

HENRY RAMOS
Employee/Petitioner

v.

THE MALNATI ORGANIZATION
Employer/Respondent

Case # 15 WC 11059

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 **MARIA S. BOCANEGRA**, Arbitrator of the Commission, in the city of **CHICAGO**, on **FEBRUARY 22, 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 **Dependents at the time of the accident; Credit for paid medical expenses, 8a**

FINDINGS

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

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent. On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

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

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

On the date of accident, Petitioner was **25** years of age, ***single*** with **0** dependent child.

In the year preceding the injury, Petitioner earned **$15,251.60**; the average weekly wage was **$293.30**.

Respondent ***has not*** paid all reasonable and necessary charges for medical services.
Respondent shall be given a credit of **$7,186.19** for TTD, **$0** for TPD, and **$0** for maintenance benefits, for a total credit of **$7,186.19**.

ORDER

Respondent shall pay Petitioner statutory minimum temporary total disability benefits of **$220.00/week** for **58 weeks**, commencing **January 14, 2016** through **February 22, 2017**, as provided in Section 8(b) of the Act.

Respondent shall pay the reasonable and necessary medical services of which total in gross **$36,337.00**, as provided in Sections 8(a) and 8.2 of the Act. Against this specific award for these specific dates of service, Respondent shall be given a credit for medical benefits that have been paid and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay for and authorize the recommended lumbar fusion by Dr. Erickson, along with any and all incidental care thereto.

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

5-9-2017
Date

MAY 10 2017

FINDINGS OF FACT

Henry Ramos ("Petitioner") testified that he worked at The Malnati Organization's ("Respondent") factory, making frozen pizzas, for a period of 1½ years, preceding his January 7, 2015 injury and that his job duties varied day to day and throughout the day. He testified that his general required job duties were as follows: In the morning, he would get the pizza dough from the basement and load approximately 15 boxes, each weighing about 50 pounds, onto a pallet by himself. He would then wheel the pallet onto the elevator, up to the third floor, where he would unload it, put the pizza dough on the table, and then start cutting it into pieces. He would than place the pieces onto a conveyor. He testified that the speed with which he worked was based on the speed the conveyor belt was set on, but approximately 200 pizzas per hour, would move thru the conveyor. When the pizzas came out on the other end of the conveyor he would put 15 pizzas in each of the boxes and stack the boxes on a pallet. Each of these boxes weighed about 30 pounds and each of the pallets had 25 boxes on it. After the boxes were placed on the pallet he would shrink wrap it and then take the pallet back down to the lower level. Petitioner's job duties also included cleaning out all the machines and the freezers and the entire floor area which included mopping and cleaning with a squeegee, at the end of each day.

Petitioner testified and it was undisputed between the parties that on January 7, 2015, Petitioner injured his low back when he slipped on water and fell onto his low back while coming out of a cooler/freezer. He said he had immediate pain in his back and could not straighten out or get up and two of his co-workers had to assist him to stand. He reported the incident and was sent by Respondent to Concentra.

Petitioner testified that he had no previous problems with his back nor had he received any treatment for his back prior to the date of his work injury. He testified that he continued to see Dr. Erickson during the period he was working light duty and Dr. Erickson advised him in January 2016 that he should not return to work until he had the back surgery and he has not worked since January 13, 2016. (T 26-30). His TTD was cut off on January 13, 2016.

Petitioner was sent to Concentra Clinic, by his employer, on January 8, 2015, the day following his accident and their records reflect that he was complaining of sharp low back pain and stiffness and that bending, sitting, standing and twisting, all exacerbated pain. He was diagnosed as having a contusion of his lower back and prescribed Ibuprofen and given work restrictions of no squatting, kneeling or stair climbing and no lifting over 5 pounds and that he be allowed to sit as needed. He was also referred for physical therapy. No diagnostic imaging tests were performed.

On January 12, 2015, Petitioner returned to Concentra. He had ongoing complaints regarding his lower back bilaterally, which he described as stabbing and aching. He also stated that coughing, lifting, twisting and extension increased his pain. It was noted in his records that he had already attended two physical therapy sessions. Upon examination, the doctor noted that he had swelling of his lumbosacral spine at L3, L4, and L5 and tenderness and his work restrictions were ordered to stay in effect. Assessment was low back contusion.

On January 19, 2015, Petitioner returned to Concentra with ongoing complaints of intermittent pain in his lower back, described as aching, burning and throbbing. He stated that bending and lifting exacerbated his pain, as did standing after 1-2 hours. It was noted that he stood at work all day. Physical therapy was not helping. Examination revealed continued right paraspinal tenderness. Petitioner was referred to a physiatrist. Assessment was unchanged. Restrictions were modified to allow lifting of up to 20 pounds occasionally and pushing and pulling up to 40 pounds occasionally and he was advised to change positions periodically to relieve discomfort and to try and sit and stretch every other hour for several minutes.

On January 30, 2015, Petitioner saw Dr. Barbara Heller of Concentra. He was working light duty and denied lower extremity pain, numbness or tingling. Exam showed no distress and ability to move from sitting to standing with fair ease. However, lumbar flexion was significantly limited by discomfort in the left lateral lower

back, which radiated to the upper pelvis. Slump test was negative and gait was normal. Therapy interventions were changed to include deep tissue myofascial work. Skelaxin was added. Assessment was lumbar contusion.

On February 13, 2015, Petitioner returned to Dr. Heller. Exam and findings were largely unchanged. The doctor assessed improving lumbar contusion. Light duty was continued. On February 27, 2015, Petitioner was released full duty MMI. Rx6. Dr. Heller noted Petitioner was not consistent with proper body mechanics with lifting. He felt better relative to the contusion. Exam was unchanged from prior visit. Assessment was resolved lumbar contusion.

Petitioner testified that the treatment from Concentra did not help him much and he continued to have pain in his back and leg and his leg would go numb. Although he was released by Concentra Clinic to return to work full duty and he returned to work, he was still experiencing pain in his back and numbness in his leg. Petitioner continued to work and his pain became increasingly worse. When he told his employer about his ongoing pain he was told that he was on his own and to find his own medical provider.

Petitioner received chiropractic treatment at New Life Medical Center from March 26, 2015 through November, 2015 at the frequency of twice per week. Rx1. Eventually, Respondent's utilization review partially certified 6 out of the visits, noting no clear objective or subjective changes after the 4/3/15 date of service. Rx2-4. At his first visit he was complaining of low back pain and numbness in his left leg. Rx2. Pain was 8 out of 10. On April 7, 2015, Petitioner returned to New Life. Rx2. Pain was 6 out of 10 in the back and left leg. Eventually, MRI showed left paracentral disc herniation at L3-L4, with an annular tear causing central and foraminal narrowing at L4-L5 central and left disc herniation, showing generalized central and lateral stenosis with mass effect on the descending L5 nerve root. PxD.

On May 6, 2015, Petitioner first presented to Dr. Jain, pain management doctor. PxD. He related symptoms of low back and left lower extremity pain related to a work accident. Petitioner complained of thoracic and lumbar pain radiating into his left lower extremity. Petitioner also described numbness and pain radiating to the left lower extremity. Pain was aggravated by standing, lying for long periods of time, walking, bending backwards or forwards. Exam showed negative Waddell sign, antalgic gait favoring the right side, spasms, restricted lumbar range of motion, positive left straight leg raise, positive Patrick's test on the left and severe pain to palpation both a lumbosacral area and over the medial sulcus bilaterally. The doctor reviewed the MRI which he felt showed left paracentral disc herniation at L3 four with an annular tear causing central and neural foraminal narrowing. At L4-5, the doctor noted central and left herniation with central and lateral stenosis with mass effect on the descending L5 nerve root. The plan was for injections having failed conservative therapy to date. Petitioner was removed from work. Dr. Jain opined that Petitioner symptoms were related to his injury and that treatment thus far has been reasonable and necessary.

On June 11, 2015, examination findings at New Life were minimally changed with reports of moderate pain along with continued spasm, trigger points and decreased motion. Rx2.

On June 18, 2015, Petitioner was evaluated by Dr. Babak Lami at the request of Respondent. Rx1. Dr. Lami personally reviewed an MRI that had been performed on April 27, 2015. Dr. Lami noted that the MRI showed a normal disc at L5-S1 and at L4-5 noted a degenerative disc with herniation of the disc material to the left side. At L3-4 there was mild desiccation and degenerative changes. Based on examination, review of prior medical records and the MRI, Dr. Lami diagnosed low back pain with disc herniation at L4-5 with left leg radiculopathy at this visit. Dr. Lami found the diagnosis to be related by either being caused by the injury or that the injury aggravated a pre-existing condition. It was his opinion that Petitioner had low back pain with herniation at L4-L5, with left leg radiculopathy. He also noted that the disc herniation on the left side corresponded to his leg symptoms and the MRI findings. He also opined Petitioner was capable of work of no lifting more than 20 pounds and no repetitive bending and that the length of time the restrictions would be in

effect was unknown at the time. He further stated that the restrictions were related to the injury in question and that Petitioner had not yet reached MMI for his work injury.

On August 12, 2015, Petitioner underwent his first epidural injection at L3-L5 performed by Dr. Jain and saw him for follow up on August 18, 2015. He relayed that he felt good for a couple of days but that the pain returned. Prescribed medications of Tramadol, Meloxicam, Omeprazole, Flexeril and Teracin cream and patches provided complete relief of low back pain and radicular symptoms down the back of the left leg. He denied bowel or bladder deficits. Upon review of the EMG Dr. Jain found that it showed L5-S1 radiculitis and he recommended a repeat of the left transforaminal epidural steroid injection and selective nerve root block and continued his physical therapy.

On September 15, 2015, a left L4-L5 and L5-S1 transforaminal epidural steroid injection and selective nerve root block was performed. At the follow up appointment on September 30, 2015 a recommendation was made by Dr. Jain for a third transforaminal epidural steroid injection and physical therapy was ordered to continue.

On October 28, 2015 Dr. Jain again noted that the patient continued to have low back pain, worse on the left side, with numbness and tingling down the posterior leg, all the way down to the foot. It was also noted that the back pain was consistent, but that the numbness and tingling would come and go and vary in intensity. The plan was for discogram to source Petitioner's lumbosacral radiculopathy and for referral for surgical consultation. Light duty was continued, which consisted of a 10-pound lifting and 4-hour work day restriction.

A discogram was performed on November 3, 2015 from L2-S1. Indications included recalcitrant back and left lower extremity pain and his having failed with a reasonable course of conservative therapy, which included medications, physical therapy and injection therapy. The discogram confirmed discogenic pain at L3-L4 and L4-L5. PxD. CT imaging noted radial tears at L3 through L5 with extension of contrast posteriorly to the outer annulus, worse at the left L4-5.

On November 6, 2015, Petitioner saw Dr. Lami for a second evaluation. Rx1. Dr. Lami noted that Petitioner had been continuing treatment through New Life Medical Center. Petitioner had also started seeing Dr. Neeraj Jain at Pinnacle Pain Management Specialists. Petitioner advised Dr. Lami that injections had been performed but none of them had helped. Petitioner further reported that a discogram had been performed which resulted in additional pain. Petitioner rated his pain at 6/10 at this visit which was shortly following the discogram. Petitioner's pain disability questionnaire score was 96 at this visit. Dr. Lami noted that upon physical examination reflexes were symmetric, sensation was intact, straight leg raising was negative, and Faber testing was negative. Dr. Lami noted that Petitioner's subjective complaints did not match his objective findings. Dr. Lami continued Petitioner with light duty work with a gradual return to full duty after two to three months. Dr. Lami placed Petitioner at MMI at this visit. An AMA impairment rating of 10% whole person was assigned.

On November 10, 2015, Petitioner informed Dr. Jain that he saw Dr. Lami but ultimately was not evaluated or examined. Petitioner tried to return to work in November 2015, on light duty with the proviso that if he had pain he was to stop every 20 minutes and perform certain movements to his leg and lower back. He stated that despite restrictions, Respondent had him performing the same pre-injury work. He stated that he felt bad during his return to work and that he had pain which was in his lower back and traveled down his left leg.

On November 17, 2015 Petitioner saw Dr. Jain again and advised him that he had returned to work on October 28, 2015 for the 4 hours of light duty with the 10-pound lifting restriction and 10 pounds pushing and pulling restrictions, but that he was having difficulty due to his back pain and requested that he be given off duty work status. Dr. Jain noted that his complaints and examination were the same as those at his last visit and advised him to see Dr. Robert K. Erickson. This is the last date of service with Dr. Jain.

On October 30, 2015, Petitioner first saw Dr. Robert K Erickson, a Board certified orthopaedic surgeon, who noted in his history, that he was employed in the manufacture of frozen pizzas. PxC1. It was also noted that he stated that his pain was steadily increasing and that the pain was in the lumbar spine and left gluteal area. A review of systems revealed morning stiffness, difficult positional changes, restricted sitting and occasional numbness extending to the ankle. Doctor Erickson did not want to discuss any surgical options with Petitioner before reviewing the diagnostic discogram and the post discogram CT scanning.

On December 2, 2015, Dr. Erickson opined that Petitioner will require decompression and instrumentation from L3-L5 and treatment at his predominantly left-sided mechanical low back pain. At a follow-up visit on March 11, 2016, Dr. Erickson noted that Petitioner now has severe radicular pain along with mechanical back pain. On March 16, 2016, Dr. Erickson again noted that Petitioner had pain of 6-7/10 and was still unable to work and filled out a form to that effect. Another SSEP test had been performed to confirm the earlier results of the electrodiagnostic examination done by George Thurston DC on May 4, 2015, which showed mild-moderate left radiculitis involving L5 and S1, after IME Dr. Lami, called them into question.

The new SSEP testing, performed by Dr. Shakuntala Chhabria, again was correlative, showing moderately severe delay at L4 nerve root on the left side and the L5 nerve root on the left side. PxF. Dr. Erickson noted that Petitioner had severe radicular pain and mechanical low back pain after sitting more than 10-30 minutes at a time and that he could only walk up to 60 minutes before radicular leg pain would begin. He also noted that the diagnostic discography confirmed the radial tears affecting the L3-L4 disc and the L4-L5 disc and supported Petitioner's described pain.

There was a return visit on May 4, 2016 which revealed the same ongoing problems and complaints of pain as previously and the doctor's opinion remained the same. Petitioner continued to see Dr. Erickson thru 2016 with the same ongoing complaints and the doctor's recommendation remained the same, that surgery was necessary.

On February 17, 2016, Petitioner was re-evaluated by Dr. Lami at the request of Respondent for a third time. Rx1. At that time Petitioner advised Dr. Lami that he had been evaluated by Dr. Robert Erickson, who told him that he needed surgery and who explained the procedure to him. He stated that his pain was 5/10 and still present in his lower back and left buttock. Per Dr. Lami there were no findings from his own examination of Petitioner. Dr. Lami reviewed additional medical notes from Dr. Erickson. The doctor diagnosed Petitioner with axial low back pain without clinical radiculopathy or neurological deficit. Dr. Lami did not agree with Dr. Erickson's recommended fusion for Petitioner given his age, risks and benefit. He placed Petitioner at MMI and recommended full duty. On November 9, 2016, Dr. Lami was deposed and testified consistent with his reports. Rx1.

On October 18, 2016, Dr. Erickson wrote that there was correlation between findings on diagnostic discography CT scan and neurophysiological findings to predict Petitioner would respond positively to definitive surgical treatment at L3 through L5. PxC2. The doctor noted Petitioner's primary pain was mechanical in nature and thus a simple nerve decompression via hemilaminectomy was not effective. He opined causation between Petitioner's condition and the work accident.

Petitioner testified that he wished to proceed with the recommended lumbar fusion and is aware of the type of procedure. Currently, Petitioner is not working and continues to take care of his child who is 7 months old. He tries to prepare meals, sweep and mop. He testified he has difficulty sleeping and spends a lot of time laying down. He testified he currently takes Tramadol, which manages his pain but does not take away his pain. Petitioner said if he remains seated, it hurts and he can sit or stand a little more than 30 minutes at most. On cross, he stated he is not married and has one child. He was off work from July 2015 until November 2015 and was paid $7,186.99 in TTD, for that time.

CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment

Petitioner was the only witness to testify at trial. The Arbitrator observed Petitioner's testimony via his assigned translator/interpreter and notes that Petitioner appeared honest and credible in his testimony regarding his mechanism of injury, course of treatment and subjective beliefs as to his current level of ill-being.

ISSUE (F) Whether the Petitioner's condition of ill-being is causally related to the injury?

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. The Arbitrator concludes that Petitioner's current condition of ill-being as it relates to his low back, including his lumbar condition(s) identified at L3-4 and L4-5 are causally related to his work accident. In so finding, the Arbitrator notes that Petitioner was injury and symptom free relative to the low back prior to his undisputed work accident. Petitioner described an immediate onset of low back pain, with eventual onset of lower left leg extremity symptoms primarily consisting of leg pain, numbness and tingling. No doctor, including Dr. Lami, disputes Petitioner suffered disc herniations at L3 through L5. It is also undisputed between doctors, including Dr. Lami, that Petitioner suffers from radiculopathy. The Arbitrator is aware that the doctors do dispute causation and the need for fusion surgery. As it pertains to causation, the Arbitrator is not persuaded by Dr. Lami that Petitioner's causally related condition has stabilized or reached maximum medical improvement. Dr. Lami's first evaluation found herniation and radiculopathy. At the second evaluation, however, Petitioner's symptoms were thought to be subjective and the Arbitrator does not accept as persuasive the reasons given by Dr. Lami. Dr. Lami's subsequent opinions that Petitioner's condition has stabilized or reached MMI stands in contrast to Petitioner's treating records and the Arbitrator chooses to adopt the treatment records and medical opinions of Drs. Jain and Erickson, who opined Petitioner's condition is causally related to his work accident.

Here, Petitioner's condition was confirmed on both MRI and post discogram CT scans. In addition, SSEP testing confirmed radiculopathy as well as conduction delay at the L4 and L5 nerve root. Similarly, the Arbitrator declines to adopt the opinion by Dr. Heller that Petitioner suffered a contusion and the suggestion that Petitioner's complaints may have been due to poor body mechanics. Dr. Heller's opinion as to diagnosis, impression and resolution of same stands in contrast to Drs. Jain, Erickson and Lami, all of whom opined Petitioner sustained a disc herniation.

The Arbitrator also finds that Petitioner's condition has not stabilized or otherwise reached MMI. In support thereof, the Arbitrator finds that Petitioner has reasonably exhausted all conservative care by way of physical therapy, medications, diagnostic testing, lumbar injections and discography. Petitioner's credible and unrebutted testimony was that he was not better and was told to seek treatment elsewhere after Concentra. Petitioner did in fact seek out additional treatment after being prematurely placed at MMI for what was thought to be a lumbar contusion. Petitioner's treating doctors noted Petitioner's lack of improvement or response to all modalities undertaken. In addition, the Arbitrator also notes that Petitioner's unrebutted testimony, as supported by his treatment records, was that he also attempted to return to work in a light duty capacity and either had trouble or such restrictions were not honored by Respondent.

Based on the evidence presented the Arbitrator therefore finds that the Petitioner established that his present condition of ill-being, with regard to his low back, is casually related to his accident of January 7, 2015.

ISSUE (J) ***Whether the medical services provided to the Petitioner were reasonable and necessary? Has Respondent has paid all appropriate charges for all reasonable and necessary medical services?***
ISSUE (O) ***Respondent credit for medical expenses***

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. The Arbitrator concludes that Petitioner's medical treatment to date as submitted into evidence has been reasonable and necessary to cure or attempt to relieve Petitioner from the effects of his injury. Petitioner submitted into evidence four bills showing a total gross balance of **$36,337.00**, as follows: a medical bill from Pinnacle Pain Management Specialists showing a gross balance of $28,731.00, a medical bill from Windy City Anesthesia, P.C, showing a gross balance of $4,856.00, a medical bill from American Center for Spine & Neuro (Dr. Robert K. Erickson) for services showing a gross balance of $1,250.00 and a medical bill from Lake County Neuro monitoring showing a gross balance of $1,500.00.

The Arbitrator lists the above balances in gross as the payments issued on some of these bills are unclear as to its origin. The Arbitrator need not consider any other medical bills or UR, as Petitioner failed to submit such bills into evidence. Respondent asserts that it is entitled to a credit in the amount of $24,266.22 for medical expenses already paid. The issue of such credit was disputed at trial. Ax2, Rx7. Respondent's evidence as to its purported credits appears to show payments made to various providers for dates of service that appear to be listed in the "from" and "through" columns. However, the Arbitrator notes that Rx7 appears to also contain payments made to the providers noted herein for possible dates of service not disclosed in any medical record. For example, Windy City Anesthesia appears to have been paid for an August 12, 2015 date of service for which no medical record exists. The Arbitrator is therefore unable to rely entirely on Rx7 to calculate Respondent's credit and no further record was made to assist in this regard. However, the Arbitrator notes that the dispute as to credit does not necessarily challenge Respondent's entitlement to a credit but rather the amount of the credit.

Based on the evidence presented and having found in favor of Petitioner on the foregoing issues, the Arbitrator therefore finds that Petitioner has established that all medical services provided to him were reasonable and necessary. The Arbitrator notes that the outstanding charges reflect dates of services for which reasonable and necessary treatment was undertaken by Petitioner and his doctors to diagnose, treat or cure his lumbar spine condition. Respondent shall pay the reasonable and necessary medical services of which total in gross **$36,337.00**, as provided in Sections 8(a) and 8.2 of the Act. Against this specific award for these specific dates of service, 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) ***Whether Petitioner is 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 preponderance of the evidence that he is entitled to prospective medical care, as his causally related condition has not yet stabilized and he is not yet otherwise at MMI. As the Arbitrator found in Paragraph F above, the Arbitrator has found that Petitioner's current condition of ill-being, is causally related to the work injury of January 7, 2015. The Arbitrator finds that the Petitioner continues to suffer from herniated discs (annular tears) at L3-L4 and L4-5 along with lower left leg radiculopathy.

Regarding Dr. Lami's opinion that Petitioner was not in need of a fusion, that opinion was based on an MMI finding due to subjective symptoms, Petitioner's age and his opinion that the fusion was not likely to improve physical capabilities. First, the Arbitrator is not persuaded that Petitioner's condition is at MMI because Petitioner's complaints are subjective. Dr. Lami fails to adequately explain how Petitioner's axial low back pain, herniated discs and/or radiculopathy resolved. Dr. Erickson noted that Petitioner's condition has failed conservative care and that it is mechanical in nature due to disc disruption rather than radiculopathy due to nerve root compression. There is sufficient evidence in the record to support Dr. Erickson's conclusions, which are

based upon more than mere subjective complaints. Second, the Arbitrator is also not persuaded that Petitioner's fusion will not improve physical capabilities insofar as that was not the stated purpose of the fusion surgery. Rather, the fusion surgery proposed by Dr. Erickson would not itself debilitate Petitioner but rather make it more likely that he could return to full duty work. See PxC3. Third, the Arbitrator notes that while Petitioner's age is certainly a factor to be considered, Dr. Erickson adequately addressed this concern at the 3/11/16 date of service and presumably discussed the risks and benefits with Petitioner, as he noted they also discussed other surgical options. Moreover, when pressed at trial, Petitioner appeared to understand the nature of the procedure and testified he still wished to proceed.

Based on the record the Arbitrator concludes that Respondent shall pay for and authorize the recommended lumbar fusion by Dr. Erickson, along with any and all incidental care thereto.

ISSUE (O) The number of dependents at the time of the incident on January 7, 2015?

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. The Arbitrator concludes that Petitioner has failed to prove by preponderance of the evidence that he was married with two dependents at the time of the work accident as alleged in Ax1. Petitioner admitted at trial that he was single and had one 7-month-old child with his girlfriend. The 7-month-old child cannot count as his dependent for the purposes of this claim as the child was born after the date of accident. Instead, Petitioner claims his girlfriend's 8-year-old child was his dependent on January 7, 2015. The stipulation sheet was amended at trial to allege single with one dependent. Respondent disputes that Petitioner had any dependents on the date of accident. The Illinois Workers' Compensation Act states:

> **"The term "child" means a child of the employee including any child legally adopted before the accident or whom at the time of the accident the employee was under legal obligation to support or to whom the employee stood in loco parentis, and who at the time of the accident was under 18 years of age and not emancipated. The term "children" means the plural of "child"."**

Petitioner bears the burden of proof on this issue. There was no proof that Petitioner was under legal obligation to support his girlfriend's daughter nor was there any proof of in loco parentis. Thus, the Arbitrator finds that the statutory minimum TTD and PPD rate in this matter is $220.00 based on a single individual with no dependents at the time of the accident.

ISSUE (L) Whether Petitioner is entitled to TTD benefits?

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 issues, the Arbitrator concludes that Petitioner has proven by preponderance of the evidence that he is entitled to temporary total disability (TTD) benefits as a result of work related injuries and because he has not yet reached MMI.

Having adopted Dr. Erickson's opinions, the Arbitrator notes that the doctor removed Petitioner from work beginning December 2, 2015 and that Petitioner remains unable to work. Based on the evidence presented the Arbitrator therefore finds that Respondent shall pay Petitioner statutory minimum temporary total disability benefits of **$220.00/week** for **58 weeks**, commencing **January 14, 2016** through **February 22, 2017**, as provided in Section 8(b) of the Act.



Signature of Arbitrator

5-9-2017
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

Cordero Hightower,
Petitioner,

vs.

Elite Pay Global,
Respondent.

18IWCC0021

NO: 14 WC 23344

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 all issues 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 24, 2107, 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: JAN 10 2018
o12/14/17
DLS/rm
046

Deborah L. Simpson

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0021

HIGHTOWER, CORDERO
Employee/Petitioner

Case# **14WC023344**

ELITE PAY GLOBAL
Employer/Respondent

On 3/24/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.89% 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:

0000 HIGHTOWER, CORDERO
1400 N LAKESHORE DR
UNIT 14E
CHICAGO, IL 60610

5074 QUINTAIROS PRIETO WOOD & BOYER
KYLE P JEFFERSON
233 S WACKER DR 69TH FL
CHICAGO, IL 60606

18IWCC0021

18IWCC0021

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

Cordero Hightower
Employee/Petitioner

v.

Elite Pay Global
Employer/Respondent

Case # 14 WC 23344

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 **Maria Bocanegra**, Arbitrator of the Commission, in the city of **Chicago**, on **12/13/16 and 1/17/17**. 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 **Petitioner's Prior Attorney Fee Petition**

FINDINGS

On **6/11/14**, 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.

Because Petitioner failed to prove accident, the other disputed issues of average weekly wage, causal connection, liability for unpaid medical bills, temporary total disability, nature and extent and petition for attorney's fees is hereby rendered ***moot***.

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

On the date of accident, Petitioner was **27** 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 **$0.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$0.00**. Respondent is entitled to a credit of **$0.00** under Section 8(j) of the Act.

ORDER

Petitioner has failed to prove by a preponderance of the evidence that he suffered any accident on June 11, 2014 arising out of and in the course of his employment with Respondent. All other issues are hereby moot and all other claims for compensation 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

3-24-2017
Date

MAR 24 2017

BACKGROUND

Cordero Hightower ("Petitioner") alleged injuries arising out and in the course of his employment with Elite Pay Global ("Respondent") on 6/11/14. By agreement, Petitioner, appearing Pro Se, and Respondent proceeded to arbitration on 12/13/16 and again on 1/17/17. Ax1-2. Petitioner's former counsel also appeared on the collateral issue of a pending attorney's fee petition. The parties agreed that the Arbitrator should rule on the attorney's fees issue at the time an arbitration decision would issue. The following is a recitation of the facts adduced at trial.

FINDINGS OF FACT

Petitioner testified that he was employed by Respondent on June 11, 2014. (T.26) He began working for Elite Pay on February 8, 2014, which was located on the 8th floor at 212 W. Van Buren Street, Chicago, IL 60607. (T.26) Petitioner testified that his job title at Elite Pay was Executive Sales Agent, which required him to travel across the United States selling their product. (T.63) He was also involved with Inside Sales, which required him to place sales calls from the office. (T.63) Petitioner's manager, Jim Tibor, testified that Petitioner was removed from the position of traveling sales after one week due to a temperament issue and poor job performance. (T.86) Tibor testified that Petitioner's job was strictly limited to placing sales calls from the office. (T.85-86)

Petitioner testified that on June 11, 2014 around 11:00 AM while at work, smoke started to come out of the mechanical room and he started to choke. (T.21) He testified the mechanical room was located directly behind his cubicle. (T.21) Tibor testified that Petitioner's cubicle was nowhere near where the mechanical room was located. (T.123) Tibor provided a drawing of the office layout at trial, and the drawing reflects that the mechanical room was not directly behind Petitioner's cubicle. (PX1) Petitioner testified that "the drawing pretty much speaks for itself." (T.126)

Petitioner testified that the Vice President of the company announced to employees to remain seated. (T.21) He testified that the Vice President tried to "put out the fire." (T.21) He stated that the VP then told the employees to clean out the mechanical room, and he forced them to move all of the water jugs out that had been stored in the room. (T.22) Tibor testified that the door to the mechanical room was never opened until the fire department arrived. (T.138)

Petitioner said the entire room was filled with smoke. He could see but the smoke had filled the room. (T.22) Petitioner described that his eyes were burning and he could not breathe. (T.22) He stated that he had to be helped down the stairs by other employees. (T.22) He testified that he was dizzy and almost passed out. (T.22) He stated that a fire chief directed him to an ambulance. (T.22) Petitioner testified that he was provided with oxygen at the scene, on the ambulance and again at the hospital. (T.32) Chicago Fire Department records show arrival on scene and that no fire was found. At that time, Petitioner denied treatment offered by CFD. Px4. Impression was dizziness and exam at that time was essentially normal. Oxygen levels were normal.

Petitioner testified he then was sent to Rush Hospital and treated for mild smoke inhalation. (T.22) He testified that he then saw Dr. Munoz and was diagnosed with PTSD. (T.23) He testified he then treated with Dr. Kelly at Integrated Behavioral for PTSD. (T.23)

Petitioner's manager, Jim Tibor ("Tibor") testified regarding the events of June 11, 2014. Tibor testified that there were about 50 employees in total working on the 8th floor at Elite Pay on that date. (T.88) Tibor first noticed a light amount of smoke coming out from under the closed door of the mechanical room. (T.89) Tibor had an unobstructed view of the mechanical room. (T.90)

Tibor could not smell the smoke initially but could see it. (T.89) He described it as looking like a handful of people were smoking cigarettes on the other side of the door or like a smoky bar. (T.90) The smoke had a white color and it was coming from under the door at a small pace. (T.90-91) Tibor stated that the fire alarm went off shortly after the smoke appeared. (T.91)

Tibor testified that all employees were notified that they should exit the building at that time. (T.91) He stated that no employees were panicked and none appeared to be having any issues breathing. (T.93) He testified the employees evacuated in an orderly fashion and he specifically recalled the Petitioner exited in an orderly fashion. (T.92-93) He further testified the Petitioner was not exhibiting any specific physical symptoms at that time and appeared to be acting normally. Tibor recalled that the fire department responded quickly and by the time they arrived, the bulk of Elite Pay's employees, including Petitioner, had already evacuated the building to the street. (T.103)

Tibor testified that he and a handful of other employees including the General Manager remained on the 8th floor throughout the entire process and did not evacuate. (T.108) He testified that he did not feel in any danger by remaining on the floor. (T.102) He stated that he and his colleagues putted golf balls while they waited for the fire department to arrive. (T.102) Tibor denied seeing fire or flames. Tibor testified that the fire department was able to assess that the HVAC unit posed no ongoing danger, and the fire department indicated that the area was safe for employees to return that same afternoon.

Tibor testified that the 8th floor did not have any windows that could be opened so a door adjacent to a fire escape was propped open and a fan was utilized to ventilate the room. (T.116) He testified that all of the smoke had cleared the 8th floor by the time the other employees returned to the floor. (T.116)

Tibor testified that all of the Elite Pay employees returned to the 8th floor that same afternoon, with the exception of Petitioner. Upon their return, management gave the remaining employees the option to remain in the office and work or go home if they wished. The ones who stayed were able to finish the work day with no complaints. Tibor stated that the office was open the following day and again there were no complaints. Tibor testified that all of the office equipment such as computers, phones, and all other electronic devices remained in proper working order at all times.

Tibor spoke with several employees regarding the actions of Petitioner on the street during the evacuation process. Elite Pay employee, Dorothy "Dolly" Reitinger, took a cell phone video of the Petitioner on the date of the alleged accident. Tibor received and watched the video.

The cell phone video was played at trial and Tibor verified it was the same video he watched on June 11, 2014. The video depicts the Petitioner sitting on a stretcher and is observed smiling, giving a "thumbs up" and without any oxygen mask. Rx9.

Petitioner first sought treatment on June 11, 2014 at Rush University Medical Center. Px5, Rx3. Petitioner described a fire in his office a few cubicles down from him. Petitioner stated that he saw smoke, was in the office for an hour and did not see flames. Exam revealed Petitioner was oriented to person, place, time and was in no distress. Exam of the chest and lungs revealed normal breath sounds and no respiratory distress. He admitted to smoking cigars.

Petitioner returned to Rush on June 16, 2014. *Id.* He told the physicians that he was able to work on June 12 and June 13, but left work on June 16 to go back to the ER. He complained of anxiety attacks when he went back to work, and he said he would begin to become diaphoretic, had palpitations, and became short of breath. The records indicate that Petitioner did not have shortness of breath, coughing or headaches at his baseline. These records reference that Petitioner had seen a psychiatrist/therapist just 9 months prior to the

alleged accident. At the time of the alleged accident, Petitioner was taking medications for anxiety and depression, including Prozac. Petitioner requested on that date that the ER physicians double up his medications. Petitioner appeared awake, alert, cooperative, and in no apparent distress. An exam of the lungs revealed no increased work of breathing, good air exchange, clear to auscultation bilaterally, and no crackles or wheezing. The records noted Petitioner had no lingering physical side effects from the incident. He was referred to a psychiatrist at Cook County to review his anxiety complaints.

Petitioner then presented to Dr. Munoz at WorkCare Occupational Medical Center on June 17, 2014. Px6. On that date, Petitioner offered Dr. Munoz a description of the alleged accident. Petitioner described that he began to smell smoke and quickly noted he was having difficulty breathing, along with irritation of his eyes and nose. He described filing down eight flights of stairs to awaiting ambulances. He explained that he was taken to Rush ER where he was told he had elevated CO2 levels and was directed to follow up with a personal physician. Petitioner complained of being anxious, nervous, and having panic attacks when he recalls the work accident. The doctor diagnosed occupational bronchitis and PTSD. He again saw Dr. Munoz in follow up on June 25, 2014.

Petitioner presented to Dr. Daniel Kelley at Integrated Behavioral Medicine on June 18, 2014 and June 20, 2014. Px7, Rx7. Dr. Kelley noted that Petitioner's past medical history is reportedly unremarkable. Petitioner denied a past psychiatric history. Petitioner also reported that he was not currently on any prescribed medications. Petitioner described to Dr. Kelley that he was working at his cubicle when the mechanical door to the left of him started smoking. The history he gave to Dr. Kelley was that the room immediately filled with smoke in about 4 seconds and he thought the building was burning. He related others tried to put the fire out and employees formed a line to move everything out of the mechanical room. He described that people could not breathe and had shirts over their noses. He then felt he had to leave and stumbled down eight flights of stairs. He recalled that an ambulance took him to the hospital and said his CO2 levels were high.

Nearly 3 months later, on September 8, 2014, Petitioner presented to the ER at Northwestern Hospital with complaints of anxiety attacks and shortness of breath. Px8, Rx4. Respiratory, cardiovascular, neurological and psychiatric exams were normal. Chest x-rays were normal. Petitioner testified that these x-rays revealed mild smoke inhalation. No mention of a work incident is noted.

On September 13, 2014, Petitioner returned to Northwestern ER. *Id.* Petitioner complained of anxiety triggered by a fire at his apartment building the night prior. Petitioner testified that he had called the fire department and reported that he saved woman's life at 1400 N. Lake Shore Drive on that date. Petitioner came to the ER stating "I need my Lexapro" and was yelling "I can't breathe, my hands are numb." The treatment notes indicate Petitioner denied any exposure to the fire or any injuries. Exams were normal. No mention of a work incident is noted.

Petitioner then presented to Dr. Alexander Obolsky and Dr. Karla Felske for Section 12 examinations. Rx1. Petitioner gave the physicians a description of the alleged accident. Petitioner stated that he was working on June 11, 2014 when a fire broke out and his office building filled with smoke. Petitioner stated that he blacked out and was awoken by another employee who helped him out of the building and down eight flights of stairs. He then recalled going to the hospital where he was told he had high CO2 levels and was given oxygen that made him feel better. Petitioner told Dr. Obolsky that he went back to the hospital on June 13, 2014.

Dr. Felske concluded that Petitioner's self-reported symptoms are inconsistent with the nature and scope of the injury in question. Rx2. Petitioner reported and endorsed symptoms that are markedly inconsistent and improbable in number, pattern and severity given the typical expectations. She noted inconsistencies between his self-reported symptoms and his observed behavior. The doctor concluded Petitioner was malingering.

Dr. Obolsky concluded that Petitioner was malingering. He found Petitioner at MMI with regard to the work event because he did not experience any mental injury at that time.

Petitioner's prior medical history is positive for pre-existing anxiety. Rx5. Petitioner admitted to a history of filing lawsuits related to alleged mental and physical trauma arising out of an alleged physical and sexual assault by the Chicago Police Department. Petitioner alleges this incident occurred on November 1, 2011. Petitioner treated for these issues following the alleged incident. Rx5. Petitioner admitted to filing suit against Northwestern Hospital for refusing to provide a rape kit in connection with the suit against the City.

Petitioner presented no witnesses at trial. The Arbitrator declined further continuances based upon previous agreement of the parties.

Petitioner presented testimony and documents in connection with his allegation that he had concurrent employment with Chi-Glow, his personal business, at the time of the incident. The Arbitrator questioned Petitioner on how he earned money from this business and Petitioner did not provide an explanation.

CONCLUSIONS OF LAW

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

The Arbitrator incorporates the foregoing findings of fact as though fully set forth herein. The Arbitrator concludes that Petitioner has failed to prove by a preponderance of the evidence that he suffered any accident

arising out of and in the course of his employment on June 11, 2014 with Respondent. The Arbitrator notes that this case is one of credibility.

In so finding, the Arbitrator specifically finds Petitioner to be an incredible witness, not believable and questions the validity of much of his testimony. Petitioner's testimony that a fire occurred is not supported by Tibor's testimony, to which the Arbitrator assigns more weight to, or by the video provided depicting Petitioner is an otherwise state of normal appearing health, affect and mood.

Moreover, Petitioner's testimony as to the facts surrounding the incident is not supported by any credible record. In addition, the medical records amongst one another are not compatible or corroborative of any alleged accident. Indeed, there is little doubt an incident occurred involving Respondent's mechanical room but it did not occur according to any version of events portrayed in numerous records. Petitioner testified that he was forced to stay yet in other records; he relates a story of him and other employees emptying out the mechanical room. Neither version is believable or likely given the severity to which Petitioner places upon the circumstances. In another version, Petitioner relates that he fell asleep and was awoken in order to evacuate. Petitioner's emphasis of suffering smoke inhalation is also not supported by any record as all records revealed normal exams. In summary and in light of the foregoing, the Arbitrator concludes that Petitioner has failed to prove by a preponderance of the evidence that he suffered any accident on June 11, 2014 arising out of and in the course of his employment with Respondent. All other issues are hereby moot and all other claims for compensation are denied.



Signature of Arbitrator

3-24-2017
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

Vielman Cordon,

Petitioner,

18IWCC0022

vs.

NO: 15 WC 28577

Healthcare Solutions,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 24, 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.

18IWCC0022

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: JAN 10 2018
O11/16/17
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

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

CORDON, VIELMAN
Employee/Petitioner

Case# 15WC028577 18IWCC0022

HEALTHCARE SOLUTIONS
Employer/Respondent

On 2/24/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.67% 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:

0154 KROL BONGIORNO & GIVEN LTD
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2837 LAW OFFICES JOSEPH MARCINIAK
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CHICAGO, IL 60602

18IWCC0022

18 IWCC0022

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)

Vielman Cordon
Employee/Petitioner
v.
Healthcare Solutions
Employer/Respondent

Case # **15 WC 28577**

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 **1/28/2016**. 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. ☒ 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, **10/24/2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$34,147.88**; the average weekly wage was **$656.69**.

On the date of accident, Petitioner was **39** 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 **$21,514.25** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$21,514.25**.

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

ORDER

Respondent shall pay the following unpaid medical bills of Petitioner:

1. Illinois Sports Medicine & Orthopedics: $331.83.
2. Illinois Bone & Joint Institute: $83.00.
3. Athletico: $224.59.

Respondent shall pay Petitioner temporary total disability benefits of **$437.79**/week for **49 & 5/7** weeks, commencing **11/3/2014** through **3/11/2015**, and also commencing **4/29/2015** through **12/7/2015**, as provided in §8(b) of the Act.

Respondent shall be given a credit of **$21,514.25** for temporary total disability benefits that have been paid.

Petitioner failed to prove that he is entitled to the recommended prospective medical treatment is reasonable or necessary, therefore additional medical benefits and prospective medical treatment 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

February 23, 2017
Date

ICArbDec19(b)

FEB 24 2017

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?; ***L:*** What temporary benefits are in dispute? TTD; ***K:*** Is Petitioner entitled to prospective medical care and services?

FINDINGS OF FACT

Petitioner Vielman Cordon was a 39-year-old driver-technician employed by Respondent Healthcare Solutions to deliver oxygen tanks since approximately 2008-2009. Petitioner testified that on October 24, 2014, he was delivering an 85-pound oxygen tank to Grayslake, Illinois. He transferred the tank from his truck to a hand dolly. The handle on the dolly broke and the oxygen tank came off the dolly. Neither the tank nor the dolly struck Petitioner. Petitioner testified that he bent his left knee as he tried to catch the tank. He immediately felt sharp pain in his left knee. Petitioner testified that he went back to the office and reported the accident to his supervisor and the owner, who then referred him to a hospital.

On that same day Petitioner treated at Our Lady of the Resurrection Medical Center (PX #1). He was diagnosed with a left knee sprain/strain and referred to Dr. Ari Kaz of Illinois Bone and Joint Institute.

On November 5, 2014 Petitioner treated with orthopedic surgeon Dr. Chadwich Prodomos at Illinois Sports Medicine and Orthopedic Center (PX #1). Petitioner reported the injury to his left knee when moving an 85-pound oxygen tank at work on October 24, 2014. Petitioner reported that the oxygen tank came loose when the handle broke and it landed on his knee. He was complaining of 8/10 pain in his knee.

Upon examination, there was tenderness over the medial joint line. Dr. Prodromos diagnosed a torn medial meniscus and chondromalacia patella. Dr. Prodromos recommended an MRI of the left knee and physical therapy. Petitioner was to remain off of work.

On November 10, 2014, Petitioner began a course of physical therapy at Illinois Sports Medicine (PX #1). He reported an injury to his left knee while taking an oxygen tank from a dolly off of a truck when he twisted his left knee.

On November 15, 2014, Petitioner underwent an MRI of the left knee at 3T Imaging (PX #1). The MRI revealed patellar chondromalacia/fissuring, medial meniscal intrasubstance degeneration without tear, and mild prepatelllar bursal inflammation.

On November 19, 2014, Dr. Prodromos examined Petitioner again, noting that the MRI revealed no meniscus tear (PX #1). Petitioner's left knee was tender over the medial joint line and had reduced strength. Dr. Prodromos diagnosed chondromalacia patella and left knee strain. He administered a Depo-Medrol injection to Petitioner's left knee.

Petitioner's last session of physical therapy at Illinois Sports Medicine was on December 1, 2014 (PX #1).

On December 3, 2014, Petitioner saw Dr. Prodromos, reporting worsening anterior left knee pain and clicking and popping. Dr. Prodromos noted tenderness over the inferior pole of the patella, especially with transverse compression of the upper aspect of the tendon, and pain with prone and forced flexion. Dr. Prodromos prescribed a PRP (Platelet-Rich Plasma) injection. On January 5, 2015, Dr. Prodromos administered a PRP injection to Petitioner's left knee retropatellar tendon (PX #1).

On January 14, 2015, Petitioner returned Dr. Prodromos, reporting no relief from the PRP injection (PX #1). The left knee was tender over the inferior pole of the patella. The diagnosis was chondromalacia patella and patellar tendonitis. Dr. Prodromos discussed a retropatellar versus patellar tendon injection.

On February 4, 2015, Dr. Prodromos noted that Petitioner had remaining symptoms and had failed physical therapy, steroid injection, and a PRP injection. Dr. Prodromos did not recommend surgery and instructed Petitioner to follow up after an IME.

Petitioner was examined by Dr. Craig Westin of Illinois Bone and Joint Institute On February 16, 2015, pursuant to §12 (PX #2). Petitioner reported an injury to his left knee on October 24, 2014, when he lost control of a dolly carrying an 85-pound oxygen tank. As the dolly dropped to the floor, Petitioner flexed his left knee with full weight trying to control the tank and felt immediate left knee pain.

Upon examination Dr. Westin noted Petitioner's left knee revealed visible atrophy of the left quadriceps muscle, moderate tenderness at the medial patellofemoral area, greater at the medial tibiofemoral joint line, and flexion up to 120-degrees with pain. Dr. Westin diagnosed Petitioner with persistent anterior and medial left knee pain resulting from a small meniscus tear not seen on MRI or patellofemoral inflammation with impinging soft tissue mimicking a meniscal tear related to the work injury on October 24, 2014.

Dr. Westin recommended a left knee arthroscopy. Dr. Westin opined that Petitioner could not perform his regular job delivering oxygen tanks and was restricted to 50% seated work, with no bending, squatting, kneeling, or lifting over 20 pounds.

On March 11, 2015, Dr. Prodromos discharged Petitioner to continue treatment and undergo surgery with Dr. Westin (PX #1).

Dr. Westin examined Petitioner as a treating physician April 3, 2015 (PX #2). He noted tenderness of the anteromedial left knee and point tenderness at the medial tibiofemoral joint. Dr. Westin again recommended arthroscopic surgery for the left knee. On April 29, 2015, Dr. Westin performed arthroscopic surgery on Petitioner's left knee, repairing patellar microfracture of a grade-4 lesion, removal of multiple loose bodies, and removal of medial synovial plica. The post-operative diagnosis was medial synovial plica with grade-4 chondral lesion patella, several loose bodies, and no medial meniscus tear.

On May 5, 2015, Dr. Westin examined Petitioner and prescribed four weeks of physical therapy (PX #2). Petitioner began a course of physical therapy at Athletico on May 8, 2015 (PX #3).

On June 2, 2015, Petitioner saw Dr. Westin, exhibiting left leg weakness and decreased range of motion (PX #2). Dr. Westin recommended continued physical therapy. On July 7, 2015, Petitioner saw again by Dr. Westin, complaining of continued pain. The left knee exhibited a click in the retropatellar area and passive range of motion to 130°. He was unable to do stairs. Petitioner's last session of physical therapy at Athletico was August 3, 2015 (PX #3).

On August 4, 2015, Petitioner saw Dr. Westin again, reporting pain in the left patella (PX #2). The left knee exhibited a painful click at 45° of flexion, which is where the patellar defect came into contact with the trochlea on the arthroscopy. Petitioner could only climb stairs sideways. Based upon Petitioner's recurrent pain and inability to

advance with therapy, Dr. Westin recommended discontinuing therapy and proceeding with a two-operation treatment involving cartilage restoration with a Carticel implantation and a probable anterior medialization of the tibial tubercle. This procedure was not approved after utilization review (RX #3).

On September 18, 2015, Dr. John Cherf of Chicago Institute of Orthopedics, a §12 examiner retained by Respondent, reviewed Petitioner's medical records (RX #2). Dr. Cherf felt it was unclear if Petitioner's grade 4 patellar chondrosis was the result of the work-related injury or a pre-existing condition. He opined that Petitioner was not at MMI. He recommended an intraarticular cortisone injection and further conservative treatment.

On October 6, 2015, Dr. Westin reexamined Petitioner. He noted crepitus and tenderness in the patella and retropatellar areas of the left knee (PX #2). Dr. Westin noted that Petitioner probably had some pre-existing chondral changes in his left knee, but suffered an acute injury at the time of accident, including a transverse full-thickness defect with sharp edges on top of the chronic chondromalacia. Dr. Westin explained that he recommended the anteromedialization of the tibia based on his clinical experience with Carticel implantation. He cited to the experience of Dr. Brian Cole at Midwest Orthopaedics at RUSH. Dr. Westin again recommended that Petitioner undergo a left knee arthroscopy with Carticel biopsy and implantation with cells and a second procedure anteromedialization of the tibial tubercle to ensure proper tracking.

On December 7, 2015, Petitioner was examined by Dr. Cherf at the request of Respondent under §12 of the Act (RX #1). Dr. Chef found left knee showed minimal effusion, no soft tissue-swelling, erythema, or ecchymosis. There was left quadriceps atrophy. Petitioner was tender in the area of the mid-patellar tendon region with grade 1+ crepitation. X-rays of the left knee revealed osteopenia.

Dr. Cherf opined that the work-related injury on October 24, 2014, was unlikely to have caused Petitioner's patella-femoral pathology because there was no direct blunt trauma. He opined that Petitioner had sustained a left knee sprain/strain. Dr. Cherf also noted that the April 29, 2015, operative report also notes that the fragments had an appearance of "being chronic", and that pathology likely predated the work injury. He noted that it is difficult to correlate the need for additional surgery with the work-related injury. Dr. Cherf further opined that Petitioner did not require any further work restrictions related to the accident. He recommended a possible functional capacity exam. Dr. Cherf performed an AMA Impairment Rating and found 2% lower extremity impairment, or 1% whole person impairment (RX #1).

Petitioner saw Dr. Westin on December 15, 2015 (PX #2). There was continued crepitus of the left knee that was palpable with active extension. In rebuttal of Dr. Cherf's opinions Dr. Westin explained that his operative report did not classify Petitioner's injury as chronic, but rather indicated that the loose fragments found in the joint of the left knee resulted from ongoing fragmentation of surface cartilage. Dr. Westin opined that the flexion and twist injury of the knee without direct impact is a credible mechanism to produce a chondral injury of the patella. The fact that the MRI did not show a marrow lesion of the patella does not mean that the patella was not injured, it means that the injury was not deep enough to cause marrow signal or injury.

Dr. Westin further clarified that Carticel is commonly used for patellas despite being approved only for tibiofemoral lesions. Dr. Westin again recommended a left knee arthroscopy and Carticel biopsy followed by Carticel implantation and anteromedialization of the tibia as a good alternative to no treatment. He did acknowledge that, as Dr. Cherf noted, the prior surgery was not particularly successful and, further, there was no guarantee of success with the recommended procedure.

Petitioner testified that he wants the surgery recommended by Dr. Westin because his left knee is still in pain.

Petitioner testified that he had worked for Respondent as a driver/technician delivering 50 to 110-pound oxygen tanks since about 2008-2009. Prior to the accident on October 24, 2014 Petitioner never had any problems with his left knee. Petitioner testified that he currently experiences sharp pain when he tries to climb up or down stairs, when he walks for longer than 20 minutes, and when he tries to run at all. He gets pain in his left knee when he stands in one place longer than 30 minutes. The pain is the worst when he wakes up in the mornings. He no longer takes his children to the mall because he constantly has to sit down. He testified that the pain gets worse when the weather changes. When the pain increases, he ices his left knee and takes more pain medication.

Petitioner testified that he did not work from the date of the accident through March 11, 2015, and again from April 29, 2015, through the date of hearing, January 28, 2016.

CONCLUSIONS OF LAW

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

The Arbitrator finds that Petitioner failed to prove that his current condition of ill-being is causally related to his work accident on October 24, 2014. The Arbitrator was faced with conflicting opinions of qualified healthcare professionals regarding Petitioner's condition.

Petitioner was initially treated by Dr. Chadwich Prodromos, who diagnosed a left knee torn medial meniscus and chondromalacia patella. Dr. Prodromos treated Petitioner with physical therapy, a steroid injection, and a Platelet-Rich Plasma injection. These therapies did not relieve Petitioner's complaints.

Petitioner was examined by Dr. Craig Westin pursuant to §12 of the Act, whereupon Dr. Westin became Petitioner's treating physician. Dr. Westin diagnosed Petitioner with persistent anterior and medial left knee pain resulting from a small meniscus tear not seen on MRI or patellofemoral inflammation with impinging soft tissue mimicking a meniscal tear related to the work injury on October 24, 2014. Dr. Westin performed arthroscopic repair of patellar microfracture of a grade-4 lesion, removal of multiple loose bodies, and removal of medial synovial plica. No meniscus tear was found in surgery. Dr. Westin now recommends another surgical procedure which is not FDA approved and was denied authorization on utilization review.

Respondent's retained examining expert, Dr. John Cherf, opined that that Petitioner's current condition is not causally related to the work accident. He opined that Petitioner sustained a knee strain which overlaid a pre-existing degenerative condition. He further opined that Petitioner's current complaints are related to his pre-existing condition and not the work accident on October 24, 2014.

In weighing conflicting opinions such as here deference is often given the opinion of the treating physician, whose goal is nominally to cure or relieve the patient's condition. Here, however, Dr. Westin's adherence to recommending a non-approved procedure and the lack of his rebuttal to the utilization review denial detracts from his overall credibility. This lack of credibility also affects his opinion of causation of Petitioner's current condition.

The Arbitrator finds the opinions of Dr. Cherf persuasive, that Petitioner sustained a sprain/strain of his left knee in his March 24, 2014 work accident and that Petitioner had reached MMI by the time of his examination by Dr. Cherf on December 7, 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?

Petitioner received extensive medical care following his left knee work injury: Our Lady of the Resurrection Medical Center, Dr. Prodromos, and Dr. Westin. The medical care included physical therapy, Depo-Medrol and PRP (Platelet-Rich Plasma) injections, and, ultimately, arthroscopic surgery by Dr. Westin. Petitioner was examined pursuant to §12 of the Act by Dr. John Cherf December 7, 2015, after having reviewed Petitioner's medical records.

Dr. Westin has recommended further treatment with a procedure not approved by the FDA, which also was not authorized pursuant to a utilization review. Clearly, Dr. Westin believed Petitioner is not at MMI. On the other hand, Dr. Cherf opined that Petitioner's current condition of ill-being is related to a pre-existing condition in Petitioner's left knee rather than his work-related injury. Dr. Cherf voiced no opinion of what medical care was reasonably necessary to treat Petitioner's left knee sprain/strain.

Respondent presented no evidence effectively rebutting the reasonableness and necessity of medical care up to Dr. Cherf's §12 examination. Therefore, in light of all the evidence, the Arbitrator finds that Petitioner circumstantially proved that the medical care he received for his left knee injury up to December 7, 2015, was reasonable and necessary.

Petitioner is awarded the following unpaid bills:

1. Illinois Sports Medicine & Orthopedics – DOS,11/5/2014-3/11/2015: $331.83.
2. Illinois Bone & Joint Institute – DOS, 2/16/2015-12/15/2015: $83.00.
3. Athletico – DOS, 5/8/2015-8/3/2015: $224.59.

K: Is Petitioner entitled to any prospective medical care?

Petitioner failed to prove that he is entitled to the prospective medical care recommended by Dr. Westin, namely a left knee arthroscopy and Carticel biopsy followed by Carticel implantation and anteriomedialization of the tibia.

The Arbitrator notes that deference is often given to opinions of a treating physician which conflicts with opinions of other physicians, such as physicians retained by a party opposing the petitioner. Here Petitioner's treating physician is recommending a surgical procedure which has not been approved by the FDA. Respondent's retained expert opinied that the recommended surgery was not clinically indicated. Finally, the proposed procedure was denied authorization upon utilization review. There was no peer-to-peer appeal of the utilization review.

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, Dr. Westin's opinion is overwhelmed by persuasive contradictory evidence. The Arbitrator finds the opinions of Dr. Cherf, along with the lack of FDA approval for the recommended procedure and the lack of rebuttal to utilization review, persuasive and adopts those opinions.

L: What temporary benefits are in dispute? TTD

The Arbitrator finds Dr. Cherf's opinion that Petitioner can return to work at full duty and that no further treatment for the work-related injury is indicated to be persuasive. This was a default opinion that Petitioner was at MMI. Further, Dr. Cherf did an AMA impairment rating, which would not be appropriate for anyone who has not reached MMI. He had found that Petitioner could return to full duty work.

The Arbitrator finds Dr. Westin's opinions regarding Petitioner's current condition, namely that Petitioner has not reached MMI, is not persuasive in light of Dr. Westin's recommendation for a non FDA approved procedure and failure to rebut the utilization review, are not persuasive. As such, no additional TTD benefits after December 7, 2015, the date Dr. Cherf opined that Petitioner was able to return to work without restrictions, are owed.



February 23, 2017

Steven J. Fruth, 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	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Phillip Tramel,
Petitioner,

vs.

Ford Motor Company,
Respondent.

18IWCC0023

NO: 11 WC 49229

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 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 21, 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: JAN 10 2018
o11/16/17
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0023

TRAMEL, PHILLIP
Employee/Petitioner

Case# **11WC049229**

FORD MOTOR COMPANY
Employer/Respondent

On 12/21/2016, 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 0.64% 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:

0000 PHILLIP TRAMEL
1059 E 80TH ST
CHICAGO, IL 60619

0560 WIEDNER & McAULIFFE LTD
JULIE M TENUTO
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

18IWCC0023

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

PHILLIP TRAMEL
Employee/Petitioner

v.

FORD MOTOR COMPANY
Employer/Respondent

Case # 11 WC 49229

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 **DOUGLAS S. STEFFENSON**, Arbitrator of the Commission, in the city of **CHICAGO**, on **NOVEMBER 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. [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 [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On **MAY 18, 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.

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 **$48,924.20**; the average weekly wage was **$940.85**.

On the date of accident, Petitioner was **56** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$12,992.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$12,992.00**.

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

ORDER

The Petitioner's claim for benefits under the Workers' Compensation Act 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

DECEMBER 21, 2016
Date

DEC 21 2016

PHILLIP TRAMEL v. FORD MOTOR COMPANY

11 WC 49229

FINDINGS OF FACT AND CONCLUSIONS OF LAW

INTRODUCTION

This matter was tried before Arbitrator Steffenson on November 28, 2016. The issues in dispute were accident, causal connection, medical benefits, TTD benefits, and the nature and extent of the injury.

FINDINGS OF FACT

Initially, the Arbitrator admitted into evidence a Request for Hearing form prepared and signed by the parties. (*Arbitrator's Exhibit* 1). The Request for Hearing form indicates the Petitioner, at the time of his alleged May 18, 2009 accident, was 56 years old, single and had no dependent children. (*Arbitrator's Exhibit* (hereinafter, *AX*) 1). The parties also agreed the Petitioner earned $48,924.20 in the year preceding his alleged injury and, as such, has an applicable Average Weekly Wage of $940.85. (*AX* 1 and *Respondent's Exhibit* 5). Furthermore, the parties requested a written decision and stipulated to receipt of this Arbitration Decision and any subsequent Decision and Opinion on Review via e-mail. (*Id.*).

The Petitioner, Phillip Tramel, appeared *pro se* and testified on his own behalf. (*Transcript* at 12-13, 40). The Petitioner testified on May 18, 2009 he presented to the Respondent's plant to turn in paperwork and determine if a job was available within his medical restrictions. (*Transcript* (hereinafter, *T.*) at 18, 32). He was required to be buzzed through the turnstiles at the security gates to enter the plant. (*T.* at 18). The Petitioner was utilizing a walker at the time, and, while passing through the turnstile, his walker got stuck and he "wrenched" his back. (*Id.*). He then proceeded to the plant medical department and, thereafter, sought medical care from the emergency room at Trinity Hospital. (T. at 19-20).

The Petitioner testified he was not scheduled to work a full shift at Ford on May 18, 2009. (*T.* at 31). He acknowledged that on that date he never clocked into work, never reported to a supervisor on the assembly floor, and was not paid any wages that day. (*T.* at 32). The Petitioner was not given any job duties to perform and testified he was not performing any job duties at the time of his May 18, 2009 injury. (*T.* at 32-33). At the time of his alleged incident, the Petitioner only had his walker in his hands. (*T.* at 33). He admitted he was not carrying any tools or other objects related to his work for the Respondent. (*T.* at 33). The

Petitioner also acknowledged was also not wearing any work uniform or special footwear required for his job at the time of his alleged injury. (*Id.*).

The Petitioner stated he had been off of work for approximately "four to six years" before his alleged work injury of May 18, 2009 as there was no work available to accommodate his restrictions of sitting work only. (*T.* at 20). Prior to his May 18, 2009 incident, his last full shift for the Respondent was in April of 2005. (*T.* at 28). The Petitioner remained off work on medical disability from April 2005 through May 18, 2009 for restrictions relative to his lumbar and cervical spine. (*T.* at 28-29). He testified he had restrictions for his lumbar and cervical spine which dated back to 1999. (*T.* at 29).

Between April of 2005 and May 18, 2009, the Petitioner regularly followed up with his doctor for his lumbar and cervical spine. (*T.* at 30). He treated conservatively during that time and testified that surgery was recommended sometime in 2001. (*Id.*). At the time of trial, the Petitioner had not undergone any lumbar or cervical spine surgery. (*Id.*). The Petitioner testified his medical treatment "pretty much stayed the same" following the May 18, 2009 incident. (*T.* at 33-34).

Between April of 2005 and May 18, 2009, the Petitioner applied for benefits from a multitude of disability and retirement benefit programs. His application for Social Security Disability benefits was denied in June of 2006. (*T.* at 29). He also applied for disability retirement benefits from the Respondent in early 2009. However, that request was denied in approximately February of 2009. (*T.* at 29-30). The Petitioner then retired from Ford Motor Company as of July 1, 2009. (*T.* at 34). He also applied for and received Accident and Sickness benefits from the Respondent and administered through Unicare from April of 2005 through his July 1, 2009 retirement date. (*T.* at 29, 34 and *Respondent's Exhibit* (hereinafter, *RX*) 2 & 3).

The Petitioner also filed six prior workers' compensation claims, not including the present claim. (*RX* 4 and *T.* at 35-36). Five of his prior six claims[1] were against the Respondent and four of those claims pertained to a prior back injury. (*T.* at 36). The four back claims were resolved via settlement and the applicable settlement contracts were approved on May 1, 2006, at which time the Petitioner still was off of work on medical disability. (*T.* at 36-37). The Petitioner also admitted he did not return to work for the Respondent between May 1, 2006 and May 18, 2009. (*T.* at 37). Finally, the Petitioner acknowledged he pursued a civil law suit against the Respondent alleging employment discrimination and a violation of the American with Disabilities Act in 2010 which he alleged arose out of his May 18, 2009 incident at the

[1] The Petitioner also pursued a workers' compensation claim against Saint Bernard Hospital for a 1991 injury that was resolved via settlement. (*T.* at 37).

heart of this workers' compensation claim. (*T.* at 38). This civil claim was resolved via settlement with the Respondent. (*Id.*).

CONCLUSIONS OF LAW

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

Issue C:

The Petitioner failed to establish that his May 18, 2009 injury arose out of and occurred in the course of his employment. It is axiomatic that the claimant bears the burden of proving, by a preponderance of credible evidence, every element of his claim. *Baldwin v. Illinois Workers' Comp. Comm'n*, 313 Ill. App. 3d 413, 416 (2000). A claimant's injury is compensable under the Act only if it arises out of and occurs in the course of the employment. *University of Illinois v. Indus. Comm'n*, 365 Ill. App. 3d 906, 910 (2006).

"In the course of" refers to the time, place, and circumstances of the injury. *Illinois Institute of Technology Research Institute v. Indus. Comm'n*, 314 Ill. App. 3d 149, 162 (2000). The Arbitrator notes the Respondent does not dispute that Petitioner's alleged injury occurred in the course of the employment. However, that alone is insufficient to impose liability, as the injury also must "arise out of" the employment.

For an injury to "arise out of" one's 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 (1989). An injury arises out of one's employment if, at the time of the occurrence, the employee was performing acts he was instructed to perform by his employer, acts which he had a common law or statutory duty to perform, or acts which the employee might reasonably be expected to perform incident to his assigned duties. *Id.* The fact the injury occurs at the place of employment is not sufficient in itself to prove that the injury arose out of the employment. *Castaneda v. Indus. Comm'n*, 97 Ill. 2d 338, 341-42 (Ill. 1983).

In this particular instance, the Petitioner alleges an injury to his back on May 18, 2009 while passing through the security turnstiles at the Respondent's plant. He claims while he walked through the turnstiles with his walker, the gates locked up and caused his back to become "wrenched." (*T.* at 18 and *RX* 4). However, the Petitioner had not worked a full shift at Ford since April of 2005. (*T.* 28). Between April of 2005 and May 18, 2009, he remained off work as there was no work available within his work restrictions that called for sitting work

only. (*T.* at 20). The Petitioner admitted he had restrictions for his lumbar and cervical spine which dated back to 1999. (*T.* 29).

Instead, the Petitioner returned to the Respondent's facility on May 18, 2009 simply to turn in paperwork regarding his ongoing work restrictions and to determine if a job was available within those medical restrictions. (*T.* at 18, 32). He did not present any evidence that he was performing acts he was instructed to perform by his employer, that he was performing acts which he had a common law or statutory duty to perform, or that he was performing acts which he might reasonably be expected to perform incident to his assigned duties.

Furthermore, the Petitioner acknowledged he was not scheduled to work any shift at Ford on May 18, 2009. (*T.* at 31). He never clocked into work, never reported to a supervisor on the assembly floor, and was not paid any wages for that day. (*T.* at 32). The Petitioner testified he was not given any job duties to perform, and most importantly, admitted he was not performing any job duties at the time of his May 18, 2009 injury. (*T.* at 33). He only had his walker in his hands at the time of his alleged injury. (*Id.*). He was not carrying any tools or other objects related to his job, and he also was not wearing any uniform or special footwear required for his job. (*Id.*).

Based on the testimony and evidence presented, the Arbitrator finds the Petitioner failed to meet his burden of proving a compensable injury which both arose out of and occurred in the course of his employment with the Respondent. As such, the Petitioner's claim for benefits under the Workers' Compensation Act is denied.

Issue F:

The Arbitrator also finds the Petitioner failed to meet his burden in proving his current lumbar and/or cervical conditions are causally related to the alleged May 18, 2009 incident. To satisfy the causation requirement, the claimant bears the burden of proving by a preponderance of competent evidence that the employment was a causative factor in his alleged physical disability. *Westinghouse Elec. Co. v. Indus. Comm'n*, 64 Ill. 2d 344 (1976).

"A causal connection between work duties and a condition may be established by a chain of events including petitioner's ability to perform duties before the date of the accident and inability to perform the same duties following that date." *Darling v. Indus. Comm'n.*, 176 Ill. App. 3d 186, 193 (1988). A causal connection may be established by evidence of prior good health, a work injury, resulting disability and inability to work. *Id.*

However, that is not the case here. The Petitioner already was off work on medical disability from April of 2005 through his date of alleged injury, May 18, 2009. He remained off work due to "no work available" within his lumbar and cervical restrictions, which had been imposed as early as 1999. (*T.* at 28-29). The Petitioner testified he regularly followed up with his doctor for his lumbar and cervical spine conditions from April of 2005 through the May 18, 2009 incident. (*T.* at 30). He further acknowledged his ongoing medical treatment "pretty much stayed the same" following the May 18, 2009 incident. (*T.* at 33-34). Moreover, the Petitioner did not testify whether he injured his lumbar spine, cervical spine, or both, at the time of the alleged injury.

The Petitioner also he failed to produce sufficient evidence at trial in the form of supporting medical documentation to back his contention that his current back condition is causally related to the May 18, 2009 incident. He attempted to present his Exhibit D, which consisted of uncertified medical records from various providers, into evidence. (T. at 51-54). Section 16 of the Act provides that medical records "certified to as true and correct by the hospital, physician, or other healthcare provider...shall be admissible without any further proof..." 820 ILCS 305/16 (West 2000). "[T]he legislature intended certification to be a minimum foundational requirement that must be satisfied before the records may be admitted 'without any further proof.'" *Nat'l Wrecking Co. v. Indus. Comm'n (Velasquez)*, 352 Ill. App. 3d 561, 567 (Ill. App. Ct. 1st Dist. 2004). However, the Petitioner's Exhibit D consisted of medical records that lacked the required certification and, as such, were correctly excluded from evidence.

As such, and based on the evidence as a whole, the Arbitrator finds the Petitioner failed to meet his burden of proving either his lumbar or cervical condition is causally related to the May 18, 2009 alleged injury. Accordingly, his claim for benefits under the Workers' Compensation Act is denied.

Issue J:

Based upon the Arbitrator's finding with respect to Issues C and F above, the Arbitrator finds the Petitioner is not entitled to medical benefits under the Workers' Compensation Act.

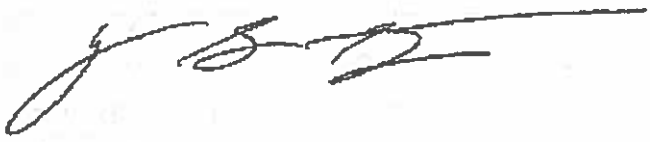
18IWCC0023

Issue K:

Based upon the Arbitrator's finding with respect to Issues C and F above, the Arbitrator finds the Petitioner is not entitled to temporary total disability benefits under the Worker's Compensation Act.

Issue L:

Based upon the Arbitrator's finding with respect to Issues C and F above, the nature and extent of the Petitioner's alleged injury is moot.



Signature of Arbitrator

DECEMBER 21, 2016
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

Calvin Gant,
Petitioner,

vs.

NO: 16WC 27005

18IWCC0025

Chicago Transit Authority,
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, 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 January 17, 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: JAN 11 2018
o010818
KWL/jrc
042

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GANT, CALVIN
Employee/Petitioner

Case# 16WC027005

CTA
Employer/Respondent

18IWCC0025

On 1/17/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.59% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0290 KARCHMAR & STONE
ADAM T KARCHMAR
111 W WASHINGTON ST SUITE 1030
CHICAGO, IL 60602

0515 CHICAGO TRANSIT AUTHORITY
J BARRETT LONG
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

C. Gant v. CTA , 16 WC 027005

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

Calvin Gant
Employee/Petitioner
v.
CTA
Employer/Respondent

Case # 16 WC 027005

18IWCC0025

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 **11-16-16**. 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 _____

18IWCC0025

FINDINGS

On **8-25-16**, 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* causally related to the accident.

In the year preceding the injury, Petitioner earned **$47,632.00**; the average weekly wage was **$916.00**.

On the date of accident, Petitioner was **63** years of age, ***married*** with **0** dependent children.

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

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

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

Respondent is entitled to a credit of **$0.00** 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 his employment by Respondent.

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 13, 2017
Date

ICArbDec p. 2

JAN 17 2017

FINDINGS OF FACT

Petitioner was employed by Respondent as a full time temporary Flagman. Petitioner worked on the Extra Board. On the Extra Board, Petitioner was not assigned to a specific work location. He would call in the night before at 16:30 and receive instructions as to where he was to work. His job duties include protecting contractors, CTA employees and customers and working on platforms and in slow zones.

The evening before the accident, Petitioner called Respondent and was advised to report to the Howard Station to pick up tools to do work at Sheridan.

On the day of the accident, August 25, 2016, Petitioner left his home in Homewood and drove to the Berwyn stop. He bought coffee and a newspaper and boarded the Red Line train to travel to the Howard terminal. He did not badge in at Berwyn. He was intending to badge in at Howard and pick up tools to be used at Sheridan. He would start his day by checking in with the clerk and badging in. His shift was to start at 8:00am.

When the train stopped at Howard, Petitioner exited to the platform and tripped and fell over a shopping cart that was being pulled by a passenger. Petitioner fell to the ground, injuring his left knee, lower back and head. Petitioner had not yet badged in. Petitioner and his supervisor filled out accident reports later on August 25th. (Px 4 & 5)

Petitioner was transported to Presence St. Francis Hospital by CFD paramedics. Petitioner told the paramedics that he injured his left knee, due to a fall. He was exiting the train and a person in front of him had a cart and stopped abruptly and he tripped and fell over the cart. The history at St. Francis was that the patient tripped over a passenger's cart exiting the train to the platform. He complained of an injury to his left knee and head. X-rays of the left knee showed degenerative changes, a likely healed tibial plateau fracture, evidence of recent trauma and evidence of remote Osgood Schlatter disease. Petitioner was discharged with crutches and an immobilizer. He was instructed to follow up with his PCP and an orthopedist. He was instructed to return to work with crutches. (Px 1)

Petitioner has been off work since the accident. He has been restricted from work by his treating physicians.

Petitioner sought follow up care by Dr. Primus. He continues under Dr. Primus' care. An MRI shows an ACL tear, a torn medial meniscus and arthritis. Dr. Primus recommends knee reconstruction. Dr. Giannoulias saw Petitioner on a referral by Dr. Primus. Dr. Giannoulias diagnoses left knee contusion with aggravation of arthrosis. The MRI was said to show degeneration of all 3 compartments, with degenerative meniscus and a degenerated ACL. An injection was given on 10/28/2016 and Petitioner was to follow up. (Px 2 & 3)

Petitioner seeks treatment for his left knee and TTD. His back and head injuries have resolved.

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's injury did not arise out of his employment by Respondent.

Petitioner was commuting from his home to the Howard Station in order to start his work for Respondent when the accident occurred. He had not yet checked in with the clerk or badged in at the time of the accident. The choice of driving his car to the Berwyn stop and going by train to the Howard Station was Petitioner's alone. He could have gotten a ride, taken a cab, or rode a bicycle (albeit a long way) to get to Howard. Petitioner's employment required him to begin at Howard. Respondent did not require Petitioner to travel to Howard by any specific means. Of course, Petitioner's choice to live in Homewood, like his choice of route and mode of transportation to Howard was his own.

"Arising out of" refers to the origin or cause of the injury. An injury arises out of the employment if, at the time of the injury causing occurrence, the employee was performing acts he was instructed to perform by his employer or acts which the employee might reasonably be expected to perform incident to his assigned duties. Caterpillar Tractor Co. v. Industrial Comm'n , 129 Ill.2d 52 (1989) Here, Petitioner was on his way to work. He was functioning as a passenger on a common carrier, not as an employee of Respondent. The injury had its origin in the acts of a fellow passenger, or in Petitioner's inattention when leaving the train. The injury was not associated with employment activities, or reasonably incident to Petitioner's work duties.

In this case, if the injury occurred as a result of a defect in Respondent's premises, such as ice on the platform or a hole in the platform, the injury would have arose out of and in the course of Petitioner's employment. "In the course of " contemplates some pre and post work activities. Suter v. The Illinois Workers' Compensation Commission , 2013 IL App (4th) 130049WC

Here the injuries did not arise out of Petitioner's employment by Respondent and, thus, the claim for compensation is denied.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, AND WITH RESPECT TO ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

As the Arbitrator has found that Petitioner's injuries did not arise out of his employment by Respondent, the Arbitrator needs not decide these issues.

STATE OF ILLINOIS)
) SS.
COUNTY OF MCCLEAN)

☒ 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

Leroy Kelly,

Petitioner,

vs.

NO: 16WC 22290

18IWCC0026

Nestle USA, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 1, 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 $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: JAN 11 2018
o010818
KWL/jrc
042

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

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

KELLY, LEROY
Employee/Petitioner

Case# **16WC022290**

NESTLE USA INC
Employer/Respondent

18IWCC0026

On 5/1/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.95% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0564 WILLIAMS & SWEE LTD
DIRK A MAY
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

2461 NYHAN BAMBRICK KINZIE & LOWRY
ADAM J COX
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

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
19(b)

Leroy Kelly
Employee/Petitioner

v.

Nestle USA, Inc.
Employer/Respondent

Case # 16 WC 22290

Consolidated cases: n/a

18IWCC0026

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 March 28, 2017. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ 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 28, 2016, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $31,088.02; the average weekly wage was $855.20.

On the date of accident, Petitioner was 50 years of age, single with 0 dependent child(ren).

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

Respondent shall be given a credit of $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 $9,813.37 under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 7 as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of $9,813.37, for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall authorize and pay for prospective medical treatment including, but not limited to, the surgical procedure(s) recommended by Dr. Lawrence Li.

Respondent shall pay Petitioner temporary total disability benefits of $570.13 per week for two and three-sevenths (2 3/7) weeks commencing March 11, 2017, through March 28, 2017, as provided in Section 8(b) of the Act.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

April 28, 2017
Date

MAY 1 – 2017

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 March 28, 2016. According to the Application, Petitioner was hit by a large block and sustained an injury to the left upper extremity (Arbitrator's Exhibit 2). This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of medical bills and temporary total disability benefits as well as prospective medical treatment. Respondent agreed Petitioner sustained a work-related injury, but disputed liability on the basis of causal relationship (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a mold line operator. On March 28, 2016, Petitioner and another employee were directed to go get a metal device called a "chocolate depositor." This was a metal device used in forming molded chocolate candies. The device was made of steel and Petitioner stated it weighed approximately 400 pounds and was about three feet long. There was a metal rod that protruded from the device that was approximately six to seven inches long. A photograph of the device was tendered into evidence at trial (Petitioner's Exhibit 8).

At the time of the accident, the device was on a table that had wheels. As Petitioner and the other employee were pushing the table down the corridor, the device started to fall off the table. Petitioner testified that when he reached for the device, the end of the metal rod struck his left wrist. Petitioner also said that, for a brief period of time, his left wrist was pinned between the metal device and the table.

The other employee who was present at the time of the accident, Willie Kelly (who was Petitioner's brother), testified on behalf of Petitioner at trial. Willie Kelly confirmed that he and the Petitioner were in the process of moving the chocolate depositor and when Petitioner attempted to grab it, the end of the rod struck Petitioner's left hand. He also stated that Petitioner's left hand was pinned between the rod and the table, but indicated he observed Petitioner's left hand on the side of the table near the corner. He also stated Petitioner was holding his left wrist after the accident.

Petitioner was initially seen by the plant nurse after the accident. According to her record, Petitioner's left wrist did not get pinned, but the object struck his wrist while falling. She noted the presence of a red mark on Petitioner's left wrist where the object struck him (Respondent's Exhibit 2).

Respondent subsequently sent Petitioner to Illinois Work Injury Network (IWIN). Petitioner was evaluated at IWIN on March 28, 2016. According to the history contained in the record of that date, a "block" fell off of a table that was vibrating and struck the top of Petitioner's left hand and wrist. Petitioner was diagnosed with a left wrist contusion, given a wrist brace and authorized to return to work (Petitioner's Exhibit 6).

On March 31, 2016, Petitioner was seen at IWIN by Dr. Dru Hauter. Petitioner still had soreness in the left wrist, but the findings on examination were normal. Dr. Hauter authorized Petitioner to work, but with light duty restrictions of a 20 pound occasional lifting restriction and a 10 pound frequent lifting restriction (Petitioner's Exhibit 6).

When seen by Dr. Hauter on April 8, 2016, Petitioner's complaints had not improved. At that time, Petitioner stated that one week prior a block fell to the floor striking his wrist as it fell. Dr. Hauter continued to impose light duty work restrictions and ordered physical therapy (Petitioner's Exhibit 6).

Dr. Hauter saw Petitioner on April 13, 20, and 27, 2016. When seen on April 20, 2016, Dr. Hauter opined that the left wrist contusion had resolved and stated Petitioner's pain was "hyper-exaggerated" and that there was symptom magnification. When subsequently seen by Dr. Hauter on April 27, 2016, Petitioner was discharged from care and authorized to return to work without restrictions (Petitioner's Exhibit 6).

At trial, Petitioner testified he continued to have left wrist symptoms after he was discharged from care by Dr. Hauter. On May 6, 2016, Petitioner was again seen by Dr. Hauter and complained of pain and clicking in his left wrist with movement. Dr. Hauter ordered an MRI scan (Petitioner's Exhibit 6).

The MRI was performed on May 12, 2016. The MRI revealed a one mm ulnar variance with ulnoabutment syndrome, small effusions of joints, a ganglion cyst and extensor carpi ulnaris tenosynovitis. Dr. Hauter opined Petitioner's left wrist symptoms were the result of congenital and degenerative disorders (Petitioner's Exhibit 6).

On June 30, 2016, Petitioner was seen by Dr. Lawrence Li, an orthopedic surgeon. At that time, Petitioner informed Dr. Li he had sustained an injury to his left hand on March 28, 2016, when he was pushing a block on a table that weighed approximately 40 pounds, the block slipped and, jammed Petitioner's wrist causing a direct blow to it and pinning Petitioner's left wrist against the table. Petitioner continued to complain of swelling, pain and numbness/tingling in the left wrist (Petitioner's Exhibit 1; pp 6-7).

Dr. Li examined Petitioner and noted swelling and tenderness over the TFC and ulnar styloid and had findings consistent with carpal tunnel syndrome. He reviewed the MRI and noted it had been performed without the use of dye. He ordered another MRI which was performed on July 6, 2016 (Petitioner's Exhibit 1; pp 8-9).

According the radiologist, there were possible tears of the ligaments in the left wrist (Petitioner's Exhibit 9). Dr. Li reviewed the MRI and his reading of it was consistent with that of the radiologist. He then referred Petitioner to Dr. Edward Trudeau for EMG/nerve conduction studies (Petitioner's Exhibit 1; p 10).

Dr. Trudeau saw Petitioner on July 14, 2016. At that time, he noted that Dr. Li's record contained what he thought was a typo in regard to the block weighing 400 pounds, not 40 pounds. Dr. Trudeau performed EMG/nerve conduction studies which were positive for moderately severe left carpal tunnel syndrome (Petitioner's Exhibit 4).

Dr. Li opined Petitioner had a left wrist luno-triquetral ligament tear with a VISI deformity, a TFC tear and carpal tunnel syndrome. He recommended Petitioner undergo surgery consisting of

a left wrist arthroscopy, ligament repair and carpal tunnel release (Petitioner's Exhibit 1; pp 11-12).

At the direction of Respondent, Petitioner was examined by Dr. Joseph Monaco, an orthopedic surgeon, on August 12, 2016. In connection with his examination of Petitioner, Dr. Monaco reviewed medical records provided to him by Respondent. Dr. Monaco opined Petitioner had sustained a left wrist contusion as a result of the accident of March 28, 2016, that Petitioner did not have carpal tunnel syndrome and that the changes observed in the MRI scan were consistent with normal aging and not related to the accident. He also opined that the need for surgery recommended by Dr. Li was not related to the accident and Petitioner could return to work without restrictions (Respondent's Exhibit 1).

In his report, Dr. Monaco noted Petitioner informed him that on March 28, 2016, he was pushing a cart with a 400 pound block on it and the block started to slide off the table. When the block fell, an appendage sticking out from it struck the back of Petitioner's left wrist. According to Dr. Monaco, Petitioner did not describe any axial loading, twisting, weight-bearing or flexion/extension of the left wrist at the time of the accident (Respondent's Exhibit 1).

Dr. Monaco also stated he had previously examined Petitioner in April, 2013, for an injury Petitioner sustained to his left hand on December 18, 2012. He noted an MRI was performed on February 12, 2013, which was normal and opined Petitioner had sustained a mild sprain that caused no permanent impairment (Respondent's Exhibit 1).

Dr. Li was deposed on December 8, 2016, and his deposition testimony was received into evidence at trial. In regard to causality, Dr. Li testified that when the block struck Petitioner's left wrist and drove it into a solid platform, this disrupted the ligaments and caused a tear in the TFC. This then caused swelling, which then, over a period of time, caused carpal tunnel syndrome. Dr. Li also stated that it was not a natural degenerative condition for Petitioner to have sustained such a ligamentous tear and it was not natural for a 51 year old to have a VISI deformity (Petitioner's Exhibit 1; pp 14-16).

Dr. Li also testified he previously recommended Petitioner undergo a left wrist arthroscopy, repair of the ligament and carpal tunnel release. However, because of the time that had passed since that surgical procedure had been recommended, it was no longer an option and he was now going to have to perform what he described as a "salvage procedure" which would be either a four corner fusion or proximal row carpectomy and a carpal tunnel release. Dr. Li explained that, over time, the deformity of the ligament gets to be so great that it cannot be surgically corrected and heal properly. He stated the initial time to perform the surgery he initially recommended was six months and that the "window" had passed (Petitioner's Exhibit 1; pp 12-14).

On cross-examination, Dr. Li testified that he did not know whether Petitioner's hand was flexed or extended at the time of impact. He also stated that if Petitioner's wrist did not hit against something that would remove the "axial load" which was the mechanism that Dr. Li opined caused the ligament tear. He stated Petitioner's left hand was "jammed" against something that was a fixed object, but he was not certain exactly what it may have been (Petitioner's Exhibit 1; pp 18-21).

In the course of his treatment of Petitioner, Dr. Li prescribed him omeprazole and dendracin. Respondent sought utilization reviews regarding the necessity of these two prescribed medications from Dr. Young Oh, an orthopedic surgeon, and Dr. David Trotter, an orthopedic surgeon. In their utilization reports dated December 20, 2016, and February 21, 2017, respectively, they both opined that the use of these prescribed medications by Petitioner was not medically necessary (Respondent's Exhibit 4 and 5). Dr. Li prepared a report dated February 3, 2017, wherein he opined that omeprazole was medically necessary as part of his treatment of Petitioner (Petitioner's Exhibit 3).

At trial, Petitioner had complaints of persistent pain in the left wrist, a lack of strength, popping of the wrist and numbness/tingling with movement. Petitioner stated he can lift approximately 10 pounds but is not able to lift 40 to 50 pounds. He also testified Respondent had provided light duty work to him until March 11, 2017, and that he had been off work since that time.

Petitioner testified he had sustained a left wrist sprain approximately 10 years ago which had resolved. He was not questioned about the left wrist injury of December 18, 2012, that Dr. Monaco referenced in his report.

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 March 28, 2016.

In support of this conclusion the Arbitrator notes the following:

There was no dispute that Petitioner sustained a work-related accident on March 28, 2016, when a chocolate depositor fell off of a table striking his left wrist.

Both Petitioner and the other employee who witnessed the accident, Willie Kelly (Petitioner's brother), testified that Petitioner's left wrist was pinned between the depositor and the table. There was an inconsistency between their testimonies regarding the precise location of Petitioner's left wrist; however, the Arbitrator does not find this to be of any great significance.

The medical records for treatment Petitioner received shortly after the accident specifically stated Petitioner sustained a left wrist injury when a "block" fell off of a table and struck his left wrist, but did not specifically note his left wrist was between the "block" and the table. The Arbitrator finds that the critical part of the history provided by Petitioner immediately or shortly after the accident was that his left wrist was struck by a falling object and the fact that it was briefly caught between the "block" and table was not of any great significance.

The Arbitrator is not persuaded by Dr. Hauter's opinion that Petitioner's complaints were "hyper exaggerated" and there was symptom magnification because of the positive findings subsequently made by Dr. Li.

Respondent's Section 12 examiner, Dr. Monaco, noted he previously evaluated Petitioner in April, 2013, for a left wrist injury Petitioner sustained on December 18, 2012. At trial, Petitioner testified he sustained a prior injury to his left wrist approximately 10 years ago. Obviously, the injury of December 18, 2012, occurred less than five years ago; however, the Arbitrator was unable to determine if the injury of December 18, 2012, was, in fact, the prior injury Petitioner testified about, because he was not questioned regarding same. The Arbitrator finds that Petitioner's prior left wrist injury does not impact the finding of causal relationship irrespective of when it actually occurred.

Dr. Li has diagnosed Petitioner with both a ligamentous injury and carpal tunnel syndrome, which he relates to the accident of March 28, 2016. He based his diagnoses on his findings on examination, the MRI scan and the EMG/nerve conduction studies. The Arbitrator finds the opinion of Dr. Li to be more persuasive than that of Dr. Monaco.

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

The Arbitrator concludes that all of the medical treatment provided to Petitioner was reasonable and necessary and that Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 7 as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of $9,813.37, for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

In support of this conclusion the Arbitrator notes the following:

As previously stated herein in disputed issue (F) the Arbitrator concluded that there was a causal relationship between Petitioner's current condition of ill-being and the accident of March 28, 2016.

In regard to the medications prescribed by Dr. Li which Respondent's utilization reviewers opined were not medically necessary, the Arbitrator does not find the opinions of two physicians who neither examined nor treated Petitioner to be more persuasive than that of Petitioner's treating physician, Dr. Li.

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

The Arbitrator concludes Petitioner is entitled to prospective medical treatment including, but not limited to, the surgery recommended by Dr. Li.

In support of this conclusion the Arbitrator notes the following:

Petitioner's treating physician, Dr. Li, has opined that Petitioner needs corrective surgery on his left hand. As previously stated herein, the Arbitrator found the opinion of Dr. Li to be more persuasive than that of Dr. Monaco.

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

The Arbitrator concludes Petitioner is entitled to payment of temporary total disability benefits of two and three-sevenths (2 3/7) weeks commencing March 11, 2017, through March 28, 2017.

In support of this conclusion the Arbitrator notes the following:

Petitioner testified that Respondent was able to provide work to him that conformed to his work restrictions until March 11, 2017. That testimony was unrebutted.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ 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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Yolanda Gutierrez-Roque,

Petitioner,

vs. NO: 08 WC 1143

Illinois Dept. of Health & Family Svcs.,

Respondent.

18IWCC0027

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, corrects a computational error in 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 corrects the computational error in the calculation of the number of weeks of temporary total disability benefits awarded. The Arbitrator awarded a total of 214-3/7 weeks for the following periods: 1) January 31, 2007 through February 7, 2007 (1-1/7 weeks); 2) June 28, 2007 through May 31, 2011 (204-6/7 weeks); 3) June 5, 2012 through July 31, 2012 (8-1/7 weeks). The Commission finds the total of these periods equals 214-1/7 weeks.

Regarding nature and extent of Petitioner's permanent disability, the Commission notes Petitioner underwent the following surgeries: June 28, 2007, right carpal tunnel release performed by Dr. Murphy; October 11, 2007, left carpal tunnel release performed by Dr. Murphy; April 8, 2011, left carpal tunnel release, left ring trigger finger release and left cyst excision thumb MCP joint performed by Dr. Kucharzyk; June 26, 2012, right ring finger trigger release performed by Dr. Kung. Petitioner testified to having residuals of pain, tingling and weakness in each hand. Based on the surgeries and Petitioner's testimony, the Commission

18IWCC0027

affirms the Arbitrator's award of 25% loss of use of the right hand (51.25 weeks) and 25% loss of use of the left hand (51.25 weeks), a total of 102.50 weeks pursuant to Section 8(e) of the Act. The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 29, 2017 is corrected 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 $721.50 per week for a period of 214-1/7 weeks, that being the period of temporary total incapacity for work pursuant to §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the reasonable, necessary and related medical expenses under §8(a) of the Act, subject to the Medical Fee Schedule pursuant to §8.2 of the Act pursuant to the parties stipulation.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $619.97 per week for a period of 51.25 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the permanent disability of the right hand to the extent of 25%.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $619.97 per week for a period of 51.25 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the permanent disability of the left hand to the extent of 25%.

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 that Respondent paid $70,714.23 in temporary total disability benefits.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit for medical expenses that have been paid by Blue Cross Blue Shield in the amount of $32,200.52 and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in §8(j) of the Act.

18IWCC0027

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

DATED: JAN 11 2018
LEC/maw
o12/05/17
43

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

Joshua D. Luskin

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GUITERREZ-ROQUE, YOLANDA
Employee/Petitioner

Case# **08WC001143**

ILLINOIS DEPT OF HEALTH & FAMILY SVC
Employer/Respondent

18IWCC0027

18IWCC0027

On 6/29/2017, 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:

0147 CULLEN HASKINS NICHOLSON ET AL
PATRICK J DURKIN
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CHICAGO, IL 60603

5782 ASSISTANT ATTORNEY GENERAL
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0502 STATE EMPLOYEES RETIREMENT
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SPRINGFIELD, IL 62794-9255

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

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

JUN 29 2017

Ronald A. Parisi, Acting Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Yolanda Gutierrez-Roque
Employee/Petitioner

v.

Illinois Dept. of Health & Family Svcs.
Employer/Respondent

Case # 08WC001143

Consolidated cases: None

18IWCC0027

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 **October 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. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury for multiple surgeries to both hands ?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On 10/13/2006, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $56,277.00; the average weekly wage was $1,082.25.

On the date of accident, Petitioner was 54 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 $70,714.23 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

The Arbitrator awards 214 and 3/7th weeks temporary total disability benefits for the periods of 01/31/2007 through 02/07/2007, 06/28/2007 through 05/31/2011 and 06/05/2012 through 07/31/2012 at the rate of $721.50 per week. TTD benefits have been paid in part and Respondent is entitled to a credit of $70,714.23.

The Arbitrator finds that reasonable and related medical services have not been paid under section 8 of the Act , pursuant to the medical fee schedule. The Arbitrator finds the Petitioner is entitled to the medical benefits under the Act plus the Respondent is liable under the Act for said medical charges per the Act. The Arbitrator finds that Respondent is entitled to credit for medical charges under Section 8(j) of the Act paid by Blue Cross Blue Shield of Illinois.

The Arbitrator hereby ORDERS Respondent to pay Blue Cross Blue Shield per its request for reimbursement in the amount of $32,200.52 pursuant to fee schedule.

The Arbitrator hereby ORDERS ,citing **multiple hand surgeries**, Respondent to pay permanent partial disability benefits in the amount of $619.97 per week for 102.5 weeks because the injuries sustained caused 25% loss of use of the right hand and 25% loss of use of the left hand under section 8 (e).

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

June 22, 2017
Date

JUN 29 2017

FINDINGS OF FACT 08 WC 001 143

Petitioner was a Child Support Specialist Caseworker II for Respondent whose employment began in 1980. She retired in 2016 prior to Arbitration. Petitioner worked most of her career at 32 West Randolph in Chicago. Petitioner's normal work schedule was Monday through Friday for 7½ hours per day. Petitioner usually worked through her "break" times and she also worked some overtime to keep up with the pressure of her caseload.

Petitioner interviewed clients both in person at the office and on the telephone, thereafter preparing notes and documents for her clients' child support cases. Petitioner used a computer keyboard and mouse to enter information in the Department's computer system. Petitioner testified under oath subject to detailed, focused cross examination that she spent 90% of her day entering data into the computer as she simultaneously conducted interviews. She asserts her work load was both fast paced and constant.

The computer, keyboard and mouse sat on top of her desk for most of her career. The keyboard was a one piece rectangular keyboard which she asserts was not ergonomically designed. The desk chair was adjustable in height. During most of her career Ms. Gutierrez typed with her wrists in a flexed due to the position of the equipment. The Department updated its computer system with newer ergonomic equipment shortly before Petitioner retired.

Ms. Gutierrez began to experience pain, numbness and tingling in her hands in 2004 and 2005. She treated with Dr. Stork at the Hammond Clinic in 2004 and 2005. She received cortisone injections, which did not relieve her symptoms. Dr. Stork referred her to Dr. Murphy. In October 2006, Ms. Gutierrez learned from Dr. Murphy that the symptoms in her hands were likely related to her repetitive work duties.
Ms. Gutierrez reported this repetitive work injury to her supervisor Lydia Colon and filed a workers' compensation claim with the Department. Dr. Murphy diagnosed her with bilateral carpal tunnel syndrome in November 2006. The January 17, 2007 EMG read as revealing bilateral carpal tunnel syndrome. Dr. Murphy performed a right carpal tunnel release on June 28, 2007. Her claim was accepted thus TTD was paid to her.

Ms. Gutierrez saw Dr. Murphy in follow up visits through the summer of 2007. On September 24, 2007 Dr. Murphy noted that Ms. Gutierrez still had persistent numbness in her hands. Thus, he performed a left carpal tunnel release on October 11, 2007.

Petitioner's symptoms continued after the second surgery so he requested authorization for additional surgery. Petitioner continued to receive temporary total disability benefits while awaiting authorization for surgery. Dr. Murphy ordered physical therapy, which was provided through Spring of 2008 from Shannon Costella, PT and Irfan Patel, PT. The physical therapy notes document Ms. Gutierrez' work duties.

Ms. Gutierrez saw Dr. Jack Gelman in August of 2008 who ordered repeat EMG testing which revealed bilateral carpal tunnel syndrome. Dr. Gelman found positive Tinel's and Phalen's testing. His diagnosis was recurrent bilateral carpal tunnel syndrome. Dr. Gelman also recommended an ulnar nerve release. Dr. Gelman recommended surgery be performed on the left hand first, followed by repeat surgery on the right hand. Dr. Gelman wrote that Ms. Gutierrez' condition was work related due to her repetitive work duties for 28 years. Notwithstanding, claims did not authorize surgery.

A Respondent Section 12 evaluation with Dr John Fernandez took place on March 26, 2009. Dr. Fernandez noted that Ms. Gutierrez' arms and hands showed wrist flexion of 10 degrees and elbow flexion of 70 degrees when she typed. Dr. Fernandez found bilateral hand numbness, tingling and bilateral palmar pain. Dr. Fernandez was unable to causally relate Petitioner's complaints with her work duties.

However, he did not address whether her work duties were an aggravating factor in the development of her bilateral carpal tunnel syndrome. Dr. Fernandez noted the Petitioner's symptoms remained even though she had not worked for two years.

Dr. Fernandez felt that Petitioner can work full duty. He recommended conservative treatment consisting of splinting and injections and FCE testing. Dr. Fernandez did not recommend repeat surgery. The Department discontinued TTD benefits and denied surgery after it received Dr. Fernandez' report.

Ms. Gutierrez remained symptomatic and she continued to treat with Hammond Clinic. She applied for disability benefits through the State Retirement System (SRS). Hammond Clinic performed repeat EMG testing done in June 2009. This test was abnormal and revealed carpal tunnel syndrome. Murphy retired from Hammond Clinic and Dr. Kucharzyk took over treatment. He advised repeat surgery.

Ms. Gutierrez was evaluated by Dr. Paul Bertrand at the request of the SRS on September 16, 2009. Dr. Bertrand's impression was bilateral carpal tunnel syndrome. Dr. Bertrand found positive Phalen and Tinel signs. Dr. Bertrand recommended additional testing (EMG and MRI) and he felt surgery was indicated, with return to work after surgery.

Ms. Gutierrez continued to treat with Dr. Kucharzyk throughout 2009 while ordering additional PT. Dr. Kucharzyk recommended repeat surgery on December 4, 2009. Surgery was delayed in 2010 due to unrelated health problems. Ms. Gutierrez continued to see doctor throughout 2010 with office visits on February 19, June 30, August 06, November 02, November 30, and December 29, 2010. On February 23, 2011 doctor scheduled repeat surgery for the left hand on April 5, 2011.

Ms. Gutierrez saw Dr. Kucharzyk on April 08, April 22 and May 27, 2011. Dr. Kucharzyk wrote that Petitioner still needed surgery on the right hand.

Ms. Gutierrez was seen on October 5, 2011 by Dr. Kung, who replaced Dr. Kucharzyk. Petitioner had repeat EMG testing on February 1, 2012 which showed evidence of bilateral carpal tunnel syndrome. Petitioner was seen in follow up visits on February 15, April 03, April 10, and June 5, 2012. Dr. Kung performed 4th surgery on June 26, 2012. Dr. Kung released Petitioner to return to work on August 1, 2012.

Ms. Gutierrez was also evaluated by Dr. Wiedrich on June 12, 2014. Dr. Wiedrich noted that Petitioner typed with her wrists held in a flexed position throughout most of her career. Dr. Wiedrich opined that this flexed position of Petitioner's wrists was an aggravating factor in a multifactorial analysis of causation. Dr. Wiedrich opined that this positioning of the wrist was an aggravating factor in the development of her carpal tunnel syndrome. He noted the Department updated its computer equipment in the Petitioner's work station, but this ergonomic improvement occurred after her surgeries.

The Arbitrator relies upon the testimony of the only witness who testified at arbitration, namely the Petitioner. She stated that late in her career the Department updated its computers and moved the keyboard to a pull-out shelf. Petitioner testified during the majority of her career she typed with her wrists in a flexed position. The Arbitrator adopts this testimony as findings of fact in determining the case at bar .

Petitioner was diagnosed with diabetes. Her diabetes is controlled with medication. Her diagnosis occurred after her first two surgeries. Petitioner testified that she has not been diagnosed with arthritis. Petitioner testified that surgery alleviated her symptoms and she could return to work after she had surgery.

Petitioner's complaints at arbitration include numbness, tingling and weakness in both her hands. She has difficulty opening jars and gripping objects. She rests her elbows on the handle of the shopping cart. Petitioner takes over-the-counter medication to help control the pain in her hands. She limits the amount of driving she does. Petitioner is no longer able to bowl, which was a hobby which she enjoyed.

Conclusion of Law:

The Arbitrator bases this Decision on the totality of the evidence, both the sole testimony of the worker without rebuttal plus the medical evidence. The Arbitrator adopts this evidence as highlighted above, in addressing the following issues.

(C.) Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent? And (F.) Is Petitioner's current condition of ill-being causally related to the injury?

The Arbitrator finds the manifestation date to be the date in the Award. The doctor advised the worker of her condition and its relationship to work duties as per above. The Arbitrator finds the keyboarding in this particular case to be the causative factor in the manifestation of said condition. The Arbitrator finds the totality of the medical records support a finding of repetitive trauma injury to petitioner's left and right hands.

Dr. Murphy wrote that Petitioner's carpal tunnel syndrome was likely related to her job duties (Exhibit 1). Dr. Gelman opined that her symptoms were caused by her 28 years of repetitive work duties. (PX 2).

Respondent's section 12 examiner Dr. Fernandez was unable to state that Petitioner's carpal tunnel syndrome was related to her work activities. Dr.Fernandez was unable to point to a specific cause for Petitioner's symptoms. Dr. Fernandez opined that the position of the Petitioner's wrists was not sufficient to cause carpal tunnel syndrome. Dr. Fernandez did not recommend additional surgery. He did recommend additional conservative treatment and he released Petitioner to full duty work following his evaluation. (RX 1).

Dr. Bertram evaluated Petitioner on behalf of the State Retirement System. Dr. Bertram noted that Petitioner did a lot of typing at work. Dr. Bertram, unlike Dr. Fernandez felt that additional surgery was needed. (PX 2).

Dr. Wiedrich examined Petitioner. Dr. Wiedrich opined that typing with wrists in flexion was an aggravating factor in a multifactorial analysis for causation of carpal tunnel syndrome. Although Dr. Wiedrich provided causation for carpal tunnel syndrome, he did feel that Petitioner's trigger finger symptoms were causally connected to her employment duties. (PX 3).

In light of the foregoing testimony plus medical opinions regarding accident and causation, Petitioner's unrebutted testimony regarding her job duties and work station and in light of the Petitioner's successful return to work after her third and fourth surgeries, the Arbitrator finds as a matter of law and of fact that petitioner sustained an accident which arose out of and in the course of her employment and further finds that Petitioner's condition of ill-being was related to her work accident of October 13, 2006.

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

Having found accident and causal connection and pursuant to the stipulation of the parties, the Arbitrator awards medical services of the treating doctors above. Payment was provided through the Respondent group insurer Blue Cross Blue Shield. The Arbitrator orders the Respondent in the case at bar to forthwith repay Blue Cross Blue Shield's request for reimbursement in the amount of $32,200.52 pursuant to fee schedule.

k. What temporary benefits are in dispute?

Having found accident and causal connection plus based upon the totality of the evidence relating to TTD : the Arbitrator finds as a matter of law and fact the Petitioner is entitled to TTD as claimed in the hearing stipulations. Thus, the Arbitrator awards 214 and 3/7th weeks TTD benefits for the periods January 31 through February 07, 2007, June 28, /2007 through May 31, 2011 and June 05 through July 31, 2012 in the amount of $154,710.52. Respondent is entitled to a credit of $70,714.23 for TTD benefits paid.

L. What is the nature and extent of the injury?

This case involves multiple hand surgeries over extended time. This is not the single release of a carpel ligament.

Having found accident and causation, plus based on the totality of the evidence , the Arbitrator awards Permanent Partial Disability benefits of $619.97 per week for 102.5 weeks because the injuries sustained caused 25% loss of use of the left hand and 25% loss of use of the right hand as provided in Section 8 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

Patricia Vargas,

Petitioner,

vs. NO: 12WC 38709

Lifetouch Portrait Studios, Inc. ,

18IWCC0028

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

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

18IWCC0028

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: JAN 11 2018
o010818
MJB/jrc
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

VARGAS, PATRICIA
Employee/Petitioner

Case# **12WC038709**

LIFETOUCH PORTRAIT STUDIOS INC
Employer/Respondent

18IWCC0028

On 2/8/2017, 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 0.62% 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:

0290 KARCHMAR & STONE
GARY P STONE
111 W WASHINGTON ST SUITE 1030
CHICAGO, IL 60602

1886 LEAHY EISENBERG & FRAENKEL
SANDY ECHEVESTE
33 W MONROE ST SUITE 1100
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Patricia Vargas
Employee/Petitioner

v.

Lifetouch Portrait Studios, Inc.
Employer/Respondent

Case # 12 WC 38709

Consolidated cases: _____

18IWCC0028

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 **11/22/16 and 1/24/17**. 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 _____

FINDINGS

On the date of accident, **Lifetouch Portrait Studios, Inc.**, 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 **$41,860.00**; the average weekly wage was **$805.00**.

On the date of accident, Petitioner was **32** years of age, ***single*** with **1** dependent children.

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$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 $47,794.08, as provided in Section 8(a) and 8.2 of the Act as follows: Hinsdale Orthopaedics-$47,351.08; Athletico Physical Therapy-$443.00. Bills to be paid pursuant to the medical fee schedule.

Respondent shall pay Petitioner temporary total disability benefits of $536.67/week for 32 3/7 weeks commencing July 11, 2014 through February 22, 2015, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner temporary partial disability benefits of $13,655.09 representing 91 2/7 weeks commencing February 23, 2015 through November 12, 2016, as provided in Section 8(a) of the Act.

Respondent shall pay all reasonable and necessary prospective medical services as provided in Section 8(a) of the Act.

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

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

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

David A. Kane
Signature of Arbitrator

February 8, 2017
Date

FEB 8 - 2017

ICArbDec19(b)

e+FINDINGS OF FACTS And CONCLUSIONS OF LAW

The Arbitrator finds that the Petitioner's current condition of ill-being is causally related to the injury and in support thereof relies upon Petitioner's Exhibits 1, 2, 3, 7, and 9.

The Petitioner testified credibly and the evidence presented by Petitioner demonstrates that the Petitioner's current condition of ill-being is causally related to the injury.

On June 26, 2013 this matter was heard on a 19(b) Petition which resulted in a finding that Petitioner sustained a work related injury to her left hip on January 26, 2012, that the treatment was reasonable and necessary, and the Respondent was to pay for any prospective medical services for the left hip injury (see Arbitrator Kane's decision filed July 18, 2013, affirmed and adopted by the Commission on February 20, 2014 (14 IWCC 0126)). Subsequent to the left hip injury, Petitioner testified that she began to notice increased pain in her right hip in the Fall of 2013 and that she never had pain in her right hip before the accident of January 26, 2012. In the Fall of 2013, Petitioner noticed stabbing pain, numbness in the back of the right hip and she was fidgety when trying to rotate her right hip. She testified that since the time of the initial injury to her left hip, the Petitioner was relying on the right hip to function as the left hip was painful. Petitioner

testified that while waiting for approval for treatment and surgery to repair her left hip, she continued to work full time for the Respondent from January 2012 through April 2014. During this period, both hips were getting worse. Despite using anti-inflammatories and undergoing injections for the right hip, the condition worsened and once she underwent surgery for the left hip in April 2014, her right hip became even worse as she relied on the right hip even more in her recovery. As her left hip improved following surgery, her right symptoms increased.

Currently, Petitioner has right hip pain every day and cannot sit too long. In addition to right hip pain, she has pain in her right buttock, has difficultly with rotation of the right hip and has difficulty sleeping. Even at the hearing, Petitioner sat with her right leg crossed over her left to take any pressure off her right hip and buttock. At her current job, Petitioner testified that she has a chair that adjusts for her hips and a pillow she uses to kneel when necessary. She also testified that she stands for periods to alleviate her pain in the right hip. Petitioner testified that the day following a work day is a recovery day in which she needs to lay on her carpet at home for hours stretching and trying to bring the inflammation in her hips down.

Petitioner testified that she has been treating with Dr. Domb and Athletico since the accident. Further, Dr. Domb has recommended surgery

to alleviate her right hip symptoms and repair the injury. She testified that if approved, she would undergo the surgery immediately.

A review of Dr. Domb's records reflects that on February 24, 2014 Petitioner returned to Dr. Domb who noted that she is awaiting approval for left hip surgery (Px 3, p.76). Additionally, Dr. Domb noted that as Petitioner is compensating for the pain in her left hip, she has begun to have a slow onset of increasing right hip pain since October or November 2013 (Px 3, p.76). Dr. Domb's assessment was right hip piriformis syndrome due to compensation of left hip pain/injury (Px 3, p.78). He recommended therapy for the right hip and scheduled an appointment for a right hip injection (Px 3, p.78). The injection for the right hip was performed on February 26, 2014 (Px3, p.73). Petitioner returned to Dr. Domb on March 27, 2014 for bilateral hip pain and he noted that the right hip was improving after the injection so that she could sit for about two hours before numbness and tingling occurred and the left hip continued to be painful (Px 3, p.70). Dr. Domb's assessment was left hip labral tear caused by an injury and right hip pain as a result of compensating for the left hip (Px 3, p.71). The plan was to proceed with arthroscopy of the left hip and obtain an MR arthrogram of the right hip (Px 3, p.72). On April 9, 2014, an MR arthrogram was performed on Petitioner's right hip (Px 3, p.126-128). The

report references both the left and right hip, but Dr. Domb clarified that the MR arthrogram was of the right hip (Px 7, p.15, p.23-4, p.40-1). Dr. Domb reviewed the MR arthrogram of the right hip which revealed a tear of the labrum, some chondral thinning, and potential pincer type impingement (Px 7, p.15-6, p.41).

On April 24, 2014, Petitioner again returned to Dr. Domb who noted continued right hip pain with temporary relief from the injection (Px 3, p.62). Surgery for the left hip was scheduled for April 30, 2014 and the surgery was performed that day (Px 3, p.65 and p.143).

In the months following the left hip surgery the focus was on post-operative recovery and left hip pain, but on July 11, 2014 Dr. Domb noted pain in the anterior right hip from standing. Physical therapy was recommended and further work restrictions were ordered (Px 3, p.44-46). On August 14, 2014 Dr. Domb noted increased symptoms in her right hip over her hip flexor and piriformis (Px 3, p.40). Physical therapy for the right hip was recommended and another injection was performed on August 26, 2014 (Px 3, p.41-2 and p.36-38).

Respondent then scheduled an IME for September 22, 2014 with a well-known IME physician, Dr. Kevin Walsh, who is a general orthopedic surgeon. It appears from Dr. Walsh's report dated October 12, 2014 that

he believes that the Petitioner's right hip symptoms are unrelated to the injury, but did not provide the basis for that opinion nor did he address what was causing the Petitioner's right hip symptoms (Rx 2, p.6). Furthermore, Dr. Walsh did not address the April 9, 2014 MR arthrogram of the right hip or the findings made by Dr. Domb thereafter regarding the tear of the labrum, chondral thinning, and impingement (Rx 2).

In contrast thereto, Dr. Domb, Petitioner's treating orthopedic surgeon, testified that he is a board certified orthopedic surgeon who performs about 500 hip surgeries per year, comprising about 70% of his practice (Px 7, p.6). He has been treating the Petitioner since March 2013 and has performed surgery on her left hip (Px 3). Dr. Domb's records show a clear history of the onset of the right hip pain and Dr. Domb's opinions as to the injury and the cause thereof are set forth in both his records and his testimony (Px 3 and Px 7). Specifically, Dr. Domb testified, and his records reflect, that as Petitioner is compensating for the pain in her left hip, she has begun to have a slow onset of increasing right hip pain since October or November 2013 (Px 3, p.76, Px 7, p. 13-4). Dr. Domb described that when one side is injured, the mechanics of walking, sitting, and standing may be altered, and one may overcompensate with what is initially at least the good hip, and overload the good hip, and subject it to abnormal

mechanics and range of motion such that it becomes injured itself (Px 7, p.14). Petitioner's history is consistent with this process and it is Dr. Domb's opinion that this is what happened to Petitioner's right hip (Px 7, p.15, Px 3).

Petitioner continued to complain of right hip pain throughout her visits to Dr. Domb after August 2014 and on September 10, 2015, Dr. Domb recommended an MRI of the right hip as Petitioner had failed conservative care (Px 3, p.12). The right hip MRI was performed on September 22, 2015 which revealed a right hip labral tear and high-grade partial thickness tear of the gluteus medius (Px 3, p.6). Dr. Domb noted that it would be appropriate for Petitioner to undergo arthroscopy/endoscopy which would involve labral repair versus debridement versus reconstruction, trochanteric bursectomy, gluteus medius repair as well as other possible procedures (Px 3, p.6). Dr. Domb further noted that the right hip pain and current condition, which necessitates surgery, were caused by the left hip injury due to compensation for her left hip pain (Px 3, p.6).

Respondent then scheduled another IME with Dr. Kevin Walsh on January 11, 2016. Again Dr. Walsh opined that it is not likely that any of the right hip findings are causally related to overcompensation (Rx 1, p.5). However, Dr. Walsh did state that the pincer lesion described on the MRI

scan of the right hip certainly can cause labral pathology (Rx 1, p.5). He stated that the labrum can tear through repetitive motion, pinching the labrum as the hip is moved (Rx 4, p.28). In his report following the January 2016 IME, Dr. Walsh opined that the surgery recommended by Dr. Domb is neither reasonable nor necessary and is not warranted (Rx 1, p.5). However, at his August 30, 2016 deposition he testified that he had "no problem with Dr. Domb recommending an arthroscopy" of the right hip (Rx 4, p.43-4).

Dr. Walsh testified that one of the underlying bases of his opinions was that Petitioner **first** complained of right hip pain 13-14 weeks after the April 30, 2014 surgery to repair the left hip (Rx 4, p.26-7). Dr. Walsh testified that he reviewed all of Dr. Domb's medical records and that this information came from his review of those records (Rx 4, p.26-7). However, Dr. Domb's office note of February 24, 2014 states that as Petitioner is compensating for the pain in her left hip, she has begun to have a slow onset of increasing right hip pain since October or November 2013 (Px 3, p.76).

It appears from even Dr. Walsh's testimony that the labral tear of the right hip could have come about as a result of increased reliance on that hip as a result of the left hip injury (Rx 4, p.28). It is evident from all of Dr.

Walsh's reports and his testimony that he does not have a clear understanding of Petitioner's history. Had he reviewed the medical records of Dr. Domb he would have seen that Petitioner told Dr. Domb in February 2014 that her right hip complaints began in October or November 2013, six months **prior** to the left hip surgery, not 13-14 weeks **after** the left hip surgery, as Dr. Walsh testified. Thus, it appears that a basis for Dr. Walsh's opinion about the causal relationship of the right hip condition is the erroneous belief that Petitioner's right hip complaints began 13-14 weeks after the left hip surgery.

Given all of the above, Dr. Walsh's opinion is of little value and is neither persuasive nor credible. Moreover, Dr. Domb's practice focuses primarily on the hip wherein Dr. Walsh is a general orthopedic surgeon where only about 20% of his practice relates to the hip. Further, Dr. Domb has been Petitioner's treating orthopedic surgeon since March 2013 and has continuously examined and treated the Petitioner since that time. Thus, he is in the best position to formulate an opinion as to the injury and causation. In addition, Dr. Domb considered all the issues and after a repeat MR arthrogram and MRI confirmed the diagnosis of a labral tear and an underlying impingement, and then provided a well-reasoned opinion as to the diagnosis and causation. Therefore, the Arbitrator places greater

weight upon the findings and opinions of the Petitioner's treating physician, Dr. Domb, whose opinions are credible and persuasive.

It is well settled that where an injury is a contributing factor, compensation will be allowed even if it is possible that the Petitioner's condition of ill-being resulted from other contributing factors or degenerative processes. (See International Vermiculite Company v. Illinois Industrial Commission, 76 Ill2d 1, 31 Ill. Dec. 789, 394 N.E.2d 1166 (1979)). Furthermore, in deciding between varying medical opinions, it is for the Commission to decide which medical view is to be accepted and it may attach greater weight to the opinion of the treating physician. International Vermiculite Company, 76 Ill2d at 3.

Accordingly, based upon the Petitioner's testimony and the opinions of Dr. Domb, the Arbitrator finds that the Petitioner's current condition of ill-being as to her right hip is causally related to the injury sustained on January 26, 2012.

As to the issue of whether the medical services that were provided to Petitioner were reasonable and necessary and the issue of whether Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds that the medical services provided to

Petitioner were reasonable and necessary and the Respondent has not paid all appropriate charges for all reasonable and necessary medical services and in support thereof the Arbitrator relies upon Petitioner's Exhibits 1-7 and 9 and further finds as follows:

It should be noted that the Respondent's IME physician, Dr. Walsh, testified that it was reasonable to inject Petitioner's right hip and he had no problem with Dr. Domb recommending Petitioner undergo a right hip arthroscopy (Rx 4, p.37-8 and p.43-4). Dr. Walsh's primary criticism was that the right hip injury was not related to the work related accident and he did not provide any other specific opinions as to whether the treatment to the right hip was reasonable and necessary. Conversely, Dr. Domb testified that all the treatment was reasonable and necessary and related to the work accident of January 26, 2012 (Px 7, p.20).

Having determined that the right hip injury is causally related to the work accident, the Arbitrator finds that the treatment rendered to the Petitioner was reasonable and necessary. Since the Respondent makes no claim of payment for the bills offered into evidence by Petitioner, the Respondent shall pay the medical bills from Hinsdale Orthopaedics-Dr. Domb (Px 4 and 5) and Athletico Physical Therapy (Px 6). All bills to be paid pursuant to the medical fee schedule.

As to the issue of whether the Petitioner is entitled to any prospective medical care, the Arbitrator finds that the Petitioner is entitled to prospective medical care for her right hip as recommended by Dr. Domb and supported by Respondent's IME physician, Dr. Walsh, and in support thereof the Arbitrator relies upon Petitioner's Exhibits 1, 2, 3, 7 and 9 and Respondent's Exhibit 4, and further finds as follows:

The Petitioner testified that she has continued complaints of pain and discomfort in her right hip. Petitioner has been under the care of Dr. Domb consistently since March 2013. She has undergone extensive conservative care that has not alleviated her symptoms and Dr. Domb as well as the Respondent's IME physician agree that surgical intervention is appropriate. Since the Arbitrator found that the right hip injury is causally related to the accident, the Arbitrator finds that the opinions and recommendations as to future medical treatment recommended by Petitioner's treating orthopedic surgeon is credible and persuasive as they are based upon consistent treatment and examinations of the Petitioner. Accordingly, the Arbitrator finds that Petitioner is entitled to prospective medical care as outlined by her treating physician. Respondent shall pay all reasonable and necessary

medical charges for the services prescribed pursuant to the medical fee schedule.

As to the issue of what temporary benefits are due Petitioner, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits commencing July 11, 2014 through February 22, 2015 and temporary partial disability benefits from February 23, 2015 through November 22, 2016, and in support thereof the Arbitrator notes Petitioner's Exhibits 1 through 3 and Petitioner's Exhibits 7 through 10 and further finds as follows:

Having found that the right hip injury is causally related to the work accident, the Petitioner is entitled to TTD and TPD benefits for the periods in question. Petitioner testified that she was terminated by Respondent on July 10, 2014 and has not received TTD benefits since that time. Further, Petitioner testified that since the date of her surgery (April 30, 2014) to the present, her treating orthopedic surgeon, Dr. Domb, has had her either off work completely or working with restrictions. She has never been returned to work full duty. Once she was able, Petitioner used her previous knowledge, skill and certification to obtain a position as a monitor technician at Advocate Christ Hospital beginning on February 23, 2015.

This job falls within her restrictions and is a part time position earning $15.30 per hour where she averages 32 hours per week. Petitioner is currently employed in this position but earns less than her pre-accident wage. Her exact earnings are contained in Petitioner's Exhibit 8 and the TPD is calculated in Petitioner's Exhibit 10. Petitioner testified that after working, she spends her off day stretching and recovering from her day at work.

Dr. Domb testified that while his records reference the Petitioner being at MMI, he was referring to her left hip only, as he intends to continue to treat the right hip and has even recommended surgery (Px 7, pp.-21 and Px 3, p.12). Additionally, Dr. Domb testified that although he allowed the Petitioner to return to work at Advocate Christ Hospital without restrictions, that did not mean she could work any job without restrictions and that only applied to this particular job (Px 7, p.19-20). Dr. Domb specifically stated that since the left hip surgery on April 30, 2014, Petitioner has either been off work or returned to work with some limitations on her ability to work (Px 3, p. 4-answer to Question 10).

A review of Dr. Domb's records support his testimony. For example, the April 11, 2014 Work Status Report indicates Petitioner can return to work light duty, no photography and no more than 20 hours per week (Px 3,

p.43). These restrictions appear in the records through January 2015 (Px 3). On May 18, 2015, Dr. Domb's Work Status Report specifically states that Petitioner can work at her job in Central Tele without restrictions (Px 3, p. 20). To date, nothing has changed and the Petitioner is awaiting approval for treatment for her right hip.

Accordingly, the Arbitrator finds that the Respondent shall pay Petitioner temporary total disability benefits of $536.67 per week for 32 3/7 weeks commencing July 11, 2014 through February 22, 2015. Further, Petitioner provided the pay stubs from her position at Advocate Christ Hospital from February 22, 2015 through November 12, 2016 (Px 8) and provided a chart calculating the TPD owed for this period (Px 10). As such, the Arbitrator finds that the Respondent shall pay Petitioner temporary partial disability benefits of $13,655.09 representing 91 2/7 weeks commencing February 23, 2015 through November 12, 2016.

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

Edward Gause,

Petitioner,

vs. NO: 12 WC 9002

State of Illinois-Elisabeth Ludeman Center,

18IWCC0029

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of the nature and extent of Petitioner's disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 4, 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: JAN 11 2018
TJT:yl
o 1/8/18
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0029

GAUSE, EDWARD
Employee/Petitioner

Case# **12WC009002**

SOI/ELISABETH LUDEMAN CENTER
Employer/Respondent

On 8/4/2017, 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:

0224 GOLDFEIN LAW OFFICE PC
DAVID R BUTZEN
77 W WASHINGTON ST SUITE 1124
CHICAGO, IL 60602

5782 ASSISTANT ATTORNEY GENERAL
KELLY KAMSTRA
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
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 4 = 2017



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

Edward Gause
Employee/Petitioner

v.

State Of Illinois Elisabeth Ludeman Center
Employer/Respondent

Case # **12** WC **09002**

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 **June 22, 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 **January 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* 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 **$55,781.96**; the average weekly wage was **$1,072.73**.

On the date of accident, Petitioner was **57** years of age, ***married*** with **1** dependent children.

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

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

Respondent shall be given a credit of **$N/A** for TTD, **$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 **$N/A** under Section 8(j) of the Act.

ORDER

This matter was tried to completion before the Arbitrator June 22, 2017. The Petitioner was the sole witness. The only issues in dispute are accident and nature and extent of the injury and whether current condition of ill-being is causally related to the injury

Petitioner's uncontroverted testimony is that on January 22, 2012, while in the ordinary course of his duties for Respondent as a mental health technician, he interceded in a physical altercation and was himself assaulted by a ward in his charge resulting in a permanent injury to his dominant left hand.

Respondent disputes that this accident arose out of, and in the course of, Petitioner's work. Respondent offered no evidence in support of, nor any legal basis for this dispute. The Arbitrator finds the accident arose out of, and in the course of, Petitioner's employment.

As a result of this accident Petitioner suffered a comminuted fracture to the fifth metacarpal and significant but lesser injury to his fourth metacarpal. Restorative surgery was recommended - percutaneous pinning and possible open reduction internal fixation - but was delayed owing to cardiological concerns.

As a result of the foregoing, Petitioner was compelled to undergo an alternative, more conservative, treatment of extensive physical therapy, splinting/cast and the use of a compression sleeve.

Petitioner was released after approximately five months to return to full duty. At that time, Petitioner continued to complain of pain and an inability to ball his fist or to fully extend and flex the affected digits. Ample disfiguration on and around the site of injury corroborates Petitioner's complaints.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no opinion comporting with the specific requirements of §8.1b(a) was submitted into evidence. However, the Arbitrator has considered the doctor's comments as a factor in the evaluation of Petitioner's permanent partial disability as required by §8.1b(b)(i).

The doctor specifically noted the pain and the limitations resulting from the injury. Because of the corroboration from the x-rays, physicians, therapists and Petitioner's own testimony, the Arbitrator therefore gives greater weight to these findings.

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 he was able to return to work in his prior capacity. The Arbitrator notes that to perform his usual duties, he is required to wear a copper glove, use medications and endure increased pain and discomfort while working. Because of the physical requirements of the employment, 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 of his experience and age, 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 Petitioner has returned to full employment. Because of his continued work in the same capacity, albeit with certain accommodations, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes as above, all the physical, medical and testimonial evidence was uncontroverted and corroborated. Because of the evidence adduced at trial and a physical examination of Petitioner, 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 17.5 % loss of use of his left hand or 37.875 weeks at the PPD rate pursuant to §8(e)9 of the Act.

Respondent shall pay Petitioner compensation that has accrued from January 22, 2012 through June 22, 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.

George J. Andros #001 — August 3, 2017

Signature of Arbitrator — Date

AUG 4 - 2017

STATEMENT OF FACTS 12 WC 9002

18IWCC0029

The Petitioner was employed by the Respondent as a Mental Health Technician. Part of his duty was to physically control the conduct of the wards under his control. On January 22, 2012, two of the Petitioner's wards engaged in a physical altercation necessitating the Petitioner's intervention. In attempting to break up the fight, one of the combatants struck the Petitioner in the left hand with a metal belt buckle. As a result of being struck by the belt buckle in the left hand, he suffered pain and loss of function.

On 1/24/12, the Petitioner sought an evaluation and treatment from his primary care physician, Dr. Smith. XRay revealed a comminuted FX of the shaft of 5th metacarpal with considerable volar angulation deformity and maximal displacement of about 3 mm. This is the diagnosis adopted by the Arbitrator in support of the Decision in the case at bar.

On 1/25/12, the Petitioner was evaluated by a Dr. Veldman who performed a physical examination of his left hand and recommended work restrictions and a referral to an orthopedic specialist, Dr. Labana. On 1/26/12, Dr. Labana for continued complaints of pain and stiffness in his left hand at the fracture site. The Petitioner informed Dr. Labana that he was experiencing aching and soreness at the 5th metacarpal neck that interfered with his daily activities. Upon physical examination by Dr. Labana, the Petitioner exhibited tenderness and swelling in dorsal surface of hand at 5th metacarpal neck. Dr. Labana diagnosed the Petitioner with a fracture of the metacarpal bone, and applied a short arm splint (forearm to hand). Dr. Labana imposed work restrictions and recommended that the Petitioner undergo surgery to repair the fracture, to wit, closed reduction, percutaneous pinning and possible open reduction internal fixation. In addition, Dr. Labana recommended that the Petitioner have a pre-operative work-up performed to clear him for the proposed surgery.

On 2/8/12, the Petitioner was evaluated by a cardiologist, Dr. Sundram, for a pre-op clearance. Dr. Sundram interpreted the petitioner's EKG to be abnormal, and as a consequence, recommended that the Petitioner undergo an echocardiogram and a nuclear stress test before being cleared for surgery. After these tests were performed, the Petitioner was cleared for surgery on 2/21/12.

On 2/23/12 Dr. Labana interpreted as showing significant healing of the fracture. Dr. Labana recommended the use of a splint/brace and continued work restrictions. On 3/8/12, Dr. Labana recommended the Petitioner undergo physical therapy two to three times a week for three weeks to improve his range of motion. On 3/13/12, Petitioner was found to have a large "nodule" on the dorsum of his left hand at the site of the fracture. He was also found to have pain, edema, decreased range of motion, impaired strength and function, and atrophy. His physical therapists recommended that he wear a compression sleeve to be worn at night to decrease the edema. The findings of the therapist of the large nodule on the dorsum is adopted, thus said findings did not have to be stated in the record after a visual observation by the Arbitrator. 8 sessions ensued.

On 4/9/12 Petitioner exhibited some stiffness of his ring finger. Dr. Labana believed that condition was likely the result of previous splinting. X-rays on the Petitioner's left hand that revealed "healed abundant callous, as well as some angulation to the same degree shown on the previous x-rays." Due to the healing that had occurred during this time, Dr. Labana recommended that the Petitioner not undergo surgery. The Petitioner testified that Labana informed him that in order to perform the surgery, he would have to re-break the bone and then perform the surgery. The Petitioner opted to forego the surgery and receive further conservative treatment, including more physical therapy, as well as continued work restrictions.

On 4/26/12, the Petitioner returned to receive further physical therapy treatments. On 4/30/12 Dr. Labana recommended more therapy for the Petitioner's ring finger, two to three times a week for three weeks. He also recommended continued work restrictions. On 5/1/12, the Petitioner began another course of physical therapy and attended six sessions before returning to Dr. Labana. On 5/21/12 the Petitioner continued to exhibit some residual stiffness in his ring finger, but overall was "doing well." On 5/22/12, the Petitioner began a course of work conditioning therapy. Upon his initial evaluation, the Petitioner complained mainly of stiffness and soreness of his left 4th and 5th fingers, mildly decreased active range of motion of the left hand and wrist and reduced strength. The Petitioner underwent work conditioning sessions between 5/22/12 and 6/1/12. During that time, and upon his discharge, the Petitioner continued to complain of left hand stiffness of the 4th and 5th fingers.

On 6/11/12, Dr. Labana released the Petitioner to return to work without restrictions. Thereafter, from June of 2012 to September of 2012, the Petitioner was evaluated by his primary care physician for the injury to his left hand and fingers. Dr. Smith noted that;

(1) the Petitioner was still unable to completely ball his fist;
(2) there was a bony deformity at the 5th PCP area;
(3) the 5th digit exhibited mild flexion contracture and swelling at the PIP joint; and
(4) the 4th digit exhibited incomplete flexion.

The Petitioner testified that the pain and stiffness in the 4th and 5th finger of his left hand has never gone away. He still to this day experiences pain and stiffness in his fingers 3 to 4 times a week, and rated that pain as a 5-6/10 when he does experience the pain. He said the pain can last the whole day and is usually associated with use of his left (dominant) hand, as well as changes in the weather. Petitioner further testified that he continues to be unable to make a full fist and is limited in performing his ADLs and recreational activities. The Petitioner testified that any activity that requires him to use his left hand, particularly to grip objects, causes him increased pain. In addition, the Petitioner testified that he uses a copper glove to reduce the pain in his hand and various topical ointments, such as Bengay and Tiger Paw.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Thomas Allen Smith,

Petitioner,

vs.

NO: 15 WC 34372

Champion Roofing, Inc.,

18IWCC0030

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 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 August 31, 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.

18IWCC0030

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: JAN 11 2018
TJT:yl
o 1/8/18
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

SMITH, THOMAS ALLEN
Employee/Petitioner

Case# **15WC034372**

CHAMPION ROOFING INC
Employer/Respondent

18IWCC0030

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

1408 HEYL ROYSTER VOELKER & ALLEN
BRAD ANTONACCI
120 W STATE ST 2ND FL
ROCKFORD, IL 61105

18 IWCC0030

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) 8(a)

Thomas Allen Smith
Employee/Petitioner

v.

Champion Roofing, Inc.
Employer/Respondent

Case # **15** WC **34372**

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 **Jessica Hegarty**, Arbitrator of the Commission, in the city of **Wheaton**, 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. ☒ 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, **10/15/15**, 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 **$35,360.00**; the average weekly wage was **$680.00**.

On the date of accident, Petitioner was **55** years of age, ***married*** with **0** dependent children.

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

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

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

ORDER

Medical benefits

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $52,647.72 to Midwest Orthopaedics at Rush, $6,372.89 to Elmwood Park Same Day Surgery Center, $2,897.00 to Alexian Brothers Medical Center and $4,260.54 to Instant Care Equipment Leasing, as provided in Sections 8(a) and 8.2 of the Act.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of **$453.33/week for 36 5/7 weeks**, commencing **10/16/15 through 6/28/16**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **10/16/15 through 6/28/16**, and shall pay the remainder of the award, if any, in weekly payments.

Prospective Medical Care

The Petitioner is awarded reasonable and necessary medical care related to his low back condition as prescribed by Dr. Mehta and Dr. Singh pursuant to Section 8(a) of the Act.

Penalties

The Arbitrator declines to award any penalties/fees.

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.

Jason C. Hyatt

Signature of Arbitrator

8/29/16
Date

ICArbDec19(b)

AUG 31 2016

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

THOMAS ALLEN SMITH, Petitioner,	)	
	)	No.: 15 WC 34372
vs.	)	
CHAMPION ROOFING, Defendant.	)	

ADDENDUM TO THE DECISION OF THE ARBITRATOR

Testimony of the Petitioner

The Petitioner testified he had been employed by the Respondent, a roofing contractor, for three years as a truck driver and deliveryman on the alleged accident date.

On the morning of October 15, 2015, the Petitioner drove his work truck from the Respondent's shop in Bensenville, Illinois to a jobsite in Elmhurst, Illinois. The Petitioner testified that he was acting at the direction of his brother, Joseph C. Smith, the owner of Respondent's company and his boss (TR. at 15). The Petitioner manually loaded lumber at the Respondent's shop onto the bed of his truck and then drove to the jobsite in Elmhurst. The Petitioner estimated that he loaded twenty (20) to twenty-five (25) pieces of lumber onto his truck bed that morning (TR. at 13). He estimated the weights of some of the pieces of lumber to be over sixty (60) pounds (TR. at 14.). When the Petitioner arrived at the jobsite in Elmhurst, he testified that he backed his truck up and proceeded to unload the lumber from his truck (TR. at 17). The Petitioner testified that in order to unload the lumber, he had to lift the materials up and over the truck tailgate, to above shoulder height and then passed the materials off the truck to a subcontractor's employee (TR. at 17). In the process of unloading the lumber from the truck, he felt sharp pain in his back (TR. at 19). The Petitioner testified he finished his shift in pain that day (TR. at 19).

Petitioner then went to an occupational medical facility in Elmhurst after leaving the jobsite to get his truck driver's medical certificate renewed. His medical certificate was still valid so he did not need to proceed with an exam at that facility and left (TR. at 20-23).

The Petitioner then traveled back to Respondent's shop in Bensenville and informed his boss/brother that he hurt his back lifting lumber that morning at the jobsite in Elmhurst. (TR. at 23-25). He testified his boss/brother, told him to "...go home and do what you have to do..." (TR. at 24).

The Petitioner drove home and waited for his wife to finish her work shift so she could take him to the emergency room (TR. at 25-26). The Petitioner testified to having aches and pains in his back prior to his alleged work accident and rated such as a 2/10 to 3/10 on a pain scale. (TR. at 27-29). According to his testimony, the pain he experienced after lifting the lumber at the jobsite on October 15, 2015 was a sharp, unbearable back pain that he had not experienced previously (TR. at 28). According to Petitioner, he never sought medical care for his back prior to October 15, 2015 (TR. at 29).

Testimony of Joseph C. Smith

Joseph C. Smith testified for the Respondent at trial. He is one of the owners of the Respondent's roofing business and the Petitioner's brother and supervisor (TR. at 79-80). He testified he did not direct the Petitioner to pick up lumber from the Respondent's shop on October 15, 2015 and deliver it to the job site in Elmhurst (TR. at 90). He acknowledged that the Petitioner told him his back hurt but denies the Petitioner told him that his back was hurting from a work injury sustained that day (TR. at 91). He testified that the Petitioner's job duties generally for the Respondent included driving the Respondent's truck with materials in it to various jobsites and loading and unloading the materials from the truck (TR. at 109-110). He testified that the Petitioner is the only driver that the Respondent employed on October 15, 2015 (TR. at 114). He again testified that he did not instruct the Petitioner that day to drive to the roofing jobsite in Elmhurst (TR. at 112-114). He testified that he was made aware that the Petitioner was at the Respondent's jobsite in Elmhurst that day (TR. at 116-118). He also testified that when the Petitioner came back from the jobsite he spoke with the Petitioner about his back pain (TR. at 118).

Testimony of Pedro Vazquez- Tavarez

Pedro Vazquez- Tavarez testified for the Respondent at trial. He testified that he unloaded the Petitioner's truck by himself when the Petitioner arrived at the jobsite in Elmhurst on October 15, 2015. When he was asked on cross-examination if the Petitioner drove the wood to the jobsite he testified "He didn't unload anything" (TR. at 137).

Medical Evidence

Petitioner's Exhibit 2 shows that on the alleged accident date, October 15, 2015, the following history at Alexian Brothers Hospital was noted:

> 55 *year old male here with complaints of lower back pain for the past three months-constant, aching pt reports heavy lifting at work and today pain was much worse after having to lift and unload heavy boards-pain at times radiates down the right leg-sharp shooting, and dull in the right buttock-slight numbness to right anterior thigh...pain 10/10...* (Pet. Ex. #2).

X-rays of Petitioner's lumbar spine noted "diffuse but mild degenerative disease at all lumbar levels with disc space narrowing that is mild and small anterior posterior endplate osteophytes. There is no fracture or subluxation. No lytic bone lesion. That sacral iliac joints and pubic symphysis are not diastatic". (Id.).

Petitioner was examined and administered pain medication at the hospital. He was later discharged with prescriptions for Flexeril, Norco, Motrin and a Medrol Dose Pack and advised to follow-up for his condition. (Id.).

The Petitioner sought follow up medical care for his back pain with Dr. Amit Mehta, Pain Management/Anesthesiologist at Elmwood Park Same Day Surgery Center on October 27, 2015 (Pet. Ex. #3). On that at date, Dr. Mehta noted a history of a October 15, 2015 work related injury while Petitioner was off loading lumbar causing sharp, low back pain with some radiations into the right lower extremity. Petitioner reported these symptoms were a 10/10 on a pain scale. (Id.). Petitioner further reported experiencing some numbness and tingling going

down his right upper extremity and numbness in the anterior aspect of the right leg with tingling and shooting sensations. Dr. Mehta also noted complaints of diffuse low back pain left greater than right, worse with activity, range of motion, and movement. (Id.).

On exam, Dr. Mehta noted pain on palpation of the paralumbar region as well as increased pain with facets left greater than right at L2 through L5.

Dr. Mehta ordered a CT scan of the lumbar spine, physical therapy three times a week for 1 month and prescriptions for Neurontin, Mobic and topical Terocin cream. (Id.) Petitioner was kept off of work and told to follow-up after obtaining the recommended CT scan. (Id.).

On October 28, 2015 the Petitioner underwent a CT scan of his lumbar spine which revealed:

- At the L4-L5 level, there is a 5-6 mm broad-based posterior disk herniation noted to indent the thecal sac with generalized spinal stenosis and bilateral neuroforminal narrowing.

- At the L5-S1 level, there is a 3-4 mm posterior disk herniation noted to indent the thecal sac with mild bilateral neuroforaminal narrowing, exacerbated by facet arthrosis and some ligamentum flavum hypertrophy. (Id.).

The Petitioner followed up with Dr. Mehta on November 3, 2015 and a lumbar injection was recommended which was performed on November 10, 2015 (Pet. Ex. #3). On November 24, 2015, Dr. Mehta noted Petitioner's report that the epidural steroid injection provided 75-80% relief initially, however, the symptoms would return on the days he participated in physical therapy. (Id.). Dr. Mehta noted the CT imaging showed disc protrusions at L3-L4, L4-L5 and L5-S1 along with stenosis and foraminal narrowing. (Id.) Dr. Mehta discontinued physical therapy and told Petitioner to follow-up in two weeks for consideration of a repeat epidural steroid injection. (Id.).

On February 3, 2016 Petitioner met with Dr. Andrew Zelby for a Section 12 exam at the request of Respondent. (Resp. Ex. #1). Petitioner provided Dr. Zelby with the history of the alleged work accident and a history of soreness and aching in the low back with no prior history of significant low back pain. Dr. Zelby noted a normal neurologic exam other than non-anatomic sensory findings that were inconsistent with any spinal condition. After performing an examination and reviewing the lumbar CT scan, Dr. Zelby diagnosed the Petitioner with lumbar spondylosis. Dr. Zelby concluded Petitioner had, at most, a temporary exacerbation of a pre-existing, symptomatic condition. Dr. Zelby noted Petitioner's three-month history of back pain when Petitioner sought medical treatment on October 15, 2015. He also noted the diagnostic studies did not reveal any acute findings, which further supported his opinions. Dr. Zelby noted that Petitioner's reported increased symptoms were a soft tissue musculo-ligamentous strain in the context of an underlying degenerative condition. Further, Dr. Zelby reported that Petitioner should also be advised of the deleterious effect that smoking has on the spine. Petitioner has smoked one pack of cigarettes per day, on and off, since he was 23 years of age.

Dr. Zelby felt that Petitioner's physical therapy was reasonable and necessary for the injury he sustained as a consequence of his reported increase in pain while lifting boards at work. The epidural steroid injection was not necessary for his work injury. He concluded that Petitioner was at maximum medical improvement for any infirmity arising as a consequence of his work injury. Further, he felt Petitioner could return to full-duty work, without restrictions.

On March 15, 2016, Petitioner followed-up with Dr. Mehta who referred Petitioner for a surgical opinion regarding his back condition. (Pet. Ex. #3).

On March 24, 2105, Petitioner consulted with Dr. Kern Singh at Midwest Orthopaedics at Rush. (Pet. Ex. #5.). Petitioner completed pain history questionnaires indicating that his pain frequency was intermittent and his pain was dull. He also noted that his pain was very mild at that time. Petitioner provided a history of lifting large lumber over his head and experiencing lower back pain down his lower extremities. Dr. Singh diagnosed lumbar radiculopathy and a lumbar muscular strain. He ordered an MRI of the lumbar spine and restricted Petitioner from work. (Id.).

On April 15, 2016, an MRI of Petitioner's lumbar spine noted mild/moderate disc bulging at L4-L5 and at L5-S1. This was causing a compromise on the central canal as well as slight narrowing of the neuroforamen bilaterally at L4-L5. At L5-S1, the disc bulging was causing mild compromise on the central canal and neuroforamen. (Pet. Ex. #3).

On April 28, 2016, Dr. Singh reviewed the recent MRI noting a large, right sided L5-S1 foraminal disc herniation, sub-articular in nature, resulting in severe foraminal stenosis accompanied by disc height loss at L4-L5. Dr. Sing recommended a laminectomy and fusion at L5-S1. (Id.).

On June 7, 2016, the Petitioner underwent a L5-S1 spinal fusion and L5-S1 laminectomy with bilateral partial facetectomy and foraminotomy performed by Dr. Singh. (Pet. Ex. #3). The Petitioner testified to significant symptom relief in his back pain following the surgery (TR. at 40-41).

Dr. Mehta and Dr. Singh have kept the Petitioner in an off-work status the entire time he has been under their care for his October 15, 2015 work injury. (Pet. Ex. #3, #5).

Petitioner testified that at the time of trial, he experienced a slight numbness in his right thigh and no pain in his back. He was still following up with Dr. Singh at the time of trial. He was taking Hydrocodone for the "cuts" that were still healing from the surgery.

The Petitioner acknowledged a prior muscular injury to his back from work over 25 years ago that has resolved (TR. at 48). Petitioner had filed a prior workers' compensation claim for a back injury with the date of injury of 07/21/89. (Resp. Ex. #2). Petitioner claimed this was for a "muscular" injury to the middle of the back. The case settled for 2.5% person-as-a-whole.

CONCLUSIONS OF LAW

C. WHETHER AN ACCIDENT OCCURRED THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, THE ARBITRATOR RENDERS THE FOLLOWING FINDINGS OF FACT AND CONCLUSIONS OF LAW:

The Petitioner testified to injuring his back on October 15, 2015 while unloading lumber from his truck at the Respondent's jobsite. Medical records from that day are consistent with the Petitioner's description of his work injury (Pet. Ex. #2).

Although there is conflicting testimony as to whether Petitioner was directed by Joseph C. Smith to perform the work duties that caused his work accident, the Petitioner was the only driver employed by Respondent on October 15, 2015. Respondent also admitted that loading and unloading materials was within the scope of Petitioner's employment. (TR. at 109). When asked if the Petitioner unloaded his truck, Joseph C. Smith, added at the end of his answer "... and the crew would help him unload as well." (TR. at 109).

Respondent Smith further testified that Petitioner complained of back pain back in August of 2015 which is corroborated by the records from Alexian Brothers Hospital. Further, Respondent Smith testified that Petitioner performed his regular job duties after his August, 2015 complaints until the accident date.

Pedro Vazquez-Tavarez testified he did all of the unloading of the lumber from the Petitioner's work truck on October 15, 2015 (TR. at 134). Mr. Vazquez-Tavarez was later asked on cross-examination to confirm that the Petitioner drove the lumber to the jobsite and answered that the Petitioner "...didn't unload anything" even though he was not asked whether the Petitioner unloaded anything. In addition to the non-responsive nature of this testimony, the Arbitrator noted his testimony appeared rehearsed.

The Petitioner's testimony on the issue of accident was consistent with the credible medical evidence, corroborated to some extent by Respondent, and further corroborated by the contemporaneous medical records from Alexian Brothers Hospital. Accordingly, the Arbitrator finds that Petitioner has sustained his burden with respect to this element.

E. WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO THE RESPONDENT, THE ARBITRATOR RENDERS THE FOLLOWING FINDINGS OF FACT AND CONCLUSIONS OF LAW:

Timely notice of the Petitioner's October 15, 2015 work accident was provided to the Respondent on the date of injury and by written notice from a letter from the Petitioner's attorney's office to the Respondent (Pet. Ex. #7). The Petitioner credibly testified to informing his boss, Joseph C. Smith of the work injury on October 15, 2015. Further, a letter was admitted into evidence from the Petitioner's attorney's office to the Respondent dated October 28, 2015 that put the Respondent on notice of the injury. The Respondent received oral and written notice of the work injury prior to the forty-five day notice requirement to report a work injury. Accordingly, the Arbitrator finds timely notice of the accident was given to the Respondent by the Petitioner.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR RENDERS THE FOLLOWING FINDINGS OF FACT AND CONCLUSIONS OF LAW:

The Petitioner's current condition of ill-being in his back is causally related to his October 15, 2015 work injury. The Petitioner had minor aches and back pain prior to his October 15, 2015 work injury, but the work injury made his pain significantly worse (Pet. Ex. 2). This fact points to a causal connection between his current condition of ill-being and his October 15, 2015 work injury. Further, the Petitioner has also treated consistently for his back injury since the time of the accident. The Petitioner's work injury is confirmed by the medical records and diagnostic testing (Pet. Ex. #2, #3, #4, #5).

The Respondent's IME physician, Dr. Andrew Zelby, indicates in his IME report that if the Petitioner sustained a work injury on October 15, 2015 that it was only minor. However, the Petitioner's trial testimony and medical records document a traumatic injury causing a herniated disc in the Petitioner's back.

Accordingly, the Arbitrator finds that the Petitioner's current condition of ill-being is causally related to his October 15, 2015 work injury.

J. WERE THE MEDICAL SERVICES THAT WERE 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 medical services provided to the Petitioner have been both reasonable and necessary. The Petitioner's medical treatment has consisted of emergency room care, physical therapy, doctor's visits, diagnostic testing, and surgery. These treatment measures constitute a course of reasonable and necessary medical treatment for the Petitioner's lumbar spine injury. The treatment he received has helped the Petitioner significantly as evidenced by his trial testimony. The Arbitrator awards the Petitioner $66,178.15 for his reasonable and necessary outstanding medical bills (Pet. Ex #2, #3, #5, #6).

K. IS THE PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR RENDERS THE FOLLOWING FINDINGS OF FACT AND CONCLUSIONS OF LAW:

The Petitioner is awarded continuing prospective medical care as recommended by Dr. Kern Singh and Dr. Amit Mehta, the Petitioner's treating physicians for the back injury at issue.

L. WHAT TEMPORARY BENEFITS ARE IN DISPUTE, THE ARBITRATOR RENDERS THE FOLLOWING FINDINGS OF FACT AND CONCLUSIONS OF LAW:

The Petitioner is awarded temporary total disability (TTD) benefits from October 16, 2015 through June 28, 2016, a period of 36 5/7 weeks. This is the time the Petitioner has been off of work since his October 15, 2015 work injury.

M. WITH REGARD TO ITEM (M), SHOULD PENALTIES AND FEES BE IMPOSED UPON THE RESPONDENT, THE ARBITRATOR RENDERS THE FOLLOWING FINDINGS OF FACT AND CONCLUSIONS OF LAW:

The Arbitrator declines to award penalties and/or fees in this case as the evidence does not support a finding that Respondent's conduct was so unreasonable and vexatious as to justify such findings.

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

LOLA HASSELBRING,

Petitioner,

vs. NO: 95 WC 006929

SAM'S CLUB,

Respondent.

ORDER ON REMAND

An Order was entered on January 24, 2017, by Judge Carl Anthony Walker of the Circuit Court of Cook County, Illinois, remanding the matter back to the Illinois Workers' Compensation Commission ("Commission") to address the Commission's failure to rule on the Motion to Reopen 19(h) Proofs Petitioner filed with the Commission on December 9, 2015. The Commission takes notice that its Order, filed on April 13, 2016, did not address Petitioner's Motion to Reopen 19(h) Proofs. Pursuant to the Court's Order, the Commission considers Petitioner's Motion to Reopen 19(h) Proofs.

Petitioner's claim dates back to June 13, 1994, when she sustained an injury to her lumbar spine as a result of lifting cases of soda while working for Respondent as a check-put supervisor. As result of this injury, Petitioner underwent a hemilaminectomy and discectomy at the L5-S1 level on July 14, 1994; a discectomy, hemilaminectomy, and decompression on January 11, 1996; and a decompressive laminectomy, disc removal, decompression, and bilateral posterior lateral fusion on an unspecified date. She resumed working for Respondent on October 13, 1999, but as a store greeter. On July 11, 2005, she had a spinal cord stimulator implanted and

a revision procedure performed on January 31, 2007. Petitioner was working as a greeter at the time of her arbitration hearing on October 14, 2008.

The Commission finds Petitioner cites no authority that confers upon the Commission jurisdiction to reopen proofs. Petitioner's cites Redelmann v. Claire Sprayway, Inc., 874 N.E.2d 230, (1st Dist 2007), to advance her argument that proofs, at the court's discretion, can be reopened. In so doing, however, Petitioner failed to differentiate that she is asking the Commission to reopen proof whereas the claimant in *Redelmann* had filed a motion for reconsideration of that court's decision. The Illinois Administrative Procedure Act provides for motions for reconsideration. 5 ILCS 100/10-50 (2017). The Commission declines to interpret the Illinois Administrative Procedure Act to find "reconsideration" and "reopen" to be synonymous. Notwithstanding the Commission's declination, even if the Commission was to entertain Petitioner's Motion to Reopen 19(h) proofs as a Motion for Reconsideration, the Commission would find against Petitioner.

The court in Redelmann found the "purpose of a motion to reconsider is to bring to the court's attention newly discovered evidence which was not available at the time of the hearing . . .." Redelmann, 874 N.E. 2d at 245. The evidence Petitioner seeks to have admitted is Petitioner's treatment records with her pulmonologist, Dr. Buccattelo, and the additional testimony from Petitioner herself.

Petitioner's pleading does not indicate which, if any, of her treatment records written by Dr. Buccattelo existed at the time of the 19(h) hearing before Commissioner Lamborn on August 21, 2014, but, for whatever reason, were unavailable at the time of the hearing, or why, if they existed prior to that date, were they not tendered into evidence. August 21, 2014, represents a clear line of demarcation. The admission of those treatment records that were created after that date would obviously be precluded under Redelmann. Those treatment records that existed prior to that date have not been argued to be either "newly discovered" or "not available at the time of the hearing." The only known evidence, per Petitioner's pleading, that could be construed as "newly discovered" and "not available at the time of the hearing" is the claimed opinion of Dr. Buccattelo that Petitioner's decreased pulmonary function was caused by her back pain. That opinion, according to Petitioner, was expressed to her in October 2015, more than a year after proofs were closed. Redelmann requires the evidence to be "newly discovered," not new evidence. Petitioner's pleading implies the former.

Petitioner's pleading to allow for her to provide additional oral testimony is without merit. She seeks to offer testimony that her back pain worsens when her breathing worsens. She did not make any such claim when she was before Commissioner Lamborn on August 21, 2014. If this relationship existed as of August 21, 2014, Petitioner was remiss for failing to state so at that time.

As stated above, the Commission believes it has not been empowered by the Act to reopen proofs as it cannot find any such provision to do so under either the Illinois Workers' Compensation Act or the Illinois Administrative Procedure Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Motion to Reopen 19(h) Proofs is denied.

As there was no award of compensation herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: DEC 2 1 2017
KWL/mav
42

KEVIN W. LAMBORN

THOMAS J. TYRRELL

MICHAEL J. BRENNAN

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DEBORAH A. ALDERMAN,
Petitioner,

vs.

NO: 14 WC 23515

STATE OF ILLNOIS EPA,
Respondent,

18IWCC0031

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causation, medical expenses, temporary total disability, and nature and extent, and being advised of the facts and law, reverses the Decision of the Arbitrator on the issue of accident but attaches the Decision for the Findings of Fact, which is attached hereto and made a part hereof, with the changes noted below.

The Commission finds that Petitioner failed to prove that her left carpal tunnel syndrome arose out of and in the course of her employment with Respondent. We are persuaded by the medical causation opinion of Respondent's Section 12 examiner, Dr. Emanuel, who examined Petitioner on November 17, 2015. It was his opinion that Petitioner's carpal tunnel syndrome was due to her "underlying medical condition, and multiple risk factors" including insulin-dependent diabetes, hyperlipidemia, obesity, hand arthritis, and being female. He wrote that there have been no peer reviewed prospective studies that implicate typing as a cause of carpal tunnel syndrome and, although typing can aggravate the symptoms, it is not causative.

As the Court noted in *County of Cook v. The Industrial Commission*, "Every employee whose disease or preexisting condition disables him while at work is not automatically entitled to a recovery under the Workmen's Compensation Act. [citation omitted]." 68 Ill. 2d 24, 31, 368 N.E.2d 1292 (1977). "The mere fact that she was at work or even engaged in some job-related activity when the episode occurred is not sufficient to support an award." *Id.* at 33. A causal connection must exist between the work duties and the resulting condition of ill-being, "not merely the result of the normal degenerative process of the preexisting condition." *Bernadoni v. Industrial Commission*, 362 Ill. App. 3d 582, 597, 840 N.E.2d 300 (2005).

As Dr. Emanuel noted Petitioner complained of symptoms of numbness and tingling while typing. Dr. Emanuel further noted Petitioner complained of the same symptoms while

18IWCC0031

driving a car. RX1. When Petitioner ceased the offending activities, her symptoms abated. As Dr. Emanuel explained:

> There has been no peer reviewed prospective studies that implicate typing on a computer or data entry causes carpal tunnel syndrome. The activity of typing can aggravate symptoms, but is not causative. Sleeping at night with the hands bent at the wrist can aggravate symptoms of carpal tunnel syndrome. Holding a steering wheel with grip can aggravate symptoms of carpal tunnel syndrome but are not causative. RX1.

The matter of *Long v. The Industrial Commission*, 76 Ill. 2d 561, 394 N.E.2d 1192 (1979), is instructive. In *Long*, on January 9, 1974 the claimant sustained an injury to his back while operating his personal vehicle unrelated to his employment. He continued to work at the drilling company. As part of his work duties, he was required to walk through mud wherein the pain in his back increased. The employer's expert testified "walking through mud 'may certainly have been a contributing factor to increasing the symptoms and discomfort." *Id.* at 565. The Commission denied the claim. In affirming the Commission's denial, the Court noted a distinction between an aggravation of the underlying condition versus an aggravation of symptoms stating "that walking through the mud caused pain and discomfort, which had no causal relation to the condition of ill-being which brought about his disability." *Id.*

Typing caused an increase in Petitioner's symptoms as did driving a car. As Dr. Emanuel opined Petitioner's typing did not aggravate her underlying condition.

We find Dr. Emanuel's causation opinion to be more persuasive than that of Dr. Neumeister and hereby reverse the Arbitrator's decision on the issues of accident and causation.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, dated July 3, 2017, is hereby vacated and benefits are denied.

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

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: JAN 16 2018

Joshua D. Luskin

L. Elizabeth Coppoletti

SE/
O: 12/6/17
49

18IWCC0031

Dissenting Opinion

I must respectfully dissent and would have affirmed and adopted the Arbitrator's decision. Petitioner had a hand-intensive job, which required typing and computer keyboarding at least 50% of her workday. This percentage increased to 70% for a period of seven to eight months in 2013 due to an increased work load. Petitioner testified that it was during this timeframe when she began noticing symptoms. T.22. She saw Dr. Steward on April 17, 2014 who diagnosed carpal tunnel syndrome and ordered electrical testing. She was referred to Dr. Neumeister who, on June 11, 2014, diagnosed left carpal tunnel and pronator syndromes, and recommended surgery pending workers' compensation insurance approval. He noted a history of "a significant amount of typing 5 days a week, during most of her day at work, and has been doing so for the past 16 years. Her symptoms improve with rest on the weekends, when she is not working." On September 1, 2015, Dr. Neumeister wrote a letter to Petitioner's attorney indicating that he would be willing to elaborate more if he was given details of her job but that it appeared that work was aggravating Petitioner's condition.

On February 15, 2016, Dr. Neumeister wrote that Petitioner was developing right carpal tunnel symptoms as well. However, I note that Petitioner is not claiming the right hand as part of this claim. Dr. Neumeister stated, "She has been a [typist] for the last 18 years which is likely either causing or significantly worsening her symptoms over time."

Petitioner underwent left carpal tunnel and pronator releases on March 23, 2016. On January 6, 2017, after he was given Petitioner's job description, Dr. Neumeister wrote:

> In general, if her work activities bring on the symptoms of numbness and tingling in her hands and resolution of the symptoms when she stops those activities, I believe that those work duties would aggravate her condition. There are many causes of carpal tunnel and so it is difficult to discuss causation, however, again, if her work activities bring on the symptoms then they are aggravating her condition.

Despite Petitioner's other risk factors, I would affirm the Arbitrator's findings on accident and causation. It is clear to me that Petitioner's job duties were at least "a" contributing factor in her development of carpal tunnel syndrome. I would, likewise, affirm the Arbitrator's awards for temporary total disability, medical expenses, and permanent partial disability.

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ALDERMAN, DEBORAH A
Employee/Petitioner

Case# **14WC023515**

STATE OF ILLINOIS EPA
Employer/Respondent

18IWCC0031

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:

0352 LaMARCA LAW OFFICE PC
WILLIAM LaMARCA
1118 S 6TH ST
SPRINGFIELD, IL 62703

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

1368 ASSISTANT ATTORNEY GENERAL
CHRISTINA J SMITH
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

JUL 3 = 2017

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

18IWCC0031

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

DEBORAH A. ALDERMAN
Employee/Petitioner

v.

STATE OF ILLINOIS EPA
Employer/Respondent

Case # **14** WC **023515**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Springfield**, on **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. ☒ 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 17, 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 **$50,418.16**; the average weekly wage was **$969.58**.

On the date of accident, Petitioner was **59** 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 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

Petitioner failed to prove that her left pronator teres syndrome or any conditions in her right hand/wrist were causally related to her injury of April 17, 2014 or her employment duties for Respondent.

Respondent shall pay Petitioner temporary total disability benefits of **$646.39/week** for **5 6/7 weeks**, commencing **March 23, 2016** through **May 3, 2016**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$581.75/week** for **15.2 weeks**, because the injuries sustained caused the **8% loss of the left hand** as provided in Section 8(e) of the Act.

Respondent shall pay all medical expenses related to Petitioner's left carpal tunnel syndrome found in Petitioner's Exhibit 8. Respondent shall be given a credit for medical benefits that have been paid by its group medical plan, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act. Respondent shall also reimburse Petitioner the sum of $55.00 for her out-of-pocket expenses for related treatment.

Respondent shall pay Petitioner compensation that has accrued between **April 17, 2014** and **May 24, 2017** and shall pay the remainder of the award, if any, in weekly installments.

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

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

Signature of Arbitrator

June 28, 2017
Date

ICArbDec p. 2

JUL 3 - 2017

FINDINGS OF FACT and CONCLUSIONS OF LAW

Petitioner has filed a claim against Respondent for injuries to her left hand/wrist and arm due to alleged repetitive job duties. She alleges a manifestation date of April 17, 2014. (AX 1,2)

The Arbitrator finds:

According to medical records, Dr. Steward referred Petitioner for left elbow physical therapy in November of 2012. On November 28, 2012 Petitioner presented to PhysioTherapy Professionals with complaints of left elbow pain, medially and laterally. She was noted to have symptoms of both medial and lateral epicondylitis. Her neck and shoulder quadrants were negative. She had extremely tight wrist flexors and extensors and lacked some range of motion in her elbow. She needed skilled therapy for eccentric strengthening, joint mobilizations and gentle stretching. She was to attend therapy 2 -3 times per week for ten weeks. By December 27, 2012 Petitioner was working, shopping, driving, and participating in all activities of daily living without any pain. She was ready to be discharged and was. (PX 7)

On April 17, 2014, Petitioner presented to Dr. David Steward at SIU Healthcare. Petitioner reported complaints of dizziness, no feeling in her fingers, and a sharp pain in her neck. With regard to the finger complaints, Petitioner reported left hand median nerve distribution numbness with persistent dropping of some things. She reported symptoms of over one year's duration. She denied any weakness or nighttime pain. Dr. Steward also recorded that Petitioner had been having episodes of dizziness that were worse with head movements. Petitioner also reported short sharp episodes of discomfort radiating from her left neck to her face. Dr. Steward recorded under Physical Exam: Neurologic: "[d]ecreased light touch and pin in medial nerve distribution on left." (PX1) Under "Patient Instructions", Dr. Steward recorded that, "For your hand numbness, we'll arrange a nerve conduction test to be sure whether this is carpal tunnel or a pinched nerve in your neck, or related to the diabetes." Dr. Steward also recorded that the brief head pain was also likely from a pinched nerve. (PX1) It was recorded on this date under "Impressions and Recommendations" that Petitioner's presenting problems were: Problem #1: Diabetes, Type 2 (ICD-250.00), Problem #2: Intermittent Vertigo (ICD-780.4), Problem #3: Carpal Tunnel Syndrome, Left (ICD-354.0) and Problem #4: Hypertension (ICD-401.9). It was further noted that Petitioner had a history of diabetes for which she took twice daily medications of Metformin and Lantus and once daily medication of Benicar and Lantus. Petitioner also had a history of hypertension and took Atenolo and Benicar for it. New lab testing reported included hemoglobin A1C for her diabetes management which tested at 6.7%A1C. The ADA recommended goal for therapy was noted to be a Hemoglobin A1C of less than 7%. (PX1)

On May 13, 2014, Petitioner saw Dr. Allen DevlescHoward with SIU HealthCare Department of Neurology and underwent an EMG/NCV study. It was recorded that "Patient complains of right neck pain which shoots to the left top of her head for approximately 20 seconds when her head is turned in a certain way. Also complains of numbness and tingling in left arm and hand and first 3 digits. Patient has been diabetic for 13 years. Patient is on daily aspirin." (PX 2) The NCV report noted the left median motor nerve showed prolonged distal onset latency (6.2ms) with normal onset being less than 4.5. The report also noted reduced amplitude (Elbow, 2.4 mV) with normal being greater than 4 mV and decreased conduction velocity (Elbow-wrist, 47m/s) with normal being greater than 48m/s). Under Impression it states, "[S]evere motor and sensory demyelinating slowing and axon loss are seen with the left median nerve through the carpal

tunnel." Dr. DevlescHoward concluded that Petitioner was suffering from left carpal tunnel syndrome. Petitioner was referred to a plastic surgeon. (PX2)

On June 11, 2014, Petitioner saw Dr. Michael W. Neumeister at SIU Healthcare Division of Plastic Surgery. Petitioner's history of illness notes that:

> This is a 59 year old female who has complaints of numbness in her median nerve distribution of her left hand and weakness in the left hand. Patient states that she had tried wrist splints, ibuprofen, Tylenol, and physical therapy without any success of (*sic*) improvement in sensory or motor symptoms. Her symptoms worsen with work as she does a significant amount of typing 5 days a week, during most of her day at work, and has been doing so for the past 16 years. Her symptoms improve with rest on the weekends, when she is not working. Patient states that she has difficulty with complex hand movement and grip strength and also drops objects secondary to decreased sensation. Patient reports that the symptoms are worse at the end of her work days and she has some discomfort and pain in her wrist and forearm as well. (PX2)

Dr. Neumeister recorded his findings on physical examination of the extremities as:

> Left hand with median nerve distribution decreased sensation, worsened with wrist flexion and pronation of the hand. Positive Tinel's at the wrist as well as mid volar forearm. Patient has muscular weakness with flexion of her FPL and first FDP along with wrist flexion compared to the contralateral hand. Patient also seems to have some CMC arthritis on the left; however, this pain is independent from the rest of her symptoms. Upon flexion of the wrist and pressure at the mid volar forearm, patient has increased symptoms including paraesthesias in the median nerve distribution as well as pain and discomfort. She has no sensory or motor deficits in the ulnar nerve distribution at this time. Nerve conduction studies show prolonged distal onset latency, reduced amplitude, and decreased conduction of velocity of the left median nerve. (PX2)

Dr. Neumeister's assessment was that Petitioner had symptoms of left carpal tunnel syndrome and pronator syndrome and he recommended left pronator and carpal tunnel releases. (PX3)

On June 17, 2014, a TriStar Workers' Compensation Employee's Notice of Injury form was completed by Petitioner. She indicated that her jobs duties were "typing documents on computer, copying, folding and mailing. Entering information in databases" and cited "repetitive work activities" as how the injury occurred. Petitioner reported the injury as "carpal tunnel left hand, possible cubital tunnel, possible right hand." (RX2)

Petitioner signed her Application for Adjustment of Claim herein on June 19, 2014 alleging left hand and left arm injuries (carpal tunnel syndrome and mild cubital tunnel syndrome). (AX 2)

On October 17, 2014 Petitioner's attorney wrote to Dr. Neumeister requesting a narrative report addressing causation. Counsel informed the doctor that Petitioner had been employed by Respondent as an office coordinator for over 14 years and that in a typical day she typed permits, performed data entry,

and performed mailing, folding and copying activities. Much of her activities involved repetitive gripping or grasping with her left hand. Petitioner was right handed. The letter states, "[Petitioner] notices that increased work activities cause increased symptoms." The doctor was asked to base his opinion on the foregoing information as well as the work activities described by Petitioner at her June 11, 2014 visit. (PX 4)

On September 1, 2015, Dr. Neumeister wrote back to Petitioner's counsel stating, "I saw Ms. Alderman only one time in my office regarding her complaints of numbness and weakness in her median nerve distribution of her left hand. According to my note, she stated to me that the symptoms were worse at the end of the work day, therefore, would appear that work is aggravating her condition. I do not however, have any details of the work that she is doing. I would be happy to elaborate given more detail on what brings on the symptoms of carpal tunnel and the type of work that she is doing." (PX4)

Respondent's IME doctor, Dr. James Emanuel of Parkcrest Orthopedics examined Petitioner on November 17, 2015. Petitioner reported to Dr. Emanuel that she was employed by the State of Illinois in the Environmental Protection Agency-Bureau of Water. She explained that she was an office coordinator and that her job duties involved a lot of computer entry and mailing of permits. Petitioner also advised Dr. Emanuel that during the Spring of 2013, the Federal Government was putting pressure on her department to output more permits resulting in a lot of typing and mailing over a 7-8 month period. The majority of her work was computer work. Petitioner indicated that folding and mailing papers did not contribute to her problems. She also indicated that she processed 150 permits during that period of time. Permits range from 4-5 pages all the way up to 30 pages. (RX1)

Dr. Emanuel's history as contained in his report indicated that Petitioner reported that she had left hand discomfort with numbness and tingling sometime in the Spring or Summer of 2013 and that she had been placed in a wrist splint by her primary care doctor. When the symptoms did not resolve, Petitioner treated with her primary care doctor who sent her to a neurologist for nerve conduction/EMG studies. Petitioner also reported similar symptoms in her right hand and a locking of her thumb. Petitioner reported decreased grip strength in both the left and the right hands and that she was dropping thing in the left. Petitioner reported no night symptoms but indicated that driving a car induced symptoms of numbness of tingling and that vacuuming caused achiness in her left hand. Petitioner indicated that wearing night splits had no significant benefit. (RX1)

Petitioner reported to the doctor that she was/is a Type 2 diabetic which she believed was well controlled by taking oral medication and a long acting insulin medication. Petitioner also reported she was on Crestor for hypercholesterolemia, and medication for hypertension and that she had coronary artery disease resulting in bypass surgery in 2002 and a stent placement in 2008. Petitioner was described as overweight. (RX1)

Upon physical examination, Dr. Emanuel recorded that Petitioner was 5 foot 4 inches tall and weighed 194 pounds with a BMI of 32.78. Dr. Emanuel recorded his findings on examination as:

> "There was slight thenar atrophy on the left compared to the right. Her bilateral grip strength was weak. Her pulses were normal and intact. She had a trigger thumb of her right thumb with tenderness at the A1 pulley significantly on the right and mildly so on the left. There was evidence of arthritic changes in the hand at the carpometacarpal joint of her thumbs. The

patient demonstrated positive Tinel's and positive Phalen's test at both wrists. She had a negative Tinel's and Phalen's test at the elbows. Subjectively, she had decreased sensation in the median nerve distribution of the hand." (RX 1)

Dr. Emanuel reviewed Petitioner's medical records and provided a summary of those records. Dr. Emanuel agreed that Petitioner had bilateral carpal tunnel syndrome. He also felt she had a right trigger finger.

With respect to causation, Dr. Emanuel opined that Petitioner, "has a very high risk factor for development of carpal tunnel syndrome. These include female gender, insulin-dependent diabetes type II, hyperlipidemia, obesity and hand arthritis. The patient's usual work activity includes data entry typing, folding and mailing permits. Data entry is her primary job on the computer. Medical records indicate most of her day is working on the computer. The patient's diagnosis is bilateral carpal tunnel syndrome. In my medical opinion, it is more likely than not the patient's diagnosis of carpal tunnel syndrome is related to her underlying medical condition, and multiple risk factors. Patients with insulin dependent diabetes are 15 times more likely to developed (*sic*) carpal tunnel syndrome than the normal population. There has been no peer reviewed prospective studies that implicate typing on a computer or data entry causes carpal tunnel syndrome. The activity of typing can aggravate symptoms, but is not causative. Sleeping at night with the hands bent at the wrist can aggravate symptoms of carpal tunnel syndrome. Holding a steering wheel with grip can aggravate symptoms of carpal tunnel syndrome but are not causative." (RX1)

Dr. Emanuel agreed that Petitioner required carpal tunnel releases, especially on the left and also agreed that treatment up to the date of his examination was reasonable and necessary. He further noted that Petitioner's right trigger finger could be addressed at the time of her carpal tunnel release.

Dr. Emanuel concluded, "I do not believe her carpal tunnel syndrome is related to her work activities." (RX1)[1]

On January 22, 2016, Dr. Carlos Morales, an internal medicine doctor at SIU, issued a letter "To Whom It May Concern" regarding Petitioner. He noted Petitioner had been under his care since 2014 for left carpal tunnel syndrome and pronator syndrome. She presented that day with worsening symptoms despite the use of wrist braces for the condition and he felt she would benefit from re-evaluation by the plastic surgery department. (PX 5)

Petitioner returned to Dr. Neumeister on February 15, 2016, with continued complaints of left carpal tunnel syndrome and pronator syndrome and it was also noted that she had developed a significant right thumb trigger finger which consistently catched and caused significant pain and discomfort. She had also reportedly developed right carpal tunnel syndrome-like symptoms. Dr. Neumeister noted, "She has been a type *(sic)* this for the last 18 years which is likely either causing or significantly worsening her symptoms over time." Dr. Neumeister treated Petitioner's trigger finger with an injection of Kenalog. He also discussed setting up surgery for a left carpal tunnel release and a pronator release. (PX3)

[1] The yellow highlighting found in RX 1 was not done by the Arbitrator.

On March 23, 2016, Petitioner underwent surgery for left carpal tunnel release and open left pronator tunnel release performed by Dr. Neumeister. Dr. Neumeister did not record any surgical problems or complications. (PX 6)

On April 4, 2016, Petitioner again presented to Dr. Neumeister's office for two-week follow up after surgery. Petitioner reported her pain was well-controlled and that she had no concerns. It was noted that Petitioner "is following the postoperative course better than expected with complete resolution of her acute symptoms associated with median nerve compression and she is starting to regain sensation better than her preoperative status." They discussed desensitization and scar care and she was to return in one month. (PX3)

On April 26, 2016, Petitioner's counsel wrote back to Dr. Neumeister enclosing a copy of Petitioner's work description from her employer and additional details of Petitioner's work duties. Petitioner's counsel wrote:

> During a typical day [Petitioner] performs computer entry and mailing of permits. She is right hand dominant but also has left hand discomfort and tingling. These symptoms began sometime two or three years ago.
>
> During the Spring of 2013 [Petitioner's] office was being directed by the Federal Government to process more permits. This resulted in a lot of typing and mailing over a 7 to 8 month period. A majority of her work was computer work. She was also required to fold papers and stuff envelopes on a daily basis. Each permit could be 4 to 5 pages in length or up to 30 pages at a time. Besides operating a keyboard, her mailing and folding activities seem to aggravate her symptoms. It should be noted that [Petitioner] is an insulin dependent diabetic. However, she is totally compliant and is always told her A1C levels are within normal limits.(PX4)

Petitioner's counsel closed this letter by asking if Petitioner's work activities "may have caused or contributed to the development of her left carpal tunnel syndrome." (PX 4)

On May 2, 2016, Petitioner returned to Dr. Neumeister's office for her six-week post-surgical follow up appointment. It was noted that Petitioner's incisions were healed, clean, and dry without any signs of infection, and the sutures were removed. It was also noted that Petitioner had good strength of the hand with minimal numbness. Petitioner was using her hand without difficulty and felt like she was getting her strength back. Petitioner was released from care and returned to work full duty on May 4, 2016 with no restrictions. (PX3)

Petitioner has undergone no further treatment for her left upper extremity since being released on May 2, 2016.

In response to Petitioner's attorney's request for a causation opinion/narrative, Dr. Neumeister responded on January 6, 2017. He wrote, "[A]s for your specific questions, I do not have any documentation as to what type of duties Ms. Alderman performed in my clinic notes, however, I am in

receipt of her job description that you provided for me[2]. In general, if her work activities bring on the symptoms of numbness and tingling in her hands and resolution of the symptoms when she stops these activities, I believe that those work duties would aggravate her condition. There are many causes of carpal tunnel and so it is difficult to discuss causation, however, again, if her work activities bring on the symptoms then they are aggravating her condition." (PX4)

Petitioner's case proceeded to arbitration on May 24, 2017. The disputed issues were accident, causal connection, medical bills, temporary total disability, and permanency. Petitioner was the sole witness testifying at the hearing.

Petitioner testified that she has been working for Respondent approximately 19 years, 17 1/2 of which have been as an employee. Prior to that she was a temporary employee for Respondent. After her time as a temporary employee she was hired as an "Office Associate II." Petitioner testified that both jobs involved the same job duties. She further testified that she remains in that position and that over the years, due to lack of staffing, she has assumed additional job duties.

Petitioner testified that prior to April 17, 2014, she spent 50 % of her time on her computer keyboard typing permits. She and one other person typed all state-wide permits for the Bureau of Water. She explained that, once typed, the permits go from a 15-day review process to a 30-day public notice process and then out for the final review. In each step, Petitioner was responsible for copying the permits and sending them out in envelopes and then re-filing them. Her other physical activities included staple pulling, writing, typing on the typewriter (to type dates and sometimes envelopes), adding stickers to all envelopes that go out, folding the permits, and putting them in envelopes. Petitioner estimated that if she included time spent on the typewriter, her typing duties were slightly over 50% of her job. Petitioner testified that the folding and copying work was performed with both hands. She also testified that the Department is now using smaller envelopes for the permits in an effort to save postage.

Petitioner testified that she had a keyboard for her computer that sat on top of her desk with the typewriter right next to it sitting a little bit higher. Petitioner testified since her surgery she has received a wrist pad for her keyboard so that the same thing doesn't happen to her right hand. Petitioner testified that while operating her keyboard and typewriter, she typed with her hands slightly upward and her wrists down.

Petitioner testified that in the Spring of 2013, the quantity of her work increased because the U.S. Environmental Protection Agency was pressuring the Illinois EPA to clear out a back log of permits. Petitioner testified that she worked overtime and on Saturdays to finalize these permits. During this time, Petitioner testified that she spent 70% of her shift typing as she would typically work 2 extra hours in the evenings and 5-6 hours on Saturday. Petitioner testified that this work project ended in approximately October of 2013 and then she went back to a normal workload (ie. approximately 50% typing). Petitioner testified that it was during this time frame that she noticed symptoms developing in her left arm and hand.

Once she returned to her normal workload, Petitioner testified that she was back to typing 50% of her shift. Petitioner testified that this is when she noticed symptoms developing in her left arm and hand.

[2] Included in PX 4

Petitioner testified that on April 17, 2014, she presented to Dr. David Steward at SIU Healthcare. She testified that prior to her office visit she had been noticing that her left hand and left arm had been going numb and aching. When asked if she told Dr. Steward that she had noticed these symptoms getting worse for about a year she replied, "Yes, probably." Petitioner also agreed that when she saw Dr. Steward in April of 2014 she discussed her symptoms and work activities with him. According to Petitioner, Dr. Steward had her use an arm brace at night but it didn't do any good. Petitioner testified that around this time in April 2014, Petitioner discussed her condition with her supervisors, Laura Casper, Jill Johnson and Deana Poe. Respondent does not dispute that Petitioner provided timely oral notice.

Petitioner testified that after the EMG/NCS she was referred to Dr. Neumeister and at her June of 2014 appointment with him they discussed that her symptoms were worse at work and better on the weekends. Petitioner testified that after she received the surgical recommendation, she filed a workers' compensation claim which was denied. She testified that she then waited as long as she could to do anything more but eventually returned to her doctor when the pain was really bothering her to schedule the surgery. Petitioner testified that she put her medical bills through her group health insurance.

Petitioner testified that she has a heart condition and Type 2 diabetes which she treats with long acting insulin at night and Metformin twice a day. Petitioner testified that the last two times her A1C levels were checked they were recorded as 6.5 (which is perfect) and 7.1. Petitioner testified that her daily blood sugars have been recorded as 98 to 120 and she was told they should be under 140. Petitioner also testified that no one has ever told her that her left arm condition was associated with either of those conditions.

Petitioner testified that in 2012 she had physical therapy for her left elbow after it became sore and aching. Petitioner testified that therapy helped somewhat. Petitioner indicated that she did not know what triggered the elbow pain and she was not alleging that the elbow pain was related to her work or associated with this claim.

Petitioner testified that after surgery her left hand and arm were sore but as it healed the numbness resolved and she had a gradual improvement and resolution of symptoms. Petitioner testified that she does not believe she has her full strength back and still drops thing periodically. Petitioner testified that when she returned to work, she gradually returned to her full duties and is back to normal now.

Petitioner acknowledged undergoing an IME in November of 2015.

Petitioner further testified that when she returned to see Dr. Neumeister in February of 2016 she again discussed her work activities in relation to her condition with him and she gave him a copy of her normal workday activities.

Petitioner testified that Dr. Steward retired so she was seen by Dr. Morales in January of 2016.

On cross-examination, Petitioner testified that since she returned to work, she has been performing all the material duties of her job, her workload has not decreased, and she has not requested any reduction of her workload. Petitioner testified that other than her wrist pad, she has not requested a

different job assignment or any accommodations to her work duties. Petitioner testified that since she was released to return to work, she has not returned for any additional treatment.

Petitioner explained the process for preparing the permits and testified that the engineers have a mock up that they fill out by hand and then Petitioner types the information into a template. By way of example, Petitioner testified that the day prior to the trial, she typed a permit that took her two and a half hours. Petitioner testified that the amount of typing in any given permit will vary with some requiring large amounts of typing and some just adding small paragraphs to the template. Petitioner also testified that the permits contain a lot of numbers and that are added into tables. Petitioner testified that some portions are standard for every permit but then specific information needs to be plugged into each permit. Petitioner testified that there are often tables that can be anywhere from one page to three or four pages of a permit and that the information must be entered in multiple places in the permit but it will auto fill after it is entered once in the preface of the permit and then the main body of the permit. Petitioner testified that permits can be anywhere from 5 to 30 pages and that she will typically prepare 2 to 3 permits a day. During the busy period in 2013, the engineers had a quota for permits per day and then Petitioner would do 3 or 4 a day or even more if she was working extended hours.

Petitioner testified that she held her wrist in a flexed position while typing and that she used the typewriter maybe 1% or 2% of her day. Petitioner testified that she is right handed and that of her keyboarding time, approximately 10-15% of that 50% is spent using the mouse with her right hand. Petitioner testified that the remaining 40% of her day is spent copying the completed permits along with the whole file. Petitioner testified she works 8 ½ hour days with a half hour for lunch and two 15 minute breaks a day. Petitioner works a 9 day week so every other Monday she has off and the other Monday is a 7 hour day. Petitioner testified she works a 38.5 hour week.

Petitioner testified that when preparing permits, she will typically complete typing a full permit and then copy it and copy the file and prepare the documents for mailing to the necessary parties. Petitioner testified that she will type a permit and then intermittently perform the other necessary activities.

Petitioner testified that she had heart surgery in 2000 and was diagnosed with diabetes shortly after that. Petitioner acknowledged being right hand dominant.

Petitioner testified on re-direct that she used both her left and right hand when stapling and copying documents. Petitioner testified on further re-cross that from March 23, 2016 to April 1, 2016, she received her full salary and used her benefit time and that from April 1, 2016 to May 3, 2016, she was on unpaid leave.

The written job description for an Office Coordinator indicates that the based job duties and responsibilities are, "utilizing a personal computer, serves as a word processing operator, utilizing Word Perfect and dBase for file merges, macros, uploading and downloading, conversion of information, developing stored and revised documents and coding documents in processing National Pollutant Discharge Elimination System (NPDES) and state permits." It is noted that 50% of the time is spent utilizing the word processing functions on the computer system such as file merges, macros, uploading and downloading for file information to store, revise and code documents for filing and recall purposes. Also within this 50% is typing, formatting and editing NPDES and state permits, correspondence, memos, engineering evaluations, technical reports, tables and forms for Permit Section professional staff. 30% of the remaining time is spent processing state permits and NPDES permits by updating the

tracking system on the computer and sending out various notices and letters. 10% of the time is spent performing support duties for the Permit Section professionals such as receiving and sorting incoming mail, scheduling appointments, making travel arrangements and answering incoming calls. 5% of the time is spent operating office machinery to copy and print typed or written materials. 5% of the time is spent on performing other duties as required.[3] (PX4)

Petitioner's medical bills are found in PX 8.

The Arbitrator concludes:

Issue C: Did Petitioner sustain and accident arising out of and in the course of her employment with Respondent?

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

Petitioner sustained an accident on April 17, 2014, that arose out of and in the course of her employment with Respondent and her current condition of ill-being in her left hand/left wrist, resulting in left carpal tunnel syndrome, is causally related to her accident. Petitioner failed to prove that her condition of left pronator teres syndrome is causally related to her accident. Petitioner also failed to prove any right hand/thumb injuries were causally related to her accident.

Petitioner bears the burden of proof on the issues of accident and causal connection. It is axiomatic that in a repetitive trauma case the unique facts of each case must be closely scrutinized and the Arbitrator has done so carefully considering the exhibits and testimony of Petitioner as well as Respondent's exhibits. Petitioner's testimony regarding her job duties, including the increasing demands beginning in the Spring of 2013, was very credible.

Neither party submitted an expert medical opinion regarding Petitioner's left pronator syndrome and its relationship to Petitioner's work duties. Dr. Neumeister did not discuss or address Petitioner's left pronator teres syndrome and, therefore, the Arbitrator concludes that Petitioner has not established by a preponderance of the evidence that there was a causal connection between her left pronator teres syndrome and her work duties.

While Petitioner's Application for Adjustment of Claim is limited to alleged left upper extremity injuries, Petitioner's Notice of Injury included allegations regarding her right upper extremity and she has been diagnosed with right trigger thumb and right carpal tunnel syndrome. However, she failed to submit an expert medical opinion regarding those conditions and their relationship to her work duties for Respondent.

There are numerous statements and reports of Petitioner's work duties throughout the record and these statements appear to be largely consistent with Petitioner's testimony at trial. Petitioner testified that she typed permits approximately 50% of her day on a computer keyboard and 70% of her day during a 7-8 month period in the year prior to the accident. Petitioner estimated that of her computer use, approximately 10-15% would be using the mouse with her right hand. Petitioner's other work duties for the remaining time she was working included copying, stapling, stuffing envelopes and mailing permits and some typing on a typewriter. Petitioner testified she worked 8 ½ hour days with a half hour for lunch and two 15-minute breaks a day. Petitioner works a 9-day week so every other Monday she has off and the other Monday is a 7-

[3] This is the job description forwarded to Dr. Neumeister.

hour day. Petitioner testified she works a 38 ½ hour week. Petitioner testified that she would fully prepare and mail one permit at a time. After typing in the permit, she would then perform the other necessary duties of copying the file and preparing the documents for mailing, etc. While her typing could be perceived as intermittent through-out the work day with breaks in between, she nevertheless spent half of her work day (and in 2013, over two-thirds of her workday) engaged in typing. Petitioner was a very credible witness and Respondent produced no witnesses to rebut Petitioner's description of her job and its attendant duties. The medical records corroborate Petitioner's testimony that she had symptoms with work duties, especially typing.

The Arbitrator is aware that there are two discrepancies among the various accounts of Petitioner's job duties. The first is the October 17, 2014 letter of Petitioner's counsel to Petitioner's doctor, Dr. Neumeister, stating that "much of [Petitioner/s] activities involve repetitive gripping or grasping with her left hand." (PX4). Petitioner testified at trial that other than her typing duties, she was primarily copying documents and preparing them for mailing which could include staple pulling, writing, typing on a typewriter, adding stickers to envelopes and folding them and putting them into envelopes. Petitioner testified that she was right hand dominant but used both her hands for these remaining duties. Thus, it does not appear that "much" of her duties required repetitive gripping or grasping with her left hand. In fact, the only duty mentioned that might have required gripping was removing staples and it is unlikely that an individual would use their non-dominant hand for that activity. Further, since this is just one of the many intermittent activities Petitioner testified that she performed for the remaining 40% of her day that she was not typing, it probably did not constitute "much" of her activities.

The second area of deviance related to reports of aggravation. In Petitioner's counsel's 2nd letter to Dr. Neumeister on April 26, 2016 he stated, "besides operating a keyboard, her mailing and folding activities seem to aggravate her symptoms." (PX4). However, when reporting her duties to Respondent's IME doctor, Petitioner specifically stated that "folding papers and mailing really didn't contribute to her problems." (RX1).

These discrepancies, however, do not defeat Petitioner's claim for her left carpal tunnel syndrome. The focus remains on Petitioner's typing activities and whether she proved, by a preponderance of the evidence, that those duties aggravated her left carpal tunnel syndrome. Both Respondent's doctor, Dr. Emanuel, and Petitioner's treating doctor, Dr. Neumeister, agreed that her work did not necessarily cause her left carpal tunnel syndrome; however, and more importantly, they also agreed that typing could aggravate her carpal tunnel syndrome.

Dr. Emanuel acknowledged that patients with insulin dependent diabetes are fifteen times more likely to develop carpal tunnel syndrome than the "normal" population. Petitioner is an insulin dependent diabetic. Thus, she was at risk of developing carpal tunnel syndrome. While Dr. Emanuel noted there have been no peer reviewed prospective studies implicating typing on a computer or data entry work as being a "cause" of carpal tunnel syndrome, he did not address whether there are any studies focusing on "aggravation." He clearly and succinctly stated in his written report "The activity of typing can aggravate symptoms." (RX 1) He also mentioned that sleeping at night and gripping a steering wheel can aggravate symptoms. Under the law in Illinois, Petitioner's work need only be "a cause" of the condition, not the only cause. See Sisbro. Additionally, Petitioner did not attribute her symptoms to sleep or driving. Dr. Emanuel agreed that Petitioner had left carpal tunnel syndrome and agreed that she needed surgery. He acknowledged that typing can aggravate one's symptoms. He did not comment or address how the increased typing Petitioner performed for seven to eight months in the spring of 2013 could have further aggravated her symptoms.

Petitioner relied upon her treating surgeon's narrative opinion letter dated January 6, 2017 to support the allegation that her work activities aggravated her condition. Dr. Neumeister's statement was in response to Petitioner's counsel letter of April 26, 2016 asking him to provide an opinion as to whether Petitioner's work activities "may have caused or contributed to the development of her left carpal tunnel syndrome." (PX 4) Dr. Neumeister did not address any of Petitioner's work duties specifically but concluded that "in general, if her work activities bring on the symptoms of numbness and tingling in hands and resolution of these symptoms when she stops those activities, I believe those work duties would aggravate her condition. There are many causes of carpal tunnel and so it is difficult to discuss causation, however, again, if her work activities bring on the symptoms then they are aggravating the condition." (PX4) Dr. Neumeister noted that he had the Position Description for Petitioner's job to consider.

Dr. Neumeister was not solely relying on Petitioner's counsel's statement that certain activities elicited symptoms. Petitioner testified credibly, and without rebuttal, that she discussed her job duties with Dr. Neumeister in early 2016. His February 15, 2016 office indicates that she has been a typist for the past eighteen years which is likely "either causing or significantly worsening the symptoms over time." (PX 3) The Arbitrator also notes an initial worker' compensation medical report from Dr. Neumeister dated June 24, 2014 referring to Petitioner's complaints of numbness and weakness in the left hand, worse with work (typing) difficulty with complex hand movement and grip strength.

In summary, Petitioner has proven that her left carpal tunnel syndrome was aggravated by her repetitive job duty of typing. However, she failed to prove that any other conditions in her left or right upper extremities were aggravated or caused by those duties.

Issue J: Has Petitioner's medical treatment been reasonable and necessary and has Respondent paid all reasonable and necessary bills?

The Arbitrator has reviewed the medical exhibits introduced by Petitioner and the medical bills contained in Petitioner's Exhibit 8. The medical expenses for Petitioner's left carpal tunnel syndrome appear to be reasonable and necessary and related to Petitioner's accident of April 17, 2014. Having ruled that Petitioner sustained an accidental injury that arose out of and in the course of her employment for Respondent and that her condition of left carpal syndrome is related to her accident, the Arbitrator finds that Respondent is responsible for the payment of any and all unpaid related medical expenses incurred by Petitioner for the treatment of that condition. The parties agree that Petitioner's medical bills have been paid in full by Petitioner's group insurance and that Respondent is entitled to an 8(j) credit for any such payments.

The Arbitrator also finds that Petitioner is entitled to reimbursement of $55.00 for her out-of-pocket expenses for related treatment.

Issue K: Is Petitioner entitled to any temporary and total disability benefits?

Petitioner is awarded temporary total disability (TTD) benefits from March 23, 2016 through May 3, 2016 for a period of 5 and 6/7 weeks.

Respondent disputed liability for temporary total disability benefits but agreed that Petitioner was on an unpaid leave from April 1, 2016 through May 4, 2016. Respondent's attorney subsequently requested that the period be changed to May 3rd consistent with what Petitioner was claiming. Petitioner testified that after her surgery on March 23, 2016 she was taken off work by Dr. Neumeister. Petitioner testified she

returned to work on May 4, 2016. In his note dated May 2, 2016, Dr. Neumeister stated Petitioner could return to work May 4, 2016 with no restrictions.

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

Consistent with 820 ILCS 305/8.1b, permanent partial disability shall be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of Section 8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. No single enumerated factor shall be the sole determinant of disability. *Id.*

With respect to impairment under Subsection (i) of Section 8.1b(b), the Arbitrator notes that no AMA rating was offered by either party. Therefore, the Arbitrator places no weight on this factor.

With respect to occupation under Subsection (ii) of Section 8.1b(b), the Arbitrator notes that Petitioner was employed as an Office Coordinator/Office Associate II at the time of the accident and that she has returned to this job in its full capacity. Petitioner testified that she is performing all the material duties of her job and that she never sought any accommodations or reduction in work duties. While Petitioner's injury was to her non-dominant hand/wrist, she does use both hands/wrists for performance of her job duties. Petitioner did not identify any current and specific issues she was having with her left hand while working. The Arbitrator gives great weight to this factor.

With respect to age under Subsection (iii) of Section 8.1b(b), the Petitioner was 59 at the time of the accident. At the time of the arbitration hearing she was 62. As such, she, most likely, will not work with the effects of her injury for as long as a much younger member of the work force. Beyond that, the parties presented no evidence as to how Petitioner's age is relevant to this case and, therefore, the Arbitrator gives very little, if any, weight to this factor.

With respect to Petitioner's future earning capacity under Subsection (iv) of Section 8.1b(b), no evidence was presented as to how Petitioner's injury might affect her future earning capacity. Therefore, the Arbitrator gives no weight to this factor.

With respect to evidence of disability as corroborated by the treating medical records under Subsection (v) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that the numbness and tingling she experienced prior to surgery has resolved. Petitioner testified, and the medical records corroborate, that after her 6 week post-surgical follow-up, Petitioner has not sought any additional medical treatment for her left wrist and hand. On her first post-operative office visit on April 4, 2016, it was recorded that Petitioner experienced a "complete resolution of her acute symptoms." (PX3) On the May 2, 2016 visit, Dr. Neumeister noted that Petitioner had good strength in her hand with minimal numbness. Petitioner credibly testified that she feels the does not have her full strength back and that she still drops things occasionally. Petitioner's injury was to her non-dominant hand. The Arbitrator gives some weight to this factor.

Taking these factors into consideration, the Arbitrator finds that Petitioner's accident caused permanent partial disability of 8% loss of use of the left hand (190 weeks x 8% equals 15.2 weeks).

****

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOHN CAPADONA,

Petitioner,

vs. NO: 15 WC 13283

ILLINOIS SWITCHBOARD CORP.,

18IWCC0032

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical, prospective medical, temporary total disability, and evidentiary rulings, and being advised of the facts and applicable law, clarifies 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 writes to clarify page 6 of the Decision of the Arbitrator. In her Decision, the Arbitrator stated "Further, the doctor's (Dr. Guido Marra) opinion appears to be premised on his assumption that the job activities need to be the sole cause of the condition which is inconsistent with Illinois law. *Hart Carter Co. v. Industrial Commission*, 89 Ill.2d 487 (1982)."

Following its review of Dr. Marra's testimony, it is the Commission's opinion that, while Dr. Marra spoke to an incorrect standard of a "pure work-related injury" in his June 18, 2015 report, Dr. Marra clarified his opinion relative to a "pure work-related injury" during his deposition

stating that "where someone doesn't have a traumatic event, they have osteoarthritis...of their joint, and the question posed to me, do I think that this job caused or aggravates preexisting conditions, then I would say it's related." Despite disagreeing with Dr. Marra's ultimate opinion that the condition is not related, it is the Commission's opinion that Dr. Marra did not premise his opinion upon an incorrect "sole cause" standard. Despite the aforementioned, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 8, 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 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: JAN 18 2018

Michael J. Brennan

Kevin Lamborn

Thomas J. Tyrrell

MJB/tdm
O: 1/8/18
052

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

CAPADONNA, JOHN
Employee/Petitioner

Case# **15WC013283**

ILLINOIS SWITCHBOARD CORPORATION
Employer/Respondent

18IWCC0032

On 12/8/2016, 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 0.61% 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:

0293 KATZ FRIEDMAN EAGLE ET AL
DAVID M BARISH
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602-2983

0507 RUSIN & MACIOROWSKI LTD
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10 S RIVERSIDE PLZ SUITE 1925
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
19(b)

John Capadona
Employee/Petitioner

v.

Illinois Switchboard Corporation
Employer/Respondent

Case # 15 WC 13283

Consolidated cases: _____

18IWCC0032

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica Hegarty**, Arbitrator of the Commission, in the city of **Wheaton**, on **9/29/2016**. 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. ☐ 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, **Illinois Swithboard Corporation**, 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 **$55,375.32**; the average weekly wage was **$1064.91**.

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, $ for TPD, $ for maintenance, and $ 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, pursuant to the medical fee schedule, of $259.58 to Dr. Singh, $660.00 to Dr. Burra, $12,720.00 to Bone and Joint Physicians,$1,100.00 to Dr. John, $2,820.00 to Progressive Radiology/Advanced Open MRI, $360.00 to Primary Healthcare Associates, $4,375.00 to Harvey Anesthesiologists, $43,686.95 to Ingalls Memorial Hospital and $2,550.00 to Ridge Ortho Rehab, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $709.94/week for 28 2/7 weeks, commencing 12/3/2015 through 6/18/2016, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner temporary partial disability benefits of $611.83/week for 14 5/7 weeks, commencing 6/19/2016 through 9/29/2016, as provided in Section 8(a) of the Act.

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

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

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

Jessica C. Illgartz

Signature of Arbitrator

11/22/16
Date

DEC 8 - 2016

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION 19(b)/8(a) DECISION

JOHN CAPADONA, Petitioner,	)	
v.	)	**15 WC 13283**
ILLINOIS SWITCHBOARD, Respondent.	)	**18IWCC0032**

BACKGROUND

This matter proceeded to hearing before the Arbitrator on September 29, 2016 in Wheaton, Illinois. (Arb. 1)

Petitioner alleges his job duties as a welder caused repetitive injuries to his left shoulder, necessitating left shoulder replacement surgery.

STATEMENT OF FACTS

Petitioner, John Capadona, was employed by Respondent, Illinois Switchboard, for forty years. During that time, he performed essentially the same job: building electrical supply cabinets ranging in size from 38" x 30" x 90" to 42" x 30" x 90". His other duties involved operating a press machine and removing copper bars from their packaging. He performed the majority of his work alone.

Petitioner testified that he normally built two cabinets per day but could build three if required. Each cabinet took him about two and a half hours to build. During the building process, a given cabinet became heavier as additional pieces of steel were added. The process also involved flipping the cabinet over by pushing it, starting at waist level and extending his arms overhead in order to access the portion of the unit he needed to work on. Petitioner testified that he flipped any given cabinet unit eleven times during the building process. Finishing a cabinet unit involved the use of a 15 lb. hand grinder to smooth out the corners and sides of the cabinet which took about a half hour per cabinet.

Aside from building the steel cabinets, Petitioner spent the rest of his time working on a press machine for approximately 1-2 hours. This process consisted of pulling ten sheets of 48" x 96" steel, weighing 140 lbs., off of a rack and placing them on a cart. In order to loosen the sheets from one another, Petitioner used a pry bar. After prying the top sheet loose, Petitioner would grab it with both hands and shake the steel sheet, enabling it to slide from the shelf to the cart. Petitioner testified that he felt vibration and weight when he would slide the sheets from the rack and off of the cart. He estimated that he pushed the cart 50 to 60 feet from the rack to the machine. After the piece of steel emerged from the machine, it is a frame or skeleton that weighed 25 to 30 lbs. Petitioner would carry the "skeleton", arms lifted over his head, to a rack.

Paige Shafer, an occupational therapist, performed an ergonomic assessment, which included a condensed video of selected job activities, at the request of Respondent. (R. Ex. 2) Ms. Shafer

videotaped Petitioner working on May 11, 2015. The job duty video was broken down into various segments: cutting machine, cut and trim, bending, drill press, welding. She did not videotape the grinding activities. Ms. Shafer testified to observing the grinding activity, noting that the welding gun was held in the right hand and measuring the force of the activity. Ms. Shafer testified that she recorded the video for three and a half hours and later edited it down to seventeen minutes and fifty-two seconds. Based upon her assessment, Ms. Shafer concluded that Petitioner's duties as a welder did not present with excessive, acute force on the arm with the shoulder flexed, forearm supinated and elbow extended. She further concluded that Petitioner's job duties did not involve repeated use of the arm above 70 degrees to 90 degrees. She found that Petitioner had sufficient rest and recovery time for the left arm, as the right arm held the welding gun. Ms. Shafer testified that "repetitive" requires performance of the activity 300 to 800 times per day. She did not consider Petitioner's job duties to be repetitive. Further, she found that lifting was done equally with both arms.

Respondent called Bill Zastawny, employed by Respondent since 1987, President for the last 15 years, to testify at the hearing. Mr. Zastawny estimated that a completed, standard sized box weighs about 200 lbs. and took Petitioner three and a half hours to complete. With respect to the grinding tool, he agreed the apparatus operates at a high RPM and estimated Petitioner's daily use lasted 30 to 40 minutes per day. He further testified that the press machine process is done one sheet at a time and that larger loads are transported via fork lift.

According to Petitioner, he began experiencing left shoulder pain in 2010 and treated with Dr. Thometz who injected the shoulder. Petitioner testified he noticed his left shoulder hurting when pulling his car door shut with his left arm or during damp or wet weather.

Petitioner underwent an x-ray of his left shoulder on April 16, 2010 and was noted to have osteoarthritic changes in the glenohumeral joint with some arthrosis in the acromioclavicular joint.

On April 23, 2010, a left shoulder MRI showed prominent arthritic changes in the posterior glenoid with a paralabral cyst, rotator cuff tendinopathy and some articular surface tearing of the supraspinatus and subscapularis tendons without a full thickness tear.

Dr. Thometz saw Petitioner on May 10, 2010, noting a history of left shoulder pain for the past year. The doctor diagnosed glenohumeral arthropathy and administered a subacromial injection.

Petitioner consulted with his general practitioner, Dr. Rick Singh in 2012 with bilateral shoulder complaints, particularly in the left shoulder. The doctor diagnosed degenerative disease.

On February 3, 2015, Petitioner consulted with his rheumatologist, Dr. John, who noted there had been a negative workup for inflammatory arthritis. An injection was administered to Petitioner's left shoulder.

Petitioner saw Dr. Thometz on April 9, 2015 with a history of left shoulder complaints while working as a welder.

On April 15, 2015, a left shoulder MRI demonstrated severe glenohumeral arthritis with full thickness cartilage loss, posterior decentering of the humeral head, glenoid and degenerative

tearing of the posterior glenoid labrum with a cyst and tearing at the undersurface of the supraspinatus tendon at its insertion.

On April 16, 2015, Dr. Thometz noted that Petitioner's work was quite physical and that he did not think Petitioner could continue performing the job for any length of time. On July 16, 2015 the doctor noted the difficulty of the job and recommended arthroplasty.

Petitioner filed this claim on April 23, 2015 claiming the date of accident as April 15, 2015, the date Dr. Thometz reviewed the MRI and recommended surgery.

Petitioner was evaluated by Dr. Marra on June 18, 2015 pursuant to Respondent's Section 12 request. The doctor noted in his report that he would expect the dominant right arm to be more effected if this were a "pure" work injury. He later reviewed Ms. Shafer's video and concluded that the left shoulder is positioned away from the body and welding activities were primarily done with the right arm. He did not see the left shoulder elevated. Based on his review of the video he declined to find the condition work related.

Petitioner sought second opinions regarding the need for arthroplasty. He saw Dr. Romeo on June 24, 2015. Dr. Romero agreed with the prescription but stated that he could do a hemiarthroplasty. Petitioner testified that he felt this halfway solution would eventually require him to obtain a second surgery.

Petitioner returned to Dr. Thometz who referred him to Dr. Nigro for surgery.

On December 3, 2015, Dr. Nigro performed the arthroplasty. Petitioner stopped working on December 2, 2015.

Dr. Paul Prinz evaluated Petitioner at his attorney's request on March 12, 2016. Dr. Prinz reviewed the video of Petitioner's job duties but did not see Ms. Shafer's ergonomic report. Dr. Prinz further reviewed Petitioner's medical records and diagnostic tests.

Dr. Prinz diagnosed Petitioner's condition as longstanding shoulder and glenohumeral arthritis. He further testified that Petitioner's job activities caused significant force across the shoulder, causing, aggravated or exacerbated the arthritic process. On cross examination Dr. Prinz acknowledged an individual in their mid-fifties could have glenohumeral arthritis absent any type of traumatic cause or precipitating repetitive work activity. Further, once present it could progress with age. He conceded it is likely Petitioner had osteoarthritis in other joints and likely has osteoarthritis in his shoulder joint.

Petitioner was released by Dr. Nigro on June 13, 2016 to work with a 10 lb restriction from floor to shoulder and a 2 lb restriction above the shoulder.

After his medical release, Petitioner found work stuffing envelopes for Allegra Printing Co. He has worked intermittent hours since the end of June, 2016. His earnings are shown in Petitioner's Exhibit 10, which has year to date earnings up to a few days before arbitration. Petitioner testified that he was paid $600 in cash for trial work before he was put on the payroll. He averages a couple days per week and testified that the earnings help him pay for his physical therapy. The work is very light. Petitioner testified that he contacted Respondent but no light work was offered to him.

With respect to his left shoulder, he testified that it hurts more on damp days. He feels pretty good on dry or warm days. He says within the restrictions imposed by Dr. Nigro. He has pain when he raises his arm or reaches out with his left arm to pull the car door.

CONCLUSIONS OF LAW

In support of the Arbitrator's decision relating to C, D and F the Arbitrator finds the following facts:

Based on the record as a whole, the Arbitrator finds that Petitioner sustained accidental injuries arising out of and in the course of his employment due to repetitive trauma, injuring his left shoulder. The date of manifestation being April 16, 2015 when Petitioner and Dr. Thometz noted his work activities with regard to the shoulder and the need for surgery. The Arbitrator found Petitioner's testimony credible. His demeanor at the hearing was sincere and straightforward. His testimony with respect to his job duties was in-depth and detailed. The medical records in evidence corroborate his testimony regarding his medical history.

The fact that Petitioner sought opinions from Drs. Burra and Romeo regarding causation does not lead the Arbitrator to assume that the doctors found the condition not to be causally related. Dr. Marra agreed that this was not the case, and he did not wish to offer an opinion. This Arbitrator will not make any assumptions from the opinions that have been redacted by agreement of the parties from the records of Drs. Singh, Nigro and Thometz.

Petitioner's description of his job activities which he performed for approximately 40 years, along with the job duties video created by Ms. Shafer, showed significant, repetitive left arm and shoulder activities. The majority of Petitioner's job involved building electrical cabinets that ranged in size from 38" x 30" x 90" to 42" x 30" x 90". Petitioner testified that as he builds the cabinet, it gets heavier because he is adding additional pieces of steel. Both he and Mr. Zastawny estimated that a completed standard sized box weighs about 200 lbs. As Petitioner builds the unit he has to flip it over pushing it starting at waist level and extending his arms to overhead to roll the box over. The building of the cabinets is demonstrated in Respondent's Exhibit #2. Petitioner. testified that the video showed the overview of the job but that many parts of the job were missing. He testified that it takes two and one half hours to build a box. Mr. Zastawny testified that it takes three and a half hours. Paige Shafer, an occupational therapist, who created the video, testified that she recorded the video for three and a half hours. The video, which contained both the cut machine and building the box, was edited down to seventeen minutes and fifty-two seconds.

The flipping activity is shown one time on the video at 14:13. Petitioner is seen putting his left shoulder and arm under the box and lifting upwards. Once he is about halfway through this maneuver, he puts the left arm up on top of the piece as he completes the roll with both arms extended overhead. Petitioner testified that he flips the box eleven times each time he builds a box. He does so on the table and the floor depending on the stage of the process he is at. When flipping from the floor he bends over and extends his arms out in front of him as if he is really overhead but bent over while doing so. He does this in order to get leverage to move the weight of the box. None of the flips from the floor are depicted on the video.

Petitioner also uses a hand grinder that he estimates weighs 15 lbs. to smooth out the steel on the corners and sides of the cabinet. Petitioner testified that he grinds for about a half hour per box. Mr. Zastawny estimated 30 to 40 minutes. Ms. Shafer testified that Petitioner used the

grinder for an hour to hour and a half per day. None of this activity was depicted on the video in Respondent's Exhibit # 2. Petitioner testified that he feels vibration in his left arm as he uses the grinder. He and Mr. Zastawny agreed that the machine operates at a high RPM. Petitioner testified that he had to hold the grinder very tight. Ms. Shafer testified that the grinder device posited 65 lbs. of force on the right hand. Ms. Shafer could not recall whether the grinder was held with one or two hands. Petitioners Exhibit #9a shows Petitioner holding the grinder with both hands. The right is on the trigger and the left is at the head where the grinding wheel is turning. Ms. Shafer testified that most of the force would be where the grinding wheel comes in contact with the piece being grinded. If there are 65 lbs. of force at the handle in the right hand and the most force is where the wheel is in contact it seems clear that the left arm would have at least 65 lbs. of force or perhaps greater force as the left hand is closest to the wheel. Petitioner's left hand is seen in Petitioner's Exhibit 9a right by the head of the grinder while the right hand was at the other end holding the trigger.

Apart from building electrical cabinets , Petitioner worked on a press machine for an 1-2 hours per day. This process involved pulling ten sheets of 48" x 96" steel that weighed 140 lbs. off of a rack and putting them on a cart. He would then take a pry bar to loosen the sheets from one another. The sheets came in an oil that protected the steel but tended to keep the sheets which had been stacked upon one another stuck together.

After prying the top sheet loose, Petitioner would grab it with both hands. The height would depend where on the shelf he was working which could be from the knees to above the shoulders. Lighter gauge steel tended to be at the higher levels. He would then shake the steel to make it free to slide from the shelf to the cart. He would bear part of the weight of the sheet but not the complete weight as part of the sheet would be on either the shelf or the cart during the transfer. This activity was depicted on Respondent's # 2, a video of purported job activities at :30. Petitioner testified that he would normally take ten sheets individually and stack them on the cart before moving to the machine. William Zastawny, the company President, testified that this is done one sheet at a time and that larger amounts would be taken by fork lift. If this is the case it would account for movement of the sheets onto the rack but would still not account for the movement of the sheets from the rack to the machine. That would presumably be done one at a time by Petitioner. The video only showed one sheet but was clearly made as a demonstration for this claim. At 1:50 of the video Petitioner is seen shaking the sheet and sliding it off the cart and onto the machine. This is after pushing the cart from the rack to the machine.

Petitioner also described racking bars of copper for the electricians. This is not shown on Respondent's Exhibit # 2. He testified that the weight varied depending on the width of the copper and can vary from light to very heavy.

Mr. Zastawny testified that Petitioner only assembled 200 cabinets per year.

There are two medical opinions in evidence. The parties stipulated to redacting any records that contain opinions of other doctors.

Dr. Prinz testified that Petitioner's job activities caused significant force across the shoulder, causing, aggravated or exacerbated the arthritic process

Dr. Guido Marra opined that the job activities were not the sole cause of Petitioner's condition leading to arthroplasty:

It comes mainly with the ergonomic assessment and my look at the video. In the end, when you look at the video, he primarily uses his right arm in his welding position; and when we -- when I try to form an opinion based on whether or not I think an arthritic condition is going to be the sole cause or a significant contributing factor to the development and need for treatment for osteoarthritis of the shoulder, I make an assessment based on the ergonomics to see if the amount of impact loading or static loading to the shoulder is anymore than what I would expect with normal activities of daily living. And based on my review of that video, I did not feel that the left arm subjected itself to the point where it would require a shoulder replacement as a result of that activity.

The Arbitrator gives Dr. Marra's opinions less weight due to the fact that he relied upon the job duties video which only partially depicts Petitioner's job duties, minimizes the amount of lifting, above the shoulder reaching, and vibration. Further, the doctor's opinion appears to be premised on his assumption that the job activities need be the sole cause of the condition which is inconsistent with Illinois law. *Hart Carter Co. v. Industrial Commission*, 89 Ill.2d 487 (1982).

In support of the Arbitrator's decision relating to J the Arbitrator finds the following facts:

Having found Petitioner's condition of ill-being causally related to his work activities, the bills offered as Petitioner's Exhibit #8 are hereby awarded pursuant to the Medical Fee Schedule in section 8.2 of the Act. There is no contest from any of the physicians who have reviewed this case that Petitioner was a candidate for arthroplasty. The bills are for treatment to Petitioner's shoulder and for the arthroplasty.

In support of the Arbitrator's decision relating to K the Arbitrator finds the following facts:

Petitioner was temporarily totally disabled from December 3, 2015, the date of the arthroplasty surgery, to June 18, 2016. This is the date when Petitioner began working part time at a light duty job at Allegra Printing. Petitioner was authorized off of work by the surgeon, Dr. Nigro until the visit of June 13, 2016. At that time, Petitioner was still under care but was allowed to return to job activities lifting up to 10 lbs from the floor to the shoulder and lifting 2 lbs over the shoulder.

Petitioner testified that his employer did not have such work available. He found work at Allegra Printing stuffing envelopes on intermittent days earning $11 per hour. He was paid $600 cash and then paid via payroll. Petitioner's Exhibit #10 is a paystub showing year to date payments through September 25, 2016. As of that date, Petitioner had earned $600 in cash and $1460.25 in payroll for a total of $2060.25. This was earned from June 18 through September 25, a total of 14 weeks for an average of $147.16 per week.

Petitioner has been temporarily partially disabled since June 18, 2016 and should be paid at a rate of $611.83. The average weekly wage is $1,064.91. After considering the income from Allegra Printing, Petitioner is losing $917.75 and 2/3 of that loss is $611.83. Petitioner remains temporarily partially disabled at the time of arbitration, September 29, 2016. He is not yet at maximum medical improvement.

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

Joseph Hendrickson,

Petitioner,

vs. NO: 15WC 21892

Caterpillar Inc.,

18IWCC0033

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, 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 March 9, 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 $52,300.00. 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: JAN 18 2018
o112117
MJB/jrc
052

Michael J. Brennan

Thomas J. Tyrrell

DISSENT

I respectfully dissent from the decision of the majority. To obtain compensation under the Act, a Petitioner must prove that some act or phase of his or her employment was a causative factor in creating the ensuing injuries. *Land and Lakes Company v. Industrial Commission*, 359 Ill.App.3d 582, 834 N.E.2d 583 (2005). The Petitioner's testimony as to the mechanism of accident is not persuasive when contrasted with the established evidence. I find the opinions of Dr. Fabrique and Dr. Weiss better grounded in fact and in the understanding of the tools the Petitioner was using and the circumstances under which he was performing the task in question. I assign these opinions greater weight and find them persuasive in rebutting the Petitioner's causation evidence. I would deny compensation based upon a failure to prove causation

Kevin W. Lamborn

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

HENDRICKSON, JOSEPH
Employee/Petitioner

Case# **15WC021892**

CATERPILLAR INC
Employer/Respondent

18IWCC0033

On 3/9/2017, 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 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:

1157 DELANO LAW OFFICES LLC
CHARLES H DELANO IV
1 S E OLD STATE CAPITOL PLZ
SPRINGFIELD, IL 62705

2994 CATERPILLAR INC
MARK FLANNERY
100 N E ADAMS ST
PEORIA, IL 61629-4340

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
19(b)

JOSEPH HENDRICKSON
Employee/Petitioner

v.

CATERPILLAR, INC.
Employer/Respondent

Case # 15 WC 21892

Consolidated cases: _____

18IWCC0033

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 **Quincy**, on **August 3, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **May 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 **$42,731.00**; the average weekly wage was **$821.75**.

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

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

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

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

ORDER

As explained in the Arbitration Decision, Petitioner sustained an accident which arose out of and in the course of his employment with Respondent on May 29, 2015. Petitioner's current condition ill-being with regard to his right shoulder is related to the accident. Petitioner has not reached maximum medical improvement.

Respondent shall pay reasonable and necessary medical services totaling $52,159.74, as reflected in Petitioner's Exhibits 8-12 that remain unpaid. Specifically, Respondent shall pay the following bills, subject to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act: Dr. Rodney Herrin/Orthopedic Center of Illinois $22,709.00; Dr. Saurabh Jha/Springfield Clinic $5,728.64; St. Mary's Hospital $491.00; Orthopaedic Surgery Center of Illinois $18,983.00; and Decatur Memorial Hospital $4,248.10. Respondent shall receive credit for amounts paid, including those paid through its group medical plan, for which credit is allowed under Section 8(j) of the Act. Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving credit under Section 8(j).

Respondent shall pay Petitioner temporary total disability benefits of $547.83 per week for 31 1/7 weeks, for the period of December 30, 2015, through August 3, 2016, for a total of $17,060.99. As stipulated to by the parties, Respondent shall receive credit for payments made to Petitioner under its short term and long term disability policies during that time period.

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 7, 2017
Date

ICArbDec19(b)

MAR 9 - 2017

STATE OF ILLINOIS)
) SS
COUNTY OF ADAMS)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

JOSEPH HENDRICKSON
Employee/Petitioner

v.

Case #: 15 WC 21892

CATERPILLAR, INC.
Employer/Respondent

18IWCC0033

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On May 29, 2015, Petitioner was 53 years old, married, and had no dependent children. He was employed as a fabrication welder at Respondent's Decatur plant and had been so employed for 12 years. On that date he was cleaning the inside of a case with a sander, which consisted of sanding the weld spatter off the inside of the case. He testified that as he was doing so the sander got wedged in between two bolts that hold the case to the rollover and then "kicked out real hard", twisting his right arm. He is right-hand dominant and was operating the sander with that hand.

Petitioner viewed Respondent's Exhibit 11, labeled as "Ergonomic Report" and consisting of three photographs, a description of the task performed, and tool specifications for the sander he was using. He identified the side and inside of the case, as depicted in the photos, and noted it was necessary to "go inside the case" to reach into the back to clean or sand it. He testified that due to previous open heart surgery he has to have the case at an angle, and he goes into it at an angle and sort of lies down while sanding. He drew a circle on the photo to indicate where the sander came into contact with the bolts, and testified that the space between the two bolts was an inch or inch and a half and that the sander surface was two inches wide.

Petitioner denied problems with his right arm prior to the accident, but admitted he had prior surgery on the right shoulder in 2007 for impingement. He was released from care in 2007, had not sought additional treatment prior to the accident at issue, had worked full duty for Respondent during that period of time, and had no limitations with regard to his right arm.

With regard to the accident, Petitioner testified that when the sander kicked out it jerked his arm and he felt a twinge and a pull, with resulting pain and discomfort. He reported the incident right away to his supervisor Jim Misner, who sent him to the onsite medical department.

The medical department recommended icing the shoulder and eventually referred him for an MRI on June 12, 2015. The MRI results were discussed with him by the company doctor and he was sent back to work. He continued working his regular job, though continued to have problems with his arm. He could not pick up anything over chest level or over his head and had trouble reaching and grabbing things.

He eventually sought treatment with Dr. Rodney Herrin, an orthopedic surgeon, who performed surgery on December 29, 2015. He worked up until his surgery, but has been off work since that time. His understanding was he had a full tear in his shoulder that had to be reattached with an anchor and hook. He underwent physical therapy following surgery, which did not help a great deal. Due to continued problems, he recently had a repeat MRI and was scheduled to return to Dr. Herrin the day after the hearing to go over the results. He testified he had not had much improvement since his surgery. He attended an IME with Dr. Weiss on one occasion, and testified the doctor spent about ten minutes with him. Petitioner testified he continues to have problems picking things up, cannot reach out to grab things, cannot reach over his head, and cannot sleep at night due to the pain. He cannot reach behind his back to tuck in his shirt and cannot reach into the refrigerator and grab anything with his right hand. He demonstrated for the Arbitrator an inability to lift his outstretched right arm above chest level.

On cross-examination, Petitioner confirmed he had been paid group disability for the time he had been off work and that his medical bills had been submitted to his group health insurance carrier through his employer. With regard to the accident, he testified that his arm was jerked about two feet inside the case and that he struck his hand on the side when the sander kicked back. He was wearing protective gloves and did not sustain an injury to his hand. He did not strike his arm or elbow. In looking at Respondent's Exhibit 11, Petitioner noted that the second photograph was not accurate, in that the man pictured was not wearing full personal protective equipment (PPE). Full PPE includes a leather jacket, leather chaps, full leather and insulated gloves, and a helmet with fresh air to it. He described his own helmet like that of a deep sea diver's, with a type of hood. The PPE also has three hoses going into it. The PPE makes moving around difficult. Petitioner also testified that the man shown in the middle photo was not positioned in the same way that he was positioned at the time of his accident, in that he would have had the case tilted more, rather than at sitting level. Wearing all of his equipment is bulky, and it is easier to in at an angle and lay down on the case itself, and then reach in and do the sanding. In addition, the man shown in the photo is not in the case as far as would be needed to do the sanding, and Petitioner would have been laying much further in than what is depicted.

Petitioner testified that the tool he was using at the time of the accident was a 90 degree angle grinder with a two-inch sanding disc that turned with speeds up to 15,000 RPM's. It weighed one pound or so. The grinder shown in the third photo in Respondent's Exhibit 11 is the one he would have been using at the time of the accident; however, he could not tell if that was the same tool being held by the man in the second photo. When wearing full PPE, there is quite a bit of restriction of movement, especially with dragging the hoses.

Petitioner confirmed he had viewed both videotapes submitted as Respondent's Exhibits 7 and 8. The grinder used in the videos appeared to be the same type he was using at the time of the accident, but he could not say for sure. He reiterated that when he ran the grinder up against

the two bolts, it caused his arm to kick up a foot and a half to two feet, and that was when he felt pain in his shoulder.

Respondent's first witness was Molly Major. She is the Environmental Health and Safety Supervisor in Respondent's Decatur plant and has been so employed for 11 years. Her duties include record keeping, compliance, and ergonomics. She has a Bachelor of Science degree in Safety, with a minor in Environmental Health. She performs five to ten ergonomic evaluations a month. On September 8, 2015, she shot a video in the work area where Petitioner indicated he was injured, such video submitted as Respondent's Exhibit 7, video one. She testified it truly and accurately depicted what she saw. The individual in the video is Kyle Weston, a manufacturing engineer for the fabrication line. In the video he is positioned in the same type of case that Petitioner was in on May 29, 2015, and the configuration of the bolts inside the case was the same. He used the actual grinder Petitioner used. The video showed Mr. Weston running the sander against the bolts to see what would happen. Ms. Major reviewed Respondent's Exhibit 11, which contained dimensions of the case and the distance between the bolts at the top and the edge of the case. She testified she verified the measurements and dimensions as depicted. She also verified the specifications of the sander as depicted. She used a force gauge to measure the weight of the sander and to measure the pressure of the trigger. For the rotational speed she consulted the specifications on the sander itself. She testified that her methods of measurements were generally accepted in her field as being reliable.

On cross-examination, Ms. Major acknowledged she did not see Petitioner get injured and she was not aware of how his body or the case were positioned when he was injured. Rather, her attempt to re-create Petitioner's accident was to use the part in the same fixture and same location. She explained that the part was secured to the fixture with bolts, which must align. She acknowledged that different workers could position themselves in different ways when sanding out the bursts in the case.

Respondent's second witness was Kyle Weston. He is a manufacturing engineer in Respondent's Decatur plant and has been so employed for more than four years. He is responsible for creating, developing, implementing, and improving the processes used to build Respondent's products. He works in the case area of the wheel tractor scraper fabrication section, which is the same area where Petitioner was working on May 29, 2015. He has been in that area for about three years. He is frequently on the shop floor and is familiar with the tools used in the job Petitioner was doing on that date, as well as the cases and work environment. He has observed employees performing the task of grinding inside a case assembly.

Mr. Weston testified he participated in the creation of the videotape submitted as Respondent's Exhibit 7, video one, and was the person operating the grinder shown in the video. In the video he was attempting to get the sander to kick back in between the bolts by hitting it around the bolts. He confirmed that the grinder in the video is the same grinder Petitioner was using on May 29, 2015. He testified the grinder weighed about three pounds with a three-inch pad on the end, did not generate a lot of force and was not hard to hold or to use. It is used to remove spatter from the weld and to surface clean the part. The speed of the grinder is controlled by the amount of pressure put on the handle. He confirmed that video one depicted the same type of case and same type and configuration of bolts as that being worked on by

Petitioner on May 29, 2015. When operating the grinder in the video, he used full pressure or force and was not able to get the grinder to kick back and it did not jerk or pull his arm or shoulder. He testified that, based on his experience, he would not expect such kick back to occur as there was not enough force or torque created from that grinder to create kick back.

Mr. Weston testified he also reviewed Respondent's Exhibit 8, video 2. The employee doing the sanding in that video was Welby Scogin, who is a fabrication specialist like Petitioner. Mr. Scogin is shown doing an outlying process to clean the inside of a case, specifically where it is bolted to the fixture, to remove weld spatter. Mr. Weston explained that weld spatter is sparks created from the welding process that naturally fall onto the "parent material" and create fusion. He testified that, based on his training and experience, video two truly and accurately depicts someone doing the task of grinding or sanding weld spatter inside the case.

On cross-examination, Mr. Weston acknowledged he saw Petitioner in the work area on a fairly regular basis and never noticed him having problems with his right arm prior to the accident. No one had complained to him about problems Petitioner was having with his right arm or an inability for him to do his job in any way. His observation was Petitioner's right arm was fully functional prior to the accident. He had no idea how Petitioner may have injured his right arm if it did not happen as he reported on May 29, 2015. Mr. Weston testified that workers who remove weld spatter all do so with their bodies positioned at the same angle. When asked about Ms. Mason's testimony to the contrary, Mr. Weston acknowledged the workers "have the capability to do it at any open angle, but typically from what I have seen they do it at the same angle". He conceded that he did not know what angle Petitioner was in when doing his job on May 29, 2015, that he did not witness it, and that he did not ask anyone else how Petitioner's body was positioned at the time of his injury.

Respondent's third witness was Jim Misner. He has been employed by Respondent for 15 years. He has been the Section Manager for the wheel tractor scraper, frame fabrication section, since July 2014 and was Petitioner's direct supervisor. He is familiar with the tools used in Petitioner's job and with the specific grinder Petitioner was using on May 29, 2015. He is also familiar with the general dimensions and configurations of the case. The grinder is a three-inch, 90 degree grinder that is more like a sanding tool and is used to clean up weld spatter. It can also be used to get into smaller spaces where a bigger sander could not be used. Mr. Misner has operated this same model of sander and testified it was not hard to hold, hard to trigger, or hard to hold on a surface where weld spatter was being sanded. He has experienced the sander running up against a weld seam or bolt or the like and never had it kick back on him.

On May 29, 2015, Mr. Misner was on the opposite end of the building from Petitioner. He received a text from him stating he felt a pop in his shoulder when the grinder got away from him and that he needed to go to the medical department. Mr. Misner returned to the area, sent Petitioner to medical, and began investigating what happened. The grinder Petitioner was using has a pressure activated switch to control the rpm speed, which he described as being "very touchy". Mr. Misner testified he viewed Respondent's Exhibit 7, video one, and that it truly and accurately depicted the grinder and case Petitioner was working on at the time of the accident, as well as the operation of the grinder. Mr. Misner testified he also viewed Respondent's Exhibit 8, video two, and that it truly and accurately depicted the work that is done in grinding inside a

case, as well as the tools used. Based on his experience and training, he testified he would not expect the grinder in question to have a large kickback if it ran into something while sanding, or a kickback large enough to jerk someone's arm substantially.

On cross-examination, Mr. Misner conceded that even though he would not expect a large kickback from the sander, he could not say that it would not happen. As of May 29, 2015, he had been Petitioner's supervisor for six to nine months and saw him on a daily basis during that time. He acknowledged that prior to that date he had never noticed Petitioner having any problems with his right arm, he had never complained about pain with his right arm, and he had never had trouble using his right arm to perform his job duties. Following the reported incident, he sent Petitioner to the medical department but he was not kept informed of specifics of his injuries, except to the extent that Petitioner had not been released to return to work. Mr. Misner testified he has observed employees performing the duties of a fabricator. He agreed that different individuals would position themselves at different angles when doing the job.

Following the accident, Petitioner completed an Employee Incident Report. He noted the incident occurred at about 1:30 p.m. and he notified his supervisor at about 2:00 p.m. He noted he was cleaning the inside of a "WTS case" and that it was not ergonomically correct, but "you do what you can". He stated he was, "Bent over reaching inside holding with my left arm and reaching with my right to the left to clean, when the grinder got caught between the two bolts that hold the case to the rollover and kicked out jerking my shoulder in the process." PX5, RX1. Petitioner also completed a written statement, with essentially the same information. RX6.

Petitioner presented to the medical department at about 2:45 p.m. that same day and gave a consistent history of how the accident occurred. He reported he had positioned the case to a point where he could stand on the floor and lean into the frame, that he was holding onto the frame with his left hand and leaning into the frame with his right side on the bottom of the frame, and that he was grinding with his right hand and bumped a bolt with the grinder, which jerked his right arm. He was instructed to take over the counter medication and ice and rest his shoulder over the weekend. On Sunday, May 31, 2015, the medical department spoke with Petitioner, who complained of ongoing pain over the weekend and increased pain after waking Sunday morning. He followed up with medical on Monday June 1 and reported no relief in pain. Examination showed decreased range of motion as compared to the left and "extreme weakness" at 80 degrees elevation. It was noted he had previous surgery by Dr. Jones in 2007. Impression was acute strain of the right shoulder. He was given work restrictions of no lifting over five pounds, no pushing or pulling over ten pounds, and no reaching above the chest. PX5, RX1. Right shoulder x-rays showed moderate osteoarthritis of the AC joint and a fusion plate involving the lower cervical spine. PX6, RX5.

Later in the day on June 1, 2015, Petitioner reported back to medical to ice his shoulder and reported his pain at 1/10. He was observed using his right hand and arm to open doors without a problem or obvious grimace. He reported for ice on June 2 and June 3 and asked to speak with the doctor, at which time he reported pain of 6/10 and complained of numbness in his fourth and fifth fingers. It was noted he had decreased movement as compared to the left and cogwheel weakness on the empty can test. Work restrictions continued. He returned on June 4 for ice treatment and rated his pain at 3/10. On June 5, 2015, the doctor made the following

entry, "Viewed job video today. Condition is denied. Non-occupational, accepted by Jamie S.". An MRI/arthrogram was ordered and approved. PX5, RX1.

On June 12, 2015, Petitioner underwent an MRI Arthrogram, which revealed a full-thickness, full-width rotator cuff tear supraspinatus, partial-width, full-thickness tear of the infraspinatus, and suspected anterior-inferior labral tear. PX3, RX4.

Petitioner returned to Dr. Fabrique in the medical department on June 17, 2015, to go over the results of the MRI Arthrogram. Examination showed reduced range of motion and "profound weakness" on the right. He was allowed to return to his regular job without restrictions. It was noted the MRI results were sent to the insurance adjuster and a letter was sent to the radiologist for comparison of new and old MRI's. He returned to the medical department on June 23 for an ice treatment. He advised he wanted to talk to someone about getting a second opinion and was told he should contact "Jamie in W/C". On June 25, 2015, Dr. Fabrique made an entry indicated he had completed an evaluation of Petitioner's incident, which included a history, physical examination, review of still photography of the work site and job activities, and x-ray and MRI images. He then stated, "It is my opinion that imaging studies' abnormalities regarding the right shoulder more likely than not did not involve the activities of 05/29/2015. My medical opinion is rendered with a reasonable degree of certainty." PX5, RX1.

On June 25, 2015, a denial letter was sent to Petitioner from the worker's compensation claim adjuster. The letter stated, "There is nothing to indicate that the findings on your 6/12/15 MRI would be caused by any incident that may have occurred on 5/29/15." RX1.

On July 9, 2015, Petitioner presented to Dr. Rodney Herrin at Orthopedic Center of Illinois. He reported he injured his right shoulder on June 15, 2015, when he was using a grinder to clean the inside of a case when the grinder got caught between two bolts, causing his arm to be twisted and pulled. He complained of pain and difficulty lifting his arm. The MRI results were noted. Dr. Herrin also noted Petitioner had a previous right shoulder arthroscopy for rotator cuff repair in 2007, though he did not have the report available. Petitioner reported his shoulder had been fine up until the recent injury. On examination, he had pain with motion, pain and weakness with testing of the supraspinatus, and pain with impingement testing. Dr. Herrin recommended surgery for rotator cuff repair and possible revision subacromial decompression and noted it would be scheduled once approved by worker's comp. PX2. That same day, Petitioner underwent an EKG as part of a preoperative evaluation, due to his active coronary artery disease. On July 29, 2015, he was given cardiac clearance for surgery. PX4.

On August 31, 2015, Petitioner returned to Dr. Herrin, who noted surgery had not been approved due to concern about the prior surgery. Dr. Herrin had obtained the prior operative report from Dr. Tyler Jones of May 7, 2007. He noted the surgery was a diagnostic arthroscopy with debridement of the anterior labrum; debridement of partial-thickness rotator cuff tear, supraspinatus; subacromial decompression; and mini open distal clavicle excision. He further noted that Petitioner did not have a full-thickness tear of the rotator cuff at that time, that he did well after the surgery until his recent injury, and that his most recent MRI revealed a full-thickness tear of the rotator cuff. He opined that Petitioner's current problem of a rotator cuff tear was related to his described work injury. He based his opinion on the history, physical

examination, lack of symptoms between the time of his prior surgery and recent reported accident, and new finding of full-thickness rotator cuff tear. He continued to recommend surgery to address the issue. PX2.

On September 9, 2015, Dr. Fabrique in Respondent's medical department made an entry in Petitioner's chart. He stated he had observed the video from Safety and Operations, which depicted the tool and activity alleged to have caused Petitioner's injury to his right shoulder. He stated, "It is my opinion that the operation of the involved grinder when bumping against isolated bolts or between closely spaced bolts would not generate sufficient force to cause the rotator cuff or labral tears demonstrated on the…MRI…completed on 06/12/2015." RX1.

On November 10, 2015, Petitioner was evaluated by Respondent's Section 12 physician, Dr. Stephen Weiss of PMRI. With regard to history, Dr. Weiss noted a prior right shoulder injury in 2007 which resulted in surgery for debridement of partial tears of the supraspinatus and labrum as well as a Neer/Mumford procedure. He reached maximum medical improvement in November 2007 and reported he did very well after surgery. He had another episode of right shoulder pain in 2010 after loosening some bolts. An MRI showed supraspinatus and infraspinatus tendinosis with impingement. He did not have additional surgery or injections at that time, but did undergo cervical surgery and did very well after that. As to the accident of May 29, 2015, Petitioner reported he was using a grinder inside a "box-like object" and had to reach through a confined space to get the grinder to reach the object. The grinder, "which had a high speed torque", bounced off two bolts and forcefully jerked his right shoulder. Dr. Weiss noted that Dr. Fabrique at Caterpillar determined the injuries were probably not work related. Petitioner was working his regular duties, pending surgery recommended by Dr. Herrin. He complained of a constant ache in his shoulder and increased pain if he tried any overhead activities or put his arm in an awkward position. RX9, Dep. RX2.

Dr. Weiss reviewed medical records from the Caterpillar Clinic and noted that many of the records were indecipherable. He also reviewed the MRI, operative report, and records from Dr. Jones from 2007; a therapy evaluation, x-rays, and the MRI from 2010; and the x-rays, MRI, records Dr. Fabrique, and two office notes from Dr. Herrin. Dr. Weiss also reviewed a "Job Video", but it is unclear which of the two videos he is referring to. He noted the grinder was used in awkward positions but he did not see how its use could forcefully twist the shoulder sufficiently to cause a full-thickness supraspinatus tear. RX9, Dep. RX2.

On examination, range of motion was greatly reduced on the right, as compared to the left. There was supraspinatus and infraspinatus atrophy on the right, and impingement signs were positive. His diagnoses were: (1) status post surgery for partial labral and supraspinatus tears (2007); and (2) full thickness supraspinatus and partial thickness infraspinatus tears. He opined that it was improbable that the grinder Petitioner used on May 29, 2015 would twist with enough force to cause a full thickness supraspinatus tear, and that his current complaints and need for treatment were the result of a normal progression of his pre-existing shoulder condition. Dr. Weiss agreed with Dr. Herrin that surgery was appropriate, but did not believe it was related to the work incident. Pending surgery, he recommended restrictions of no overhead work, no lifting more than five pounds frequently, and no lifting more than ten pounds occasionally with the right arm. He opined the restrictions were unrelated to the work incident. RX9, Dep. RX2.

On December 4, 2015, Petitioner applied for Disability Benefits in anticipation of his scheduled surgery, noting the injury occurred at work on May 29, 2015. Dr. Herrin completed his portion, indicating the disability was related to work "but disputed by W.C.". RX2.

Petitioner underwent surgery on December 30, 2015, which consisted of a revision subacromial decompression, arthroscopic rotator cuff repair of the supraspinatus, and debridement of the superior glenoid labral tear. PX7. He followed up with Dr. Herrin on January 7, 2016, at which time sutures were removed and x-rays showed the anchors were satisfactorily positioned. He returned on February 18, 2016, and reported he had started physical therapy with assistive range of motion. He was to progress to active range of motion and remain off work. PX2.

Dr. Weiss testified by way of deposition on March 2, 2016. He is a Board Certified Orthopedic Surgeon and is also certified to perform AMA impairment ratings. He testified consistent with his report of November 18, 2015. In addition to reviewing Petitioner's prior and current treating records, he also viewed the two videos produced by Respondent (Respondent's Exhibits 7 and 8). With regard to the videos, Dr. Weiss testified, "It was an extraordinarily awkward task he was doing, having to reach inside the box and do that with a grinder." He further testified that he did not see anything on either video that was similar to what Petitioner described as occurring, did not see how it could have happened, and did not believe he could have had a forcible injury on the shoulder sufficient to tear a rotator cuff tendon. RX9.

Dr. Weiss testified Petitioner presented with a full-thickness supraspinatus and a partial-thickness infraspinatus tear. He explained that a full-thickness rotator cuff tear is usually the result of a significant injury, such as a traction injury sustained when someone falls and grabs on to something to keep from falling, and sort of hangs from their hand. He testified, "It usually takes a significant force to produce a rotator cuff tear." He did not believe that Petitioner's pathology was caused or aggravated by the incident he described to have occurred. Rather, he opined that the pathology was preexisting for two reasons. First, the medical records established Petitioner had preexisting rotator cuff pathology; and second, the video did not depict an activity that could have generated sufficient force to cause or aggravate the preexisting tear. Dr. Weiss agreed with the need for Petitioner's surgery and believed he needed work restrictions, but opined that neither was related to his accident of May 29, 2015. RX9.

On cross-examination, Dr. Weiss testificd he had been retired from the active practice of medicine for about seven years and had not performed surgery for about twelve years. His prior practice included surgery of the knees, shoulders, carpal tunnels and cubital tunnels. His examination of Petitioner was performed through PMRI, an independent medical evaluation company in which he is a 50 percent owner and the medical director. RX9.

Dr. Weiss acknowledged that the MRI completed on October 13, 2010, did not show any full-thickness tears of either the right supraspinatus or the infraspinatus, and further that medical treatment in 2010 and 2011 was ultimately for Petitioner's neck. He conceded that he did not review any medical records for right shoulder treatment from February 2011 through the date of Petitioner's accident on May 29, 2015, and was not aware of any such treatment, or complaints

or limitations referable to his right shoulder. Dr. Weiss did not review a job description of Petitioner's position, and testified it would not have been pertinent, as he was alleging a traumatic injury. He did not have an opinion as to whether Petitioner's job was considered heavy duty. RX9.

On April 6, 2016, Petitioner followed up with Dr. Herrin, and reported he was making progress in physical therapy but noted some continued discomfort and popping in the shoulder. He was instructed to continue with therapy and remain off work. He returned on May 18, 2016, and reported he had been slowly increasing the weights in therapy and had some increased discomfort. Examination reviewed discomfort with abduction. He was instructed to continue with therapy for progressive strengthening and was allowed to return to restricted work of no use of the right upper extremity, if available. He returned on June 15, 2016, and reported continued pain and difficulty reaching. He noted he had not returned to work, as his employer could not accommodate his restrictions. Due to his ongoing complaints, Dr. Herrin administered a subacromial injection and recommended continued therapy and restricted work. Petitioner followed up on July 7, 2016, with continued complaints of pain. He noted the previous injection did not help very much. On examination, he had slightly decreased range of motion, and end range of motion and abduction against resistance caused some pain. Dr. Herrin opined that Petitioner's rotator cuff had possibly not healed and/or that he may have mild adhesive capsulitis. He recommended an MR arthrogram to further assess. PX2.

Dr. Herrin testified by way of deposition on July 14, 2016. He is a Board Certified Orthopedic Surgeon with a subspecialty certification in Orthopedic Sports Medicine. He treats shoulder injuries as a regular part of his practice. He treated Petitioner for his current right shoulder complaints, but also previously treated him for his right knee, including a total knee replacement in October 2008. PX13.

Dr. Herrin and his Physician's Assistant first saw Petitioner for his shoulder injury on July 9, 2015. At that time Petitioner provided a history of injuring his right shoulder when he was using a grinder to clean the inside of a case. He reported the grinder got caught between two bolts, which caused his arm to be twisted and pulled. He complained of pain along the lateral shoulder and had difficulty lifting his arm. PX13.

Dr. Herrin reviewed Dr. Fabrique's record of May 29, 2015, and testified the history of accident in that record was essentially the same history he had received from Petitioner. He testified as to Petitioner's physical examination and MRI findings on July 9. He testified that his office note from that day stated Petitioner had a previous right shoulder arthroscopy for rotator cuff repair in 2007; however, he reviewed the operative report from 2007 and testified that Petitioner did not in fact have a rotator cuff repair. Rather, he had a debridement of the supraspinatus and "potentially a partial thickness tear but not a full thickness tear" of the rotator cuff at that time. Dr. Herrin reviewed Dr. Weiss's report, which indicated there was an MRI of the right shoulder in October 2010 which showed tendinosis of the supraspinatus and infraspinatus with impingement. Dr. Herrin testified this finding showed an abnormality in the tendon, but did not show a full thickness rotator cuff tear. PX13.

Following Petitioner's examination on July 9, 2015, Dr. Herrin diagnosed a full thickness tear of the supraspinatus and most likely a partial thickness tear of the infraspinatus as a result of an injury at work. He recommended surgical repair of the tears at that time, which was completed on December 30, 2015. Petitioner remained under Dr. Herrin's care at the time of the deposition and due to continued complaints of pain and stiffness, he recommended an MR Arthrogram to assess the complaints. He continued to keep Petitioner off work. PX13.

Dr. Herrin testified that patients who have the surgical findings which Petitioner had typically experienced pain in their shoulder and had problems with overhead activities. They may also have pain with use and at night. These are the common complaints of a patient with a rotator cuff tear, and these were the problems Petitioner reported he was experiencing. With regard to causation, Dr. Herrin testified that based on Petitioner's examination, review of his diagnostic films and records, and his reported history of the accident, Petitioner's rotator cuff tear occurred at the time of his described injury at work. PX13.

On cross-examination, Dr. Herrin testified that his causation opinion was dependent upon the accuracy of Petitoner's history and that he was primarily basing his opinion on that history, although the physical examination and other factors were relevant, as well as the fact that prior to the work incident Petitioner stated he was working and doing okay. He conceded he did not have a history of the type of grinder Petitioner was using at the time of the incident, its size or weight, how much torque it had, or whether it vibrated or how much. He noted, however, that he did not believe it would change his opinion. He testified that Petitioner's 2007 surgery resulted in an incomplete decompression, which could have been due to the failure to remove enough bone or the regrowth of bone following surgery. He agreed that, theoretically, this would put him at risk for additional injury to the shoulder. PX13.

Respondent submitted prior Caterpillar corporate medical records from 2007 and 2010. Many of the records were duplicative and many were poor quality copies and/or were indecipherable. The records included an operative report from May 7, 2007, when Petitioner underwent: (1) diagnostic arthroscopy with debridement of the anterior labrum; (2) debridement of partial thickness rotator cuff tear, supraspinatus; (3) subacromial decompression; and (4) mini open distal clavicular excision to his right shoulder. He treated postoperatively until his release by Dr. Jones on November 13, 2007. In 2010, he reported an injury to his right shoulder and neck on September 16, 2010. A right shoulder MRI of October 13, 2010, revealed: (1) abnormal increased signal within the distal supraspinatus and infraspinatus, without full thickness or complete rotator cuff tear; (2) type 3 acromion process with hook shape mildly indenting the bursal surface of the rotator cuff; and (3) small AC joint effusion. The cause of Petitioner's complaints at that time were ultimately deemed to originate in the cervical spine and, though the records are difficult to decipher, it would appear cervical surgery was performed. RX1.

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 deliberation, 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).

The Arbitrator finds that Petitioner has met his burden of proof in establishing that an accident occurred which arose out of and in the course of his employment. In so concluding, the Arbitrator recognizes that there was conflicting testimony with regard to whether the use of the grinder in question would have generated any kickback, or kickback sufficient to have caused an injury. There was also video purporting to show that the operation of the grinder in question did not, in fact, generate kickback.

Respondent's witness Kyle Weston was shown in the video, operating the same grinder Petitioner was using on May 29, 2015. He attempted to get the grinder to kickback, but testified he was unable to do so. He testified the grinder was not heavy, not hard to hold or use, and did not generate a lot of force. He further testified he would not expect kickback, as there was not enough force or torque created from the grinder to cause kickback. Respondent's witness Jim Misner testified he had previously used the same kind of grinder and that it was not hard to hold, hard to trigger, or hard to hold against a surface while sanding. He did state, however, that the pressure activated switch to control the speed was "very touchy". He testified he had experienced the grinder running up against a weld seam or bolt and never had it kick back on him. He testified that although he would not expect a large kickback, he could not say that it would not happen. Both witnesses, along with witness Molly Major, conceded they had no idea how Petitioner was positioned when he was grinding on the day in question.

Petitioner testified that to do the grinding it is necessary to "go inside the case" to reach into the back to clean or sand. He went into detail about the angle he had to put the case in and the positioning of his own body to allow him go inside the case, due to his previous open heart surgery. He essentially has to lie down with his right arm outstretched to the back of the case. He testified that the second photo in Respondent's Exhibit 11, showing another employee holding a grinder inside the case, was not accurate. Specifically, the man pictured was not wearing full personal protective equipment, was not positioned in the same way Petitioner was at the time of the accident, was not in the case far enough to actually do the sanding, and that Petitioner would have been lying much further into the case than what is depicted in the photo. He testified that on the date of accident the grinder got wedged between two bolts and then kicked out hard, twisting his right arm. He reported this same history to his supervisor and onsite medical personnel the day of the accident and to every medical provider thereafter.

In reviewing Respondent's Exhibit 11, the Arbitrator notes that the first photo appears to more accurately depict the employee's positioning while grinding, given the testimony. That photo shows the employee actually leaning in and reaching forward with his right arm, while

holding on to the outside of the case with his left hand and arm. Whereas, the second photo appears to show the employee simply standing with his right arm inside the case and his left hand resting on the bottom of the opening. While the second photo is helpful in showing the inside of the case and the grinder in the employee's hand, it does not provide further insight.

In reviewing Respondent's Exhibits 7 and 8, the videos, the Arbitrator is struck by the close confines of the case and what Dr. Weiss described as "an extraordinarily awkward task he was doing, having to reach inside the box and do that with a grinder". Although the videos do not show a large kickback, they do show what appears to be the grinder bouncing off of bolts that it comes in contact with. It is difficult to fully appreciate whether the grinder is bouncing or whether it is the employee moving his arm, but the accompanying higher pitch noise of the grinder upon contact with the bolt leads the Arbitrator to believe the grinder is bouncing. This bouncing appears to be what Petitioner has referred to as kickback.

While it is true that there is limited room in the case for Petitioner's arm to have been jerked very far, it is also true that he was nearly lying down leaning inside the case with his right arm fully outstretched to the end of the case, operating a grinder with a bounce or kickback when it came in contact with a bolt. Any bounce that occurred while he was in that position could very well have caused his arm to be jerked. Petitioner immediately reported the incident to his supervisor, who sent him to the medical department. He reported a consistent account of the incident to the medical department at that time.

The Arbitrator found Petitioner to be forthright and credible in his testimony, and found Respondent's witnesses to likewise be credible. However, the witnesses concluded as fact that there was no kickback simply because they "would not expect" kickback. The fact that something is not expected does not negate the possibility that it may occur.

The Arbitrator finds Petitioner met his burden of proof in establishing by a preponderance of the evidence that an accident occurred which arose out of and in the course of his employment.

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

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

The Arbitrator finds Petitioner's current condition of ill-being with regard to his right shoulder is causally related to his work accident of May 29, 2015. In so concluding, the Arbitrator finds significant that the record is consistent throughout with regard to Petitioner's complaints and objective findings, which started immediately after the accident.

The Arbitrator is mindful that Petitioner had prior right shoulder surgery in 2007, but notes he had been working full duty without any reported problems since that surgery. He credibly testified, and the medical records corroborated, that he had no treatment or complaints with respect to his right shoulder until his work accident. Although he had a right shoulder MRI in 2010, it was determined that the symptoms he was experiencing at that time actually originated in his cervical spine, for which he underwent surgery. In addition, Mr. Weston and Mr. Misner both testified that prior to this accident they never noticed Petitioner having problems with his right arm, had no knowledge of him complaining of pain, and were unaware of him having any trouble performing his job duties.

On June 1, 2015, three days following the accident, Dr. Fabrique noted Petitioner had decreased range of motion and extreme weakness in the right shoulder. Two weeks after the accident, on June 12, an MR Arthrogram showed a full-thickness and full-width rotator cuff tear of the supraspinatus, a full-thickness and partial-width tear of the infraspinatus, and suspected anterior-inferior labral tear. On June 17, Dr. Fabrique again noted decreased range of motion and profound weakness. Dr. Fabrique opined that Petitioner's condition was not related to his work, based on his opinion that no accident occurred. In light of the Arbitrator's finding to the contrary, Dr. Fabrique's causation opinion is rejected.

Dr. Weiss also opined that Petitioner's condition was not causally related to his work, and testified he did not believe the described accident could have generated sufficient force to cause or aggravate Petitioner's shoulder condition. Rather, he believed Petitioner's condition was related to his pre-existing problem. Dr. Weiss conceded, however, that Petitioner's MRI in October 2010 did not show any full-thickness tears, that Petitioner's treatment in 2010 was related to his neck, and that there were no medical records or other documents evidencing any treatment or complaints or limitations with respect to Petitioner's shoulder from 2011 to the date of the accident. In reality, the Arbitrator notes there is no evidence of treatment, complaints, or limitations since 2007, eight years prior to the accident. For this reason, and in light of the ruling regarding accident, the Arbitrator declines to adopt Dr. Weiss's opinion on causation.

Dr. Herrin testified that based on Petitioner's physical examination, review of his current and past medical records and diagnostic films, and the reported history of the accident, Petitioner's rotator cuff tear occurred at the time of the described accident. He noted that prior to the accident there was no full-thickness tear and that after the accident there were two full-thickness tears.

Having viewed the videos and heard the testimony, it is clear Petitioner's job involved heavy use of his right arm. The Arbitrator finds it incredulous that he would have been able to perform his job prior to the accident with the extensive damage evidenced by the MR Arthrogram after the accident. The Arbitrator is persuaded by the record as a whole and by the causation opinion of Dr. Herrin and finds that Petitioner has met his burden of proof on the issue of causal connection with respect to his right shoulder. The Arbitrator further finds that Petitioner has not reached maximum medical improvement, in that he continues to have problems, had recently undergone a repeat MRI and was scheduled to return to Dr. Herrin.

In support of the Arbitrator's decision relating to issue (J), whether the medical services that were provided to Petitioner were reasonable and necessary, and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

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

The Arbitrator notes there was no dispute between the parties that the treatment rendered, including surgery, was reasonable and necessary. The only dispute was whether it was causally related to a compensable work accident. In light of the Arbitrator's findings with respect to issues (C) and (F), the Arbitrator finds that medical services rendered to date were reasonable and necessary in Petitioner's care and treatment relative to his accident of May 29, 2015. The Arbitrator finds Respondent is liable for outstanding medical bills as set forth in Petitioner's Exhibits 8-12, subject to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive credit for amounts previously paid, including those paid through its group medical plan, for which credit is allowed under Section 8(j) of the Act. Respondent is liable for the following medical bills:

1. Dr. Rodney Herrin/Orthopedic Center of Illinois	$22,709.00
2. Dr. Saurabh Jha/Springfield Clinic	$ 5,728.64
3. St. Mary's Hospital	$ 491.00
4. Orthopaedic Surgery Center of Illinois	$18,983.00
5. Decatur Memorial Hospital	$ 4,248.10
TOTAL	**$52,159.74**

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

In order to be eligible for temporary total disability benefits, a claimant must prove not only that he did not work, but also that he was unable to work. *City of Granite City v. Industrial Comm'n*, 279 Ill. App.3d 1087, 1090 (1996).

The Arbitrator finds that Petitioner was temporarily and totally disabled from December 30, 2015, through August 3, 2016, that being the date of hearing. In so concluding, the Arbitrator notes Petitioner was authorized to be off work for that period of time by the treating physicians. In addition, though Respondent disputed their liability for benefits, they agreed with the period of time in question. The Arbitrator finds that Petitioner is entitled to temporary total disability benefits from December 30, 2015, through August 3, 2016, a period of 31 1/7 weeks. The parties stipulated that Petitioner's average weekly wage was $821.75, and the Arbitrator finds his temporary total disability rate is $547.83 per week. Respondent is liable for temporary total disability benefits of $17,060.99. Respondent shall receive credit for payments made to Petitioner under its short term and long term disability policies during this time period.

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

IRENE D. WOODFORK,

Petitioner,

vs. NO: 13 WC 35208

UNITED PARCEL SERVICE,

18IWCC0034

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by both Petitioner and Respondent herein, and notice given to all parties, the Commission, after considering the issues of causal connection, benefit rates, medical expenses, temporary total disability (TTD) benefits, maintenance, vocational rehabilitation, 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 further remands this case to the Arbitrator for further proceedings as more specifically set forth herein pursuant to *Thomas v. Indus. Comm'n*, 78 Ill. 2d 327 (1980).

The Commission notes that the parties checked off numerous issues in their respective Petitions for Review. However, by their briefs, there are only three issues in dispute: (1) Whether Petitioner is entitled to permanent partial disability benefits (person-as-a-whole vs. wage differential) or permanent total disability benefits; (2) what is the correct benefit rate should the Commission affirm the 8(d)1 award, and, (3) whether penalties should be imposed on Respondent.

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.

For the reasons stated below, the Commission denies Petitioner's Petition for penalties and attorney's fees. The Commission further vacates the wage differential award under Section 8(d)1 of the Act, and remands this case to the Arbitrator for further proceedings, including an order for additional vocational rehabilitation.

Petitioner's Petition for Penalties and Attorney's Fees

The Commission will first address Petitioner's claim for penalties and attorney's fees. Petitioner states in her brief that she filed a Petition for Penalties and Attorney's Fees subsequent to the Arbitrator's award because Respondent failed to pay benefits as of October 26, 2016. The Commission finds no evidence of any such filed Petition in its records. According to Petitioner, Respondent stopped paying weekly differential benefits after Petitioner filed her Petition for Review, and had sent Petitioner notice that it would not pay benefits during the pendency of the appeal. (Petitioner's Brief, pg. 11).

The Commission further notes that neither party checked this issue off on their respective Petitions for Review. Under Section 9040.70(d) of the Rules Governing Practice Before the Illinois Workers' Compensation Commission, an issue must be raised in both the petition for review and the statement of exceptions in order to be properly preserved for review. *See also Zitzka v. Indus. Comm'n*, 328 Ill. App. 3d 844, 847 (1st Dist. 2002). Per the Rule, the Commission finds that Petitioner waived this issue of penalties and attorney's fees on review.

In any event, the Commission finds that an award of penalties and attorney's fees would not be appropriate in the case at bar as actual questions exist relative to the nature and extent of Petitioner's disability, and, contrary to Petitioner's position, both parties are in fact disputing the nature of benefits owed to Petitioner. By her brief, Petitioner relies on cases which are distinguishable from this claim and actually support a denial of Petitioner's petition. The cases cited by Petitioner pertain to non-payment of undisputed benefits awarded and/or where the employer provided no justification for its lack of payment on said undisputed award. This is not the case here.

Permanent Partial Disability Benefits (person-as-a-whole vs. wage differential) or Permanent Total Disability Benefits

As to the primary issue on review, Petitioner claims that she is entitled to permanent total disability benefits under an "odd-lot" theory; the Arbitrator found that Petitioner failed to prove that she was permanently and totally disabled under Section 8(f) of the Act. The Arbitrator stated that Petitioner lacked credibility, and that she did not put in a good faith effort during her vocational rehabilitation. Specifically, the Arbitrator found troubling the surveillance video of Petitioner shopping on the same date and following an appointment she had had with Respondent's vocational counselor, James Boyd. That vocational appointment was terminated early after Petitioner complained of headaches and dizziness. The Arbitrator also noted that the medical records indicate that Petitioner was not motivated to return to work, she appeared to be feigning her symptoms, and she did not provide consistent effort during her functional capacity evaluations (FCEs).

The Arbitrator did find, however, that Petitioner was entitled to a wage differential award. By way of background, Petitioner was employed as a sorter and air handler for Respondent on July 9, 2013, the accident date. (T.9; T.12; T.14). Her duties required her to sort packages, catch and pass packages over conveyor belts, and load and unload packages from airplanes and trucks. (T.10). Petitioner testified that she was required to lift 50 to 70 pounds every day. (T.10). On July 9, 2013, Petitioner injured her left shoulder and neck while attempting to unload 2,000-3,000 pounds of freight off of an 18-wheel truck. (T.19). She underwent physical therapy, injections, and a left shoulder arthroscopic subacromial decompression and distal clavicle excision as a result of her injury. (T.22-23; T.28; T.30; T.73; PX2; PX3; RX15). The Arbitrator noted that vocational experts for both Petitioner and Respondent had concluded that Petitioner could not return to her usual work with Respondent following her work-related injury, and that she had suffered an impairment of earnings. On Review, Respondent argues that Petitioner was not entitled to an award under Section 8(d)1, but rather an award under 8(d)2 of the Act.

Under the Act, when a claimant sustains a disability, an issue arises concerning the type of compensation the claimant is entitled to receive, a wage differential award (8(d)(1)) or a percentage-of-the person-as-a-whole award (8(d)(2)). 820 ILCS 305/8(d) (West 2012); *Jackson Park Hosp. v. Ill. Workers' Comp. Comm'n*, 2016 IL App (1st) 142431WC ¶39, citing *Gallianetti v. Indus. Comm'n*, 315 Ill. App. 3d 721, 727 (3rd Dist. 2000). Our Supreme Court has expressed a preference for such wage differential awards. *Jackson Park Hosp. v. Ill. Workers' Comp. Comm'n*, 2016 IL App (1st) 142431WC ¶39, citing *Gen. Elec. Co. v. Indus. Comm'n*, 89 Ill. 2d 432, 438 (1982).

To receive an award under Section 8(d)1 of the Act, an injured worker must prove (1) that he or she is partially incapacitated from pursuing his or her usual and customary line of employment and (2) that he or she has suffered an impairment in the wages he or she earns or is able to earn. 820 ILCS 305/8(d)1 (West 2002); *Jackson Park Hosp. v. Ill. Workers' Comp. Comm'n*, 2016 IL App (1st) 142431WC ¶40. The purpose of a wage differential award "is to compensate an injured claimant for his reduced earnings capacity, and if an injury does not reduce his earning capacity, he is not entitled to compensation." *Gallianetti v. Indus. Comm'n*, 315 Ill. App. 3d 721, 730 (3rd Dist. 2000). Further, such an award "presumes that but for his injuries, the claimant would have been in full performance of his duties." *Dawson v. Workers' Comp. Comm'n*, 382 Ill. App. 3d 581, 586 (5th Dist. 2008).

In the alternative, "a percentage-of-the-person-as-a-whole award under 8(d)(2) would be appropriate *only* if she has suffered no loss in her 'earning capacity,' or having suffered a loss in 'earning capacity,' she elected to waive her right to an award under 8(d)(1)." *Jackson Park Hosp. v. Ill. Workers' Comp. Comm'n*, 2016 IL App (1st) 142431WC ¶42. Petitioner in the case at bar has not waived her right to an award under Section 8(d)1 of the Act.

Petitioner argues that she does not fall into either category of benefits for permanent partial disability benefits, but that she is instead permanently and totally disabled under an odd-lot class pursuant to Section 8(f) of the Act.

> [A] person is totally disabled when he is incapable of performing services except those for which there is no reasonably stable market.

18IWCC0034

> [Citation]. Conversely, an employee is not entitled to total and permanent disability compensation if he is qualified for and capable of obtaining gainful employment without serious risk to his health or life . . .
>
> [I]f the claimant's disability is limited in nature so that he is not obviously unemployable, *or if there is no medical evidence to support a claim of total disability*, the burden is upon the claimant to establish the unavailability of employment to a person in his circumstances. However, once the employee has initially established that he falls in what has been termed the 'odd-lot' category (one who, though not altogether incapacitated for work, is so handicapped that he will not be employed regularly in any well-known branch of the labor market [Citation], then the burden shifts to the employer to show that some kind of suitable work is regularly and continuously available to the claimant. *Ceco Corp. v. Indus. Comm'n*, 95 Ill. 2d 278, 286-287 (1983).

Petitioner may satisfy her burden of proof in one of two ways:

> [B]y showing diligent but unsuccessful attempts to find work, or (2) by showing that, because of his age, skills, training, and work history, he will not be regularly employed in a well-known branch of the labor market. [Citation]. Once a claimant establishes that he falls within an "odd lot" category, the burden shifts to the employer to prove that the claimant is employable in a stable labor market and that such a market exists. *Sharwarko v. Ill. Workers' Comp. Comm'n*, 2015 IL App (1st) 131733WC ¶53.

In this present claim, there is no medical evidence to support a claim of total disability. However, Petitioner may qualify for permanent and total disability benefits if she can establish that she falls into the "odd-lot" category.

The Commission finds that no physician – either Petitioner's own treating physicians or Respondent's Section 12 examiners – stated that Petitioner could return to her regular duties with Respondent; there was no testimony or other evidence to state Petitioner could return to her union position with Respondent. Second, Petitioner underwent three FCEs, one of which was incomplete and the other deemed inconsistent and unacceptable. Petitioner had difficulty properly completing the evaluations due to elevated blood pressure. (T.46-47; PX5; RX11). The third FCE, was completed on November 17, 2015 at ATI Physical Therapy. (T.48; T.75; PX8). This FCE was deemed valid and indicated that Petitioner's physical capabilities was in the light physical demand level. (PX8). Specifically, Petitioner was capable of a three-hour work day, sitting and standing for two hours, and walking three to four hours. Respondent sent Petitioner a letter, dated January 29, 2016, stating that they were unable to accommodate Petitioner's restrictions. (T.50; PX14).

Although Petitioner's treating physicians, including Respondent's Section 12 examiner, Dr. Timothy Payne, varied in their recommended restrictions, they all consistently ordered some type of restriction; these restrictions were made prior to the November 17, 2015 FCE. Dr. Steven Milos, Petitioner's treating shoulder surgeon, gave Petitioner restrictions of no lifting her arm above her shoulder and no lifting more than five pounds, and Dr. Payne recommended that Petitioner not perform any heavy overhead lifting and no lifting more than 25 pounds. (T.29; PX3; RX2). Petitioner's primary doctor, Dr. James Koepsell, ordered the more recent restrictions on May 9, 2016 of no lifting more than 15 pounds above shoulder, no carrying more than 17 pounds with the left arm, no carrying more than 27 pounds with the right arm, no working more than three hours, no standing more than 20 minutes (two hours maximum), no sitting more than 25 minutes at a time (two hours maximum), and no walking more than three hours. (PX10).

The parties each hired vocational counselors to evaluate Petitioner and assist her in returning to work with her restrictions. Respondent first hired Triune for vocational rehabilitation. (T.51). Ruben Luna, the vocational rehabilitation consultant for Triune, met with Petitioner one time on June 2, 2015. (RX16). Following that initial assessment, Mr. Luna provided a list of possible jobs that Petitioner could perform based on her past work history, education, and restrictions. The jobs listed included telephone solicitor, cashier, and customer service clerk. Mr. Luna estimated that Petitioner could earn up to $37,930 based on these potential jobs. (RX16).

Thereafter, Petitioner started her own job search. (T.52). She testified that she had completed the 12th grade, had taken the GED, and enlisted in the Air Force. (T.15). She was in the Air Force for two years. (T.15). Prior to working for Respondent, Petitioner was a cook at a nursing home. (T.15). Petitioner's Exhibit 11 was documentation of Petitioner's job search from November 9, 2015 through December 2, 2015, which primarily consisted of a search for cashier work. (T.52; PX11). None of the places that Petitioner applied to were hiring. As of the date of arbitration, Petitioner was not actively looking for work. (T.88).

Respondent hired a second vocational rehabilitation company called Vocamotive, which immediately began training Petitioner how to use a computer. (T.52-54; RX17). Prior to this, Petitioner had little to no experience using computers. (T.54-55). Petitioner worked with Vocamotive from December 1, 2015 through March 2016. (T.59). In that time, she testified that she personally met with the vocational counselor three or four times. (T.59). Evidence in the record demonstrates that after some training, Petitioner was able to type up to 18 words per minute. (T.58; T.167; RX17).

Petitioner testified that Vocamotive never assisted or engaged her in any job search. (T.55-56; T.92-93). Petitioner did practice completing forms in workbooks provided by Vocamotive, and learned how to use job search sites and prepare letters. (T.57-58).

Kari Stafseth, the vocational counselor from Vocamotive, testified at arbitration. (T.132). She had recommended a rehabilitation plan that included having Petitioner undergo vocational testing under the supervision of a certified professional evaluator, "[t]o provide her with job seeking skills instruction, to develop computer literacy to a level of marketable skill. To provide her with comprehensive vocational counseling, evaluate the potential for any cost-effective retraining and to facilitate the return to work within approximately 150 days after the completion

of training." (T.143). Respondent had hired James Boyd to administer all the preliminary tests. (T.144; RX17).

Petitioner did meet with Mr. Boyd on February 26, 2016. (RX17). Petitioner testified that she did not complete her testing that day because she experienced an onset of headaches, shoulder and neck pain, and her unrelated fibromyalgia condition flared-up. (T.83). Petitioner also felt dizzy and lightheaded. (T.84). Mr. Boyd gave Petitioner several options of either resting before continuing with the evaluation, taking a lunch break, or going home. (T.84-86). Petitioner opted to go home. (T.86). Respondent had David Dylak, a private investigator, testify on its behalf at arbitration. (T.179; RX22). Mr. Dylak testified that he observed Petitioner shopping at a women's clothing store, Wal-Mart, and Dollar General Store. (T.187). Petitioner was seen carrying shopping bags from the store to her vehicle. (T.187). The Arbitrator found this evidence significant and did not find Petitioner credible. Thereafter, and consistent with Petitioner's testimony, no follow-up appointment was scheduled; Vocamotive closed its file on April 6, 2016. (RX17).

Ms. Stafseth further emphasized at arbitration the computer skills training in Petitioner's case. The training would help Petitioner acquire the introductory skills needed to look for job openings, complete online applications, send business correspondence to prospective employers, and help Petitioner become more marketable. (T.146). Ms. Stafseth stated that there was nothing during her initial evaluation of Petitioner that led her to believe Petitioner could not develop these skills. (T.147). In fact, Ms. Stafseth testified that Petitioner was set to complete her computer training on March 15, 2016. (T.148). Thereafter, she would have had Petitioner start searching for work. (T.148). However, Ms. Stafseth opined that Petitioner did not fully cooperate with the recommended plan as Petitioner failed to follow through with daily communications; she also missed assignments and appointments. (T.152). Petitioner testified that she fell behind in her work during vocational rehabilitation for several reasons; she stated that two family members had died and she was responsible for funeral arrangements; one time she had food poisoning; and, she also developed vertigo and headaches. (T.61; T.79; T.82; T.91-92). As a result, Vocamotive's March 10, 2016 progress report indicated that Petitioner fell 20 days behind in her training. (RX17).

Ms. Stafseth did conclude that based on Petitioner's skills, education, and work history, she had no readily transferable skills. (T.142; RX17). However, Ms. Stafseth believed that if Petitioner were to continue with vocational rehabilitation, she would be able to find employment. (T.153). She believed that Petitioner could work as a security guard, customer service representative, front desk clerk, office clerk and cashier – earning between $9.00 and $13.00 per hour. (T.143-144; RX17). During cross-examination, Ms. Stafseth admitted that a labor market survey had not been completed, and she did not know how many jobs actually existed for Petitioner. (T.171-172).

Petitioner hired her own vocational expert, Jacky Ormsby. (PX13). Ms. Ormsby testified that Petitioner's work for Respondent was classified as heavy duty work, wherein Petitioner was required to lift 100 pounds occasionally and 50 pounds frequently. (T.110-111). Ms. Ormsby opined that Petitioner was not a great candidate for vocational rehabilitation. The basis for Ms. Ormsby's opinion was,

> [T]hat she is almost 60-years-old, she had limited education, she had been out of the work force for several years and did not really have any computer skills. So there were really not any positions that she would be able to do that would even be comparable to her wage that she was making and there is no stable labor market based on all that. (T.113).

Ms. Ormsby also did not recommend sending Petitioner for any type of training, again considering her age, limited education, limited work history, limited skills, and being out of the work force. (T.115-116). Ms. Ormsby testified that she had reviewed Mr. Boyd's evaluation and admitted that Petitioner did not complete all the tests. (T.117). However, she testified that the information available, such as Petitioner's academic information and the clerical test and customer service skills inventory test that were completed, were sufficient for her to render a supported vocational opinion. (T.117).

Nevertheless, Ms. Ormsby did not foreclose the possibility that Petitioner may find an employer who would hire her. However, she did not believe that an abundance of jobs was available that Petitioner was qualified for. (T.113-114). On cross-examination, Ms. Ormsby stated that it was possible Petitioner could answer a phone, wear a headset, perform a job where she could sit and stand so long as it was within her restrictions, work using her dominant, right hand, or write notes on a piece of paper. (T.16; T.73; T.124-125). Ms. Ormsby further acknowledged that she did not review any resume of Petitioner's and had no information as to how many job interviews Petitioner went on or where she had previously looked for work. (T.126).

In evaluating the record thus far, the Commission finds that the parties agreed to and did commence a course of vocational rehabilitation for Petitioner, which was aborted following the receipt of surveillance video of Petitioner shopping after leaving her appointment with Mr. Boyd on February 26, 2016. The Commission finds that Petitioner's activity of shopping in and of itself is not outside any given restriction. The Commission further finds that surveillance conducted over a one-day period, approximately 12 minutes of which actually showed Petitioner, is insufficient evidence to find Petitioner incredible or uncooperative in the vocational rehabilitation process. Petitioner further agreed that she had fallen behind in her work during vocational rehabilitation. However, the Commission finds Petitioner's explanation, including the deaths of her family members within one week of each other, unrebutted and credible. (T.61; T.79; T.82; T.91-92).

In fact, Respondent's own vocational expert, Ms. Stafseth, testified to a detailed rehabilitation plan; she believed Petitioner was capable of developing the necessary skills to look for work, and more importantly, believed that if Petitioner were to continue with vocational rehabilitation, she would be able to find employment. (T.143; T.153). The Commission notes that per Ms. Stafseth's testimony, Petitioner was set to complete her computer training on March 15, 2016, and begin a formal job search. (T.148). Petitioner's vocational expert, Ms. Ormsby, also did not foreclose the possibility that Petitioner may find an employer who would hire her. However, she did not believe that an abundance of jobs was available that Petitioner was qualified for. (T.113-114). The Commission notes that Ms. Ormsby opined that no stable labor market existed for Petitioner after one evaluation; Ms. Ormsby also did not complete a labor market survey in this claim.

After considering the entire record, the Commission finds that vocational rehabilitation was terminated prematurely. The evidence as it stands now is insufficient to determine what type of permanent disability benefits Petitioner is entitled to. Based on the evidence, the Commission cannot ascertain whether a reasonable, stable labor market exists for Petitioner, and if such suitable employment, in which Petitioner is both able and qualified to perform, is available, the Commission has no evidence relative to impairment of earnings, if any, or any evidence to properly calculate a wage differential award.

As to evidence in support of a wage differential award under Section 8(d)1, the Commission is aware of and would like to note that Petitioner is not required to submit evidence of a job search. However, it is an effective and efficient way to demonstrate an impairment of earnings. *Gallianetti v. Indus. Comm'n,* 315 Ill. App. 3d 721, 731 (3rd Dist. 2000). In this claim, the evidence demonstrates only a truncated vocational rehabilitation program and no labor market survey. There was insufficient evidence in the record to serve as a basis for the entry of an award of benefits under Section 8(d)1 of the Act. Furthermore, the calculation of such an award requires even more specific evidence.

Crittenden v. Ill. Workers' Comp. Comm'n, 2017 IL App (1st) 160002WC, instructs as follows:

> In making the calculation of a wage differential under section 8(d)(1) of the Act (820 ILCS 305/8(d)(1) (West 2012)), the Commission must determine "the average amount which [the claimant] is able to earn in some suitable employment or business after the accident." In calculating this average amount, if the claimant is working at the time of the calculation, the claimant must prove his actual earnings for a substantial period after he returns to work, and the Commission may apply his then current average weekly wage to the calculation. See *Gallianetti*, 315 Ill. App. 3d at 730; see also, *Levato v. Workers' Comp. Comm'n*, 2014 IL App (1st) 130297WC ¶29-¶30. However, as in the case at bar, if the claimant is not working at the time of the calculation, the Commission must rely on functional and vocational expert evidence. See *Gallianetti*, 315 Ill. App. 3d at 730 (labor market survey); *Levato*, 2014 IL App (1st) 130297WC at ¶12-¶13 (vocational rehabilitation specialist and labor market survey); *United Airlines, Inc. v. Ill. Workers' Comp. Comm'n*, 2013 IL App (1st) 121136WC ¶4-¶7 (vocational rehabilitation specialists).

Crittenden further specifies:

> In addition, where the claimant is not working at the time of the hearing, it is important to note that section 8(d)(1) requires that an average wage be derived from suitable employment for the claimant. Suitable employment is employment in which the claimant is both

> able and qualified to perform . . . For all of these reasons, we hold that in order to calculate a wage differential award, the Commission must identify, based on the evidence in the record, an occupation that the claimant is able and qualified to perform, and apply the average wage for that occupation to the wage differential calculation. As a corollary to this holding, the claimant is required to introduce evidence sufficient for the Commission to identify an occupation that the claimant is able and qualified to perform, and the average wage for that occupation. 2017 IL App (1st) 160002WC ¶24.

Here, the parties stipulated that the current wage rate for Petitioner's job, as of August 1, 2016, was $29.24 per hour. (T.101). The Arbitrator relied on the testimony of Respondent's vocational expert, Ms. Stafseth, who opined that Petitioner could work as a security guard, customer service representative, front desk clerk, office clerk and cashier – earning between $9.00 and $13.00 per hour. (T.143-144; RX17). The Arbitrator used the average of the rates identified by Ms. Stafseth, or $11.00, to calculate a wage differential rate of $486.40 per week. Petitioner claims that the wage differential award should be based on the minimum wage of $8.25 as Petitioner never completed the vocational rehabilitation training program. (Petitioner's Brief, pg. 11). Respondent, on the other hand, claims that the wage differential award should be calculated using the amount derived by its first vocational hire, Triune, which estimated that Petitioner could earn up to $37,930 based on the various jobs it believed Petitioner could perform.

The Commission finds that neither of these methods as propositioned by the parties are correct. The Commission further finds that while it may consider evidence from vocational rehabilitation specialists and/or labor market surveys, the Commission finds that the evidence in this claim is either lacking or non-existent. Under *Crittenden*, the Commission finds that Petitioner is required to introduce evidence sufficient for the Commission to identify an occupation that the claimant is able and qualified to perform, and the average wage for that occupation. The Commission finds that if it were necessary to calculate the wage differential benefit rate, it will be unable to do so based on the evidence presented at arbitration; the Commission will not consider speculative evidence. *United Airlines, Inc. v. Ill. Workers' Comp. Comm'n*, 2013 IL App (1st) 121136WC ¶17, ¶29.

In light of the foregoing, the Commission finds that there is insufficient evidence in the record to determine what type of permanent disability benefits Petitioner is entitled to, and if Petitioner were to be entitled to a wage differential award under Section 8(d)1 of the Act, the Commission finds that there is insufficient evidence to determine the correct benefit rate. As such, the Commission vacates the Arbitrator's wage differential award and remands this case to the Arbitrator with an order for additional vocational rehabilitation, and for further proceedings as specifically set forth herein.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed on October 18, 2016, is hereby modified as stated herein and otherwise affirmed and adopted.

18IWCC0034

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner the sum of $659.22 per week for a period of 96 3/7 weeks, commencing October 22, 2013 through December 8, 2013 and February 28, 2014 through November 17, 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 the wage differential award pursuant to Section 8(d)1 of the Act is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for vocational rehabilitation, as provided in Section 8(a) of the Act, and as outlined by its vocational counselor, Kari Stafseth.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner ongoing maintenance benefits of $659.22 per week throughout the duration of Petitioner's vocational rehabilitation, commencing November 18, 2015, as provided in Section 8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit in the amount of $88,925.32 for temporary total disability benefits, maintenance, and wage differential benefits under Section 8(d)1 which were previously paid to Petitioner.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $3,045.24 for medical expenses under Sections 8(a) and 8.2 of the Act.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $3,400.00. 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 the Circuit Court.

DATED: JAN 18 2018
MJB/pm
12-12-17
052

Michael J. Brennan

18IWCC0034

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WOODFORK, IRENE D
Employee/Petitioner

Case# **13WC035208**

UNITED PARCEL SERVICE
Employer/Respondent

18IWCC0034

On 10/18/2016, 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 0.47% 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:

0529 TUITE LAW
GREGORY E TUITE
119 N CHURCH ST SUITE 407
ROCKFORD, IL 61101

2284 COZZI-GOGGIN WARD
MARK ZAPF
27201 BELLA VISTA PKWY #410
WARRENVILLE, IL 60555

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

Irene D. Woodfork
Employee/Petitioner

v.

United Parcel Service
Employer/Respondent

Case # 13 WC 35208

Consolidated cases: _____

18IWCC0034

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 **Gregory Dollison**, Arbitrator of the Commission, in the city of **Rockford, Illinois**, on **8/16/16**. 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 **7/9/2013**, 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 **$44,304.36**; the average weekly wage was **$988.93**.

On the date of accident, Petitioner was **56** years of age, ***single*** with **no** dependent children.

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

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

Respondent shall be given a credit of **$88,925.32** for all TTD, maintenance and Section 8(d)1 payments made.

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 $659.22/week for 96-3/7 weeks, commencing 10/22/13 through 12/8/13 and 2/28/14 through 11/17/15, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits, commencing November 18, 2015, of $486.40/week for the duration of the disability, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act. The wage differential shall be effective only until Petitioner reaches the age of 67 or 5 years from the date the award becomes final, whichever is later.

Respondent shall pay reasonable and necessary medical services of $3,045.24, as provided in Sections 8(a) and 8.2 of the Act.

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

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

Signature of Arbitrator

10/17/16
Date

OCT 18 2016

18IWCC0034

FINDINGS OF FACT:

Petitioner testified that she had worked for United Parcel Service (UPS) for 19 years prior to her July 9, 2013 left shoulder injury. She would normally work from 6:30 at night until 4:30 in the morning. There were two components to her work at UPS, thus the designation as a "combo job". The first part of the job was to work inside the UPS building grabbing packages and passing them onto other sorters. The second part of the job was to work outside and load packages into the cargo area of airplanes. Petitioner testified this work was heavy in nature, in that she was required to lift fifty (50) to seventy (70) pounds every day. She would normally spend three hours outside loading packages into airplanes and six hours inside helping sort packages.

Petitioner offered Petitioner Exhibit #18 which is a copy of a portion of the collective bargaining agreement between the Teamsters and UPS. That document designates the combo job as a full-time position and that combo job workers were to be treated as full-time employees for seniority purposes and being offered extra work. The parties stipulated that Petitioner's average weekly wage during the year preceding the accident was $988.93. This amount divided by her hourly wage at the time of the accident of $26.27 equals 38.34 hours. A wage statement prepared by Liberty Mutual, Respondent's workers' compensation carrier, indicates that Claimant worked 40 hours per week during the two weeks prior to her injury. Petitioner testified that was considered a full work week.

Petitioner testified that she did not complete high school, but did obtain a GED. She further indicated that she had difficulty with mathematics in high school. Currently she is able to do some math including fractions. She had no memory of how to do algebra. Petitioner testified that she had no prior neck or shoulder injuries. She had never filed a workers' compensation claim before the one in question. Over the years, she sustained a number of strains and sprains on the job, but none ever required medical treatment.

Petitioner sustained a left shoulder injury while trying to pull some heavy freight out of a truck onto a roller line. Petitioner testified that while repeatedly trying to pull the freight onto the rollers, she felt a pop in her left shoulder. She reported the incident to her supervisor and was directed to receive treatment at Physicians Immediate Care.

Petitioner reported to Physicians Immediate Care on July 10, 2013 with complaints of sharp left shoulder pain that radiated down to her neck. Petitioner was treated conservatively with medication and an arm sling. She was provided with work restrictions and advised to follow-up at another Physicians Immediate Care location, Riverside Clinic, on July 11, 2013. Petitioner presented to the Riverside Physicians Immediate Care facility as directed. She presented with a chief complaint of constant left shoulder pain. Petitioner was diagnosed with left shoulder sprain/strain. Her medications and restrictions were continued. On her next visit of July 18, 2013, Petitioner was prescribed bio-freeze and her restrictions were again continued. (PX 2) Petitioner testified that the employer was able to accommodate the restrictions.

Petitioner testified that she eventually chose to see her primary physician, Dr. Everson, on July 23, 2013. Petitioner provided that Dr. Everson recommended rest, medications and an MRI of the left shoulder. She indicated the MRI was performed on July 29, 2013 at Swedish American Hospital and thereafter, Dr. Everson referred her to Dr. Anton. In the interim, on August 2, 2013, Physicians Immediate Care had initiated physical therapy.

On August 21, 2013, Petitioner saw Dr. Oscar Anton, an orthopedic surgeon at Lundholm Orthopedics. Dr. Anton noted the previously performed MRI revealed left shoulder tendinosis and degenerative joint disease

(DJD). Dr. Anton assessed left rotator cuff tendinitis. The doctor recommended a steroid injection and physical therapy. Petitioner refused the injection but acquiesced to the therapy which was initially to be performed at Lundholm. (PX3)

Petitioner testified that during this period she noticed a lot of pain in her neck and couldn't focus because of that pain. She further indicated that the pain was normally in the center of the back of her neck, but occasionally radiated into the left shoulder and down the left arm. At the time, she was also complaining of vertigo, which she indicated she had never experienced prior to her work injury.

At Respondent's request, Petitioner attended a Section examination with Dr. Ira Kornblatt on October 10, 2013. The doctor evaluated both the left shoulder and neck. At that time, Dr. Kornblatt recorded Petitioner's complaints of left shoulder pain and significant symptomatology involving her cervical spine. After performing and examination and reviewing medical records, Dr. Kornblatt opined Petitioner had findings compatible with ongoing symptomatology due to rotator cuff tendonitis in addition to apparent symptomatology referable to the cervical spine. The doctor opined that a causal relationship existed between her complaints and the work accident. The doctor stated, "...the symptomatology was related to the work injury based on the mechanism and her seeking treatment shortly thereafter." Dr. Kornblatt indicated that it was possible that Petitioner had degenerative disc disease of her cervical spine which may have been aggravated. He however added that because there had not been any workup of the cervical spine, he was unable to discern if the aggravation was temporary or permanent. Lastly, Dr. Kornblatt opined that Petitioner's ongoing symptomatology would make it impossible for her to carry out her normal job duties indicating she is working basically at a one-arm job. (RX 3) Petitioner testified that subsequent to Dr. Kornblatt's examination, Respondent no longer accommodated the light duty restrictions. TTD payments were initiated as of October 22, 2013.

On November 21, 2013, Petitioner returned to Dr. Anton. Petitioner reported persistent left shoulder pain with any type of motion. The doctor noted that Petitioner had not attended any of the prescribed therapy sessions as she felt that she already tried that. Dr. Anton administered a steroid injection and again recommended physical therapy. Dr. Anton also returned Petitioner to full duty work effective December 9, 2013. (PX 3)

Respondent submitted Dr. Anton's physical therapy recommendation for utilization review. On December 3, 2013, Dr. Eric Ray of the Medical Review Institute of America denied the request for 12 to 24 physical therapy sessions for the left shoulder. Dr. Ray noted that the Occupational Disability Guidelines (ODG) supported 10 visits over eight weeks for a diagnosis of impingement syndrome. The doctor noted that although Petitioner had twelve (12) prior approved sessions, it appeared Petitioner had only attended three (3) of sessions as of August 19, 2013. The physician was unclear as to how many sessions of physical therapy sessions Petitioner had actually attended. Nevertheless, Dr. Ray opined that the prospective request for twelve (12) to twenty-four (24) therapy sessions was not medically necessary nor supported by the ODG recommendations. (RX 6) Said denial was appealed and on December 9, 2013, a new reviewer, Dr. Kevin Tomsic, maintained the denial based on the ODG. Dr. Tomsic noted that Petitioner had attended three (3) therapy sessions since the steroid injection. He indicated the ODG suggest formal therapy was allowable for up to one (1) to two (2) visits over one (1) week following an injection. He provided that there were no exceptional factors in the records and as such, denial of the request is appropriate. (RX 7)

Petitioner returned to Dr. Anton on January 21, 2014. Dr. Anton noted Petitioner had returned to work and the symptoms were still present. The doctor also noted that only three sessions of physical therapy had been approved, which Petitioner attended. Dr. Anton felt Petitioner would benefit from a subacromial decompression and referred her to Dr. Steven Milos, a shoulder specialist at Lundholm. On February 3, 2014, the doctor placed Petitioner back on restricted work duty. (PX 3)

Dr. Milos evaluated Petitioner on February 10, 2014. Dr. Milos noted Petitioner's pain had not improved despite conservative treatment and recommended surgery in the form of left shoulder arthroscopic decompression and distal clavicle excision. (PX 3) This was performed on March 7, 2014 at Swedish American Hospital. (RX 15)

Post-surgery, Petitioner was off work and undergoing physical therapy. Petitioner testified that she switched her primary care to Dr. James Koepsell as his office was only six blocks from her home. She first saw Dr. Koepsell on April 11, 2014, with a history of a recent shoulder surgery, back pain and fibromyalgia discomfort all over. Medication was prescribed. (PX 9)

On April 14, 2014, Petitionersaw Dr. Milos. The doctor noted Petitioner's progress was complicated by her fibromyalgia and back pains. Dr. Milos prescribed physical therapy to work on strengthening. He prescribed a compounding cream for pain and returned her to right handed duty only. (PX 3) Petitioner testified that the compounding cream was helpful and that she still uses it on occasion.

Petitioner returned to Dr. Koepsell on April 26, 2014. Dr. Koepsell noted Petitioner's concerns regarding her fibromyalgia, shoulder pain worse while lying and cervical radiculopathy. The doctor increased a previous dose of Amitriptyline and prescribed narcotic medications. (PX 9)

Petitioner began physical therapy at Accelerated/Rebound. By June 2, 2014, Dr. Milos again noted Petitioner's progress was complicated by her fibromyalgia. Petitioner also complained of left arm numbness and tingling down to her fingers. On July 7, 2014, Dr. Milos again noted Petitioner's numbness, tingling and pain. The doctor indicated Petitioner could return to work with a twenty-five (25) pound lifting restriction. He also felt it appropriated to transition her into a work hardening program. (PX 3)

On August 4, 2014, Dr. Milos noted Petitioner was not improving with therapy. He also noted she had significant neck pain and prarthesias down the left arm which was preventing progression in the therapy. After obtaining a cervical x-ray, Dr. Milos indicated she had significant degenerative changes in her neck with loss of lordosis. He ordered a cervical MRI. (PX 3)

Petitioner testified that in August 2014, she began experiencing symptoms of vertigo. As a result thereto she presented and treated at Rockford Memorial Hospital. Dr. Koepsell's records contain the Rockford Health ER visit wherein Petitioner was admitted on August 13, 2014 with a diagnosis of vertigo. She reported that it spontaneously resolves and then comes back again. She was admitted for neurological evaluation and had an MRI of the head which was negative. The vertigo improved and Petitioner was discharge. (PX 9)

On September 15, 2014 Petitioner underwent the MRI of the neck at Forest City Imaging. The impression was cervical spondylosis redemonstrated without spinal cord compression. There was severe narrowing of the left C3-4 and C5-6 neural foramina redemonstrated. Also noted were new subendplate degenerative bone narrowing signal changes at C5-6. There was no disc herniation. (RX 14)

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. Timothy Payne on September 18, 2014. Petitioner reported complaints consisted of pain at night; pain radiating from the left side of her neck into the shoulder and down her arm; decreased strength with shoulder function; loss of motion regarding the left shoulder; and, decreased sensation at times. After performing an examination and reviewing Petitioner's medical records, Dr. Payne opined that Petitioner's related diagnosis was resolved impingement syndrome of the left shoulder and cervical radicular pain secondary to foraminal narrowing of the cervical spine. He provided that the cervical MRI findings correlate with Petitioner's subjective complaints of neck pain going down the arm. Dr. Payne indicated the MRI findings pre-existed the injury but were asymptomatic. He

provided that the incident caused an aggravation to the pre-existing changes at C3-4 and C5-6. He further provided that same had not resolved. Dr. Payne added that upon exam, there was ½ cm of atrophy to the left forearm compared to the right which corresponded to C3-4 and C5-6 nerve root involvement. He further added that there was slightly decreased pinch on the left compared to the right which was consistent with C5-6 nerve root involvement. Dr. Payne opined that Petitioner was at maximum medical improvement for the shoulder, but had not reached MMI for the aggravation of her pre-existing degenerative changes of the cervical spine. He felt that she was not capable of her regular activities indicating she was restricted to light duty activities of no overhead lifting with the left arm and no lifting greater than 25 lbs. (RX 1)

After the MRI was completed, Dr. Milos referred Petitioner to Dr. Todd Alexander, a neurosurgeon for an evaluation of the neck. Records submitted show Petitioner saw Dr. Alexander on October 30, 2014. Dr. Alexander recorded Petitioner's complaints of pain in her neck which radiated into the left shoulder and down the left upper extremity to her fingertips. She reported numbness and tingling in the upper extremity to her finger tips as well as weakness with said extremity. Dr. Alexander also recorded that Petitioner had not worked since February 2014 and her feeling that she didn't think she would ever return to work. Upon examination, the doctor noted Petitioner demonstrated some exaggerated pain behaviors in the office. He noted that she would barely move her neck actively which appeared not physiologic. He also noted that her motor strength testing also required encouragement as she somewhat feigned weakness. Dr. Alexander's impression was that Petitioner had neck pain with some left-sided cervical radicular symptoms which may be due to some multilateral degenerative spondylosis at her cervical spine. He indicated that these appeared to be degenerative in nature and not traumatic. The doctor recommended conservative treatment and referred her to physical therapy. Dr. Alexander added that returning Petitioner to work would be extremely challenging as she was not motivated to return to work, and had already admitted that she likely would never return to work. (PX 4)

Respondent submitted Dr. Alexander's physical therapy prescription, 18 physical therapy visits over six weeks, for utilization review. The reviewer, Dr. Jonathan Waldbaum of the Medical Review Institute of America, concluded that physical therapy prescription was not medically necessary. Dr. Waldbaum noted Petitioner had completed twenty (20) work-hardening sessions for the left shoulder. He provided that the ODG does not recommend a lower level of care following a structured work hardening program. He also provided that ODG does not recommend institutionally based traction and further noted that the number of visits requested exceeds ODG guidelines. The doctor further questioned the need for physical therapy in an individual who demonstrated exaggerated pain behaviors on examination, did not have physiologic findings on examination, and who appeared to feign symptoms. The doctor further noted that Dr. Alexander indicated that prior sessions made her worse. (RX 9)

Petitioner testified that she attempted to return to Dr. Alexander in follow-up. Petitioner's testimony and the records of Dr. Alexander show that he would not see her since his recommendations were not being authorized. (PX 4)

Petitioner returned to Dr. Milos on December 29, 2014. The doctor noted that Petitioner's left shoulder pain failed to improve despite physical therapy and pain medication. An examination revealed mild tenderness. Her range of motion was equal bilaterally. Her strength was graded 5- of 5 with external, internal rotation as well as graded 5- of 5 with supraspinatus and infraspinatus. With respect to the neck, she had full range of motion while experiencing numbness and tingling of her fingers with cervical compression and axial loading. The doctor recommended a topical cream as she had continued pain with paresthesias of her fingers on the left side. Physical therapy was also discussed and work restrictions were continued. (PX 3)

Petitioner saw Dr. Milos on January 26, 2015. The doctor recorded Petitioner continued to experience pain, numbness in her shoulder. Petitioner reported that she had relief with the topical compound cream and that the physical therapy was not authorized. At that time, Dr. Milos released Petitioner from his care with

restrictions and expressed his preference that she continues with physical therapy to advance her range of motion, stretching and strengthening. (PX 3)

Subsequent to Dr. Milos's release, Petitioner presented to Dr. Michael Roh, a spine surgeon at Rockford Spine Center. Records submitted show she presented on March 26, 2015 with complaints of severe left shoulder pain, numbness and weakness. Also noted were pain and numbness that radiated from the neck down into the shoulder into the upper arm with numbness and paresthesias. Dr. Roh initial impression was possible left-sided C6 radiculopathy; significant left shoulder pain due to musculoskeletal etiology and possible thoracic outlet syndrome. Dr. Roh indicated that it was clear to him that Petitioner had shoulder pathology and pain, "particularly in light of the numbness and paresthesia that she is having." Because there was an absence of any focal weakness on examination, the doctor ordered an EMG/NCV study. (PX 6)

The EMG/NCV was performed by Dr. Marie Walker at April 9, 2015. Dr. Walker noted the study revealed that the left upper extremity demonstrated normal median and ulnar motor responses. The interpretation was EMG with no electrophysiologic evidence of a left cervical radiculopathy, plexopathy median or ulnar neuropathy. (PX 6)

Subsequent to the EMG, Dr. Roh referred Petitioner to Dr. Eric Freeman of the Rockford Pain Center. Petitioner presented to Dr. Freeman on May 5, 2015 with complaints of left neck and shoulder pain. She localized most her pain into the left base of the cervical spine with radiation into the left trapezius musculature and shoulder. Petitioner further reported that only two times per week will she have numbness and tingling that radiates into the left arm and that same was somewhat global in distribution. Dr. Freeman stated that the exact etiology of her pain was uncertain at that time. He indicated that she did appear to have shoulder pathology and a myofascial component involvement. He also noted the possibility that there was a cervical component as well. Dr. Freeman's impression was 1.) left neck and shoulder pain with only rare pain into the left arm, exact etiology uncertain and 2.) reported history of injury while at work resulting in current symptoms. The doctor continued Petitioner's use of Norco and the compounding cream. He also suggested performing a C6-7 selective nerve root injection on the left side. Dr. Freeman noted the procedure would be altered somewhat given Petitioner has anaphylactic-like reaction to iodinated contrast. Because he could not use contrast, he would not be able to confirm perineural spread of local anesthetic. (PX 7)

Records submitted show that although Dr. Freeman's C6-7 selective nerve root injection recommendation was pre-certified, Petitioner opted not to proceed with the recommendation. Dr. Freeman's records show Petitioner called his office on May 27, 2015 advising that she "...didn't want to take chance on [injury] of the neck." (PX 7)

Petitioner returned to Dr. Milos on July 13, 2015. The doctor recorded that Petitioner complained that she continued to experience shoulder discomfort. She also requested a prescription for a "functional capacity evaluation for PT." (PX 3)

Petitioner testified that she attended a Functional Capacity Evaluation at Accelerated on July 27, 2015. After approximately three hours, the therapist aborted the test due to elevated blood pressure indicating same would be rescheduled once she received medical clearance to continue. Also see PX 5 and RX 11. Petitioner testified that she contacted Dr. Koepsell and was given an additional blood pressure medication.

The Functional Capacity Evaluation was completed on August 28, 2015. Petitioner was deemed to have demonstrated the physical capabilities and tolerances to function at the light physical demand level. The evaluator provided that Petitioner demonstrated an inconsistent performance/unacceptable effort. The evaluator wrote, "[e]ffort indicates the client's perceived limitations and returned to work confidence are markedly affected by symptom expression, consistency and quality of effort, reliability of pain and quality of effort. The

18IWCC0034

client could have performed at markedly higher levels than willing during muscularskeletal and functional testing. Behavior affected are affecting evaluation results to such a degree that the evaluator could not identify the client's true muscular skeletal status, project full-time work tasks, and/or true impairment…" (PX 5 and RX 11) Petitioner testified that she was not offered any employment by Respondent after the Functional Capacity Evaluation. She continued to receive temporary total disability benefits.

At Respondent's request, Petitioner was re-evaluated by Dr. Payne. In his report dated September 4, 2015, Dr. Payne noted that in addition to reviewing his previous report, he performed an examination, reviewed medical documentation as well as Respondent's job description. Dr. Payne provided that Petitioner had cervicalgia, consistent neck pain but no documented radicular findings on EMG findings. The doctor also indicated she had minimal motion limitation. Dr. Payne opined that her "…work related torque/fraction strain to the neck that caused a temporary aggravation to the pre-existing changes at C3-4 and C5-6 had resolved." He indicated she had no restrictions with regard to her cervical spine and was at maximum medical improvement. (RX 2)

With respect to Petitioner left shoulder, Dr. Payne opined status post shoulder subracromial decompression for impingement. The doctor noted that she had mild residual capsulitis of the shoulder and mild limitation in shoulder function. The doctor also pointed out that in contrast to his previous examination, there was no atrophy comparing the circumference of both arms. He further noted that on examination, she had decreased range of motion and strength deficits. Dr. Payne opined that Petitioner was unlikely to show any further improvement with regard to shoulder function. He felt that she was at maximum medical improvement and permanently restricted her to light duty work with no heavy lifting overhead with left arm and no lifting more than 25 pounds with the arm. (RX 2)

Petitioner returned to Dr. Milos on September 17, 2015 for follow up of left shoulder pain and review of the functional capacity evaluation. Dr. Milos noted Petitioner continued to experience pain. He also noted Petitioner was seeking documentation that due to her results, she had a permanent disability. Dr. Milos provided that "…due to incomplete and poor effort on FCE testing, we do not feel we are able to provide accurate documentation regarding her functional/disabling status." Dr. Milos referred Petitioner to her primary care physician. (PX 3)

At Respondent's request, Ruben Luna, of Triune Health Group, conducted a vocational assessment of Petitioner. In his report dated September 25, 2015, Mr. Luna indicated that based on her work history, education, and medical restrictions Petitioner could return to work in the following types of jobs: surveillance systems monitor, escort/vehicle driver, telephone solicitor, cashier, customer service clerk, routing clerk, front desk clerk, appointment clerk, or information clerk. He noted salaries in a range from $22,700.00 to $37,930.00. (RX 16)

At her attorney's request, Petitioner underwent a functional capacity evaluation performed at ATI Physical Therapy on November 17, 2015. The assessment was deemed a valid representation of Petitioner's physical capabilities. According to the evaluator, Petitioner demonstrated functional capabilities most consistent with a light physical demand level. The evaluator noted Petitioner demonstrated desk to chair lifting 30.2 lbs.; chair to floor lifting 12.6 lbs.; and lifting 17.0 lbs. above shoulders on an occasional basis. Petitioner demonstrated deficits between her affected vs. non-affected side during unilateral lifting. It was noted that throughout the assessment, Petitioner had multiple reports and behaviors in regard to her left shoulder, neck pain. She demonstrated compensatory patterns with shoulder hiking and trunk extension with lifting at higher heights. She demonstrated an overall workday tolerance of 3 hours. Standing was recommended at 2 hours (20 minutes duration) and walking at 3 to 4 hours of occasional moderate distances and finally sitting was recommended to two hours with 25 minute durations. The FCE also indicated that due to the demonstrated limitations and behaviors during the assessment the following activities are recommended on an occasional

18IWCC0034

basis (6-33% (.5 to 2.5hrs.) of balance, bend/stoop, stairs, use of left and right feet. Petitioner was also restricted to a minimally occasional basis (1-5% (0 to .5hrs.) of crawling, crouching, head/neck flexion and rotation, kneeling and squatting. Lastly, the evaluator noted that although Petitioner exhibited pain reports and pain behaviors, the validity determination was based on objective data collected and formulas using that data. (PX 8)

Petitioner testified and the records show that Respondent switched vocational rehabilitation services from Triune to Vocamotive. The initial evaluation conducted by Ms. Keri Stafseth occurred on November 25, 2015. On December 1, 2015, Ms. Stafseth authored a report indicating Petitioner fully cooperated with all aspects of the interview. Ms. Stafseth provided that she was requested to provide an opinion with regard to Petitioner's employability, placement and wage earning potential. Ms. Stafseth noted that Petitioner was considered a "Person of Advanced Age" which would significantly affect her ability to adjust to other work. She noted that Petitioner should undergo vocational testing. She also indicated that that Petitioner did not have any transferrable skills. Based on the above situational factors, Ms. Stafseth opined that based on Petitioner's job description and her physical capabilities documented by Dr. Payne, Petitioner lost access to her usual and customary job and occupation of an Air Handler and Sorter. She opined that Petitioner was employable indicating the job targets most probably available would include; security guard, customer service representative, front desk representative, clerk and cashier. She opined that Petitioner's most probable earning capacity would range from $9.00 to $13.00 per hour. Lastly, she opined that vocational rehabilitation services should be provided to Petitioner. Said services would include comprehensive testing by a Certified Vocation Evaluator to assess aptitude, interest and temperament. She indicated the services would include completion of computer training with keyboarding and Microsoft Office. Additional services would include facilitation of on-the-job training opportunities, assistance with letter development, completion of mock interviews and participation in self-diected and supervised job searches. (RX 17) Petitioner testified that in between the vocational evaluations, from November 9, 2015 through December 2, 2015, she performed a self-directed work search. She documented the work search in a job search log. (PX 11)

Petitioner testified that she received documents from Respondent regarding accommodated work. (PX 14) This included a job description as well as a request for medical information. Petitioner provided that she gave the documents to Dr. Koepsell for completion. After completion of same, she Petitioner returned the completed medical form to Respondent. Petitioner stated that on December 17, 2015 she met with Respondent about job accommodation and was told Respondent did not have a position to accommodate her. In late January 2016, Petitioner received a letter dated January 29, 2016 confirming that Respondent could not accommodate her limitations.

Petitioner began participation with Vocamotive's rehabilitation services on December 3, 2015. In the progress report dated January 10, 2016, it was noted Petitioner had been introduced to the computer and all its components. She also began job search skills training. During the reporting period, Petitioner provided that she had been hospitalized for vertigo and could only drive short distances. The rehabilitation counselor noted Petitioner was receptive to all training. She had completed Windows 7 and her keyboarding and key padding was improving. On February 9, 2016, the counselor reported that Petitioner continued to report vertigo issue. It was noted that Petitioner was 21 days behind in her training schedule. The counselor noted that 13 of the missed days were due to two different deaths in Petitioner's family. The counselor felt it was important that Petitioner determine if she was able to participate in vocational rehabilitation. On March 10, 2016, it was noted Petitioner had completed vocational testing (the testing results were not available during this reporting period). She was unable to tolerate the entire testing appointment and left early as she reported being dizzy and having a headache. She had completed Microsoft 2013 Office Overview and was working in Word Basic. It was noted Petitioner had difficulty with the programs and had been given extensive one-on-one assistance. Further noted was Petitioner's report that she was unavailable on Wednesday mornings secondary to attending religious

18IWCC0034

services. Lastly, it was noted Petitioner was 20 days behind in her training and needed to commit to working on the computer curriculum on a fulltime basis in order to slowly catch up. (RX 17)

As noted above, Petitioner underwent vocational testing. In a report authored by James Boyd and dated March 15, 2016 show that Mr. Boyd met with Petitioner on February 26, 2016 to conduct said vocational testing. Mr. Boyd reported that although Petitioner's response to questions was short, she was cooperative with everything that she was asked to do. He noted she had difficulty physically tolerating the session and appeared uncomfortable in whatever position she assumed. He noted she alternated between periods of sitting, standing and pacing between each test; she reported an onset of a headache and dizziness within an hour of testing; and she stopped working on several occasions to close her eyes, hold her head, and rest with the lights in the room turned off. Mr. Boyd reported that because of her complaints he gave her three options which included: 1.) continue to rest in the office until symptoms subsided; 2.) take a break for lunch and return to continue testing; or 3.) discontinue the testing and go home. Petitioner opted to go home. (RX 17) Petitioner testified that she went home and rested. She didn't go anywhere else that day.

According to Mr. Boyd, Petitioner's Vocational Assets were 1) average non-verbal reasoning (IQ); 2.) reading comprehension at the 10.4 grade level; 3.) basic spelling skills at the 7.2 grade level; 4.) average clerical perception with numerical data; and 5.) borderline average orientation to customer service situations. Mr. Boyd provided that Petitioner's Vocational Challenges include 1.) Arithmetic computation at the 3.5 grade level; 2.) limited tolerance and attention for repetitive or sustained activity; and 3.) unresolved symptoms of vertigo, headache, and shoulder pain. Mr. Boyd wrote, "[g]iven the abbreviated time frame of this evaluation, comprehensive vocational test battery could not be administered. Based on what was accomplished, Ms. Woodfork's test results point to some employment potential from a skills perspective..." Mr. Boyd indicated Petitioner demonstrated aptitude and achievement levels for the following job titles: customer order clerk, shipping clerk, garment tagger, job tracer, apparel stock checker, information clerk, checker II, and stock control clerk. Mr. Boyd stated that above mentioned does not take into account the behavioral observations or reported symptoms during the evaluation which would not be compatible with either part-time or full-time competitive employment. (RX 17)

Petitioner submitted her own Vocational Assessment. The assessment conducted by Ms. Jacky Ormsby of MedVoc Resources took place on April 5, 2016. In her report dated April 11, 2016, Ms. Ormsby provided that after reviewing medical documentation and conducting an interview "...it appears there is no stable labor market for Ms. Woodfork." Ms. Ormsby wrote, "Ms. Woodfork is 59 years old. According to the Social Security Administration, she is considered a person of advanced age (age 55 or older). She has been released to return to work to a Light Physical Demand Level with a maximum of a 3-hour workday. She has limited to no transferrable skills. Her work history is physical in nature and she can no longer perform these types of positions (air handler/freight and cook). She has minimal office skills. She has only learned Microsoft Word for a few months and stated she is "just ok" at it." Ms. Ormsby indicated Petitioner has limitations with returning to work. She opined that Petitioner was not qualified for any positions requiring any type of relevant work experience. She indicated Petitioner was unable to return to her original occupation with Respondent. She added that Petitioner earned $28.74 per hour at the time of injury and that now her wages are very limited. Ms. Ormsby concluded, "I feel Ms. Woodfork would have extreme difficulty finding gainful employment. There is no stable labor market available for her." (PX 13)

Petitioner testified that shortly after the Vocamotive assessment, she started computer training. She had no prior experience with computers and no internet access. She was able to do some basic internet activity through her mobile phone. She did not have experience with using a computer with the Microsoft operating system. In addition to keyboard training, Vocamotive began training her with Microsoft Word and Excel. Petitioner testified that she was able to type at the rate of 14 words per minutes. She indicated that most of her training was done over the internet indicating she only had actual face to face contact three to four times during

18IWCC0034

the entire time that she worked with Vocamotive. She testified that she missed some of her vocational meetings due to the death of two family members within one week in late January 2016. Her last contact with Vocamotive was in late February 2016 when she met with a Vocamotive employee named Adam. She asked Adam if he could change the time of their meetings so it would not interfere with her Wednesday morning Bible study. Petitioner testified that she normally attended between 10:00 AM and noon on Wednesday and had done so even while employed with Respondent. She testified that she did not receive any response to this request and that vocational services were terminated shortly thereafter. Petitioner provided that thereafter, her weekly benefits changed from $659.00 per week to $302.00 per week.

Petitioner testified that she has not had any injuries to the left shoulder or neck since July 9, 2013. She has not worked for any other employer since the date of injury. She testified that she spends most of her day at home, using a heating pad. While at home, she spends most of her time reading and watching television and occasionally sitting outside. She attempts to do the inside cleaning for as long as she can. The outside maintenance is performed by members of a church next to her home. If there is anything heavy that needs to be done, she will get assistance from one of her daughters. If she performs activities such as vacuuming she can only do that for seven minutes. She no longer performs yard work such as gardening. She spends little time with her grandchildren because of pain that she experiences. A girlfriend will come and visit approximately two times a month. She still attends Bible studies and Sunday services. These services last approximately an hour and a half. After church, she returns home, has dinner and watches television by herself. She takes approximately four 5 milligram Norco pills on a daily basis. She uses a heating pad regularly and occasionally use the compounding cream on the shoulder. She testified that she continues to have pain and numbness and tingling going from her neck down her left arm and into her fingers. Occasionally she notices a burning sensation as well.

Ms. Ormsby testified on behalf of Petitioner. She is a certified rehabilitation counselor and licensed clinical professional counselor. She has a master's degree in rehabilitation counseling. She performs vocational services for worker's compensation claims including vocational assessments, job placement, job development, transferable skills analysis, and labor market surveys. Approximately 98 to 99% of the time she is retained by insurance companies or defense attorneys. Ms. Ormsby provided that she performed a vocational assessment of Petitioner on April 5, 2016. She noted Petitioner to be a 59-year-old right-handed single female with a left upper extremity and cervical spine injury. She also reviewed a functional capacity evaluation performed on November 17, 2015 at ATI. She noted the assessment placed Petitioner at a light physical demand with limitations on balancing, bending, stooping, crawling, crouching and flexing the head and neck. There was also a limitation to a three-hour workday, which she believed to be significant. Lifting was limited to 13 pounds on the right and 10.8 pounds on the left on an occasional basis. Ms. Ornsby indicated occasional was defined as one to thirty three percent of the workday. She indicated that Petitioner's past work was at the heavy level and that she had no transferrable skills. She indicated that this lack of skills would limit Petitioner's chances of obtaining employment.

Ms. Ormsby also reviewed vocational testing that had been performed by Mr. James Boyd at the request of Vocamotive. She noted that per the testing, Petitioner's math level was at the 3.5 grade level, comprehension was at the 10.4 grade level and basic spelling was at the 7 grade level. She did not believe Petitioner was a great candidate for vocational rehabilitation services. She noted Petitioner was almost 60 years old, has been out of the work force for many years, had limited education and computer skills. Additionally, Ms. Ormsby testified that she did not believe there was a stable labor market available to Petitioner. She defined a stable labor market as one where there is abundance of jobs that she would be able to obtain. She indicated that it was conceivable that she might be able to find one employer to hire her but that did not constitute a stable labor market. A stable labor market would be one where there are many jobs available that she could go and be a viable or competitive candidate.

Ms. Ormsby also opined that Petitioner's age would be a significant factor against finding employment. She also indicated that being limited to a 3-hour workday would also make it difficult to find someone who would hire her for such limited hours. Ms. Ormsby also indicated that even if Petitioner could work 8 hours a day her opinion would not change, due to the factors previously identified. She further testified that if Petitioner had been referred to her she would not have recommended any training program. She also stated that Mr. Boyd's vocational testing provided her with enough information to support her opinion that Petitioner was not a candidate for vocational rehabilitation. She found it significant that Petitioner tested at a below average or borderline level in clerical and customer service testing.

Ms. Ormsby admitted that she had not reviewed the August 2015 functional capacity testing from Accelerated prior to rendering her opinion. On redirect examination she was given the opportunity to review the two reports from Accelerated/Rebound. (PX 5) She noted that the limitations outlined in the Accelerated FCE were more severe than those noted by ATI. She indicated that her review of the Accelerated FCE reports did not change her opinion in any way.

Respondent presented the testimony of Ms. Kari Stafseth. Ms. Stafseth is a certified rehabilitation counselor who has a Master's of Science in rehabilitation and counseling. She specializes is vocational assessments and the preparation of reports outlining prospectively employability and provides job training and job placement services. Ms. Stafseth testified that she performed an initial evaluation of Petitioner on December 1, 2015. She noted Petitioner was 58 years old at the time of the meeting and reported an injury to her left shoulder and neck. She had reviewed various medical records, including a September 4, 2015 report from Dr. Payne, Respondent's Section 12 examiner. According to Ms. Stafseth, Petitioner was a high school graduate but did not report any other education. Ms. Stafseth reported Petitioner indicated she could perform basic math and some experience using computer, using one finger to keyboard but no computer software skills. She also noted Petitioner's past work at the Fairview Nursing Home preparing and serving food, as well as two years of housekeeping at various hotels.

Ms. Stafseth testified that Petitioner did not have any transferrable skills but she believed that Petitioner was prospectively employable. She based that opinion on Petitioner's education, her work history and the restrictions that were outlined by Dr. Payne. She further stated that the job targets that would be available to her would include security guard, customer service representative, front desk clerk, office clerk and cashier. A vocational plan was drafted for Petitioner to undergo vocational testing to provide her with job seeking skill instruction, to develop computer literacy, evaluate any potential cost effective retraining, and facilitate the return to work within approximately 150 days after completion of training. The wage earning potential was identified in the range of $9.00 to $13.00 per hour. Ms. Stafseth indicated that the vocational testing was performed by Mr. James Boyd on February 28, 2016. She further testified that the focus on computer training was to have introductory skills to look for job openings, complete applications and send correspondence to perspective employers and make her a more marketable candidate. Ms. Stafseth testified that the plan was to provide Petitioner with computer training and then have her look for work. She provided that in the initial assessment, the training was to end on March 15, 2016. She indicated that when Vocamotive services ended, Petitioner had completed training in regard to Windows Operating System and had reached the second chapter of the Microsoft Word program. Ms. Stafseth testified that Petitioner did fall behind in her training schedule. When asked if she had an opinion as to whether Petitioner was cooperating with Vocamotive, Ms. Stafseth stated that Petitioner did not fully cooperate with the plan. She testified Petitioner did not maintain daily contact with her office, either by computer or telephone. She testified Petitioner was 20-days behind in her training near the end of her work with Petitioner. It was her opinion that had Petitioner kept up with it she would have been able to find employment. She further testified that she did not believe the vertigo would have any impact upon looking for work due to the fact the job search would be in the Rockford Metropolitan area. Finally she testified that if they had continued with the vocational rehabilitation, they could have placed Petitioner into employment.

18IWCC0034

On cross-examination Ms. Stafseth testified that Petitioner had fully cooperated during the initial assessment with her. She stated that she only had one other contact with Petitioner during the entire course of vocational rehabilitation. She also testified that it was not Vocamotive's recommendation to stop vocational rehabilitation services. Instead they had received a message from Liberty Mutual to terminate services. She provided that the restrictions that she relied upon in rendering her opinions were those that had been provided to her by Liberty Mutual as contained in Dr. Payne's Section 12 evaluation. Ms. Stafseth testified that she never reviewed the Functional Capacity Evaluations performed by Accelerated Physical Therapy and ATI Physical Therapy. She also testified that the jobs she identified in her initial assessment all required frequent handling, fingering, and use of the upper extremities.

In regard to the computer-training program, Ms. Stafseth indicated that the vast majority of their clients participate in some aspect of computer training. She also indicated it was standard practice at Vocamotive that the computer training begin before vocational testing is performed. She indicated that there were a variety of training programs available for Vocamotive clients. Some individuals would go through "fast track" programs, giving the individual the fundamentals of using a computer with basic data entry and features such as cutting and pasting. Other clients would go through each of the different office software programs. In Petitioner's case, the billed charges were for keyboarding, Windows, Word and Excel. Ms. Stafseth provided that the computer-training program was a self-directed distance learning program. She indicated Vocamotive had not arranged any type of class where Petitioner could receive one-on-one assistance although they do have an onsite instructor where clients can go into Vocamotive office in person.

Ms. Stafseth testified that a clerical job would require Petitioner to type twenty (20) to thirty (30) words per minute. She indicated that Petitioner's fastest level attained was eighteen (18) words per minute when the program was terminated by Liberty Mutual.

Finally, Ms. Stafseth was asked specific questions on the number of jobs available within the Rockford Labor Market. She agreed that since a Labor Market Survey had not been performed she had no idea how many jobs existed within each of the occupations she had identified in her initial report.

Respondent presented the testimony of David Dylak, an investigator of CoventBridge. Mr. Dylak testified that he had been hired by Liberty Mutual to perform surveillance on Petitioner. Ms. Dylak began surveillance at 12:09 PM on February 26, 2016, the same day that Petitioner underwent vocational testing with Mr. James Boyd. According to Mr. Dylak, Petitioner left her residence at 12:49 PM and returned home at 2:44 PM. Video surveillance taken depicts Petitioner entering a women's clothing store, a Wal-Mart Super Center, and a Dollar General store. (RX 23) On cross-examination, Mr. Dylak admitted he had no idea of how much the bags carried by Petitioner weighed nor did he have any idea of how she was feeling at the time.

Petitioner testified in response to the video. She indicated that after she terminated the vocational testing, she went home, took some medication and rested. She then received a call from a women's clothing store indicating that they had lay-away items that they were going to put back into stock unless she picked up. Petitioner indicated that she drove to the women's store, did some grocery shopping at a Wal-Mart Super Center. She could not recall if she actually did any shopping at the Dollar General Store.

In regard to (F.) "Is Petitioner's current condition of ill being casually related to the injury," the Arbitrator finds the following:

18IWCC0034

Respondent does not dispute causal relationship between Petitioner's left shoulder condition and the July 9, 2013 accident. The dispute on causal relationship pertains to whether Petitioner's cervical condition was related to the accident.

At the outset, the Arbitrator notes that there was no evidence presented of any medical treatment to the neck that pre-dated the accident. Petitioner testified that she did not have any problems with her neck or left shoulder before the July 9, 2013 work injury. There is no evidence of a pre-existing condition that was symptomatic before the injury at UPS.

A little over two months after the accident, Respondent sent Petitioner to Dr. Ira Kornblatt for a Section 12 evaluation. Dr. Kornblatt performed an evaluation of the cervical spine in addition to the left shoulder. Dr. Kornblatt reported that there was moderate limitation of motion in all directions with tenderness over the left posterior cervical region. Dr. Kornblatt was asked to opine on whether Petitioner had any pre-existing conditions and whether those pre-existing conditions were aggravated by the injury. Dr. Kornblatt replied as follows:

> "It is possible that she has degenerative disc disease of her cervical spine which may have been aggravated. If this was aggravated, I am unable to comment on whether this is a temporary or permanent problem due to the fact that there has not been any work-up of her cervical spine."

It is unknown whether or not this evaluation was provided to Petitioner. Yet, it is clear that Petitioner was not worked up for any cervical problems until August 4, 2014 when she was seen by Dr. Milos. At that time, Dr. Milos also noted that the range of motion of the neck was 75% of normal and that pain radiated into the left arm with a Spurling's maneuver. An MRI of the cervical spine performed on September 15, 2014 revealed cervical spondylosis and severe narrowing of the left C3-4 and C5-6 neural forminal. There were new sub end plate degenerative bone marrow signal changes at C5-6.

A few days later, Petitioner was sent to Dr. Timothy Payne for a Section 12 evaluation. In Dr. Payne's September 18, 2014 evaluation, he also noted limitations in the range of motion of the cervical spine. Petitioner complained of pain upon palpitation in the left paracervical area and the left scapular area. He noted a ½ centimeter of atrophy of the left forearm when compared to the right arm. She also had slightly decreased pinch on the left when compared to the right. Dr. Payne did not have the opportunity to review the actual cervical MRI. He did have a copy of the radiologist's report to review. In his report, Dr. Payne states the following:

> "1. Her diagnosis related to the alleged July 9, 2013 work injury is that she has resolved impingement syndrome of the left shoulder and cervical radicular pain secondary to foraminal narrowing of the cervical spine. The MRI demonstrates severe neural narrowing of the left C3-4 and C5-6 foramina, which correlate with her subjective complaints of neck pain going down the arm. These MRI findings pre-existed the injury in question, but were asymptomatic. While she was attempting to move the roller, this placed a torque/traction strain to the neck causing aggravation to the pre-existing changes at C3-4 and C5-6. This aggravation has not yet resolved. On my exam, there was ½ cm of atrophy of the left forearm compared to the right arm, corresponding to C3-4 and C5-6 nerve root involvement, as well as slightly decreased pinch on the left compared to right, consistent with C5-6 nerve root involvement.
>
> 2. She is at MMI for the shoulder, but has not reached maximum medical improvement for the aggravation of her pre-existing degenerative changes of the cervical spine due to her ongoing complaints, the MRI findings, and my exam findings. Timeframe for achieving MMI would depend on the course of treatment pursued.

18IWCC0034

3. She is not capable of returning to her regular activities as it relates to the alleged July 9, 2013 work injury. She can perform light duty activities with no overhead lifting with the left arm and no lifting more than 25 pounds. The exam findings and MRI findings preclude her from safely performing regular duty at this time.

4. Her work restrictions are related to the alleged work injury of July 9, 2013 based on the reported mechanism, lack of prior neck or radicular complaints and lack of subsequent injury.

5. The restrictions at this time are temporary because she has not reached MMI.

6. Duration of restrictions depends on the course of treatment pursued.

7. Her complaints are based on her alleged work injury of July 9, 2013. As noted, she does have pre-existing degenerative changes at the C4-5 and C5-6 levels, but these findings were asymptomatic prior to the alleged work-related injury on July 9, 2013 and were aggravated based on the mechanism of injury and her ongoing complaints and examination findings which correlate with her MRI findings.

8. Because MMI has not been reached, an AMA rating cannot be given at this time."

Petitioner was seen by Dr. Todd Alexander, a neurosurgeon, on October 30, 2014. While Dr. Alexander, unlike Dr. Payne, seemed skeptical of the severity of Petitioner's pathology, he recommended a course of physical therapy for cervical traction and other active and passive modalities. The records reveal that Respondent submitted Dr. Alexander's physical therapy prescription for utilization review. The reviewer, Dr. Jonathan Waldbaum of the Medical Review Institute of America, concluded that physical therapy prescription was not medically necessary. As a result thereto, Respondent refused to authorize this treatment. The records also reveal that because of this refusal, Dr. Alexander refused to see Petitioner in follow-up. Petitioner was seen by Dr. Milos on December 29, 2014. He reiterated the need for the physical therapy recommended by Dr. Alexander. This was not authorized by Respondent. The neck was re-evaluated by Dr. Michael Roh, a spine surgeon, on March 26, 2015. He diagnosed possible left-sided C6 radiculopathy and significant left shoulder pain. He referred Petitioner to Dr. Marie Walker for an EMG that was eventually performed and reported to be negative. Dr. Roh then referred Petitioner to Rockford Pain Center where a selective nerve block was recommended but rejected by Petitioner.

Dr. Payne re-evaluated Petitioner on August 18, 2015. Petitioner's evaluation was improved when compared to his report approximately one year earlier. The ½ cm. atrophy apparently resolved despite the lack of medical care. Dr. Payne diagnosed cervicalgia and stated that the work injury had only caused a temporary aggravation. The Arbitrator notes that when Dr. Payne evaluated Petitioner for the first time, it had been fourteen months since the original injury. It seems peculiar that if the accident had only caused a temporary aggravation of a pre-existing cervical condition, one would have expected it to resolve well before Dr. Payne's first evaluation.

Based upon Dr. Kornblatt's October 10, 2013 report and Dr. Payne's initial report from September 30, 2014, along with Petitioner's testimony regarding the ongoing complaints of pain and numbness in the neck and left arm, the Arbitrator finds a causal relationship between Petitioner's cervical condition and the accident of July 9, 2014.

In regard to (J.) "Has Respondent paid all appropriate charges for all reasonable and necessary medical services," the Arbitrator finds the following:

Petitioner submitted a number of charges at the time of the hearing. After reviewing the statements, as well as the medical records contained in the file, the Arbitrator finds as follows:

Provider	Date of Service	Amount	Determination
Dr. Koepsell	5/9/16	$ 115.00	Denied – unclear what body part treated
Swedish American Medical Group	3/1/14	$ 64.08	Awarded – billing statement indicates that services were pursuant to a referral Dr. Milos. Pre-op evaluation prior to 3/7/14 surgery.
Swedish American Hospital	7/29/13	$1,502.48	Awarded. Left shoulder MRI performed 20 days post accident. Service is reasonable and necessary and related to injury.
Swedish American Hospital	3/7/14	$1,439.27	Awarded. Balance remaining after left shoulder surgery.
Out of Pocket/Dr. Koepsell	11/2/15	$ 48.00	Denied – a review of Dr. Koepsell's note indicates the visit was for completing disability forms. No treatment rendered.
Out of Pocket/Prescription	4/13/15	$ 39.41	Awarded – narcotic pain medication prescribed by Dr. Koepsell

The Arbitrator finds that the bills awarded above are causally related to the accident of July 9, 2014. All awarded treatment is reasonable and necessary. All bills awarded shall be paid pursuant the Workers' Compensation Fee Schedule. Respondent shall hold Petitioner harmless from any reimbursement claim made by an employer provided group insurance medical plan.

In regard to (K.) "What temporary benefits are in dispute? Maintenance, TTD," the Arbitrator finds the following:

It is undisputed that Petitioner was temporarily totally disabled from October 22, 2013, through December 8, 2013. It is further undisputed that Petitioner returned to light duty work and again became temporarily totally disabled beginning February 28, 2014.

Petitioner underwent left shoulder arthroscopic decompression and distal clavicle excision on March 7, 2014. Post-surgery, Petitioner was off work and undergoing physical therapy. Her treating physician, Dr. Milos, noted Petitioner's progress was complicated by her fibromyalgia and back pains. By June 2, 2014, Dr. Milos

18IWCC0034

noted Petitioner's complaints of left arm numbness and tingling down to her fingers. On July 7, 2014, Dr. Milos released Petitioner to work with a twenty-five (25) pound lifting restriction. He also felt it appropriated to transition her into a work hardening program. Petitioner had approximately ten work hardening visits.

On August 4, 2014, Dr. Milos noted Petitioner was experiencing significant neck pain and prarthesias down the left arm which was preventing progression in the therapy. A cervical MRI was ordered which when completed on September 15, 2014 demonstrated cervical spondylosis redemonstrated without spinal cord compression. There was severe narrowing of the left C3-4 and C5-6 neural foramina redemonstrated. Also noted were new subendplate degenerative bone narrowing signal changes at C5-6.

Thereafter, Respondent had Petitioner undergo a Section 12 examination with Dr. Timothy Payne on September 18, 2014. Dr. Payne opined that Petitioner's related diagnoses were resolved impingement syndrome of the left shoulder and cervical radicular pain secondary to foraminal narrowing of the cervical spine. He provided that the incident caused an aggravation to the pre-existing changes at C3-4 and C5-6. Dr. Payne opined that Petitioner was at maximum medical improvement for the shoulder, but had not reached MMI for the aggravation of her pre-existing degenerative changes of the cervical spine. He felt that she was not capable of her regular activities indicating she was restricted to light duty activities of no overhead lifting with the left arm and no lifting greater than 25 lbs.

Petitioner continued under the care of various treators. All of which placed her on some form of light duty work status. On January 26, 2015, Dr. Milos released Petitioner from his care with restrictions, albeit recommending continued physical therapy.

Petitioner, through referral, saw Dr. Freeman on May 5, 2015. The doctor suggested performing a C6-7 selective nerve root injection on the left side. Petitioner opted not to proceed with the recommendation indicating she "...didn't want to take chance on [injury] of the neck."

Petitioner completed the first of two functional capacity evaluation on August 28, 2015 (The first was aborted on July 27, 2015). Although Petitioner was deemed to have demonstrated the physical capabilities and tolerances to function at the light physical demand level, it was noted that Petitioner demonstrated an inconsistent performance/unacceptable effort. Petitioner was not offered any employment by Respondent and she continued to receive temporary total disability benefits.

At Respondent's request, Petitioner was re-evaluated by Dr. Payne. In his report dated September 4, 2015, Dr. Payne opined that Petitioner's aggravation to the pre-existing changes at C3-4 and C5-6 had resolved. He indicated she had no restrictions with regard to her cervical spine and was at maximum medical improvement. Dr. Payne also opined status post shoulder subracromial decompression for impingement. Dr. Payne opined that Petitioner was unlikely to show any further improvement with regard to shoulder function and permanently restricted her to light duty work with no heavy lifting overhead with left arm and no lifting more than 25 pounds with the arm.

At Respondent's request the Triune Health Group conducted a vocational assessment of Petitioner. On September 25, 2015 it was determined Petitioner could return to work in the following types of jobs: surveillance systems monitor, escort/vehicle driver, telephone solicitor, cashier, customer service clerk, routing clerk, front desk clerk, appointment clerk, or information clerk. The salaries ranged from $22,700.00 to $37,930.00.

At her attorney's request, Petitioner underwent a functional capacity evaluation on November 17, 2015. The assessment was deemed valid indicating Petitioner demonstrated functional capabilities most consistent with a light physical demand level. Thereafter, Respondent switched vocational rehabilitation services from

18IWCC0034

Triune to Vocamotive. The initial evaluation conducted by Ms. Keri Stafseth occurred on November 25, 2015. On December 1, 2015, Ms. Stafseth authored a report indicating Petitioner fully cooperated with all aspects of the interview. Ms. Stafseth noted that Petitioner was considered a "Person of Advanced Age" which would significantly affect her ability to adjust to other work. She opined that Petitioner lost access to her usual and customary job and occupation of an Air Handler and Sorter. She opined that Petitioner was employable indicating the job targets most probably available would include; security guard, customer service representative, front desk representative, clerk and cashier. She opined that Petitioner's most probable earning capacity would range from $9.00 to $13.00 per hour. Petitioner began participation with Vocamotive's rehabilitation services on December 3, 2015.

On December 17, 2015, Petitioner met with Respondent about job accommodation. On January 29, 2016, Respondent informed Petitioner that her work limitations would not be accommodated.

Respondent terminated the vocational services in March 2016. Petitioner testified that after the services were terminated her weekly benefits changed from $659.00 per week to $302.00 per week.

Petitioner initially claimed to be temporary totally disabled from October 22, 2013 through May 5, 2015, representing a total of 132-3/7 weeks. Respondent disputed that claim and indicated Petitioner was temporary totally disabled from October 22, 2013, through December 8, 2013 and from February 28, 2014 through October 17, 2015. The Stipulation Sheet also indicates Respondent is claiming credit for maintenance/Section 8(d)1 payments paid for the period of 18-6/7 weeks from October 8, 2015 through October 23, 2015. Said period does not correspond to that number of weeks stated. Although neither party offered a payment log of specific benefits that were paid by Respondent, it appears that the above referenced dates should have reflected payments from November 18, 2015 (the day after Petitioner underwent a functional capacity evaluation performed at ATI Physical Therapy) through February 26, 2016 (the date Petitioner stated she experienced difficulty tolerating the vocational testing session and opted to go home).

Based on all the above, the Arbitrator finds that Petitioner was temporarily and totally disabled for the periods of October 22, 2013 through December 8, 2013 and from February 28, 2014 through November 17, 2015.

In regard to (L.), What is the nature and extent of the injury, the Arbitrator finds the following:

With regard to nature and extent, the Arbitrator incorporates the findings previously noted above.

The Arbitrator notes that the parties both submitted evidence with regard to Petitioner's ability to return to work. Petitioner argues that she is entitled to a finding of permanent total disability under the odd-lot theory. It is clear that all of the practitioners in this matter are of the opinion that Petitioner is unable to return to her prior occupation with Respondent as an Air Handler and Sorter. However, the Arbitrator is not persuaded that her attempts to cooperate and give full effort with her vocational rehabilitation were in good faith. Simply put, Petitioner lacks credibility and the evidence does not support an award of an odd lot perm total. The evidence specifically includes Petitioner's testimony which was contradicted by the surveillance video. Petitioner met with vocational counselor Jim Boyd on February 26, 2016 at her attorney's office for vocational testing. Petitioner reported that she became ill. Mr. Boyd noted his observations of Petitioner on that day in his report of March 15, 2016. At 10:00 a.m. she reported losing concentration and was starting to get a headache. At 10:15 a.m. she wanted to just sit with her eyes closed. At 11:10 a.m. she reported a headache and took a break to walk around the room. At 11:37 a.m. she reported dizziness and headache. At 11:45 a.m. she reported a level 8 right shoulder pain with increased headache and dizziness. In order to get the all-day testing done, Mr. Boyd offered Petitioner the following three (3) options; 1.) rest at the office and continue; 2.) have lunch to see if she feels well enough to continue; and 3.) she could go home. Petitioner opted to go home. Petitioner

18IWCC0034

testified that she felt really bad and went home. She specifically testified she did not leave her house and rested the entire day at home. Surveillance evidence taken the same day shows the contrary. She is seen on video surveillance attending three different stores. Petitioner testified in response to the video. She indicated that after she terminated the vocational testing, she went home, took some medication and rested. She then received a call from a women's clothing store indicating that they had lay-away items that they were going to put back into stock unless she picked up. Petitioner indicated that she drove to the women's store, did some grocery shopping at a Wal-Mart Super Center. She could not recall if she actually did any shopping at the Dollar General Store. Records submitted show she was meeting with Jim Boyd at 11:45 a.m. when he recorded his last observation of her claimed illness and then was shown leaving her house about at 12:53 p.m., one hour and eight minutes later. The video clearly brings into question Petitioner's credibility.

Petitioner's medical records wherein her treators noted that she is not motivated to return to work and feigned symptoms is disconcerting. The Arbitrator is troubled that Petitioner told her treators that she would never return to work again. She asked her treating surgeon, Dr. Milos, to issue a report indicating she was disabled. He refused to do that based on her inconsistent effort with her FCE. She asked Dr. Koepsell, her family doctor, for a handicapped placard for her car which he refused to give her. Her treator, Dr. Alexander, noted that returning Petitioner to work will be "extremely challenging" as she is not motivated to return to work and has already admitted that she likely will never return to work. He further noted that Petitioner has exaggerated pain behaviors. Specifically, that she avoids moving her neck actively for reasons which appear to be non-physiologic. He also noted that her motor strength testing requires encouragement as she feigns weakness.

Lastly, Petitioner had an FCE at Accelerated Rehabilitation the same facility where she had her physical therapy and work hardening. The FCE was deemed not valid for inconsistent behavior. Following that, her own shoulder surgeon could not give her a disability rating because of the inconsistencies.

The Arbitrator finds that Petitioner failed to prove that she is permanently and totally disabled under Section 8(f) of the Act.

Under § 8(d)(1) Reviewing courts have stated that the Commission is without discretion in awarding 8(d)(1) benefits where a claimant has proved that he or she is entitled to a wage differential award unless the claimant explicitly waives the right to an award under §8(d)(1). Gallinetti v. Industrial Comm'n, 315 Ill. App.3d 721, 248 Ill.Dec 554 (2000).

To qualify for a wage differential award, the claimant must prove:

(1) Partial incapacity which prevents him from pursuing his "usual and customary line of employment," and

(2) An impairment of earnings. Albrecht v. Industrial Comm'n, 271 Ill. App.3d 756, 208 Ill.Dec. 1 (1995).

In the present case, there is no dispute that Petitioner could not return to her usual and customary line of employment at any point in time. Both vocational experts indicated that she had lost her ability to perform her work at Respondent. This preclusion of employment existed whether one used the restrictions of Dr. Koepsell and the limitations contained in the FCEs, or the Dr. Payne's Section 12 exam that allowed lifting up to 25 pounds. Therefore, the Arbitrator finds Petitioner has met the first prong of entitlement to a wage differential award.

The Arbitrator turns to the question of impairment of earnings. Vocational expert Ormsby did not render an opinion on what Petitioner could currently earn since she believed Petitioner was not employable and

no stable labor market existed. Ms. Stafseth testified that she believed Petitioner was employable in the range of $9.00 to $13.00 per hour. While actual earnings in an alternate job can be relevant to an 8(d)(1) award, there is no requirement of a job search to obtain a wage differential. Gallianetti v. Industrial Comm'n 315 Ill. App.3d 721, 248 Ill.Dec. 554 (2000). The amount of a wage differential award is set based upon earnings of the date of hearing. United Airlines v. Illinois Workers' Compensation Comm'n, 203 Ill.App. 121136 WC, 3782 Ill.Dec. 151 (2013).

The parties stipulated the wage rate at the time of arbitration was $29.24 per hour. Using the average between the rates ($11.00) identified by the vocational expert, the Arbitrator determines that Petitioner has sustained a wage loss of $18.24 per hour. This would equate to a weekly wage loss of $729.60. Two-thirds of this amount would be $486.40 per week.

Respondent argues that Petitioner is entitled to a wage differential based on the average hours worked during the year before the accident. It bases its argument on the fact that Petitioner worked a "combo job." Petitioner offered Exhibit 18, which is an excerpt from the collective bargaining agreement between the Teamsters and Respondent. That document supports the fact that Petitioner was treated as a full time employee despite the fact that she was doing the combo job. Her check stubs also support the fact that for payroll purposes she was treated as if she was doing one job. There was no separate breakdown for hours worked in each job. She was paid the negotiated hourly rate for the actual hours worked. Case law also supports payment of a wage differential on a 40 hour week. In Forest City Erectors v. Industrial Comm'n, the Appellate Court rejected the contention that a wage differential was to be based on the actual wages earned before the date of the accident. The employer contended that wage records showed Petitioner was a "part-time" ironworker and therefore, the wage loss could not be based on a 40 hour week. The Court noted that Section 8(d)(1) clearly states that the weekly payment is based on the difference between that amount Petitioner would earn in the full performance of the duties of the occupation he was engaged in at the time of the accident and the amount he is earning or is able to earn in some suitable employment or business after the accident. Forest City Erectors v. Industrial Comm'n, 264 Ill. App. 3d 246, 201 Ill. Dec. 537(1st Dist 1994). See also Greaney v. Industrial Comm'n, 358 Ill.App. 3d 1002, 295 Ill.Dec. 180 (1st Dist. 2005) and Enrique v. Burch Services, 14 IWCC 187.

Based on the above, the Arbitrator finds that Respondent shall pay Petitioner permanent partial disability benefits, commencing November 18, 2015, at a rate of $486.40 per week under Section 8(d)1 of the Act.

18IWCC0034

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ 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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Emmett Lannon,

Petitioner,

vs. NO: 16 WC 14849

S & C Electric Company,

18IWCC0035

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Respondent and notice provided to all parties, the Commission after considering the issues of accident, causal relationship, medical expenses and prospective medical care and being advised in the facts and the law reverses the Decision of the Arbitrator.

STATEMENT OF FACTS

At the October 19, 2016 hearing, Petitioner testified in that May of 2016, he worked for Respondent and had been so employed for 30 years as a general machinist. T. 17. His job duties consisted of running different machines: a drill press, an automatic press and Iron Worker to fabricate parts for electrical equipment. T. 17-18.

Petitioner testified on May 2, 2016 he reported to work at 3:00 p.m. for a 4:00 p.m. start time to work on the drill press and Iron Worker machines. T. 18-19. The Iron Worker is a machine which punches round holes of varying sizes into steel by utilizing one lever to hold the part and a second lever to punch the necessary hole. T. 19-20. Petitioner testified the levers weighed approximately 15 to 20 pounds when being pulled downward, and he pulled the levers between 100 and 200 times a day depending on the jobs performed. T. 20.

Petitioner testified as to how he was injured on May 2, 2016: "I had a part in my hand and I put it in, held it there, pulled the first lever down and it claims the part in. Then you take the other lever and you pull it down and it will catch the punch and it pushes through the steel. So I done the first one. I moved over the second one, I hung it there and when I reached down to pull the lever down for the second, for the second hole, something popped in my shoulder." T. 21.

Petitioner identified two photographs PX7 and PX8 which depicted the Iron Worker. T. 22. The Commission notes PX7 and PX8 are photographs of the same machine but at different side perspectives. Petitioner identified PX8 and described the levers: 1) the lever on the right is pulled down to hold the part between the punch and the dye and 2) the lever on the left is pulled down to make the punch into the part. T. 23. Petitioner identified the lever on the left as being utilized when he felt the pop in his left shoulder. T. 24. Petitioner testified when he initially felt the pop in his left shoulder, his left arm was positioned above his head and his left hand was on the lever on the left. T. 25. Petitioner demonstrated with his left arm, which was noted to be below shoulder level. *Id.* He then demonstrated with his right arm, which was almost fully extended. T. 25-26. Photograph PX8 also depicted a chair in front of the Iron Worker machine which Petitioner explained allows the operator to sit in front of the machine, line up the part for punching, and then reach up above his head to pull the levers down. T. 26-27. When working the Iron Worker machine, Petitioner was in a seated position. T. 27.

Petitioner testified after he felt the pop in his left shoulder, he threw the part on which he was working into the tub and cried "my arm, my arm." T. 27. Petitioner testified he felt a stabbing pain and instability and immediately reported this incident to his boss, Sidney Bolton. T. 28.

Petitioner testified he sought medical treatment from St. Francis Hospital complaining of severe pain in his left shoulder. T. 29. At the hospital he underwent x-rays, was placed in a sling, provided Norco for pain, and provided work restrictions of right-handed work only which was accommodated by Respondent. T. 29-30. Two days later, Petitioner sought treatment from his primary care physician, Dr. Farby who referred Petitioner to an orthopedic physician. T. 30-31.

Thereafter on May 10, 2016, Petitioner sought treatment from Dr. Silver, an orthopedic specialist. T. 31. Petitioner testified he presented to Dr. Silver with his MRI results which Dr. Silver reviewed and diagnosed a torn rotator cuff tear. T. 33. Dr. Silver recommended physical therapy which Petitioner attended as well as work restrictions. *Id.* During Petitioner's June 6, 2016 re-evaluation, Dr. Silver administered an injection which alleviated Petitioner's pain for approximately two weeks. T. 34-35. Petitioner testified Dr. Silver re-evaluated him on June 23, 2016 as well as in September of 2016, and during both those visits, Dr. Silver recommended a further injection, continued physical therapy, surgery, and one-handed work restrictions. T. 36-37. Petitioner testified he continues to attend physical therapy three times per week, and his shoulder continues to cause him problems. T. 37.

18IWCC0035

Petitioner testified at Respondent's request, on August 26, 2016 Dr. Atluri evaluated him. T. 38. During the examination, Petitioner provided a history and advised his left arm hurt and felt loose. *Id.* Petitioner testified prior to May 2, 2016, he did not suffer any injury to his left shoulder nor experience any problems relating to his left arm. T. 39.

On cross-examination, Petitioner testified he has been employed by Respondent for approximately 30 years. T. 40-41. For the last 25 years, he has been performing the same type of work as a general machinist. T. 41. He has operated the Iron Worker machine for about 20 years with a non-functioning foot pedal for the last 10 or 15 years. *Id.* Petitioner identified PX8 which depicted the two lever handles and the chair. T. 41-42. The left handle lever, Petitioner operated with his left arm, and the right handle lever, he operated with his right arm. T. 42. Petitioner identified RX6 and RX7 as photographs of Lawrence operating the Iron Worker machine. T. 43. Petitioner testified the photographs depict how he would operate the machine. *Id.*

Petitioner testified to knowing Sidney Bolton for approximately four or five years and identified him as "one of the best people in the company." T. 46. Mr. Bolton heard Petitioner cry out in pain but did not witness the injury as his work station is behind Petitioner's. *Id.* Mr. Bolton asked Petitioner about the circumstances of the injury and helped Petitioner to the medical department. T. 47.

Petitioner testified St. Francis Hospital personnel obtained a history from him, but he denied telling St. Francis Hospital personnel he was bending over to reach an item when he heard a pop in his left arm. T. 49. Thereafter, Petitioner returned to work, but he was unable to work and was sent home. *Id.*

Petitioner testified Respondent offers a medical clinic staffed by nurses. T. 49-50. Petitioner knows Kathleen Clawson, who is one of the nurses at Respondent's medical department. T. 50. On May 3, 2016 at 10:00 a.m., Petitioner participated in a phone conversation with Kathleen Clawson. *Id.* Petitioner was shown a written memorialization prepared by Ms. Clawson of the conversation. T. 51. Ms. Clawson's memorandum indicated Petitioner advised her that he was transferring a part from one hand to another when all of a sudden, he could not lift his arm; Petitioner denied saying this to Ms. Clawson. T. 51-52. Petitioner testified during the phone conversation, he advised Ms. Clawson he and his supervisor, Sidney Bolton would meet with her. T. 52. Thereafter, Petitioner and Mr. Bolton met with Ms. Clawson. Petitioner also met privately with Ms. Clawson and denied that she questioned him as to how the injury occurred. T. 54.

Petitioner testified he was provided with modified work, right hand work only, and he continues to perform such work which includes laying out parts, retrieving tools from Building One and assisting in training others on how to operate the machines. T. 55.

Petitioner testified Dr. Silver initially evaluated him on May 10, 2016. T. 56. Petitioner denied telling Dr. Silver he felt pain when reaching for the lever as he felt such pain when pulling the lever. Id. Petitioner testified the force involved in pulling the lever down is dependent on the weight of the part; the heavier the weight of the steel, the more effort used in pulling the lever. T. 57. Petitioner agreed on the date of accident, he worked on a part weighing one pound, and prior to the accident, he completed 21 of 22 parts. T. 57-58.

Petitioner testified he did not know if Dr. Silver advised him at one-point that his shoulder condition was inoperable. T. 58. Petitioner denied telling Ms. Clawson how he injured himself. *Id.* Petitioner was asked and answered: "Q. Did you ever tell Mr. Bolton here that you were reaching up for the lever when you heard the pop? A. No, I told him I had my hands on the lever, I was pulling it down." *Id.*

Sidney Bolton testified on behalf of Respondent. Mr. Bolton testified he is employed by Respondent and has been so for 20-plus years. T. 66-67. His current position with Respondent is senior team leader, and he has been so for six years. T. 67. He is the senior team leader for Petitioner who has worked under his direction for two years. *Id.* Mr. Bolton provided Respondent's attorney with photographs RX6 and RX7. T. 68. On May 2, 2016, Petitioner was working on the Iron Worker machine which is the same machine depicted in PX7, PX8, RX6 and RX7. *Id.* That day Petitioner was running part CU1552, which weighed one pound. *Id.* The order was for was 22 pieces of which Petitioner completed 21 pieces. T. 68-69.

Mr. Bolton identified Mr. Lawrence Collins as the person depicted in the photographs and confirmed Mr. Collins was taller than Petitioner. T. 69. Mr. Bolton testified the chair was adjustable to account for differences in machinists' height. T. 69-70. Mr. Bolton testified he used the levers from the Iron Worker machine, and the force required to pull the levers was one to two pounds, minimum as such levers could be pulled utilizing only two fingers. T. 70.

Mr. Bolton testified he did not witness Petitioner's injury as his work station is behind the Iron Worker machine. T. 70-71. Mr. Bolton remembered hearing Petitioner scream at which point Mr. Bolton offered him assistance. T. 71. Mr. Bolton transported Petitioner to the health department. T. 71-72. Thereafter, Petitioner returned to work, and Mr. Bolton sent him home. T. 72.

Mr. Bolton testified Petitioner returned to the department the following day, May 3, 2016. T. 73. Mr. Bolton asked Petitioner how the injury occurred, and Petitioner advised, "He was reaching for the lever and he heard a pop." *Id.* Mr. Bolton and Petitioner met with Kathleen Clawson at health services. *Id.* To his knowledge, Ms. Clawson and Petitioner had a conversation, but Mr. Bolton was outside the door during this conversation. T. 74. After Petitioner and Ms. Clawson concluded their conversation, Ms. Clawson asked Mr. Bolton to take her to the equipment, and he complied. *Id.* Ms. Clawson utilized the levers on the Iron Worker machine. *Id.* Mr. Bolton returned to health services with Ms. Clawson. T. 75. To Mr. Bolton's understanding, Petitioner and Ms. Clawson had a disagreement during their

conversation. *Id.* Mr. Bolton testified Petitioner continues working restricted duty. T. 76. Petitioner's restricted duties consist of entering data into a computer, transporting parts, drills, mills from Building One to Building 18, assisting operators with retrieving needed parts and training other employees on how to lay out or set up equipment. *Id.*

On cross-examination, Mr. Bolton testified his job duties as senior team leader include: writing reviews, making sure the parts needed to keep lines flowing are produced, resolving any employee disputes, meeting with senior managers to determine what is needed in the department. He is also in charge of safety, and he is on the emergency response team in the event of an emergency at the company. T. 77-78. Mr. Bolton is not involved in the operation of the heavy machinery. T. 78. Mr. Bolton confirmed he did not witness Petitioner's incident. *Id.*

Mr. Bolton testified during the past two years, Petitioner did not complain of any shoulder pain or injury. T. 81-82. At the time Petitioner was injured, he was working on the Iron Worker machine, which required him to pull a lever down. T. 82. At the very least, an operator of the Iron Worker machine uses both levers to operate it, including the lever on the left side. T. 83. The left lever activates the punch. *Id.* An employee would have to pull the left lever down for each part that they are punching a hole into. *Id.* Respondent's workers would complete this movement multiple times a day, probably over 100 times in a 10-hour shift. *Id.* At some point on May 2, 2016, Petitioner began to complain of pain, and Mr. Bolton responded to that complaint and directed him to the medical department because he believed Petitioner was in pain. T. 84.

Mr. Bolton testified he was present during the meeting between Petitioner and Ms. Clawson. T. 86. After the meeting, Mr. Bolton confirmed he and Ms. Clawson examined the Iron Worker machine without Petitioner. T. 86. Mr. Bolton agreed Petitioner knows how to use the Iron Worker machine. *Id.* Mr. Bolton did not see the exact position of Petitioner's arm when he was injured. T. 87. Petitioner advised Mr. Bolton as to how he injured his arm-reaching for the lever. *Id.* That lever would be at least level or above Petitioner's head, so that would mean his arm was at least level or above his head. T. 87-88.

On re-direct examination, Mr. Bolton testified he knows how the Iron Worker machine functions. T. 88. Mr. Bolton has witnessed Petitioner operate the Iron Worker machine. *Id.* Mr. Bolton did not see how Petitioner operated it at the time of his injury, but has seen him operate it on multiple other occasions. T. 88-89. When Petitioner operates the Iron Worker machine, he has his hands in a similar position as Mr. Collins. In looking at the photograph of Mr. Collins RX6, his arm is level to his shoulder, but his hand is above his head, consistent with how Petitioner operates the machine. T. 89.

On re-cross examination, Mr. Bolton reviewed RX6 and RX7 and testified Petitioner's arms would be in a similar position as those depicted in the two photographs; the arms do not have to be in the exact same position and could be a little bit higher, and the machine could still be used. T. 90. Mr. Bolton explained to operate this machine, a piece of metal is placed in the

opening that is depicted in the photograph and is centered, therefore, the operator needs to look at the part. T. 91.

Kathleen Clawson testified on behalf of Respondent. Ms. Clawson testified she is employed by Respondent as manager of health services and has been so for the last three years. T. 95-96. She manages Respondent's medical clinic, which treats approximately 5,000 occupational and personal visits a year, including short-term disability, workers' compensation, FMLA, ADA and any kind of medical issue related to work. T. 96. She has a nursing undergraduate degree and a master's degree in nursing and is certified in occupational health, case management and life care planning. *Id.* Respondent has 1,800 employees in Chicago. T. 97. There are two full-time nurses, a part-time nurse and an administrator at the clinic. T. 97-98. There is also a medical director who is a physician. T. 98. Danielle Woods is an occupational health nurse at the clinic. *Id.* First aid is treated at the clinic; security takes employees to the occupational health clinic; St. Francis Hospital is the emergency room used. T. 99. Her hours are 7:00 a.m. to either 6:00 p.m. or 7:00 p.m. *Id.* There are two shifts at Respondent: 7:00 a.m. to 3:30 p.m. and 9:30 p.m. to 6:00 a.m. *Id.*

Ms. Clawson identified RX2 and described the document as the electronic medical record documenting an employee's visit to the clinic. T. 100. If an injury is reported during working hours, it is memorialized in the electronic medical file. T. 101. Ms. Clawson testified she initially spoke with Petitioner on May 3, 2016 by phone which she documented in her notes. *Id.* Ms. Clawson testified Petitioner advised her he felt a sudden onset of pain while moving a part. T. 102. Later the same day, Petitioner presented to health services with Mr. Bolton. *Id.* Ms. Clawson testified she spoke with Petitioner in her office, and Mr. Bolton was not present. T. 103. During the conversation, Ms. Clawson asked Petitioner how his injury occurred. Petitioner advised her that he was transferring a part consistent with her prior telephone conversation with him. *Id.* Following the conversation, Ms. Clawson and Mr. Bolton examined the machine, and Ms. Clawson sat on the chair and operated the levers. T. 103-104. Ms. Clawson identified RX6 and RX7 and testified her arms were in the same position when operating the machine as depicted in the photographs. T. 104. Ms. Clawson testified it was not difficult to pull the lever and pulling did not stress her rotator cuff. T. 105.

Ms. Clawson testified she met with Petitioner and offered him light duty work. T. 105. Ms. Clawson also advised Petitioner that as a preliminary decision, his claim was denied but an internal investigation would be undertaken. T. 106. Ms. Clawson identified RX5 which contained denial letters to certain providers. *Id.* Ms. Clawson testified Dr. Atluri evaluated Petitioner at her request and issued two reports. T. 107.

On cross-examination, Mr. Clawson testified as manager of health services, she is not involved with the actual manufacturing of any sort of parts and is not involved with operating machinery at the factory. T. 109. Ms. Clawson is part of the ergonomics team which evaluates job sites based on force. T. 110. Ms. Clawson has observed another employee operating the Iron Worker machine. *Id.* Ms. Clawson acknowledged when she operated the machine, she was

18IWCC0035

not fabricating a part as there was no metal piece inside the Iron Worker. T. 111. Prior to May 2, 2016, Ms. Clawson testified she had not witnessed Petitioner operating the Iron Worker machine and did not know the exact positioning of his arm was in while operating it. T. 112-113.

Ms. Clawson testified Petitioner sought treatment from St. Francis Hospital on May 2, 2016. T. 115. Ms. Clawson acknowledged as of May 3, 2016, she had not reviewed any St. Francis Hospital medical records. T 115-116. Ms. Clawson acknowledged as of May 3, 2016, her decision to deny the claim was based on the mechanism of injury, but a further investigation would be undertaken. T. 116.

The records from Respondent's clinic were offered into evidence as Respondent's Exhibit 2 (RX2). The notes evidence on May 3, 2016 at 9:58 a.m., Danielle Woods noted Petitioner had a chief complaint of left shoulder injury and was sent to St. Francis for treatment. The notes further memorialized the receipt of an e-mail from Mr. Bolton regarding the circumstances surrounding the injury. The notes evidence on May 3, 2016 at 10:00 a.m., Kathleen Clawson memorialized a telephone conversation with Petitioner. The notes evidence on May 3, 2016 at 4:47 p.m., Kathleen Clawson noted Petitioner had a chief complaint of left shoulder injury. Ms. Clawson memorialized her meeting with Mr. Sidney Bolton as well as with Petitioner. The note also memorialized Ms. Clawson's inspection of the Iron Worker machine. RX2.

The medical records of Presence St. Francis Hospital were offered into evidence as Petitioner's Exhibit 2 (PX2). Petitioner presented to the emergency room and provided a history of injury which was memorialized as follows: "Patient reports that he was bending over to reach an item and heard a pop in the left arm." Petitioner reported pain in moving his left arm. X-rays were obtained which revealed degenerative changes at the acromioclavicular joint and "a high riding humerus suggesting chronic rotator cuff injury." Petitioner was discharged with a sling and advised to follow-up with his primary care physician. PX2.

The medical records of Orthopaedic Specialists- Dr. Ronald Silver were offered into evidence as Petitioner's Exhibit 3 (PX3). On May 10, 2016, Dr. Silver evaluated Petitioner and noted the following history: "Emmett was working at Essency Electric and was working on his machine. He reached up to grab a lever to pull down and felt severe pain occur in his left shoulder on May 2, 2016." On examination, Dr. Silver found tenderness over the rotator cuff insertion anterolaterally with sub acromial crepitation; forward flexion of 90 degrees; lateral abduction 70 degrees; internal rotation to the back pocket; positive impingement, Hawkins and drop arm tests. X-rays were reviewed and were noted to be within normal limits. Dr. Silver ordered physical therapy, a left shoulder MRI, prescribed Norco for pain, and placed Petitioner on light duty with no use of the left arm. PX3.

18IWCC0035

On May 17, 2016 denial of claim letters were issued to all medical providers by Respondent's Health Services. The letters advised workers' compensation benefits were denied, and invoices for services should be referred to Petitioner's group health and wellness plan. RX5.

The medical records of Lincolnwood Rehabilitation Center records were offered into evidence as Petitioner's Exhibit 5 (PX5). Petitioner was initially evaluated on May 18, 2016 and provided the following history: "Mr. Lannon presents today with left shoulder pain that began on 5/2/16 when he reached up for a lever at work and felt a pop and had immediate pain in his shoulder." The records evidence Petitioner attended physical therapy from May 18, 2016 through July 6, 2016. PX5. Medical bills from Lincolnwood Rehabilitation Center total $7,008.00. PX6.

On May 19, 2016, Petitioner underwent an MRI at 3T Imaging. The radiologist's impression was: 1) chronic retracted full-thickness tear of the supraspinatus and infraspinatus tendons with moderate to severe muscle atrophy; 2) partial and interstitial tear of the subscapularis tendon with moderate to severe muscle atrophy of the superior aspect of the subscapularis muscle; 3) mild to moderate biceps tendinosis with interstitial tear; medial subluxation of the extra-articular biceps tendon; 4) high riding humeral head with degenerative changes of the glenohumeral articular cartilage and small joint effusion; findings suspicious for superior labral tear. PX3.

On May 25, 2016, Dr. Silver reviewed the left shoulder MRI scan and noted it demonstrated a full-thickness severely retracted rotator cuff tear of Petitioner's left shoulder. Dr. Silver noted this was a non-surgical irreparable tear. Dr. Silver's plan was to provide Petitioner a steroid injection at his next visit. Petitioner was to continue physical therapy and prescribed anti-inflammatory medications. PX3.

On June 2, 2016, Dr. Silver noted the MRI scan demonstrated a completely retracted irreparable tear of his left shoulder and opined this was due to the May 2, 2016 work injury. Dr. Silver provided Petitioner a cortisone injection in his left shoulder and noted he should wean from the sling. Dr. Silver noted Petitioner was to remain temporarily totally disabled pending re-evaluation in three weeks. Petitioner was to continue physical therapy. PX3.

On June 23, 2016, Dr. Silver noted Petitioner had regained approximately 70 degrees to 80 degrees of forward flexion and lateral abduction. On examination, Dr. Silver found positive impingement, Hawkins and drop arm testing and mild soft tissue swelling. Petitioner was to continue aggressive physical therapy and follow-up in six weeks. Dr. Silver noted he would consider a second injection at that time, depending on Petitioner's pain. Petitioner was to remain at right-handed work only. PX3. Medical bills from Orthopedic Specialists total $1,069.00. PX4.

On August 31, 2016, Dr. Atluri evaluated Petitioner pursuant to §12 of the Act. In his report of that date, RX3, Dr. Atluri noted the following history reported by Petitioner: "The

18IWCC0035

patient states that he was operating a small punch press machine at work. He states this involved repetitively reaching up with his left arm to pull down a lever. He states 'something popped in my shoulder.' He reports immediate pain in his left shoulder, along with weakness. He states the incident was witnessed by his boss, who was standing next to him at the time." Dr. Atluri noted Petitioner's treatment at the emergency room and with Dr. Silver. Dr. Atluri noted the left shoulder MRI findings. Petitioner complained of left shoulder pain, weakness and difficulty elevating his left arm. Petitioner reported his symptoms and motions were improving. Petitioner denied any prior left shoulder problems.

Dr. Atluri noted Petitioner showed him some photographs on his cellphone depicting the machine he was operating when he injured his left shoulder. One of the photographs showed Petitioner in a seated position in front of the machine and he was elevating his right upper extremity towards a lever. Petitioner indicated he must pull that lever down. Petitioner then showed a photograph of the other (left) side of the machine with another lever. Petitioner reported, "He indicated that while using his right arm to keep the initial lever depressed, he then reaches above shoulder level with his left upper extremity and pulls downward to operate the machine. He states that this maneuver is performed sometimes 300-400 times during a shift." Petitioner showed Dr. Atluri photographs of the material which he must run through the machine. There are beams of metal which weigh about 48 pound each. He indicated there is a foot pedal which could be used to operate the machine, however, that foot pedal is not functioning. Dr. Atluri noted Petitioner has been doing this job for about 29 years. Petitioner was currently working with no use of his left upper extremity.

On examination, Dr. Atluri found both shoulders had some supraspinatus atrophy and a little bit of infraspinatus atrophy on the right; the inferior pole of the left scapula did protrude asymmetrically with active elevation of the left upper arm; left shoulder: no tenderness over the trapezius or AC joint; there was subacromial tenderness and tenderness along the anterior joint line as well as bicipital groove; no crepitus with range of motion; occasional snapping at end range of motion; range of motion: ERS was 60 degrees, ERA was 80 degrees, IRA was 55 degrees, IRS was to L1, forward flexion was 155 degrees, abduction was 95 degrees and extension was 70 degrees; active flexion was 95 degrees in the left upper extremity and active range of motion was otherwise the same as his passive range of motion; biceps contour was normal in the left upper arm; negative cross arm; positive Hawkin's; negative Yergason's; composite flexion strength at 90 degrees was 5/5, although there was some break-away weakness; isolated supraspinatus and infraspinatus testing were 4/5; subcap strength was 5/5; some pain reported with resisted elevation in all planes; no trophic findings; normal skin color, hair growth and sweat pattern; distal motor function was intact. Dr. Atluri noted there were no inconsistencies on examination. Left shoulder x-rays taken this day showed a type II acromion, decreased acromiohumeral distance, some arthritic changes at the inferior glenohumeral joint and degenerative changes with inferior spurring at the AC joint.

Dr. Atluri reviewed the medical records from Presence St. Francis Hospital, Orthopedic Specialists' Dr. Silver, Lincolnwood Rehabilitation Center and Case/Clinic Progress notes. It

18IWCC0035

was Dr. Atluri's impression that Petitioner suffered from chronic left shoulder rotator cuff arthropathy. Dr. Atluri opined based on the above records, x-rays and his examination, Petitioner had chronic degenerative changes in his left shoulder indicative of a long-standing rotator cuff tear with secondary arthritic changes. Dr. Atluri opined Petitioner's left shoulder condition was not work-related. Dr. Atluri noted, "The patient indicates that his job requires frequent repetitive reaching with his left upper extremity above shoulder level. I reviewed photos which he provided. He indicated that the sudden onset of his symptoms occurred when he was pulling down on a lever. This is contradicted by some of the written materials which I reviewed. There is documentation of a different mechanism of injury. Specifically, some of the written materials indicate that the patient initially reported an onset of symptoms when his arms were below shoulder level while he was moving material with his hands as opposed to when he was pulling on a lever. Regardless of which history is accepted as accurate, the maneuver described would not be expected to cause, or contribute to, this patient's left shoulder condition. Reaching upwards and pulling downwards, without significant force, even when done repetitively, could not have caused or contributed to this patient's left shoulder condition." Dr. Atluri opined further treatment was reasonable at the time. Dr. Atluri noted Petitioner was responding favorably to physical therapy and recommended additional supervised therapy. Dr. Atluri opined a reasonable course of physical therapy would include two visits a week for an additional six to ten weeks, followed by a transition to a home exercise program. Dr. Atluri agreed with Dr. Silver that Petitioner had an irreparable rotator cuff tear. Dr. Atluri opined Petitioner should be capable of working with temporary restrictions and to avoid overhead activity. Use of the left arm below shoulder level for non-lifting activities was reasonable. RX3.

In a report dated September 20, 2016, RX4, Dr. Atluri indicated he was sent a scan copy of the May 2, 2016 x-ray images of the left shoulder and the x-ray report. Dr. Atluri reviewed the scan and indicated it showed the glenohumeral joint was reduced, there was superior migration of the humeral head with a decreased acromiohumeral distance, there were arthritic changes at the acromioclavicular joint and inferior glenohumeral joint. Dr. Atluri opined Petitioner had chronic degenerative changes in his left shoulder consistent with a rotator cuff arthropathy. Dr. Atluri opined that the additional materials he reviewed did not alter any of his August 31, 2016 opinions. RX4.

The following were admitted into evidence and have been reviewed by the Commission:
PX7: Photograph of Iron Worker machine from a left perspective;
PX8: Photograph of Iron Worker machine from a right perspective;
RX6: Photograph of Iron Worker machine from a left perspective with Lawrence Collins;
RX7: Photograph of Iron Worker machine from a right perspective with Lawrence Collins.

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]. 'In the course of employment' refers to the time, place and circumstances surrounding the injury." *Sisbro Inc. v. Industrial Commission*, 207 Ill. 2d 193, 203, 797 N.E.2d 665 (2003). Petitioner was in the course of his employment when his injury occurred.

"Arising out of" speaks to risk- is the risk encountered by the employee a risk incidental to the employment as not all injures suffered while at work are compensable. See *e.g. Brady v. Louis Ruffolo & Sons Construction Company*, 143 Ill. 2d 542, 552, 578 N.E.2d 921 (1991) ("This court has previously declined to adopt the positional risk doctrine, believing that the doctrine would not be consistent with the requirements expressed by the legislature in the Act"). "To satisfy this requirement it must be shown that the injury had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Sisbro* at 203. Petitioner confronted a neutral risk - reaching- and the evidence fails to support a finding that such neutral risk was either qualitatively or quantitatively increased due to the nature of Petitioner's employment.

Petitioner testified to a specific accident occurring on May 2, 2016-while pulling downward on a machine lever with his left arm above his head, he felt a pop in his left shoulder. However, Petitioner provided inconsistent histories of accident to his supervisor, Mr. Sidney Bolton, Ms. Kathleen Clawson, and the medical providers. Seven different versions of how the May 2, 2016 incident occurred exist. One, Petitioner's testimony he was pulling a lever down, when he felt the pop in his left shoulder. Two, Mr. Bolton's testimony that Petitioner reported to him, "He was reaching for the lever and he heard a pop." Three, Ms. Clawson's testimony that Petitioner was moving a part. Four, the history memorialized in the Presence St. Francis Hospital records of May 2, 2016: "Patient reports that he was bending over to reach at an item and heard a pop in his left arm" and "Patient was at work when he bent over to pick something up and heard a pop." Five, the history memorialized in Dr. Silver's records of May 10, 2016: "He reached up to grab a lever to pull down and felt severe pain occur in his left shoulder on May 2, 2016." Six, the history memorialized in the Lincolnwood Rehabilitation Center records of May 18, 2016: "Mr. Lannon presents today with left shoulder pain that began on 5/2/16 when he reached up for a lever at work and felt a pop and had immediate pain in his shoulder." Seven, the history memorialized in Dr. Atluri's August 31, 2016 report: "The patient states that he was operating a small punch press machine at work. He states this involved repetitively reaching up with his left arm to pull down a lever. He states, "something popped in my shoulder." A consistent thread in all versions is Petitioner's act of reaching whether to pull a lever or to move a part. The act of reaching is a neutral risk.

18IWCC0035

"There are three types of risks to which employees may be exposed: (1) risks that are distinctly associated with employment; (2) risks that are personal to the employee, such as idiopathic falls; and (3) neutral risks that do not have any particular employment or personal characteristics. [citations omitted]." *Adcock v. Illinois Workers' Compensation Commission*, 2015 IL App (2d) 130884WC, ¶ 31. Further, an injury which results from a neutral risk requires the employee to show he was exposed to the risk to a greater degree than the general public. *Springfield Urban League v. Illinois Workers' Compensation Commission*, 2013 IL App (4th) 120219WC, ¶ 27. Such showing of an increased risk may be proved by "either qualitative (i.e., when some aspect of the employment contributes to the risk) or quantitative (such as when the employee is exposed to the risk more frequently than the members of the general public by virtue of his employment). [citation omitted]." *Adcock*, 2015 IL App (2d) 130884WC, ¶ 32. The Commission finds Petitioner failed to prove he sustained an accident on May 2, 2016 which arose out of his employment.

First, Petitioner's act of reaching was not qualitatively different than a member of the general public as he merely reached up. Second, Petitioner's act of reaching was not quantitatively more significant than the general public. Petitioner testified he was fabricating a part weighing one pound, and prior to his injury, he completed 21 of 22 parts. Mr. Bolton's testimony was consistent with Petitioner's in this regarding. The record is devoid of any testimony as to the time constraints or time involved in completing the 22 parts. Testimony exists which confirms Petitioner's job duties involved repeated pulling of levers with both arms, but Petitioner's theory of recovery is that a discrete event caused his injury not a repetitive trauma. Reaching one's arm up even 21 times without evidence of any additional context does not prove the risk encountered by Petitioner was to a greater degree than the general public. The Commission finds Petitioner failed to prove a specific accident arising out of his employment on May 2, 2016.

B. Causal Relationship

Even assuming *arguendo* Petitioner proved an accident occurred, the Commission finds Petitioner failed to prove a causal relationship between his accident and his resulting condition of ill-being. As the Court noted in *Sisbro Inc. v. Industrial Commission*:

> When an employee with a preexisting condition is injured in the course of his employment, serious questions are raised about the genesis of the injury and the resulting disability. The Commission must decide whether there was an accidental injury which arose out of the employment, whether the accidental injury aggravated or accelerated the preexisting condition or whether the preexisting condition was alone the cause of the injury. 207 Ill. 2d 193, 215, 797 N.E.2d 665 (2003).

There is no question Petitioner suffered from a pre-existing condition. As was noted in the emergency room records of Presence St. Francis Hospital, an x-ray obtained immediately post-injury evidenced the following: "There are degenerative changes at the acromioclavicular

joint. There is a high riding right[*sic*] humerus suggesting chronic rotator cuff injury. Calcified lymph nodes in the mediastinum. No fracture dislocation bone destruction seen." PX1, p. 14. The MRI of the left shoulder performed on May 19, 2016 just 17 days after the injury further confirmed the chronic and degenerative nature of Petitioner's shoulder- finding in part: "1. Chronic retracted full-thickness tear of the supraspinatus and infraspinatus tendons with moderate to severe muscle atrophy. 2. Partial and interstitial tear of the subscapularis tendon with moderate to severe muscle atrophy of the superior aspect of subscapularis muscle." PX3, p.10.

Dr. Atluri opined Petitioner suffered "chronic degenerative changes in his left shoulder indicative of a long standing rotator cuff tear with secondary arthritic changes." RX3. The tear was so advanced and severely retracted both Dr. Atluri and Dr. Silver opined it was an irreparable rotator cuff tear. PX3 and RX3.

Dr. Atluri after examining Petitioner and reviewing the medical records opined "[r]egardless of which history is accepted as accurate, the maneuver described would not be expected to cause, or contribute to, this patient's left shoulder condition. Reaching upwards and pulling downwards, without significant force, even if done repetitively, could not have caused or contributed to this patient's left shoulder condition." RX3. In contrast, Dr. Silver opined "Emmett Lannon [sic] left Rotator Cuff tear is due to his work injury on May 2, 2016" without any further explanation or comment. PX3, p. 21. The Commission affords greater weight to the opinions of Dr. Atluri over those of Dr. Silver. Dr. Silver's opinion is of little persuasive value as it ignores the diagnostic testing of x-ray and MRI which evidence a severely degenerative condition.

As the Court noted in *County of Cook v. Industrial Commission*:

> Every employee whose disease or preexisting condition disables him while at work is not automatically entitled to recovery under the Workmen's Compensation Act…'In each case the arbitrator ought to consider whether, in substance, as far as he can judge on such a matter, the accident came from the disease alone, so that, whatever the man had been doing, it would probably have come all the same, or whether the employment contributed to it. 68 Ill. 2d 24, 31-32, 368 N.E.2d 1292 (1977).

Petitioner failed to prove his pre-existing degenerative condition was aggravated by his act of reaching.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's February 15, 2017 decision is reversed for the reasons stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that since Petitioner failed to prove he sustained accidental injuries arising out of and in the course of his employment on

18IWCC0035

May 2, 2016 and failed to prove a causal relationship for his condition of ill-being, his claim for compensation is hereby denied.

There is no bond as there is no award. 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: JAN 18 2018
LEC/maw
o11/01/17
43

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

Joshua D. Luskin

Charles J. DeVriendt

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

LANNON, EMMETT
Employee/Petitioner

Case# 16WC014849

S & C ELECTRIC COMPANY
Employer/Respondent

18IWCC0035

On 2/15/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 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:

4564 ARGIONIS & ASSOCIATES LLC
LOUKAS N KALLIANTASIS
180 N LASALLE ST SUITE 2105
CHICAGO, IL 60601

0481 MACIOROWSKI SACKMANN & ULRICH
ROBERT MACIOROWSKI
105 W ADAMS ST SUITE 2200
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Emmett Lannon
Employee/Petitioner

v.

S & C Electric Company
Employer/Respondent

Case # 16 WC 14849

Consolidated cases: _____

18IWCC0035

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 Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **10/19/16**. 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 _____

FINDINGS

On the date of accident, **5/2/16**, 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 **$45,760.00**; the average weekly wage was **$880.00**.

On the date of accident, Petitioner was **60** years of age, ***single*** with 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

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $1,332.80 to St. Francis Hospital, $1,069.00 to Dr. Ronald Silver, Orthopaedic Specialists, and $7,008.00 to Lincolnwood and Joint as provided in Sections 8(a) and 8.2 of the Act.

The prospective treatment recommended by Dr. Silver is reasonable and necessary to treat Petitioner for the injury to his Left Shoulder. Respondent shall authorize and pay for all medical services associated with said treatment as prescribed by Dr. Silver 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.

Deborah L. Simpson

Signature of Arbitrator

February 15, 2017
Date

ICArbDec19(b)

FEB 15 2017

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Emmett Lannon,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 16 WC 14849**
	)	
S & C Electric Company,	)	**18IWCC0035**
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on May 2, 2016, 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 further agree that the Petitioner gave the Respondent notice of the accident which is the subject matter of this dispute within the time limits stated in the Act. They also agree that in the year preceding the injuries, the Petitioner earned $45,760.00, and that his average weekly wage was $880.00.

At issue in this hearing is as follows: (1) Did an accident occur that arose out of and in the course of the Petitioner's employment with Respondent; (2) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; and (3) Is the Respondent liable for the following unpaid medical bills: Presence St. Francis Hospital $1,332.80, Dr. Ronald Silver $1,069.00, and Lincolnwood Rehabilitation Center $7,008.00.

STATEMENT OF FACTS

It is undisputed that on May 2, 2016 until present, the Petitioner, Emmett Lannon, worked for the Respondent, S&C Electric Company, as a general machinist. (T 16). Petitioner testified that he has worked for Respondent for nearly 30 years. (T 16-17). Petitioner testified that his job duties included the operation of heavy machinery to manufacture electrical parts. (T 17). This included operating drill presses and the "Iron Worker" for approximately ten hours a day. (T 17, 19). Petitioner testified that these machines are operated manually. (T 18).

Petitioner testified that the Iron Worker is a machine that punches round holes into different metal pieces, including steel. (T 19). Petitioner's Exhibits 7 and 8 depicts the Iron Worker machine. (Petitioner's Exhibit 8 and 9; hereinafter Pet. Ex. 7 and 8). This machine requires the employee to load a metal piece onto the center of the machine and then pull down

multiple levers to complete the punching process. (T 19-20). Petitioner testified that the Iron Worker is equipped with a foot pedal to hold the metal piece in place, however the pedal had been broken for 10 to 15 years. (T 24). Petitioner testified that because of the broken foot pedal, employees would be required to hold the metal piece in place with a lever on the right side of the Iron Worker. (T 19-20). Petitioner testified that, after holding the metal piece in place, employees would reach upwards pull down a lever on the left side of the Iron Worker to punch the necessary hole into the piece. (T 19-20, 23). Petitioner testified that the left lever requires 15 to 20 pounds of force to properly punch the necessary hole into a metal piece. (T 20).

Petitioner testified that an employee would complete this job duty while in a seated position because the employee must have a clear view of the Iron Worker's hole-punch to ensure an accurate punch. (T 26-27). Petitioner also testified that he is approximately 5 feet 8 inches tall. (T 59). Petitioner testified that pulling down the left-side lever required him to raise his arm above his head and pull down. (T 25). Petitioner testified that he would perform this motion 100 to 200 times per day. (T 20).

Petitioner testified that he suffered a work injury on May 2, 2016. (T 18). Petitioner testified that he reported to work at approximately three o'clock in the afternoon. (T 18). Petitioner testified that he was assigned to the Iron Worker to punch holes into copper parts. (T 19). Petitioner testified that while operating the Iron Worker, he suffered a left shoulder injury. (T 21). Per the testimony of Petitioner's manager, Mr. Sidney Bolton, Petitioner had completed the hole-punching process for 21 of 22 copper metal parts on the date of injury. (T 68-69). Petitioner testified that, while in a seated position, he placed a metal part onto the Iron Worker and stabilized it by pulling the right lever down. (T 21, 27). Petitioner testified that he then reached up to pull the left lever and punch a hole into the metal part. (T 21). Petitioner testified that as he pulled the lever down, he felt a pop in his left shoulder. (T 21). Petitioner testified that it felt like there was cracking and popping in his arm. (T 27). Petitioner testified that the pain felt like "someone took an ice pick and stuck it right through the joint." (T 27). Petitioner testified that the pain came from inside his shoulder, and that his shoulder felt loose and unstable. (T 28). Petitioner testified that he notified his supervisor, Sidney Bolton, of the injury. (T 28)

Mr. Bolton also provided testimony regarding the date of injury. Mr. Bolton testified that he did not witness the actual incident, but testified that he heard Petitioner scream and complain of pain in his arm. (T 71). Mr. Bolton testified that he ordered Petitioner not to move and requested a personal carrier to transport the Petitioner to health services. (T 71). Mr. Bolton testified that he sent Petitioner home for the rest of the day due to the injury. (T 72). Mr. Bolton also testified that Petitioner stated that he hurt his arm reaching for the lever on the Iron Worker. (T 73).

Petitioner testified that he immediately sought treatment from health services at S&C Electric on May 2, 2016. Petitioner testified that he then sought treatment from the emergency room at St. Francis Hospital. Petitioner testified that he complained of severe left shoulder pain

and an inability to move his left shoulder. Upon physical examination, Petitioner exhibited a decreased range of motion. (Petitioner's Exhibit 1, hereinafter Pet. Ex. 1, p. 12). The examining physician also suspected a rotator cuff tear. (Pet. Ex. 1, p. 13). Petitioner was discharged with a prescription for hydrocodone. *Id.* Petitioner testified that he was instructed to follow up with a physician. Petitioner testified that he followed up two days later with his primary care physician, Dr. Farby. (T 30). Petitioner testified that Dr. Farby recommended that he seek consultation from an orthopedic surgeon. (T 31).

Petitioner followed up with Dr. Ronald Silver at Orthopaedic Specialists on May 10, 2016. (Petitioner's Exhibit 3, p. 7; hereinafter Pet. Ex. 3). Upon physical examination, Petitioner exhibited decreased range of motion and subacromial crepitation. *Id.* Petitioner also exhibited a positive impingement syndrome test, Hawkins' test, and drop arm tests. *Id.* Dr. Silver ordered an MRI and prescribed Norco and Terocin patches. *Id.* Dr. Silver also ordered Petitioner to begin physical therapy. *Id.* Petitioner started physical therapy and Lincolnwood Rehabilitation Center on May 18, 2016. (Petitioner's Exhibit 5, p. 2; hereinafter Pet. Ex. 5). Dr. Silver also ordered a work restriction of light duty with no use of the left arm. (Pet. Ex. 3, p. 7). Petitioner testified that his employer accommodated this restriction and provided him with a light duty job.

Petitioner underwent an MRI at Lincolnwood on May 19, 2016. (Pet. Ex. 3, p. 10). The MRI revealed a full-thickness tear of the supraspinatus and infraspinatus tendons, a partial and interstitial tear of the subscapularis tendon, and biceps tendinosis. *Id.* Petitioner returned to Dr. Silver on May 25, 2016. (Pet. Ex. 3, p. 5). Dr. Silver confirmed the full thickness rotator cuff tear and opined that this injury was due to his work injury. (Pet. Ex. 3, p.5, 21). Dr. Silver ordered a steroid injection upon Petitioner's next evaluation. (Pet. Ex. 3, p. 5). Dr. Silver also ordered further physical therapy and a right-hand-only work restriction. Petitioner underwent a cortisone injection in the left shoulder on June 2, 2016, performed by Dr. Silver. (Pet Ex. 3, p. 4). Petitioner testified that the injection provided relief for approximately two weeks, and then the pain returned. Petitioner testified that Dr. Silver ordered him to continue physical therapy. Petitioner testified that Dr. Silver ordered a right-hand-only work restriction, which was accommodated by his employer. (Pet. Ex. 3, p. 23).

Petitioner returned to Dr. Silver on June 23, 2016. (Pet. Ex. 3, p. 2) Petitioner continued to exhibit a positive impingement, Hawkins', and drop tests. (Pet. Ex. 3, p. 2). Petitioner testified that Dr. Silver recommended a second injection and recommended surgery. (Pet. Ex. 3, p. 2, p. 22). Dr. Silver ordered additional physical therapy and placed Petitioner on a right-hand-only work restriction. (Pet. Ex. 3, p. 22). Petitioner testified that he returned to Dr. Silver sometime in September. Petitioner testified that Dr. Silver recommended a second an injection, additional physical therapy, and a left shoulder surgery. (T 37).

Petitioner testified that he is currently undergoing physical therapy at Lincolnwood Rehabilitation Center. (T 37). Petitioner testified that he has undergone therapy three times a week from May 18, 2016 up until the present day. (T 37). Petitioner testified that the therapy

helps his pain during the exercises and when icing his left shoulder. (T 37). Petitioner testified that his pain returns once he begins working. (T 37). Petitioner testified that his arm continues to feel loose and painful. (T 37). Petitioner testified that his joint "doesn't sit right." (T 37).

Petitioner testified that he presented to Dr. Prasant Alturi on August 26, 2016. (T 38). Petitioner testified that Dr. Alturi performed a physical examination. (T 38). Petitioner testified that his left shoulder felt painful and loose during examination. (T 38). Petitioner stated during this examination that he injured his left shoulder when pulling down a lever on a "small punch press machine." (Respondent's Exhibit 3; hereinafter Res. Ex. 3). Dr. Alturi noted that Petitioner could perform this maneuver sometimes 300-400 times per shift. (Res. Ex. 3). Dr. Alturi noted a positive Hawkins' sign and decreased strength in Petitioner's left shoulder. (Res. Ex. 3). Dr. Alturi reviewed Dr. Silver's notes, the therapy notes, records from St. Francis Hospital, and "Case/Clinic Progress Notes" – which were submitted at trial as Respondent's Exhibit 2. (Res. Ex. 3). Dr. Alturi agreed with the diagnosis of a torn rotator cuff. (Res. Ex. 3). Dr. Alturi opined that the left shoulder condition was not work-related and opined that reaching upward and pulling downward, without significant force, could not have caused Petitioner's injury. (Res. Ex. 3). However, Dr. Alturi's report is silent as to the amount of force that would or could be required to operate the Iron Worker.

Petitioner testified that he did not suffer any injury to, or have any problems with, his left shoulder prior to May 2, 2016. (T 38-39). Mr. Bolton testified that, in the two years he had worked directly with Mr. Lannon, he had never heard Petitioner complain of any shoulder pain. (T 81). Petitioner testified that he did not re-injure his left shoulder after May 2, 2016. (T 39). Petitioner testified that his arm continues to ache and feel loose. (T 39). Petitioner testified that his left shoulder condition affects his ability to perform his job duties. (T 39). Petitioner testified that he sometimes requires help to complete his job duties and them more slowly. (T 39-40). Petitioner testified that his arm also feels sore after a day of light-duty work. (T 40).

At trial, Respondent entered photographs of an S&C Electric Employee on an Iron Worker machine. (Respondent's Exhibits 6 and 7). Mr. Bolton testified that these photographs demonstrated the operation of the Iron Worker. (T 79). Petitioner and Mr. Bolton testified that the employee in this photograph is Lawrence Collins. (T 59, 69). Petitioner testified that Mr. Collins is approximately one foot taller. (T 59). Mr. Bolton admits that Mr. Collins is taller than Petitioner. (T 69). Petitioner testified that, contrary to what was depicted in Respondent's photographs, he would have to reach above his head to pull down the lever of the Iron Worker. (T 60). Mr. Bolton admitted that for the Petitioner, the lever would be at least level or higher than his head. (T 87). Mr. Bolton admitted it is possible to operate the Iron Worker with one's arm in a higher position than what was depicted in Respondent's Exhibits 6 and 7. (T 80).

Respondent also called Kathleen Clawson to testify at trial. Ms. Clawson testified that she is the Manager of Health Services at S&C Electric Company. (T 96) She testified that she is responsible for managing the clinics at S&C electric and handling Worker's Compensation

issues. (T 96). Ms. Clawson testified that she does not operate machinery for Respondent. (T 109).

Respondent also submitted clinic notes from S&C Electric. (Respondent's Exhibit 2; hereinafter Res. Ex. 2). All entries on these records are dated May 3, 2016. (Res. Ex. 2). Ms. Clawson admitted that she cannot diagnose patients. (T 117). Ms. Clawson admitted that the case clinic notes are not made for the purpose of diagnosis or treatment recommendations. (T 118-119). Ms. Clawson admitted that the clinic records state that this injury is not work-related. (T 119). Ms. Clawson admitted that the clinic records do not list any previous injuries to Petitioner. (T 122-123). Ms. Clawson admitted that she was not aware of any prior injuries to Petitioner. (T 123). Ms. Clawson admitted that, even though there are no prior complaints of shoulder pain, her opinion was that Petitioner's injury was not work-related. (T 125). Ms. Clawson admitted that she did not witness the incident when Petitioner was injured. (T 126). Ms. Clawson stated that the decision that the injury was not work-related was made without review of any medical records from Dr. Silver or the MRI report. (T 127).

The clinic records indicate that Ms. Clawson called Petitioner via telephone at approximately 10:00 a.m. on May 3, 2016. (Res. Ex. 2). Petitioner testified that Ms. Clawson claimed that Petitioner's injury did not happen at work and stated "that will give me time to figure out what to do with you." (T 61-62). Petitioner, Mr. Bolton, and Ms. Clawson all testified that Petitioner arrived at the health clinic at approximately 3:00 p.m. on May 3, 2016. Mr. Bolton testified he arrived with Petitioner to Ms. Bolton's office. (T 73-74). However, Mr. Bolton testified that he was not present in the room for the conversation between Petitioner and Ms. Clawson. (T 74).

Petitioner testified that a conversation occurred with Ms. Clawson inside the office. (T 52). Petitioner testified that Ms. Clawson did not ask any questions about how he was injured. (T 52, 62). Petitioner testified that after this conversation, Ms. Clawson informed him to remain in the room while she would go inspect the Iron Worker. (T 62). Mr. Bolton testified that he and Ms. Clawson went to inspect the Iron Worker. (T 74).

Mr. Bolton testified that Ms. Clawson operated the Iron Worker to try it out. (T 74-75). Ms. Clawson testified that she was not making a metal part when she operated the machine. (T 111). Ms. Clawson admitted that there was no metal piece inside the Iron Worker at the time she operated the machine. (T 111). Ms. Clawson admitted that she never witnessed Petitioner operate the Iron Worker. (T 113). Ms. Clawson also admitted that she does not know what position Petitioner's arms would be when operating the Iron Worker. (T 113). Petitioner testified that upon returning to the office, Ms. Clawson informed him that he would not be receiving worker's compensation. (T 62). Petitioner testified that he previously informed Ms. Clawson that the injury occurred while at work. (T 61-62). Mr. Bolton testified that Petitioner and Ms. Clawson "objected to each other" and were not in agreement. (T 76).

Ms. Clawson admitted that she informed Petitioner that worker's compensation is unlikely to "pick up" his injury. (T 114). Ms. Clawson stated this conversation occurred after she operated the Iron Worker. (T 114). Ms. Clawson admitted that this conversation occurred prior to receiving any medical records from St. Francis Hospital or from Dr. Silver.

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)

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. Indus. Comm'n*, 128 N.E.2d 718, 720 (1955). Injury need not be the sole factor, or even the primary factor of an injury, as long as it is a causative factor. *Sisbro, Inc v. Indus. Comm'n*, 797 N.E.2d 665 (Ill. 2003)

In support of the Arbitrator's decision relating to (C), whether the petitioner's present condition of ill-being arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following facts:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

The Arbitrator finds Petitioner's current condition of ill-being arose out of and in the course of Petitioner's employment. An employee's injury is compensable under the Act only if it arises out of and in the course of his employment. 820 ILCS 305/2. "In the course of" employment refers to the time, place and circumstances under which the accident occurred. *Lee v. Industrial Comm'n,* 167 Ill.2d 77, 81 (1995). 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. Industrial Comm'n,* 129 Ill.2d 52, 58 (1989). Additionally, 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. *Durand v. Industrial Comm'n,* 224 Ill.2d 53, 65, (2006). A repetitive-trauma injury is one which "has been shown to be caused by the performance of the claimant's job and has developed gradually over a period of time, without requiring complete dysfunction." *PPG Indus. v. Illinois Workers' Comp. Comm'n*, 2014 IL App (4th) 130698WC, ¶ 19, reh'g denied (4th Dist. 2014).

Accordingly, based on the credible testimony of the petitioner, and the medical records and opinions of Dr. Silver and Lincolnwood Rehabilitation Center, the Arbitrator finds that Petitioner has affirmatively demonstrated that his current condition of ill-being arose due to the May 2, 2016, incident. Petitioner testified clearly and credibly as to his mechanism of injury. Petitioner testified that his left arm was above his head and pulling a lever that required approximately 15 to 20 pounds of force to operate. This is further corroborated by Respondent's employee, Mr. Sidney Bolton, and the medical records of Dr. Silver. (Pet. Ex. 3). Mr. Bolton specifically admitted that the Petitioner stated that he was reaching for the iron worker lever when the injury occurred. Mr. Bolton also admitted that the lever on the Iron Worker would be at least head-level or higher for the Petitioner. Petitioner also testified that that this operating this Iron Worker was part of his job duties as a general machinist. As such, the Arbitrator finds this to be a competent mechanism of injury for a rotator cuff tear and arose in the course of his employment.

Petitioner testified that he had no instances of prior left shoulder injuries or pain, and there is no evidence suggesting the contrary. Petitioner also reported immediate and severe pain and sought immediate medical treatment. Mr. Bolton corroborates the Petitioners recollection of the event, as he testified that he heard the Petitioner cry out in pain and upon learning what happened immediately called for transportation to health services. There is no evidence that Petitioner suffered any injury other than the May 2, 2016 work-related injury. Thus, the Arbitrator finds that Petitioner's current condition of ill-being arose out of and in the course of Petitioner's employment.

The Arbitrator is not persuaded by the testimony of Ms. Clawson and the report of Dr. Alturi that the injury is not causally related to the Petitioner's employment. Ms. Clawson's testimony lacks credibility. Ms. Clawson's is directly responsible for worker's compensation claims for the Respondent. The corresponding Clinic Notes are self-serving and do not consider any records from Dr. Silver or the MRI report. Ms. Clawson admitted that she informed Petitioner that worker's compensation would not accept his injury claim prior to receiving or reviewing any medical records. Ms. Clawson, who does not operate the machinery at Respondent's company, based her decision off of her inspection of the Iron Worker. This inspection did not include a demonstration while there was a piece of metal inside the machine. Therefore, she cannot know the amount of force needed to operate the machine and she even

admits, that she does not know what position Petitioner's arms would have been in. This is not indicative of a credible investigation and undermines the credibility of her testimony and opinions.

Similarly, Dr. Alturi's report is not credible. Dr. Alturi notes positive objective findings and agrees with Dr. Silver's diagnosis of a rotator cuff tear. (Res. Ex. 3). Yet, Dr. Alturi makes a determination that Petitioner's condition was a result of a long-standing rotator cuff tear even though there is no credible evidence of prior injuries. (Res. Ex. 3). Dr. Alturi also failed to review the MRI. (Res. Ex. 3) Dr. Alturi also states that reaching up and pulling downward, without significant force could not have caused Petitioner's injury. (Res. Ex. 3). However, his report is silent as to the amount of force required to operate the machine in question. (Res. Ex. 3). His report also states that Petitioner injured himself while operating a "small punch press." (Res. Ex. 3). This is contradictory to the photographs submitted by Petitioner and Respondent, which depicts a large Iron Worker machine. (Pet. Exs. 7-8; Res. Ex. 6-7). Based on Dr. Alturi's non-comprehensive review, the lack of prior injuries, and the speculative nature of his opinion, the Arbitrator finds Dr. Alturi's report to be not credible.

Alternatively, Petitioner current condition of ill-being could have been caused by the repetitive use of his left shoulder in completing his job duties. Petitioner testified that he would pull down the lever of the Iron Worker approximately 100 to 150 times per day. Dr. Alturi's report suggests it could be upwards of 300 to 400 times per day. This type of repetitive use of one's arm above their head could certainly cause a pre-existing rotator cuff injury to become painful. Regardless, the evidence in the present case proves by a preponderance of the evidence that Petitioner's injury arose out of and in the course of employment.

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 incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

The Arbitrator finds Petitioner's current condition of ill-being is causally related to the work-related injury on May 2, 2016. Accordingly, based on the credible testimony of Petitioner as well as the medical records and opinions of Dr. Ronald Silver, the MRI results, and Lincolnwood Rehabilitation Centers records, the Arbitrator finds that the petitioner has affirmatively demonstrated a causal relationship between his work-related injury and his current condition of ill-being. Prior to his injury, Petitioner did not have any issues with his left shoulder or arm. Again, Petitioner only began feeling pain after he pulled a lever down from above his head. Petitioner testified that in order to operate the Iron Worker, it is important to be able to view the Iron Worker's hole punch this ensures that the piece would be punched correctly. When considering Petitioner's height, the photographs of the Iron Worker, Petitioner would have had to

pull the Iron Worker lever from above his head to operate the machine properly. Mr. Bolton corroborates this when he admitted that the lever would be at Petitioner's head level or higher.

Dr. Silver also specifically opines that Petitioner's rotator cuff injury was caused by Petitioner's work injury. (Pet. Ex. 3, p. 5, 21). Clearly, the motion of pulling down from above the head is a competent mechanism for a rotator cuff injury and Petitioner testified that he suffered immediate pain after he felt a pop. Respondent's photographs depicting Lawrence Collins on the Iron Worker does not prove otherwise. Petitioner testified that Mr. Collins is a foot taller than him. Mr. Bolton admits that Mr. Collins is taller than Petitioner, and admits that Petitioner would be operating the lever at head-level or higher. Therefore, the Arbitrator finds that the Petitioner established a causal connection between his left shoulder injury and the work incident on May 2, 2016.

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, the Arbitrator finds no inconsistent history or any evidence of any intervening cause for the petitioner's current condition. The fact that the St. Francis Hospital records indicate that Petitioner may have been reaching for a metal piece as opposed to a lever does not suggest that there is no causal connection. Petitioner clearly and credibly testified that he did not have any prior injury to his left shoulder. Mr. Bolton stated that he had never heard Petitioner complain of any shoulder pain prior to the May 2, 2016. Even Ms. Clawson stated that she was not aware of any prior injuries to Petitioner's left shoulder. Clearly, after reviewing the records of Dr. Silver, Dr. Alturi's Section 12 examination report, as well as the therapy records, the May 2, 2016, incident caused or contributed to Petitioner's injury. Therefore, the Arbitrator concludes that the petitioner's current condition of ill-being is causally related to the work injury that occurred on May 2, 2016.

In support of the Arbitrator's decision relating to (J), whether the medical services provided to Petitioner were reasonable and necessary and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following facts:

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 were reasonable and necessary. Petitioner underwent treatment from the emergency department from St. Francis Hospital on May 2, 2016. At the time of the hearing, Petitioner presented medical records and bills, along with valid subpoenas, for St. Francis Hospital. (Pet. Ex. 1; Pet. Ex. 2). The Arbitrator finds that the treatment rendered by physicians at St. Francis Hospital was reasonable and necessary to treat Petitioner for the work-related injury he suffered on May 2, 2016. The Arbitrator also finds that since the Petitioner's condition of ill-being was causally related to his injury on May 2, 2016, the Respondent is responsible for the aforementioned medical charges. The Arbitrator finds that the related bills on Petitioner's Exhibit 2, totaling $1,332.80 are to be paid by Respondent according to the medical fee schedule.

Petitioner also sought treatment from Dr. Silver beginning on May 10, 2016. At the time of the hearing, Petitioner presented medical records and bills, along with valid subpoenas, for Dr. silver at Orthopaedic Specialists. (Pet. Ex. 3; Pet. Ex. 4). The Arbitrator finds that the treatment rendered by Dr. Silver was reasonable and necessary to treat Petitioner for the work-related injury he suffered on May 2, 2016. The Arbitrator also finds that since the Petitioner's condition of ill-being was causally related to his injury on May 2, 2016, the Respondent is responsible for the aforementioned medical charges. The Arbitrator finds that the related bills on Petitioner's Exhibit 4, totaling $1,069.00 are to be paid by Respondent according to the medical fee schedule.

Finally, Petitioner underwent physical therapy, and continues to undergo physical therapy, at Lincolnwood Rehabilitation Center. At the time of the hearing, Petitioner presented medical records and bills, along with valid subpoenas, for Lincolnwood Rehabilitation Center. (Pet. Ex. 5; Pet. Ex. 6). The Arbitrator finds that the treatment rendered by the therapists at Lincolnwood Rehabilitation Center was reasonable and necessary to treat Petitioner for the work-related injury he suffered on May 2, 2016. The Arbitrator also finds that since the Petitioner's condition of ill-being was causally related to his injury on May 2, 2016, the Respondent is responsible for the aforementioned medical charges. The Arbitrator finds that the related bills on Petitioner's Exhibit 6, totaling $7,008.00 for treatment rendered from May 18, 2016 to July 7, 2016 are to be paid by Respondent per the medical fee schedule. Any further physical therapy after July 7, 2016, are to be paid by Respondent per 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 incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

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 instruction. The MRI's taken of the Petitioner's right shoulder clearly show a tear in Petitioner's rotator cuff. (Pet. Ex. 3, p. 10). Further, Dr. Alturi's Section 12 examination agrees with this diagnosis. The Arbitrator finds, that since Petitioner's current condition of ill-being is causally related to his injury on May 2, 2016, Dr. Silver's treatment recommendations should be followed. Therefore, the Arbitrator finds that the Respondent must authorize and additional injection and surgical repair of Petitioner's left shoulder. (Pet. Ex. 3, p. 2, 22). The Arbitrator finds that payment for this 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 to ascertain whether additional treatment is necessary.

In support of the Arbitrator's decision relating to (N), is the Respondent due any credit, the Arbitrator finds the following facts:

Respondent has not paid any TTD, TPD, or Maintenance benefits. Per the stipulation of the parties, the Respondent is entitled to any 8(j) credit applicable and pursuant to the fee schedule, if any. Further, per said stipulation, the Respondent agrees to hold the Petitioner harmless for all bills paid.

ORDER OF THE ARBITRATOR

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $1,332.80 to St. Francis Hospital, $1,069.00 to Dr. Ronald Silver, Orthopaedic Specialists, and $7,008.00 to Lincolnwood and Joint as provided in Sections 8(a) and 8.2 of the Act.

The prospective treatment recommended by Dr. Silver is reasonable and necessary to treat Petitioner for the injury to his Left Shoulder. Respondent shall authorize and pay for all medical services associated with said treatment as prescribed by Dr. Silver pursuant to the medical fee schedule as provided in Sections 8(a) of the Act.

Deborah L. Simpson

Signature of Arbitrator

February 15, 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

EDWARD SLAD,
Petitioner,

vs.

NO: 02 WC 001339

ANNING JOHNSON, INC.,
Respondent.

18IWCC0036

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, benefit rates, TTD, medical, PPD, PTD, 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.

Petitioner claims to have suffered significant injuries to his back on September 15, 1999, while working as a construction carpenter. The Arbitrator incorrectly opined that the Illinois Occupational Diseases Act applies as Petitioner continued working subsequent to the work accident. Petitioner did not suffer a compensable disease arising out of and in the course of the employment or which has become aggravated and rendered disabling as a result of the exposure of the employment. Petitioner suffered a back strain while engaged in work activities and this matter is therefore governed by the Workers' Compensation Act (820 ILCS 305/1 *et.* seq). The Commission strikes the language on page 7 of the Arbitrator's decision regarding the Occupational Diseases Act.

The Arbitrator correctly found that the Petitioner suffered from a back strain, and that the strain was causally related to the work accident. The Arbitrator additionally correctly found that the Petitioner's degenerative disc disease was not causally connected to Petitioner's work accident. From the time of Petitioner's injury in 1999 until his retirement in 2008, Petitioner worked full-time, including working significant overtime. (T. pp. 111-112, 115) Based on the fact that Petitioner worked an additional nine years post-accident, without restriction, and including significant overtime, the evidence does not support a finding that Petitioner's current condition of ill-being was caused by the work accident. Petitioner did not have any radiographic imaging evidence for an acute injury to his lumbar spine in September or October of 1999. All of the findings on Petitioner's MRI were degenerative in nature. The development of a disc herniation two years later when a repeat MRI was performed in 2001, is consistent with the typical course of degenerative disc and joint disease in the lumbar spine and not trauma.

18IWCC0036

Finally, the Commission finds that Respondent is entitled to a credit of $22,700.03 pursuant to 820 ILCS 305/8(j) for benefits paid by group insurance.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $679.93 per week for a period of 9 4/7 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 $485.65 per week for a period of 50 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 10% loss of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit of $22,700.03 under §8(j) of the Act; 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.

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 $8,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 22 2018

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

CJD/dmm
O:121317
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SLAD, EDWARD
Employee/Petitioner

Case# **02WC001339**

ANNING JOHNSON INC
Employer/Respondent

18IWCC0036

On 1/27/2016, 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 0.41% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0393 THOMAS R LICHTEN LTD
53 W JACKSON BLVD
SUITE 1634
CHICAGO, IL 60604

0532 HOLECEK & ASSOCIATES
STUART M PELLISH
161 N CLARK ST SUITE 800
CHICAGO, IL 60601

18IWCC0036

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

EDWARD SLAD,
Employee/Petitioner

v.

ANNING JOHNSON, INC.,
Employer/Respondent

Case # 02 WC 001339

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 **September 3, 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, 1999**, 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 $**53,034.80**; the average weekly wage was $**1,019.90**.

On the date of accident, Petitioner was **38** years of age, ***married*** with **2** dependent children.

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

Respondent shall be given a credit of $**6,674.56** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**6,674.56**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $679.93/week for 9 4/7 weeks, for the periods of 9/16/1999 to 10/21/1999; 3/13/2000 to 3/28/2000; 4/6/2000 to 4/8/2000; 5/25/2000 to 5/29/2000; 1/25/2001 to 1/29/2001; 2/12/2001 to 2/19/2001; 9/20/2001; 10/25/2001; 3/28/2006 to 3/29/2006, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 9/16/1999 through 9/3/2015, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay Petitioner permanent partial disability benefits of $485.65/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

1·26·16
Date

JAN 27 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION

EDWARD SLAD, Petitioner, vs. ANNING JOHNSON, INC. Respondent.	)	No. 02 WC 001339 18IWCC0036

STATEMENT OF FACTS

Petitioner, Edward Slad, was born on January 5, 1961. He worked full time, unrestricted work as a union carpenter for 27 years, attaining the title of master carpenter. He stopped working in October, 2008. Prior to becoming a carpenter, he worked as a mechanic and a semi-tractor truck driver.

Mr. Slad describes his duties as a carpenter as entailing anywhere from demolition to architectural millwork.

On September 15, 1999, Mr. Slad was employed by Anning Johnson, the Respondent. He was working in Schaumburg, Illinois, at the streets of Woodfield. He and a partner were framing walls for theaters being constructed.

The steel-framed walls came in 10-foot pieces, weighing approximately 350 pounds. His partner lost control of his end of the wall. In an effort to save his partner from being stricken by the wall, Mr. Slad jerked the wall up. As he did so, he felt a sharp jolt through his spine. He and his partner were successful in getting the wall to stand up.

Mr. Slad reported the injury right away. He sought out medical attention from Dr. Mansfield, an orthopedic surgeon. Mr. Slad was prescribed conservative treatment consisting of physical therapy and medication. He had therapy for five weeks. He was discharged from therapy, as noted by the therapist, as having met his goals.

Dr. Mansfield made a referral to Dr. Roger Tolentino, a pain management physician. Mr. Slad began seeing Dr. Tolentino in March, 2000. Mr. Slad saw Dr. Tolentino for approximately nine years. Following Dr. Tolentino's retirement, Mr. Slad came under the care of Dr. Guman. He continued under Dr. Guman's care through 2014. Mr. Slad also received pain management treatment from Dr. Ahsan at the Northwest Suburban Pain Clinic, from January 2004 until June of 2007. Mr. Slad testified of receiving pain medication, epidural injections, as well as radiofrequency treatments during the course of his pain management care.

Mr. Slad continued working full-time, unrestricted work as a master carpenter until October 20, 2008. Mr. Slad continuing working full-time for Anning Johnson for approximately two years after the September accident. He subsequently worked for other construction companies, including Tower Construction and Monarch Construction, performing full time, unrestricted work.

Mr. Slad testified he worked as a full-time master carpenter, acknowledging the union does not have light-duty work.

Mr. Slad testified he stopped working as a carpenter in October, 2008, nine years after his accident. He was not eligible to obtain a retirement pension. He applied for and was granted a disability pension by his union.

Mr. Slad did not look for any type of work, from any employer, when he stopped working as a union carpenter in October 2008.

Mr. Slad was examined at the request of his attorney by Dr. Samuel Chmell. Pursuant to §12 of the Workers' Compensation Act, Mr. Slad was examined both by Dr. Gary Skaltsky and by Dr. Avi Bernstein.

The Latin phrase, *post hoc ergo proter hoc* ("after this, therefore because of this") and its contorted logic should have no application in determining causal relationships. Simply because a condition follows an event does not mean the event caused the condition.

At the time of his September 15, 1999 accident, Mr. Slad had degenerative disc disease of his lumbar spine. When seen by Dr. Mansfield on September 19, 1999, he tells Dr. Mansfield he had prior back pain related to his years working as a carpenter.

Diagnostic testing confirmed the presence of a degenerated lumbar spine. The September 24, 1999 MRI was interpreted by the radiologist as showing disc desiccation of the L3-L4 and L4-L5 discs. Dr. Tolentino's March 27, 2000 chart notes confirms the September 29, 1999 MRI showed degenerative disc disease.

A March 21, 2000 CT scan and myelogram were interpreted by the radiologist to show no disc protrusion or focal disc herniation at any level. Dr. Tolentino agreed the March 21, 2000 myelogram and CT scan only showed disc degeneration of the lumbar spine. The November 8, 2000 MRI of the lumbar spine was interpreted to show disc dehydration at the L3-L4, L4-L5 and L5-S1.

Subsequent to the September 15, 1999 accident, Mr. Slad missed less than 10 weeks of intermittent work. Otherwise, he worked full-time unrestricted work for the nine continuous years. When Mr. Slad was seen by Dr. Tolentino on October 2, 2000, it was noted he was doing well except when he engaged in repetitive bending in which case, his back pain and sciatica would recur. In March 2002, Dr. Tolentino notes Mr. Slad experienced an aggravation of his back pain due to heavy lifting and repetitive bending while working.

On October 3, 2002, Mr. Slad denied to Dr. Tolentino of having any significant low back pain. Dr. Tolentino comments repetitive lifting and bending could exacerbate Mr. Slad's back symptoms.

Subsequent medical records confirm Dr. Tolentino's comments. When Mr. Slad is seen on January 22, 2009, Dr. Tolentino notes Mr. Slad's physical activity related to his occupation as a construction worker caused aggravations of his low back pain.

On February 11, 2010 Mr. Slad tells Dr. Tolentino he had increase in his back pain after lifting activities at home. Similarly, when seen by Dr. Tolentino on September 20, 2010, Mr. Slad comments he noted the return of his back pain after a busy few weeks doing home remodeling.

Mr. Slad's testimony recognizes the ongoing worsening of his lumbar spine due to his work activities subsequent to September 15, 1999.

Question: Dr. Tolentino's September 4, 2003 notes indicate you told him that your back pain was being aggravated by your work as a construction worker. You remember making such a comment to him?

Answer: Well, the pain that I'm suffering is from *construction work.* – (emphasis added)

Question: While you were working after 1999, was your back pain becoming more troublesome?

Answer: Yes.

Question: And so the work that you were doing subsequent to 1999 through 2008, whether it was demolition work or all the other type of activities one does as a carpenter, those were aggravating your back?

Answer: Yes.

Question: And I think what you are saying is similar to what Dr. Tolentino recorded in November of 2003 where he says there has been an aggravation of your back pain with work-related activities?

Answer: Yes.

Question: Right?

Answer: Yes.

Question: So as you were working for all these various employers, it wasn't helping things and things progressively got worse?

Answer: Yes.

(Record pages 90 through 93.)

Mr. Slad testified 16 years after his accident. His complaints at hearing were not present when he returned to full time carpentry work.

Question: And the numbness that you described as being in my notes or that you said it was from your knee to your foot.

Answer: To my ankle.

Question: To your ankle, right?

Answer: Yes, on both legs.

Question: That's on both legs?

Answer, Yes, sir.

Question: And you had that from the beginning?

Answer: No. It's progressively gotten to that point.

Question: And so when you are working for a year or two after the accident, in other words while you were still working for Anning, working as a construction or carpenter, right?

Answer: Yes.

Question: You weren't having any of those numbness?

Answer: Not the numbness.

(Page 90 to 93 in transcript.)

When examined by Dr. Gary Skaltsky in 2006, Mr. Slad had been working seven years of full-time work as a carpenter. Dr. Skaltsky described Mr. Slad as having back pain with

intermittent lower radicular complaints secondary to degenerative disc and joint disease of the lumbar spine. Dr. Skaltsky opined Mr. Slad's complaints of pain were not due to the injury of September 15, 1999. Rather, Dr. Skaltsky opined Mr. Slad's complaints of pain were due to the worsening degenerative disc and joint disease.

Mr. Slad was also examined by Dr. Avi Bernstein. He, like Dr. Skaltsky performed a physical examination. He reviewed medical records including diagnostic studies. Dr. Bernstein noted the September 24, 1999 lumbar MRI showed degenerative changes from L3 to L5. He specifically comments that the MRI failed to show any nerve root compression.

Dr. Bernstein concluded Mr. Slad had a progressive degenerative condition of the lumbar spine. He opined Mr. Slad suffered a lumbar strain when injured on September 15, 1999. He further opined Mr. Slad was at maximum medical improvement six months after the work-related accident in September, 1999.

The Arbitrator finds the testimony and opinions of Dr. Bernstein more persuasive than the testimony of Dr. Chmell. The diagnostic studies of 1999, 2000, and 2001 fail to show the accident of September 15, 1999 caused any structural changes to the lumbar discs. The 2001 MRI shows Mr. Slad had evidence of disc dehydration at L3-L4, L4-L5, and L5-S1.

Nothing within the medical testimony convincingly establishes the dehydration of the lumbar discs were caused by anything other than the aging process. Dr. Chemell's opinions are unpersuasive in his attempt to argue the degenerative lumber spine continued to degenerated due to the September 15, 1999 accident.

The Arbitrator adopts the opinion of Dr. Bernstein. The Arbitrator finds Mr. Slad's condition to his lumbar spine had stabilized six months after the September 15, 1999. Any unpaid medical subsequent to September 15, 2000 is solely attributable to Mr. Slad's personal condition, i.e. a degenerated lumbar spine, and not the result of the September, 1999 accident.

By its very nature, a degenerative spine will continue to degenerate. The Arbitrator finds the Petitioner fails to meet his burden showing his inability to work in October 2008 was attributable to the September 15, 1999 accident.

It is apparent to the Arbitrator Mr. Slad's degenerative disc disease continued to degenerate during the nine ensuing years which he continued to work full time.

Since October, 2008 when he stopped working as s union carpenter, Mr. Slad has been receiving a duty-related pension from his union. To date, he has received nearly $300,000 in benefits. Mr. Slad will continue to receive his disability pension in the future. His inability to work as a carpenter is due solely to his degenerative lumbar disc disease, a personal condition. The inability to work is not attributable in whole or in part to the exacerbation of his condition nine years prior to the cessation of his full time work activities.

The Arbitrator takes guidance in the language of the Workers' Occupational Diseases Act as to the intention of the legislature with respect to employees who continue to work subsequent to a work-related accident.

Section 1 of the Workers' Occupational Diseases Act provides:

> The employer liable for the compensation in this act provided shall be the employer in whose employment the employee was last exposed to the hazard of the occupational disease claimed upon regardless of the length of time of such last exposure. . . The only employer liable shall be the last employer in whose employment the employee was last exposed, regardless of the length of time of such last exposure.

Mr. Slad demonstrated he was capable of fully performing his work as a carpenter when he returned to work five weeks after the September 15, 1999 accident. He worked for nine years continuously, full-time, earning substantial overtime. If Mr. Slad's inability to return to full-time work as a carpenter in 2008 was attributable to his 27 years of working as a carpenter, then the legislature's intent was clear: The last employment during which Mr. Slad last worked as a

carpenter, regardless of the length of such employment, is the employer who the legislature had intended would be assessed with liability. Such employer is not Respondent.

The Arbitrator cannot ignore the nine years of repeated aggravations to the degenerative spine which occurred to Mr. Slad while working on a full-time basis. Whether Mr. Slad has a bona fide claim against his last employer is not before the Arbitrator and therefore he reaches no conclusion of law on this point. He simply states one cannot have effective, foreseeable and predictable entitlement for benefits under the Workers' Compensation Act if one ignores nine years of continuous work and attempt to assess liability for a degenerative spine onto an employer for whom an employee last worked 14 years prior to testifying.

WITH REGARD TO THE AVERAGE WEEKLY WAGE

Petitioner testified prior to September 15, 1999, he did not always work a 40-hour work week. There is no testimony within the record Mr. Slad was ready and willing to work during those weeks or parts thereof in which he did not work a full work week. As such, the Arbitrator concludes Petitioner fails in his burden to establish the average weekly wage should be calculated on a presumptive 40-hour work week. As such, the Arbitrator concludes the average weekly wage must be calculated based on the actual regular hours worked by Mr. Slad. The Arbitrator adopts Respondent's calculation of a $1,019.90 average weekly wage.

WITH REGARD TO CREDIT

The issue of whether or not the Respondent is entitled to a credit is only applicable if the Arbitrator awards benefits subsequent to the termination of his employment in October, 2008. The Arbitrator, having concluded, Mr. Slad's inability to work was not attributable to the September 15, 1999 accident, therefore finds the issue of credit is not applicable to any benefits awarded by him.

WITH REGARD TO MEDICAL BENEFITS

Respondent has paid reasonable, necessary and related medical expenses. The arbitrator finds Respondent is not liable for any medical expenses sought by Petitioner

WITH REGARD TO PERMANENCY

Mr. Slad suffered a lumbar strain on September 15, 1999. It exacerbated but did not permanently aggravate his degenerated lumbar spine. As noted by Dr. Bernstein, Mr. Slad returned to his pre-injury condition six months after his work-related accident. He subsequently worked full-time, unrestricted including overtime for over eight more years. The Arbitrator finds that because of the September 15, 1999 accident, Mr. Slad sustained a 10% loss of use of a person as a whole.

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

TERRI FREEHILL,

Petitioner,

vs.

NO: 12 WC 7646

CASEY'S RETAIL CO.
d/b/a CASEY'S,

18IWCC0037

Respondent,

DECISION AND OPINION ON REVIEW

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

Petitioner's Application for Adjustment of Claim alleged a date of accident of July 1, 2011. This was amended at hearing, without objection, to July 11, 2011. The Findings section on page two of the Decision states that Petitioner's alleged date of accident was July 1, 2014. We correct this clerical error to reflect that Petitioner's alleged date of accident was July 11, 2011.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed May 13, 2016, is hereby affirmed and adopted with the clerical correction noted above.

18IWCC0037

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 the alleged 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: JAN 22 2018

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

SE/
O: 12/5/17
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FREEHILL, TERRI
Employee/Petitioner

Case# 12WC007646

CASEY'S RETAIL COMPANY D/B/A CASEY'S
Employer/Respondent

18IWCC0037

On 5/13/2016, 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 0.38% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0564 WILLIAMS & SWEE LTD
STEVEN R WILLIAMS
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

3150 JAMES M KELLY
4801 N PROSPECT RD
SUITE 832
PEORIA HEIGHTS, IL 61616

18IWCC0037

STATE OF ILLINOIS)
)SS.
COUNTY OF McLean)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Terri Freehill
Employee/Petitioner

v.

Casey's Retail Company d/b/a Casey's
Employer/Respondent

Case # 12 WC 007646

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 **Bloomington**, on **2/26/16**. 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. ☒ 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 _____

18IWCC0037

FINDINGS

On **7/1/14**, 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 **$17,290.00**; the average weekly wage was **$292.70**.

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.

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

Because Petitioner failed to establish that she sustained an accident which arose out of and in the course of her employment with Respondent, and further failed to prove that her current condition of ill-being is causally related to her employment, benefits are denied.

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

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

Signature of Arbitrator

4/27/16
Date

ICArbDec p. 2

MAY 13 2016

FINDINGS OF FACT

The Petitioner worked as a pizza maker/donut maker for Casey's General Stores. She started on April 19, 2011. Her scheduled work hours were 5 days a week for 7 hours, midnight to 7:00a.m. She typically worked between 36 and 40 hours a week.

The Petitioner's job duties included making pizzas, sandwiches, donuts, brownies, muffins, and cookies. Petitioner described her job, which required bending, twisting, flexing and extending of the wrist. Petitioner testified that she would handle, finger and grip objects at least 4 to 6 hours of her 8 hour shift. These job activities included bending, twisting, flexing and extending. She would have to occasionally lift 20 pounds and throughout her day would have to handle objects that weighed up to 10 pounds.

When making Pizzas Petitioner would pull out pre-made dough in an amount the approximate size for a small, medium or large pizza. Petitioner would then put it into a dough roller machine to flatten the dough. Petitioner testified she would twist and knead the dough to fit it onto the pan. Petitioner would then put sauce on the pizza with a ladle or plastic spatula. She made both regular pizzas and breakfast pizzas. Petitioner testified she had to do pushing/pulling with her arms, hands and back while making pizzas.

Petitioner made sandwiches every other evening for a couple of hours. Petitioner would use hoagie rolls and pre-cut sandwich ingredients to assemble the sandwiches. She then wrapped them and put them in the cooler. Petitioner indicated she would have to twist her elbow, wrist and fingers making sandwiches.

Petitioner made both conventional and cake donuts. She made "conventional" doughnuts by taking pre-made doughnuts and placing them on a tray and putting them in the oven. She made cake doughnuts by mixing water with powered batter. She mixed the batter by hand with a spatula. Generally two batches of cake donuts were made each evening. (Petitioner testified that the mixing took 20 to 25 minutes. Jena Boase is an area supervisor for Casey's. She testified on behalf of Respondent. She began working for Casey's in 1995 as a pizza/doughnut maker like Petitioner. Ms. Boase testified the entire process only took 2 minutes to mix the cake doughnut batter.) Petitioner would then place the batter into a "doughnut chute" and form the doughnuts. Petitioner testified the cake doughnuts required a lot of twisting of her hands and were more labor intensive than the conventional doughnuts. She testified she had strain on her fingers, wrists, elbow and arm making doughnuts.

Petitioner also made breakfast burritos to be ready to serve at 5 am. Making the burritos required lifting a pre-made tortilla and then using an ice scream scoop to put a pre-mixed filling of eggs, cheese and ham onto the tortilla. Petitioner then sprinkled on cheese and folded it into a burrito. Petitioner testified burrito making required twisting and pulling of her wrist, elbows, arms and fingers. She also made brownies every other night. They were frozen and she would take them out of the freezer and let them thaw partially. Then, Petitioner placed them on a pan and put them in the oven. Although not required, some of the brownies she would decorate with powdered sugar and sprinkles to be attractive to kids. Petitioner used her hands, fingers, wrists and elbow with some twisting to make brownies. Petitioner also made a few muffins every night. She testified that they were frozen. She would take them out of the freezer and then put them in the oven. The process took 20-30 minutes. Cookies were also made for an hour and a half to two hours per night. The larger cookies were pre-made and she would simply put them on a sheet and bake them. To make mini cookies, she would simply

cut the pre-made cookies into four and then bake them in the oven. Petitioner testified she used her arms, wrists, fingers and elbows to make cookies.

Petitioner testified that over the course of the seven hour shift she would also use a dating gun. Everything that she made had to have the time the item was made and an expiration date. Petitioner sometimes used the dating gun with one hand and other times with two hands. Petitioner also had to clean pans every night throughout her shift. She estimated it took about an hour, or maybe less. She described them as "big pans." She testified she had to use a lot of twisting of her fingers, arms and wrists washing pans.

Petitioner testified her whole shift required a lot of bending, twisting, flexing and extending of her wrists. Petitioner also had to lift boxes and the dough bucket. Petitioner testified that the dough bucket was very heavy. Petitioner indicated that her duties required her to lift, twist, and bend to get anything. Petitioner described all of the equipment necessary for her job. Petitioner used a rubber spatula to mix doughnuts, ladles for sauce, little cups to hold cookies, a frosting spatula and pans.

After approximately 5 days of performing these job duties Petitioner noticed tingling and numbness in her hands. She specifically noticed the problems when mixing the cake donut ingredients.

On July 11, 2011 the Petitioner underwent an EMG. The EMG showed moderate to severe right median neuropathy at the wrist. There was mild left neuropathy at the left wrist. (PX2)

Petitioner's original Application for Adjustment of Claim listed an accident date of July 1, 2011. During arbitration, Petitioner amended her application to allege an accident date of July 11, 2011.

The Petitioner saw Dr. Newcomer on August 11, 2011. Dr. Newcomer noted numbness and tingling in the right median nerve distribution. Dr. Newcomer noted the Petitioner worked at Casey's General Store. She had been there about five months. She noticed pain when she was stirring donuts. Prior to working at Casey's she was off work for two years and had no symptomatology. During his exam he found a positive direct compression test and a positive Phalen's sign. He diagnosed moderate to severe carpal tunnel syndrome. He suggested surgery. (PX3)

On April 6, 2012 Dr. Newcomer authored a letter. (PX4) Dr. Newcomer stated that the Petitioner told him that she noticed this all started while working for Casey's General Store when she had been there for about five months. While making donuts by hand she started having pain in her right hand. She was diagnosed with carpal tunnel syndrome. He stated there was no question in his mind as the result of causation that the activities that were required of her at Casey's if not a direct cause were certainly an aggravating factor to the development of carpal tunnel syndrome. *Id.*

On January 3, 2014 Dr. Newcomer performed a right carpal tunnel release. The diagnosis was right carpal tunnel syndrome. Petitioner returned to restricted work on January 31, 2014, to resume full duty on February 28, 2014. Petitioner was unable to work due to the surgery on her right hand from January 3, 2014 through January 31, 2014.

On June 11, 2014 Petitioner returned to Dr. Newcomer with regard to her left hand. Dr. Newcomer placed restrictions of no lifting greater than 10 pounds, and continue with cash register work only until further treatment of left carpal tunnel syndrome. On October 3, 2014 Dr. Newcomer performed a left carpal tunnel

release and a left trigger thumb release. (px8) Following surgery Petitioner was initially limited to right handed work only. Following his examination of Petitioner on November 3, 2014 Dr. Newcomer placed no restrictions. When Petitioner saw Dr. Newcomer on May 4, 2015 he reported that she was doing well with respect to range of motion and strength. Dr. Newcomer released Petitioner from care at MMI. Petitioner was unable to work due to the surgery on her right hand from October 3, 2014 through November 3, 2014.

The Petitioner's medical bills totaled $17,748.00. Workers' Comp did pay $267.34 to Premier Orthopedics. $12,541.00 remains outstanding to McLean County Orthopedics. $3,553.00 remains outstanding to Bloomington/Normal Healthcare Center and $1,352.00 remains outstanding to McLean County Anesthesiology.

Dr. Newcomer testified by way of deposition. Dr. Newcomer testified on direct that Petitioner's job duties would cause carpal tunnel syndrome. His opinion was based on the repetitive nature of what she described along with a temporal relationship of the onset of symptomatology. Dr. Newcomer stated that at a minimum this represented an aggravation. Dr. Newcomer stated that it is the repetitive manual tasking that favors a causal relationship between the job duties and Petitioner's carpal tunnel syndrome. He referenced the stirring, gripping and handling. Even understanding that the Petitioner was female, her age, smoking and hypertension he still felt her job duties would have at least aggravated her condition.

Dr. Williams also testified by way of deposition. He performed a Section 12 examination for Respondent. Dr. Williams reviewed Petitioner's written job description and went over it with Petitioner. Petitioner gave him an explanation of her duties and advised there were some duties in the written description which she did not have to perform. Dr. Williams opined that Petitioner's condition was not caused or aggravated by her work duties. Dr. Williams testified that Petitioner had a number of pre-disposing factors, including: her gender; age; obesity; she was a smoker; and she had high blood pressure. Dr. Williams testified that her job duties did not cause or aggravate her condition.

The Arbitrator notes that there is conflicting evidence regarding the volume and repetition of Petitioner's work. Petitioner herself conceded that she had multiple and varied job duties. She could work at her own pace. She agreed that many of her job duties merely involved placing frozen food on a pan and putting it in the oven. Petitioner agreed that all of her utensils were light weight. Petitioner testified it only takes her 3 minutes to make a pizza. She made about eight pizzas per night depending on traffic, but on average one pizza an hour. Petitioner testified all pizza toppings were pre-made. She worked at her own pace:

Petitioner's right hand has improved since her surgery. She testified her right hand hurts when it is really cold outside. Her incision is a little tender. Sometimes her hand hurts when she is at work, but she paces herself. Sometimes her hands swell up. Petitioner testified her left hand is pretty good with no pain or discomfort.

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?

Petitioner was hired on April 18, 2011. She worked three days shadowing a co-worker monitoring the job. Up to April 30, 2011, Petitioner had worked minimal hours as documented in her time records. Petitioner claims she developed severe symptoms within five days of beginning work for Casey's. Petitioner indicated she had never experienced these symptoms before working for Casey's.

The Arbitrator finds Petitioner's limited number of hours worked as of the date she first developed symptoms, and the lack of repetitive, strenuous job duties significant. Further, the Arbitrator finds the testimony and opinions of Dr. Williams more persuasive than those of Both Dr. Newcomer in this case.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has failed to meet her burden of establishing she sustained accidental injuries which arose out of and in the course of her employment. Petitioner has further failed to establish that her current condition of ill-being (bilateral carpal tunnel syndrome which ultimately required surgical repair) is causally related to her employment with Respondent.

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 submitted medical bills of $17,748.00. Both Dr. Newcomer and Dr. Williams agree that Petitioner required surgery to address her bilateral carpal tunnel syndrome. The Arbitrator finds the medical expenses submitted were reasonable and necessary to treat those conditions. However, based on the Arbitrators decision with regard to issues C and F, benefits are denied.

Issue (K): What temporary benefits are in dispute?
Issue (L): What is the nature and extent of the injury?

It is undisputed that as a result of the surgical procedures performed on Petitioner's right and left hands, she was temporarily and totally disabled from January 3, 2014 through January 31, 2014 and again from October 3, 2014 through November 3, 2014. However, based on the Arbitrators decision with regard to issues C and F, benefits are denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mark Carlock,
Petitioner,

18IWCC0038

vs.

NO: 15 WC 10925

City of Springfield,
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, temporary 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 July 21, 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: JAN 22 2018
o12/7/17
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

18IWCC0038

CARLOCK, MARK
Employee/Petitioner

Case# **15WC010925**

CITY OF SPRINGFIELD
Employer/Respondent

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:

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

0332 LIVINGSTONE MUELLER ET AL
L R MUELLER
620 E EDWARDS ST
SPRINGFIELD, IL 62703

18IWCC0038

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

Mark Carlock
Employee/Petitioner

Case # 15 WC 10925

v.

Consolidated cases: N/A

City of Springfield
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Springfield**, on **May 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 _____

FINDINGS

On **October 2, 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 **$105,372.90**; the average weekly wage was **$2,026.40**.

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*** 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 general credit for any medical bills paid by its group medical plan for which credit may be allowed under Section 8(j) of the Act, and as reflected in Petitioner's Exhibits.

ORDER

With regard to Petitioner's bilateral hand/carpal tunnel syndrome claim:

Petitioner failed to prove he sustained an accident on October 2, 2014 that arose out of and in the course of his employment with Respondent or that his current condition of ill-being in his hands and wrists is causally connected to his injury. Petitioner's claim for compensation is denied and no benefits are awarded.

With regard to Petitioner's left elbow/cubital tunnel syndrome claim:

Petitioner did prove that he sustained an accident on October 2, 2014 to his left elbow that arose out of and in the course of his employment with Respondent. However, he failed to prove that his current condition of ill-being in his left elbow, or his need for surgery, was causally connected to his injury. 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 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.

Mary Lindsay
Signature of Arbitrator

July 14, 2016
Date

JUL 21 2016

Mark Carlock v. City of Springfield, 15 WC 10925

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner alleges repetitive trauma injuries to his hands and left elbow with a manifestation date of October 2, 2014. The parties stipulated that Petitioner's left trigger finger injury is unrelated to this claim.

The Arbitrator finds:

On August 5, 2014 Petitioner completed a City of Springfield Employee Accident Report for Respondent. He reported that both of his hands were going numb when driving and using a computer. Petitioner indicated that he drove a city vehicle for 5 ½ hours per day and used a computer for 2 hours per day and that the steering wheel and computer work "possibly" were the cause of his problems. He had tried hand exercises without help. He stated that he had been behind the steering wheel at least five hours per day for almost 25 years and on the computer. He thought that perhaps wearing a brace while driving might have helped his condition and possibly could have prevented it. (RX 1 – res. ex. 2, p. 3)

Petitioner's personal health care is handled through Priority care HSHS Medical Group. (PX 2) On October 2, 2014 Petitioner presented to Dr. Juranek complaining of bilateral hand numbness, bilateral locking of the third finger on each hand, and bilateral elbow pain, especially on the left. Petitioner reported driving a car six hours/day. More specifically, Petitioner complained of right hand numbness in the 4th and 5th digits and left hand numbness in the first three digits, all of which was reportedly worse at night and when driving a car. The doctor noted, "It has been coming on for a while but has gotten much worse her over the last couple of months." Petitioner reported using a brace during the day but it didn't make much of a difference. On physical examination, Petitioner had a positive Tinel's in the left hand and some tenderness over his right elbow. He also had a positive trigger finger on the left hand. Petitioner was diagnosed with carpal tunnel syndrome, cubital tunnel syndrome, and trigger finger. He was referred to a hand surgeon, Dr. Maender. (PX 2)

Petitioner, along with a nurse case manager, presented to Dr. Maender on November 11, 2014 reporting bilateral hand complaints, worse on the left. Petitioner was being seen on referral from a "work comp adjuster." Petitioner's job was noted to be that of a supervisor of construction for Respondent. He gave a history of a gradual onset in symptoms, starting the first of August with progressing pain. Aggravating factors were gripping, but not lifting or motion. The doctor noted, "They have tried NSAIDs(ibuprofen), surgery (left thumb tendon surgery, 3 years ago) and brace (bilateral hand/wrist braces, finger splint for left middle finger) but no steroid injections, no narcotic pain medications, no Tylenol and no physical therapy." His symptoms included swelling, catching and popping. His bilateral numbness was reportedly equal to both hands and involved all digits and was worse at night as he would wake up with "dead hands." From about 1990 to 2000 Petitioner was a line man for Respondent but since the year 2000 he worked as a supervisor. He did intermittent computer work and spent most of his time driving around checking on crews. X-rays were taken and reviewed, with the left wrist showing evidence of previous thumb arthritis and mild widening of the scapholunate joint and a cyst within the lunate. Petitioner was diagnosed with carpal tunnel syndrome, bilaterally, and trigger finger of the third digit on his left hand. Petitioner was advised the trigger finger was unrelated to

his work. He further recommended an EMG for the hand numbness and tingling. In conjunction with the visit, Dr. Maender completed a "Loss Control-Medical Slip" for Respondent. He indicated Petitioner could return to work that day without restrictions but needed further medical care. He listed Petitioner's diagnoses as bilateral carpal and cubital tunnel syndromes. An EMG was ordered. (PX 3)

Petitioner underwent an EMG with Dr. Smucker on November 20, 2014. Petitioner, who was noted to be right hand dominant, reported a history of bilateral hand pain and paresthesia, left greater than the right side, which had been progressively worsening since the past summer. The EMG/NCS was noted to show bilateral medical neuropathy of moderate severity bilaterally. There was no evidence of cubital tunnel syndrome. Petitioner was to follow up with Dr. Maender. (PX 4; PX 3)

Petitioner returned to see Dr. Maender on November 26, 2014. Petitioner reported ongoing and fairly significant numbness and tingling of both hands. Dr. Maender noted, "He asked about causation today. In regards to the left middle trigger finger with his job as a supervisor I think that is unlikely related to his work. The numbness and tingling of his bilateral hands has progressively increased. He notices it more during the day time especially while driving for prolonged periods. Many people notice their numbness and tingling more while driving. Driving for prolonged periods like in his situation can be an aggravating factor to his carpal tunnel syndrome and brought it to need surgical release sooner." Dr. Maender recommended a right carpal tunnel release. Petitioner was allowed to continue working with no restrictions. (PX 3)

Petitioner stopped working for Respondent in December of 2014 and was formally retired in January of 2015.

At the request of Respondent, Petitioner underwent an examination with Dr. Rotman on January 5, 2015 in St. Louis, Missouri. (RX 1, dep. ex. 2) Dr. Rotman issued a written report that same day in which he summarized his examination, findings, and opinions. Dr. Rotman noted that Petitioner was a lineman supervisor for Respondent and that Petitioner "feels his present condition [bilateral carpal tunnel syndrome and trigger fingers] is related to overtime, use of the hands, use of hand tools and computer work for years on the job." Petitioner reported increasing symptoms since 2014 associated with using a hammer to stake a job or when driving. The numbness and tingling on the left hand was more in the ring and small fingers than the median nerve distribution. Petitioner had last worked for Respondent on December 12, 2014. Petitioner attributed the numbness and tingling in his ring and small fingers from leaning his elbow on the arm rest of his door, noting "he had leaned on it for so long, he put an indentation on it." Petitioner was now trying to avoid leaning on it as that may have been the problem all along. (RX 1, dep. ex. 2, pp. 1-2)

Dr. Rotman was provided information concerning Petitioner's employment with Respondent including the various jobs he had held while so employed. Also provided to him was an Accident Report dated August 5, 2014 in which Petitioner reported both of his hands would go numb and tingly when driving and using a computer. Petitioner reportedly drove a vehicle 5 ½ hours per day and used a computer 2 hours a day. Petitioner further stated that he had been behind the steering wheel at least five hours per day for almost 25 years and on the computer. He also believed that wearing a brace while driving might have helped prevent it. Dr. Rotman was

provided with a job description for Petitioner's job as a maintenance supervisor. His report discussed Petitioner's medical history beginning in October of 2014 and through November 26, 2014. (RX 1, dep. ex. 2)

Dr. Rotman's impression was that Petitioner had bilateral carpal tunnel syndrome (right greater than left) and, based upon clinical exam and history, left cubital tunnel syndrome. He wrote, "His cubital tunnel condition certainly could have been aggravated by resting his inner elbow on the arm rest of his vehicle for prolonged periods of time." In light of Petitioner's retirement he felt those symptoms should resolve, especially in light of normal nerve conduction studies." (RX 1, dep. ex. 2, p.5)

Dr. Rotman was of the opinion Petitioner's bilateral carpal tunnel syndrome was idiopathic due to Petitioner's weight. His hands had a "puffy look to them" and he was 58, which was also considered a risk factor. Dr. Rotman felt Petitioner had no work risk factors since becoming a maintenance supervisor nor would his job duties for the first fourteen years of his career have been a factor as they did not involve repetitive heavy gripping. Petitioner had significant carpal tunnel syndrome by EMG study and, therefore, it would not be surprising that he would have symptoms after holding onto a steering wheel while driving or when holding onto a newspaper. Such activities "merely bring out symptoms or cause symptoms but would not be aggravating factors for the condition. The same holds true for the numbness and tingling when he goes to sleep." (RX 1, dep. ex. 2, p. 5)

Dr. Rotman took no issue with the need for surgery on Petitioner's wrists. He recommended a brace or elbow pad for Petitioner's elbow. (RX 1, dep. ex. 2, p. 5)

Petitioner signed his Application for Adjustment of Claim herein on March 15, 2015. (AX 2)

Petitioner underwent a pre-operative physical examination with Dr. Juranek on April 3, 2015. Petitioner was noted to be retired. He was cleared for surgery. (PX 2)

Dr. Maender performed a right carpal tunnel release on April 14, 2015. (PX 5; PX 3)

Petitioner presented to Dr. Juranek on April 24, 2015 for an annual health examination. Petitioner's surgical history included a history of arthrodesis to the thumb carpometacarpal joint with Dr. Greatting along with rotator cuff surgery. He had recently undergone a carpal tunnel release. They reviewed labs and discussed recommendations for losing weight which Petitioner was already attempting to do. (PX 2)

Dr. Maender performed a left carpal tunnel release and left trigger finger release on April 28, 2015. (PX 6; PX 3)

Post-operatively, Petitioner reported improved sensation and well controlled pain. The numbness and tingling associated with Petitioner's right carpal tunnel syndrome had improved. Petitioner "still" had pain over the left medial elbow in the area of the ulnar nerve. On exam he had a positive Tinel's over the ulnar nerve at the elbow and a positive bent elbow test. He was also tender over the nerve and minimally tender over the medial epicondyle. They decided to continue with observation. (PX 3)

Petitioner returned to see Dr. Maender on June 8, 2015 reporting satisfaction with the prior carpal tunnel releases and quite a bit of sensitivity over the ulnar nerve at the left elbow. Numbness and tingling in his hands was noted to be "rare." Ongoing observation was agreed upon. (PX 3)

Dr. Maender re-examined Petitioner on August 10, 2015. Petitioner denied any numbness or tingling but reported constant achiness in his elbow with occasional numbness and tingling to the 4th and 5th digits of his left hand. Petitioner had good mobility of his fingers but exquisite tenderness over the left medial elbow. Petitioner was given a left elbow injection and told to return in two months if still problematic. (PX 3)

Petitioner returned to see Dr. Maender on October 3, 2015 reporting left medial elbow pain and numbness in his left thumb. The injection into his elbow only helped for about five to ten days. Petitioner was driving over the weekend and noticed increased numbness of his left thumb which had been progressively increasing. He denied any numbness in other digits. His right hand was doing well. He reported good strength but tenderness over his medial left elbow. A repeat EMG/NCS was ordered as well as an ultrasound for the left ulnar nerve to look for swelling or compression. (PX 3)

The deposition of Dr. Christopher Maender was taken on October 6, 2015. (PX 7) Dr. Maender is a board certified orthopedic surgeon with a fellowship in hand and upper extremity surgery. Ninety percent of his practice is focused on hand and upper extremity surgery, including carpal tunnel surgery and cubital tunnel surgery. (PX 7, pp. 1 – 7)

Dr. Maender testified that he remembered Petitioner as he had just examined him the day before the deposition. Dr. Maender testified regarding Petitioner's care, treatment, history, and complaints consistent with his medical records discussed above. (PX 7) Dr. Maender further testified that Petitioner told him at the time of their initial meeting that he was a lineman for the city from 1990 to 2000 and then, in 2002, became a supervisor of construction. Petitioner described his job duties as intermittent computer work with the majority of his time being spent driving around checking on the work crews. While Dr. Maender had treated other employees of Respondent's City Water, Light and Power Department he did not recall having ever treated a supervisor. He had treated linemen. (PX 7, pp. 9-10) Dr. Maender initially diagnosed Petitioner with "bilateral hand numbness and tingling, most likely carpal tunnel syndrome and cubital tunnel syndrome, and bilateral middle trigger fingers." Dr. Maender did not feel the trigger fingers were work-related. (PX 7, pp. 13- 14)

Dr. Maender testified that diabetes mellitus, hypothyroidism, pernicious anemia, and chemotherapy exposure can give one peripheral neuropathy where the whole length of the nerve does not work as well. If one lacks a history of those medical conditions, it decreases one's chances of having a peripheral neuropathy. (PX 7, p. 15) Dr. Maender testified that the EMG/nerve conduction study findings were consistent with his clinical findings. He also testified that there was clinical evidence of cubital tunnel syndrome, although the EMG findings with regard to the ulnar nerve were unremarkable. Dr. Maender explained that a patient can have cubital tunnel syndrome and still have a normal nerve study because the nerve can be inflamed and sensitive, but not bad enough to show up on the nerve study. (PX 5, pp. 16-17) Dr. Maender also testified that Petitioner was overweight and that obesity is one of the factors that can contribute to carpal tunnel syndrome; however, he went on to point out that Petitioner's obesity

made him more susceptible for other factors to cause or aggravate his carpal tunnel syndrome. He explained that one factor alone doesn't usually cause enough trouble to require treatment; however, the more factors one has increases the need for treatment. (PX 7, pp. 19-20)

Dr. Maender was asked to assume a number of facts concerning Petitioner's job duties, length of employment, and the details of his accident report (PX 7, pp. 20-22). He testified that only engaging in computer work for about two hours a day was "probably not a large contributing factor to his need for treatment or to the development of his carpal tunnel." (PX 7, p. 22) With regard to Petitioner's driving duties, the doctor testified, "With his driving, he needed to drive a good portion of the day. I think holding onto the steering wheel, especially if you have your wrist flexed back, a lot of people complain of worse numbness and tingling as they are driving. I think that is a contributing factor to his development." (PX 7, p. 22; see also p. 25) He went on to explain that holding one's wrist either fully flexed or fully extended increases the pressure within the carpal tunnel. (PX 7, p. 23)

Dr. Maender was also asked to assume that the job description as contained in PX 1[1] was accurate and, if so, whether the job duties described therein could be causative or a contributory cause of the etiology of Petitioner's carpal tunnel syndrome to which the doctor replied, "Yes, I do think it would be one of those contributory factors." (PX 7, pp. 25, 24)

Dr. Maender further testified that he subsequently performed carpal tunnel releases on Petitioner and his intra-operative findings were consistent with Petitioner's symptoms. (PX 7, pp. 27-28)

Dr. Maender testified that at the first post-operative visit Petitioner was complaining about his left elbow in the area of the ulnar nerve. He had no right elbow complaints. While Petitioner continued to recover for his bilateral carpal tunnel syndrome his left ulnar nerve remained sensitive. As of August 10, 2015 Petitioner's bilateral carpal tunnels were well healed with good finger motion, lack of tenderness, and excellent strength. Petitioner voiced no hand/wrist complaints related to the bilateral carpal tunnel releases and the doctor released him from his care at that time regarding those conditions. However, Petitioner remained symptomatic over the left ulnar nerve at the elbow. On physical examination, Petitioner had a positive Tinel's at the elbow but a negative bent elbow test, the latter of which was a new finding since earlier examinations. (PX 7, pp. 28 – 33)

Dr. Maender testified that he had just re-examined Petitioner the day before regarding his cubital tunnel syndrome which Petitioner felt was progressively increasing. His carpal tunnels were doing well but he had positive Tinel's and bent elbow tests at the elbow. The doctor recommended a repeat nerve study on the elbow. (PX 7, pp. 34-35; p. 44)

As of the date of the deposition Dr. Maender felt Petitioner was at maximum medical improvement for his hands/wrists but not his elbow. (PX 7, p. 35)

Dr. Maender was shown a photograph of Petitioner's truck (PX 7, p.23, dep. ex. 4) [2] Dr. Maender noted that the photograph showed upholstery or fabric in the area where Petitioner's left elbow would sit that was "most worn through." He believed that the area in the photograph

[1] PX 3 of the doctor's deposition (PX 7)
[2] Also identified as PX 10 in the exhibits.

would be consistent with the placement of the medial portion of one's elbow. The doctor was then asked to assume that if Petitioner was driving a vehicle for work either 30% or 55% of his day and would place his medial/inner aspect of his elbow on the driver's side of the door as shown in the photograph what, if any, cause would it have to the etiology of Petitioner's cubital tunnel syndrome. The doctor replied, "I think if any of us lays directly on our nerve for that length of time, day in and day out, you're going to cause cubital tunnel syndrome." (PX 7, pp. 36-37)

On cross-examination Dr. Maender acknowledged that Petitioner had some positive findings regarding his right elbow the first time he saw him but "that did not come into play at all." (PX 7, p. 38) The doctor explained that Petitioner has never complained about his right elbow and the EMG was negative. (PX 7, p. 38)

Dr. Maender also agreed that if the facts of the hypotheticals were not true, his opinions could change. He didn't believe driving one hour a day would be enough to cause or contribute to the condition but two hours probably could. (PX 7, pp. 39-40, 47) The doctor also understood that Petitioner did not perform his driving all at one time. (PX 7, p. 40) Dr. Maender acknowledged that Petitioner is probably in the "morbid obese" category but that wouldn't mean he had a bigger chance of getting carpal or cubital tunnel syndrome. (PX 7, pp. 40-41) The doctor could not find any medications taken by Petitioner that would predispose him to either condition. (PX 7, p. 41) Petitioner's age, according to the doctor, fell into the most common age group for the conditions. (PX 7, p. 42)

Dr. Maender further testified that people, in general, can have symptoms of carpal tunnel syndrome while driving a car or any vehicle. He could not state whether the driving of the car caused the EMG results to be worse. He did feel that if Petitioner was driving and had his wrist in an extended or flexed position for a prolonged period of time, it would increase the pressure to the median nerve and decrease the blood supply to that nerve and, therefore, could cause a change in the underlying carpal tunnel condition. (PX 7, pp. 42-43, 48) The doctor was also asked whether the carpal tunnel syndrome must be at some "advanced stage" for the driving to cause symptoms and the doctor replied, "You have to have some level of carpal tunnel, yes." (PX 7, p. 43) With regard to Petitioner's left elbow, the doctor "expected" his symptoms would be better now that he's not resting it in the car and if he's not doing that and is still symptomatic (as he was the day before the deposition) "something else is adding to it." (PX 7, pp. 45-46)

On redirect examination Dr. Maender was asked additional questions about Petitioner's elbow condition post-retirement. He noted that if Petitioner continued to rest on his left arm on a surface "exposed to the median nerve" that would be explanatory to the continued symptoms. (PX 7, p. 47) He also testified that the four month gap between the request for carpal tunnel surgery and the actual date of surgery could have been because Respondent denied the request for surgery. (PX 7, p. 50)

Dr. Maender was unfamiliar with any activities Petitioner engaged in post-retirement. (PX 7, p. 44) He felt retirement would help the symptoms some but once one "hit[s] that certain pressure in carpal tunnel, I don't think it ever goes away." (PX 7, p. 44)

Petitioner underwent an EMG and ultrasound testing with Dr. Watson on October 20, 2015 due to ongoing left elbow pain and paresthesia into the left 3 radial fingers. His right side

was reportedly doing "very well." Dr. Watson found electrodiagnostic evidence of a moderate left upper extremity ulnar neuropathy consistent with cubital tunnel syndrome. Ultrasound testing showed hypoechoic swelling of the nerve along with an extra muscle compressing the nerve which was absent in the right upper extremity. This most likely represented "anconeus epitrochlearis." Dr. Watson also noted that Petitioner had an atypical median motor response consistent with "anomalous anastomosis" such as a "Martin Gruber connection." He felt it might explain Petitioner's atypical anatomical paresthesia in the median distribution. (PX 3; PX 8)

Petitioner followed up with Dr. Maender on October 28, 2015 who recommended surgery for the left elbow. (PX 3)

The deposition of Dr. Rotman was taken on November 3, 2015. Dr. Rotman testified that he is an orthopedic surgeon with a subspecialty in hand surgery. (RX 1, p. 3)

Dr. Rotman testified that he reviewed documents forwarded to him, took a history from Petitioner, and performed a physical examination (RX1, p. 5). Dr. Rotman also reviewed the job description with Petitioner, who confirmed that it was accurate. (RX1, p. 7) Dr. Rotman testified that his physical examination findings were consistent with bilateral carpal tunnel syndrome. (RX1, pp. 8-9) Dr. Rotman also testified that there were physical examination findings consistent with left cubital tunnel syndrome; however, there were no findings consistent with right cubital tunnel syndrome. Dr. Rotman described Petitioner's hands as puffy and stocky which he deemed significant with regard to bilateral carpal tunnel syndrome as it increases the water content and the pressure in the carpal tunnel. (RX 1, pp. 9-10) Dr. Rotman also testified that the EMG from November of 2014 had findings consistent with bilateral carpal tunnel syndrome but no evidence of cubital tunnel syndrome on either side. Dr. Rotman diagnosed Petitioner with bilateral carpal tunnel syndrome and left cubital tunnel syndrome. (RX1, p. 10) The doctor noted that Petitioner rested his inner elbow on an arm rest for a long time and that, hopefully, those symptoms would go away if he stopped leaning on it. Dr. Rotman felt that Petitioner's bilateral carpal tunnel syndrome was idiopathic. He indicated it is called an idiopathic condition because the doctors do not know why the ligament becomes thick. They do know risk factors, but the cause is unknown (RX1, p. 11). According to Dr. Rotman, the majority of carpal tunnel cases are considered idiopathic. He also testified that experiencing carpal tunnel symptoms while somebody is driving is a very common complaint. It is also common to have complaints of numbness and tingling. He testified that the same goes for reading a newspaper. Sleeping is also a common cause for symptoms because when lying down, the water goes to the hands. (RX1, p. 12) Dr. Rotman testified that Petitioner's job as a maintenance supervisor or lineman was not a causative factor in his bilateral carpal tunnel syndrome. He explained that carpal tunnel syndrome is felt to be work-related if one does repetitive heavy grasping or forceful-type activities with his hands. Repetition alone is not considered a risk factor unless it is associated with high forces – with or without vibration. He further explained that the other risk factor would be somebody's doing things in a very awkward hyperflexed or hyperextended wrist position, which it's not very common at all these days. He does driving. He works on a computer. He fills out forms. He did not consider the gripping of a steering wheel to be a forceful gripping activity. Dr. Rotman did not think Petitioner had done any kind of forceful repetitive gripping activities for 24 years. (RX 1, pp. 13-14)

On cross-examination Dr. Rotman agreed that the placing of Petitioner's left elbow on the doorframe as described would be an aggravating factor for cubital tunnel syndrome. (RX 1, pp. 14-15) Dr. Rotman agreed that if Petitioner's driving involved hyperflexion or hyperextension it would place pressure on the carpal ligament. (RX 1, p. 16) Dr. Rotman further testified that if Petitioner was driving 5 ½ hours with his wrists either hyperextended or hyperflexed, it would be an aggravating factor for his carpal tunnel syndrome. (RX 1, p. 16) He also acknowledged, given Petitioner's obesity, it would require less time if he was performing activities with either a hyperflexed or hyperextended position of his hands. (RX 1, pp. 17-18)

On further cross-examination Dr. Rotman testified that if Petitioner's cubital tunnel worsened after his retirement, he would anticipate that some other factor was involved in making it worse (RX1, p. 21-22). Dr. Rotman agreed that bilateral carpal tunnel surgeries would be reasonable and necessary. He did not think that Petitioner was a candidate for a left cubital tunnel release as of the date of his examination in January of 2015. In support thereof, he noted the normal nerve studies and the fact that Petitioner had retired and would not be leaning on his elbow anymore (RX1, pp. 18-19). However, Dr. Rotman testified that if Petitioner had an abnormal nerve study with regard to the elbow, his opinions would change. (RX 1, p. 22)

Dr. Rotman testified that he had possibly more than 20 referrals for Section 12 Examinations from Respondent in the past five years. (RX 1, p. 19) He testified that well over 90 percent of his medical/legal work is for respondents. (RX 1, p. 19) He further testified that he earns over $400,000.00 per year from medical/legal work, and he performs four to five IMEs each Monday afternoon, and that he has been consistently seeing that many individuals for IME referrals for the past 10 years. (RX 1, pp. 19-20) Dr. Rotman testified that he charged $1,800.00 for the Petitioner's evaluation and $1,800.00 for the deposition. (RX 1, pp. 20-21) He testified that he performs two depositions per week. (RX p. 21)

On December 15, 2015 Petitioner underwent a history and physical examination with Dr. Juranek in anticipation of his upcoming left elbow surgery. He was cleared for surgery. He underwent left elbow surgery (an ulnar nerve release) that same day with Dr. Maender. During the procedure, Dr. Maender noted that Petitioner had a "large and developed epitrochlearis muscle" and he divided the muscle during the procedure as part of the ulnar nerve release. (PX 2; PX 3; PX 9)

As of December 23, 2015 Petitioner was doing well. He was told to slowly progress his activities as tolerated . (PX 3)

Dr. Maender re-examined Petitioner on February 24, 2016. Petitioner reported his elbow was "excellent" and he did not have any pain or issues at that time. Dr. Maender noted, "He states he is doing better than he has been in a long time." He was mildly tender over the surgical site and told to resume his activities as his pain allows but to try and avoid direct blows to the nerve as it continues to heal. He was released to return as needed. (PX 3)

Petitioner has undergone no further treatment to his upper extremities since February 24, 2016.

Petitioner's case proceeded to arbitration on May 20, 2016. Petitioner was the sole witness. Respondent's representative at the hearing was Greg Yakle. The issues in dispute were accident, causal connection, medical expenses, and the nature and extent of any injury.

Petitioner testified that he worked for Respondent's City Water Light & Power Department for approximately 34 and ½ years prior to his retirement in January of 2015. He attended Brown County High School and received a supervisory certificate from Lincoln Land Community College prior to going to work for City Water Light & Power in August of 1980.

Petitioner began working for Respondent as a groundman performing tasks that the journeyman or lineman didn't want to do such as digging holes and getting material for the crews. He described it as a labor intensive job. After he was a groundman, Petitioner worked as an apprentice lineman for four years. He then became a lineman. Petitioner testified to the various types of tools he used as a lineman, some of which he brought with him to the hearing – cable cutters, a lineman's hammer, and Klein pliers. The cutters and Klein's were used to cut copper wire, aluminum wire or guy wire and the hammer was used to drive in staples, lags, and bolts. Petitioner also used a mechanical shotgun which he described as a long stick with a handle that goes up and down for grabbing energized parts, switch sticks, and hot cutters.

Petitioner testified that around 1998 or 1999 he became a job foreman which meant he performed supervisory duties in addition to the physical work of a lineman. He performed that job for about two years before becoming a maintenance supervisor, the job he held up until the day he retired.

Petitioner testified that when he first became a supervisor he worked from 8:00 a.m. to 4:30 p.m. He had a thirty minute lunch. Petitioner testified that in the mornings he tried to get the crews ready to go and out of the shop by 8:30, which did not always happen. Once they were out of the shop, he would leave the office and drive to different locations making sure the crews were on the jobs. He would also stake any jobs that he needed to and turn in "locates" to keep work going. Petitioner testified he would drive for 4 to 5 ½ hours. He testified that on rare occasions he would use tools as a maintenance supervisor. The last vehicle he drove was a 2002 Jeep Liberty. It had an adjustable steering wheel which he would have all the way up for comfort sake. Petitioner testified that the photograph (PX 10) showed the door frame where he would rest his left elbow while he drove around town. Petitioner further testified that he would try to get back to the shop anywhere between 2:00 and 2:30 p.m. every day. He noted that a few years after he started his hours were switched to 7:30 a.m. to 4:00 p.m. When Petitioner was in the shop for approximately two hours, he would answer phone calls and return calls for messages. He would take out all of the complaint tickets that the crews had taken care of the previous day explaining that a complaint ticket would be what was written up when a member of the public called in to report a problem to the service department. They would be removed from the computer at the end of the day once the crew had addressed the issue. The amount of typing he did would depend upon how many crews there were with complaint tickets. Generally, it would be an hour and 45 minutes of the two hours. Petitioner testified that he would try to lay out jobs for the next day if he had enough time during his two hours back at the shop.

Petitioner thought that the City of Springfield job description (PX1) was accurate. He noted that about 55% of his day was involved with driving a vehicle to work sites to check on crews. He supervised the contract crews for state jobs. Petitioner testified that when he first

started as a maintenance supervisor he had five or six crews that he oversaw. Towards the end, he probably had seven or eight crews. He further testified that over 90% of the crews would be working in the city limits of Springfield. Petitioner visited each crew at least twice a day, once in the morning and again in the afternoon. If there were complications, he would visit more often. Petitioner testified that when he went to the various locations, he occasionally got out of his vehicle, but not very often. He thought that most of the time it was in the alley or on the street. He would always talk to the job foreman.

Petitioner testified that he was assigned a company vehicle as part of his job. He testified that during his 25 years as a maintenance supervisor, he had four different vehicles; most recently a 2002 Jeep Liberty. Generally while he was driving, Petitioner rested his left arm on the edge of the door near the window. Petitioner identified Petitioner's Exhibit 10 as a photograph that he had taken in approximately October 2014 of the area of the door where he rested his arm. PX 10. He testified that the photograph shows where he rested his elbow "for quite a few years." He pointed out a small indentation and wear on the door where his left elbow would rest. Petitioner further testified that the Jeep had an adjustable steering wheel and he had it "all the way up" for comfort sake. Petitioner is right handed. He identified PX 10 as a photograph showing where his left arm would be when driving.

Petitioner attributed the problems with his elbow and hands to driving and computer work. Petitioner testified that he noticed it a few years before October of 2014 but did not want to do anything in light of his position. He further testified that in October he started noticing his hands really going numb a lot more and he had pain in the elbow. Petitioner testified that when he was driving he would notice that his hands would go numb all the way from the elbow to the tip of his fingers.

Petitioner testified that his left hand didn't really improve after his left carpal tunnel release so Dr. Maender sent him to Dr. Watson for more diagnostic testing. He then underwent left elbow surgery.

Petitioner testified that since his retirement in January of 2015 he has taken up golf. He testified that he golfs approximately three times per week. He has noticed that his grip strength is weaker than is used to be and he can feel the club twist in his hands. Petitioner further testified that after he retired be began building barn wood furniture. He testified that he did not start building furniture until after his retirement. He testified that he uses hammers, saws, and rulers in his building, and that he works on furniture two days per week.

Petitioner testified that his hands will still go to sleep after working with a hammer or anything that he has to grip. He testified that he experiences numbness when sitting in a chair, and that his hands had gone numb while he was testifying at hearing. He testified he can alleviate the numbness by straightening out his arm or putting it up higher. He testified that the left side is worse than the right.

Petitioner further testified that he continues to have tenderness on his left elbow in the area of the incision and has numbness below it. He testified that he cannot rest his arm on a car door anymore.

PX 1, the job description for a maintenance supervisor dated July 16, 2014, states that one of the physical requirements for the position is the ability to drive in a vehicle for extended periods of time. (PX 1, p. 2) Fifty-five percent of the supervisor's time is spent driving a vehicle to preview worksites and supervising crews. Forty-five percent of the day is spent on schedules, coordinating work, preparing reports, drafting correspondence, preparing appraisals, communicating with the public, and other duties as required. (PX 1, p. 1) According to the "Position Attribute Worksheet" no repetitive motions of the wrists, hands, and/or fingers is involved. (PX 1, p. 3)

Petitioner's medical bills are contained in PX 11. (PX 11)

The Arbitrator concludes:

Issue (C) Did an accident occur on October 2, 2014 that arose out of and in the course of Petitioner's employment with Respondent?

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

1. Petitioner's bilateral carpal tunnel syndrome.

Petitioner failed to prove he sustained an accident on October 2, 2014 that arose out of and in the course of his employment with Respondent or that his bilateral carpal tunnel syndrome was causally related to his accident or his job duties with Respondent.

It is axiomatic that in a repetitive trauma case the unique facts of each case must be closely scrutinized. The causation issue in such cases generally revolves around the opinions and testimony of expert physicians. In this case Petitioner has relied upon his treating physician, Dr. Maender while Respondent relies upon the opinion of Dr. Rotman. Petitioner bears the burden of proof.

Petitioner has primarily worked for Respondent as a maintenance supervisor. Petitioner testified that over 90% of the jobs he was supervising would be in the city limits of Springfield. He indicated that near the end of his employment, he probably was supervising seven or eight crews. He visited each crew at least twice a day, once in the morning and once in the afternoon. He indicated he would always talk to the job foreman when he would stop at a jobsite. Petitioner indicated he would try to be back at the shop anywhere between 2:00 and 2:30 p.m. every day. He indicated in the morning he would try to get the crews ready to go and out of the shop as soon as possible. Fifty-five percent of his workday was spent driving and supervising. Petitioner's job as a maintenance supervisor was not a hand intensive manual labor job.

The parties have focused their dispute primarily on Petitioner's driving duties. Dr. Maender testified that holding onto the steering wheel for five hours per day, especially if the wrists were in a hyperflexed or hyperextended position, would contribute to the development of carpal tunnel syndrome. In a hypothetical, he was asked to assume Petitioner's hands were in that position. He acknowledged that if the hypothetical was incorrect, his opinion might change. Dr. Rotman, on cross-examination, also acknowledged the position of the hands. The problem in this particular case is that Petitioner never testified as to how he held the steering wheel. There is no reference to hyperextension or hyperflexion in his testimony. He testified

that the steering wheel was adjustable and he had it "all the way up." He also testified that he rested his left elbow on the door frame. However, he provided no testimony as to how or where on the steering wheel his hands were situated while driving. He provided no testimony as to how much force he applied, if any, when gripping or holding onto the steering wheel. A decision cannot be based upon speculation or conjecture. Therefore, the Arbitrator cannot speculate as to how Petitioner held/operated the steering wheel when driving.

The Arbitrator has also given consideration to Dr. Maender's testimony that the job duties contained in PX 1 could cause or contribute to the etiology of Petitioner's carpal tunnel syndrome; however, he never explained the basis of that opinion. The job duties listed in PX 1 are varied and, without further explanation, the doctor's opinion is not persuasive. Furthermore, Petitioner never claimed all of his job duties caused his symptoms and complaints. He focused on the driving and computer work.

Petitioner failed to prove he sustained an accident to his hands/wrists on October 2, 2014 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. All other issues regarding Petitioner's bilateral carpal tunnel claim are moot.

2. Petitioner's left cubital tunnel syndrome.

Petitioner sustained an accident to his left elbow on October 2, 2014 that arose out of and in the course of his employment with Respondent; however, he failed to prove that his current condition of ill-being in his left elbow was causally related to his injury.

Both Dr. Maender and Dr. Rotman agreed that Petitioner had left cubital tunnel and that Petitioner's resting his left elbow on the door frame of his work vehicle could be a factor in his left cubital tunnel problems. Thus, Petitioner has proven he sustained an accident to his left elbow that manifested itself on October 2, 2014 and arose out of his employment.

However, Petitioner has not proven that his current condition of ill-being in his left elbow and/or his need for the surgery performed by Dr. Maender were causally connected to the accident. Petitioner never had electrodiagnostic evidence of left cubital tunnel syndrome when tested by Dr. Smucker. Dr. Maender's diagnosis of the condition was based upon his physical examination of Petitioner. He recommended no treatment for the condition while focusing on Petitioner's hands and wrists and testified that he thought once he stopped working for Respondent and resting it on the vehicle door frame the symptoms should resolve.

Petitiomer stopped working for Respondent in December of 2014 and officially retired with Respondent in January of 2015. Petitioner underwent his right carpal tunnel release on April 14, 2015. On April 28, 2015 Petitioner's left hand was operated on. Petitioner testified that he still had symptoms in his left hand/wrist after the surgical procedure. The doctor's notes indicate that, post-operatively, Petitioner still had left elbow pain.

Dr. Maender's deposition was taken while Petitioner was still recovering from his left-sided wrist surgery and Petitioner had just been seen by him a few days before. At that visit, Petitioner (who had been retired from his job for ten months) still had left elbow pain and

tenderness. He was also beginning to experience increasing numbness in his left thumb associated with driving over the weekend. Dr. Maender ordered a repeat EMG/NCS and an ultrasound, the latter of which was to address any swelling or compression. Dr. Maender testified that with Petitioner not having worked since December of 2014, if the cause of the left cubital tunnel was the resting of his elbow on the door frame, the doctor would have expected the symptoms to improve. He further testified that if Petitioner was not resting on that elbow, something else was causing his symptoms to be worse as of 10/05/15 (PX1, p. 45). He also testified that if Petitioner was continuing to rest his elbow on a surface that "exposed the median nerve" that could explain his continued symptoms. (PX 1, p. 47) Dr. Rotman agreed that placing the left elbow on the door frame would be an aggravating factor for cubital tunnel syndrome. He also testified that if after retirement Petitioner's cubital tunnel syndrome worsened, he would anticipate that some other factor was making it worse (RX1, p. 21-22).

Dr. Watson did not only find that Petitioner had moderate left upper extremity ulnar neuropathy consistent with left cubital tunnel syndrome. The ultrasound testing he performed also showed hypoechoic swelling of the ulnar nerve along with an extra muscle compressing the nerve which was absent in Petitioner's right upper extremity. He referred to this muscle as "anconeus epitrochlearis" and that Petitioner essentially had an atypical anatomical paresthesia in his median distribution. (PX 3; PX 8) Dr. Maender proceeded to perform left elbow surgery on Petitioner and his intra-operative findings included a discussion of Petitioner's "large and developed" epitrochlearis muscle which was divided during the procedure to free up Petitioner's nerve.

Petitioner has an extra muscle in his left elbow. That is an anatomical feature that has never been factored into the causation equation. By his own testimony at arbitration Petitioner has remained symptomatic in his left upper extremity. Dr. Maender was not deposed regarding the need for surgery to Petitioner's left elbow or whether Petitioner's condition in his left elbow (or need for surgery) after his retirement from Respondent's employment was related to his work duties or accident of October 2, 2014. Petitioner's left elbow condition worsened after his retirement. Diagnostic testing done in 2014 did not reflect it; testing in October of 2015 (ten months after Petitioner's retirement) did. Both experts agreed that if Petitioner continued to have symptoms in his left elbow after his retirement something else was contributing to the symptoms. By October of 2015 Petitioner was golfing (an activity he said he took up after retiring). Petitioner failed to prove that his current condition of ill-being in his left elbow or his need for surgery to the elbow was causally connected to his accident of October 2, 2014. Petitioner's claim for compensation is denied and no benefits are awarded. All other issues pertaining to Petitioner's left elbow are 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	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Elizabeth Harrington,
Petitioner,

18IWCC0039

vs.

NO: 16 WC 10846

City of Chicago,
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, causal connection, wage differential credit and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 1, 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: JAN 22 2018
o1/11/18
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION 18IWCC0039

HARRINGTON, ELIZABETH
Employee/Petitioner

Case# **16WC010846**

CITY OF CHICAGO
Employer/Respondent

On 8/1/2017, 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:

0154 KROL BONGIORNO & GIVEN LTD
CHARLES GIVEN
120 N LASALLE ST SUITE 1150
CHICAGO, IL 60602-3506

0010 CITY OF CHICAGO
BARBARA BURKE
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

18IWCC0039

18IWCC0039

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

ELIZABETH HARRINGTON
Employee/Petitioner

v.

CITY OF CHICAGO
Employer/Respondent

Case # 16 WC 10846

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 **MARIA BOCANEGRA**, Arbitrator of the Commission, in the city of **CHICAGO**, on **May 22, 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. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
   [ ] TPD [x] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

18IWCC0039

FINDINGS

On **February 17, 2016**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$72,571.20**; the average weekly wage was **$1,395.60**.

On the date of accident, Petitioner was **54** 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 **$48,646.63** for TTD, **$0** for TPD, **$3,721.60** for maintenance, and **$0** for other benefits, for a total credit of **$52,368.23**. Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

By stipulation, Respondent shall pay Petitioner temporary total disability benefits of **$930.40/week** for **44-2/7th weeks**, commencing **February 18, 2016** through **December 23, 2016**, as provided in Section 8(b) of the Act. Respondent shall be given a credit of **$48,646.63** for TTD.

Respondent shall pay Petitioner maintenance benefits of **$930.40/week** for **10-3/7th weeks**, commencing **December 24, 2016** through **March 6, 2017**, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits, commencing **March 7, 2017**, of **$592.40/week** until Petitioner reaches age 67 or five years from the date of the final award, whichever is later, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act.

The Respondent shall pay the bills of Midland Orthopedic Associates and ADCO Billing Solutions, pursuant to and subject to Sections 8(a) and 8.2.

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

8-1-2017
Date

AUG 1 - 2017

18IWCC0039

FINDINGS OF FACT

At the time of her accident, Elizabeth Harrington ("Petitioner") was a 54 year old Sanitation Laborer through Local Union 1001, who had worked for the City of Chicago ("Respondent") since 1997. It was undisputed between the parties that on February 17, 2016, Petitioner injured her right shoulder when throwing a 2x4 piece of wood into the back of her garbage truck while working as a sanitation laborer. Petitioner is right hand dominant. She timely reported the incident and was sent for care that same date.

On the date of the accident, Petitioner was examined by Dr. Steven Anderson at MercyWorks. X-rays of the right shoulder were negative for fracture. Petitioner was diagnosed with a sprain/strain of the right shoulder and taken off work. On March 1, 2016, she began a course of physical therapy at Chatham Physical Therapy. Petitioner attended 12 therapy sessions through March 25, 2016. She had minimal improvement with therapy. PX4.

On March 30, 2016, Petitioner underwent a right shoulder MRI that revealed a full thickness tear of the supraspinatus tendon measuring 14 mm in maximum dimension without retraction and mild undersurface tear/fraying of the infraspinatus tendon without gap or retraction. She was referred to Dr. William Heller for further evaluation. PX4.

On April 4, 2016, Petitioner was examined at Midland Orthopedic Associates by Dr. Heller. Dr. Heller diagnosed Petitioner with a full thickness rotator cuff tear due to an acute injury. He recommended surgery to the right shoulder. PX1.

On May 11, 2016, Petitioner underwent right shoulder surgery performed by Dr. Heller. The procedures performed included arthroscopic repair of the rotator cuff with subacromial decompression. PX1.

Petitioner completed a course of physical therapy at ATI Physical Therapy between June 2, 2016 and November 3, 2016. On November 4, 2016, Dr. Heller prescribed a course of work conditioning. Petitioner completed 15 sessions of work conditioning between November 8, 2016 and November 29, 2016. On December 5, 2016, Dr. Heller prescribed a functional capacity evaluation ("FCE"). The FCE was performed at ATI on December 13, 2016. The test was deemed valid and Petitioner tested at the Medium physical demand level. She was limited to lifting 21.4 pounds above shoulder level, 45.6 pounds from desk to chair, and 41.2 pounds chair to floor. PX2-3.

On December 23, 2016, Petitioner was discharged by Dr. Heller at maximum medical improvement ("MMI") with permanent work restrictions as detailed within the FCE report of December 13, 2016. PX1.

Petitioner was reexamined by Dr. Heller on February 17, 2017, with continued right shoulder pain. Dr. Heller prescribed the use of a topical cream and did not change the permanent work restrictions. PX1, PX9-10.

Petitioner's position as a Sanitation Laborer with the Respondent required heavy lifting, over 150 pounds on occasion. She was responsible for moving carts, lifting free standing garbage such as yard waste and furniture from the curb into the back of the truck, removing garbage and waste from underneath viaducts, and shoveling snow around fire hydrants and crosswalks. She worked Monday through Friday, 6:00AM to 2:30PM, 40 hours per week after considering a daily, 30 minute lunch break. Petitioner worked as a Laborer with the City from 1997 through the date of the accident. As of the hearing date she had not retired or resigned. The Laborer position is through Local Union 1001.

Before working for the Respondent, Petitioner worked at a clothing store for less than 1 year. She was a retail clerk and was responsible for working the cash register, stocking merchandise and assisting customers. She also worked at Bloomingdales as a retail clerk for 5 to 6 years. She was responsible for folding clothes and cleaning the store. She had more distant employment as a stocker for Toys R' Us and Target. PX5.

Petitioner graduated from South Shore High School in 1979. She attended some college at Harold Washington and East-West University but did not earn a degree or certificate. Petitioner does own a home computer and is able to email and use the Internet. She has used Word and has had some exposure to Excel. She has taken keyboarding classes while involved in secretarial studies and is a two-handed typist. PX5.

Petitioner testified that she provided the restrictions to the Respondent but they were unable to accommodate. Petitioner began a vocational rehabilitation program through the City of Chicago in January 2017. She was responsible for completing an independent job search. She was responsible for contacting a minimum of 10 prospective employers per week and kept track of her job search efforts on job logs. Petitioner was responsible for hand delivering the job logs to the City every Monday. Petitioner continued her job search efforts through the City of Chicago's vocational program through the date of the hearing. Her job search focused mainly on retail and customer service positions that she believed were within her restrictions. She was unable to secure any interviews and did not secure employment. PX7.

On March 2, 2017, Petitioner met with Kari Stafseth ("Stafseth"), a Certified Rehabilitation Counselor with Vocamotive, at the request of Respondent. PX5-6. Stafseth opined that Petitioner had lost her usual and customary vocation as a Laborer. Stafseth drafted an Initial Evaluation Report dated March 6, 2017 wherein she found Petitioner had some transferable skills related to previous experience in customer service. She opined Petitioner was employable at a most probable wage between $10.00 and $13.00 per hour. The job targets most probably available to her would include Driver, Counter Clerk, Customer Service Representative, Front Desk Clerk, Security Guard, Retail Clerk and similar positions. Stafseth completed a Labor Market Survey dated April 24, 2017 that concluded Petitioner had a most probable wage earning potential of $9.00 to $14.00 per hour. The current prevailing wage through Local Union 1001 for a Sanitation Laborer is $36.21 per hour. PX8.

Before this work accident, Petitioner was not having problems with her right shoulder. Petitioner testified that she continues to experience daily right shoulder pain through the date of the hearing. She has limited range of motion and is not able to reach above her head or behind her back without pain. She has difficulty with activities of daily living and her pain gets worse when she does too much during the day. She notices pain with heavy lifting. For pain relief Petitioner takes Tylenol before bedtime 5 days per week. The topical cream prescribed by Dr. Heller did not provide relief and she discontinued using it after 2 weeks.

CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment

Petitioner was the only witness to testify at trial. The Arbitrator has carefully considered that testimony along with all other evidence and finds Petitioner's unrebutted testimony to be credible, candid and forthright.

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

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Petitioner presented medical bills from Midland Orthopedic Associates ($120.82) and ADCO Billing Solutions ($2,844.00), for treatment on the date of service February 17, 2017. PX9-10. Review of Dr. Heller's chart note from this date of service shows the treatment is related to the work accident. Dr. Heller prescribed a

topical cream that was filled through ADCO Billing Solutions. Respondent presented no evidence why this bill should be part of its ongoing liability either via doctor opinion, utilization review or otherwise. The Arbitrator finds these bills to be reasonable and necessary and awards them pursuant to the medical fee schedule.

ISSUE (K) What temporary benefits are in dispute?

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. At trial, only maintenance was in dispute. Ax1. Petitioner is claiming she is entitled to maintenance benefits for 21 and 3/7 weeks, representing the period between December 24, 2016 and May 22, 2017. Respondent claims Petitioner is not entitled to any maintenance benefits. The Arbitrator finds Petitioner is entitled to maintenance benefits for 10 and 3/7 weeks, representing the period between December 24, 2016 and March 6, 2017. The evidence shows that Petitioner did not meet with Stafseth until March 2, 2017. This was the initial evaluation meeting requested by the Respondent. Stafseth's Initial Evaluation Report was issued on March 6, 2017 wherein Stafseth opined Petitioner lost access to her usual and customary employment and that she would earn less than before her injury.

Petitioner declined formal vocational rehabilitation with Stafseth after it was offered by the Respondent on March 6, 2017. Petitioner's maintenance benefits should terminate once she declined formal vocational rehabilitation. The Arbitrator notes that Petitioner conducted an independent job search through Respondent's "job search program" from the beginning of January through the date of hearing by reporting to City Hall every Monday and turning in the job search logs. Maintenance benefits are awarded for 10 and 3/7 weeks, representing the period between December 24, 2016 and March 6, 2017.

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. Petitioner reached MMI for her undisputed right shoulder injury in December 2016. She then began vocational services in March 2017. Petitioner is unable to return to her former employment and is requesting consideration of a wage differential award. Having considered all evidence, the Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that she is entitled to a wage differential award under Section 8(d)(1). In so finding, the Arbitrator relies on the vocational opinions of Stafseth and the medical opinions of Dr. Heller releasing Petitioner to light duty work and further stating that she was unable to return to her former occupation.

Prior to the accident, Petitioner was a Sanitation Laborer for the Respondent. She has lost access to this occupation due to her permanent work restrictions. PX5. The trial testimony and documentary evidence show Petitioner is unable to return to work for the Respondent in her previous position as a Sanitation Laborer due to her February 17, 2016 right shoulder injury. Furthermore, the vocational reports demonstrate the Petitioner, despite her current work restrictions, would be capable of finding employment within her work restrictions with a valid job search effort. Stafseth found Petitioner would likely earn an average hourly wage of $9.00 to $14.00. Stafseth completed a Labor Market Survey dated April 24, 2017, that identifies 23 jobs which Petitioner is qualified. PX5-6. The highest paying jobs listed are $14.00 per hour. These are as follows:

Customer Service Representative – Schillings, Teleperformance, and Club Pilates Lincoln Park.
Receptionist – Stewart Title Guaranty Company

The Arbitrator finds Petitioner is "able and qualified" to perform the work in all of these positions and is capable of earning $14.00 per hour at the present time. *Crittenden v. IWCC*, 2017 IL App (1st) 160002WC).

The Arbitrator finds it reasonable to select the highest paying jobs for which she is qualified considering Petitioner's less than maximum effort performing her independent job search. PX7. The record shows that if Petitioner had returned to work for the Respondent as a Sanitation Laborer, she would be earning $36.21 per hour. PX8.

Section 8(d)1 of the Act provides that the Petitioner: "shall, …, receive compensation…, equal to 66-2/3% of the difference between the average amount which he would be able to earn in the full performance of his duties in the occupation in which he was engaged at the time of the accident and the average amount which he … is able to earn in some suitable employment or business after the accident. For accidental injuries that occur on or after September 1, 2011, an award for wage differential under this subsection shall be effective only until the employee reaches the age of 67 or 5 years from the date the award becomes final, whichever is later." 820 ILCS 305/8(d)1. The Arbitrator, thus, finds the Petitioner's wage differential benefits under Section 8(d)1 are calculated as follows:

($36.21/hr - $14.00/hr) * (66-2/3%) = ($14.81/hr) * (40 hrs/week) = $592.40/week

Additionally, the Arbitrator finds the Petitioner was 55 years old at the time of arbitration. The wage differential benefits should begin on March 7, 2017. This is the day after the Initial Evaluation Report was completed by Stafseth. Petitioner would no longer be entitled to maintenance benefits as of that date, but would then be entitled to wage differential benefits. There was no dispute as to whether Petitioner was employable as the parties stipulated she was once Petitioner declined formal vocational rehabilitation. PX5. In summary, Respondent shall pay Petitioner permanent partial disability benefits, commencing **March 7, 2017**, of **$592.40/week** until Petitioner reaches age 67 or five years from the date of the final award, whichever is later, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act.



Signature of Arbitrator

8-1-2017
Date

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

Eric L. Sawyer,
Petitioner,

vs.

JJ Braker & Sons, Inc.,
Respondent.

18IWCC0040

NO: 13 WC 23416

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, temporary 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.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 9, 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: JAN 22 2018
o12/7/17
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0040

SAWYER, ERIC L
Employee/Petitioner

Case# **13WC023416**

JJ BRAKER & SONS INC
Employer/Respondent

On 8/9/2016, 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 0.44% 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:

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18IWCC0040

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

ERIC L. SAWYER
Employee/Petitioner
v.
J.J. BRAKER & SONS, INC.
Employer/Respondent

Case # **13-WC-23416**

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 **June 9, 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

18IWCC0040

FINDINGS

On **May 22, 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 alleged accident.

In the year preceding the injury, Petitioner earned $**62,400.00**; the average weekly wage was $**1,303.60**.

On the date of accident, Petitioner was **47** years of age, ***single*** with **-0-** children under 18.

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

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

Respondent shall be given a credit of $**35,072.48** for TTD, $**-0-** for TPD, $**-0-** for maintenance, and $**-0-** for other benefits, for a total credit of $**35,072.48**.

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

ORDER

Petitioner failed to prove he sustained an accident on May 22, 2013 that arose out of and in the course of his employment with Respondent or that his condition of ill-being in his right knee was causally related to his alleged accident.

No benefits are awarded. Petitioner's claim 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

8.7.16
Date

ICArbDec p. 2

AUG 9 - 2016

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

Petitioner began working for Respondent as a mason tender/"hod carrier" on May 1, 2013. (RX 6;RX 13)

Petitioner's job with Respondent ended on May 24, 2013. While employed by Respondent, Petitioner worked 104 hours. (RX 6; RX 13)

Petitioner began working for Illiana Construction engaged in road construction on June 1, 2013 and worked 102 hours. (RX 13)

Petitioner again worked for Illiana Construction performing road construction beginning on July 1, 2013 and worked 34 hours. (RX 13)

Petitioner sought medical treatment on July 8, 2013 when he presented to his family doctor, Dr. Sadiq. Petitioner's chief complaint was that he had caught his right leg in a strap at work and tried to walk away but his knee twisted all the way around when he did so. He didn't realize his foot had been caught in the strap. This occurred approximately a month and a half earlier. Petitioner complained that his knee felt as though it hyper-extended when he walked. A physical exam revealed no obvious abnormalities. Pain was elicited by motion of the knee and it was difficult bearing weight. The appearance of Petitioner's knee was normal. Petitioner's knee was tender on palpation at the medial aspect. Petitioner was assessed with an "orthopedic disorder, arthralgia and a sprain." Dr. Sadiq prescribed prednisone and ordered an MRI and referred Petitioner to Dr. Kohlmann for right knee injury and pain (PX1, pp. 2-3). According to the worker's compensation information section of the Danville Polyclinic notes dated July 8, 2013 Petitioner gave a history of the accident indicating it occurred on May 20 or May 21, 2013 at about 5:30 "plus or minus an hour" in the evening. He indicated he reported the accident to Jason. He described the accident as lifting two 80 pound blocks and turning when his right foot got caught by a strap and he felt a pop (PX1, Pg. 4(a); RX 7).

Petitioner signed his Application for Adjustment of Claim herein on July 9, 2013. Petitioner alleged an accident date of "on or about 5/20/13" when he was lifting blocks and turning. Petitioner alleged right knee/leg injuries. (AX 2)

By letter dated July 11, 2013 Petitioner's first attorney sent a copy of the Application for Adjustment of Claim to Respondent. (RX 1)

"Roberta Ridings" completed the "Employer's First Report of Injury" form on July 31, 2013. The form indicates the accident is "unknown – incident never reported to employer." (RX 2)

In a note dated July 31, 2013, Dr. Sadiq's office recorded that Petitioner was supposed to bring in workers' compensation information so he could be referred to Dr. Kohlmann and scheduled for a right knee MRI but he never did (PX1, Pg. 4).

By letter dated August 7, 2013 Respondent's attorney wrote to Petitioner's first attorney regarding the issue of notice. (RX 3)

By letter dated September 3, 2013 Petitioner's first attorney advised Respondent's attorney that notice had been given to "Jason" who was Petitioner's foreman on the project. He further noted that Petitioner's treating physician had referred Petitioner out for an MRI and as soon as he had the records, he would furnish them to counsel. (RX 4)

Petitioner sought no further medical care until December 12, 2013 when he was examined by Dr. Kohlmann at the request of Petitioner's new attorney. Prior to that examination Petitioner's new attorney sent a letter to the doctor outlining the nature of Petitioner's claim. That letter, dated November 13, 2013, stated that Petitioner initially thought he had strained his knee but it worsened over time and with further work. He had been laid off as of July 1, 2013 due to knee pain. As of November 13, 2013 Petitioner was complaining of a painful right knee and leg and swollen knee. He was walking on the ball of his foot to keep pressure off his knee and his calf was sore. Petitioner also reported a hyperextension sensation. His knee was "otherwise not stable." Counsel requested the doctor's opinion regarding his examination findings, treatment recommendations, prognosis, need for restrictions, and causation. (PX 11, dep. ex. B)

When examined by the doctor, Petitioner gave Dr. Kohlmann a history that he was working as a masonry worker picking up blocks that weighed about 8 lbs. each when he picked up two and walked away, but his right foot caught in a pallet strap, causing a pop in his right knee and immediate severe pain. He gave an accident date of May 21 or 22, 2013. Petitioner told Dr. Kohlmann that following the May 2013 incident, his right knee had a yellowish colored bruise on the medial side and was swollen. (PX 2, pg. 19; PX 11, dep. ex. C) Petitioner further told Dr. Kohlmann that he had continued to work on the job for Respondent until May 24, 2013 when he was laid off.[1] While working, he was in pain. He then began working on road construction from June 10, 2013 through July 1, 2013 at which time he was laid off because the job was over. Petitioner reported limping from the time he injured his knee until he saw Dr. Sadiq. Petitioner told the doctor that Dr. Sadiq had recommended an MRI but "workers' compensation denied it" and Petitioner also reported that when he went to see Dr. Sadiq he found out that he had no personal insurance as it had expired in late 2012. Petitioner denied any prior right knee problems and complained of instability and hyperextension with a feeling of "give away." He primarily reported medial-sided knee pain. He also reported ongoing swelling since the injury although it was far greater right after the injury. (PX 11, dep. ex. C)

According to Dr. Kohlmann's office note Petitioner walked with a right antalgic gait and his knee was visibly swollen and tender along the medial joint line. Lachman's test was positive. Some guarding was noted due to pain during the examination. Petitioner's left knee was exceptionally stable. X-rays of the right knee showed a perfectly normal right knee with no evidence of arthritis or other abnormality. Dr. Kohlmann further noted his review of prior medical records pertaining to Petitioner's injury. He assessed Petitioner with a probable right knee anterior cruciate ligament sprain with a medial meniscus tear. He recommended an MRI and work restrictions so that Petitioner would avoid prolonged weight bearing on his right leg or walking up and on uneven surfaces. He felt an ACL brace might help alleviate some of the instability. Treatment recommendations would depend on the MRI. Dr. Kohlmann was of the opinion that the "May 20, 2013" accident as described by Petitioner could have been the sole cause for his current knee condition as the mechanism of injury could definitely cause an ACL tear or meniscus tear. (PX 11, dep. ex. C)

[1] As would be shown at arbitration, Petitioner's lay-off at that time was completely unrelated to any alleged injury or accident.

Petitioner underwent an MRI scan which was performed on December 19, 2013. (PX 4) It revealed a tear of the posterior horn of the medial meniscus. (PX 2) Dr. Kohlmann recommended a right knee arthroscopy with posterior horn medial meniscectomy. (PX 2, pg. 23)

Dr. Kohlmann issued a "Procedure Note" on January 23, 2014 after reviewing Petitioner's MRI scan. He concurred that it showed a posterior horn medial meniscus tear and small joint effusion. His causation opinion and other opinions as set forth in his report of December 12, 2013 remained unchanged. (PX 11, dep. ex. C)

Petitioner underwent no further treatment or examinations between December 12, 2013 and February 19, 2014.

Petitioner then returned to see Dr. Sadiq on February 20, 2014 for pain related to Petitioner falling on ice. The doctor noted Petitioner had a "right ACL tear from May." Hydrocodone-Acetaminophen was prescribed. He was to follow up as needed. Dr. Sadiq authored a noted stating that "Due to knee injury [Petitioner] is unable to work." (PX3, pp. 66, 68)

At the request of Petitioner's attorney, Dr. Sadiq authored a letter dated May 15, 2014 stating that Petitioner had been seen in his office on July 8, 2013 with complaints of knee pain resulting from an injury he stated happened at work. Dr. Sadiq offered to give Petitioner a note taking him off work 100% but "[Petitioner] stated that he did not think his work would need a doctor's note." He further stated that Petitioner was going to bring in information pertaining to his workman's comp for billing purposes so the MRI could be scheduled; however, Petitioner never returned with the information. (PX5)

Petitioner underwent no medical treatment between February 20, 2014 and June 4, 2014.

Petitioner presented to Dr. Kohlman on June 4, 2014 at which time the two of them discussed surgery scheduled for June 6th as well as pre-op history and physical. A physical exam revealed the right knee had a 1 + or 2 + effusion. There was marked tenderness along the medial joint line especially towards the posterior aspect of the knee. The right knee range of motion was 0- to 125 degrees in flexion with no clicking. Lachman's test was negative. The left knee showed no abnormalities.The same treatment options were discussed with Petitioner still opting for surgery. Dr. Kohlmann explained the recovery period and how it varied from person to person depending on the presence or absence of arthritis and their response to the surgery (PX2, pp. 24 – 25).

Dr. Kohlmann performed a right knee arthroscopy and a posterior horn medial meniscus resection on June 6, 2014. The surgical report indicated there was an isolated posterior horn medial meniscus tear that was somewhat complex, and a portion of the meniscus was flipped back up onto itself in the posterior medial area. Petitioner's knee cartilage looked perfect. The basket forceps and full radius shaver were used to resect the posterior horn back to nearly the rim. He contoured the resected part of the meniscus resection into the normal anterior and mid-body. What was left was very stable. The fluid was drained from the knee. The wound was closed. (PX6, p. 95)

Dr. Kohlmann issued an off work slip on June 9, 2014 (PX2, p. 27).

Dr. Kohlmann saw Petitioner for a post-surgical examination on June 17, 2014. Nothing significant was noted other than to begin physical therapy (PX2, p. 28; PX 6).

Dr. Kohlmann issued an off work slip on June 17, 2014. (PX2, p. 31)

Petitioner attended a physical therapy evaluation on June 24, 2014. Petitioner was to attend physical therapy three times a week for four weeks. Petitioner reported he wasn't currently working as he was off until December or January. He gave an onset date of May 22, 2013. He described his pain as the biggest symptoms and noted it was a "7/10" when "jump in water." Petitioner's hobbies included golf, fishing, and camping. (PX 6, pp. 89-90, 98-101)

Petitioner attended physical therapy on June 25, 2014 and July 1, 2014. (PX 6, pp. 102 – 105)

Telephone messages from physical therapy to Petitioner were left on July 11, 15, and 17, 2014. The purpose of the calls was to get Petitioner back on schedule for therapy. (PX 6, p. 88)

Petitioner was discharged from physical therapy on July 22, 2014. The therapist noted that Petitioner had been making progress with his goals and functional tasks but therapy was being discontinued due to lack of attendance/compliance. (PX 6, pp. 106-107)

Petitioner followed up with Dr. Kohlmann on July 25, 2014 but was seen by Patricia Finnegan, his nurse practitioner. She noted that Petitioner advised that he was having "left knee pain" but when she inquired about returning to work he advised her that he could not go back to work, that he could not even walk across his back yard, that he could not mow his lawn, and numerous other complaints. The right knee was examined and the portholes were clean. There was no effusion. There was full range of motion. Petitioner complained of mild discomfort over the medial aspect of the knee. The calf was soft and supple. He was seen walkking into the reception area and into the examination room without any difficulty. She reviewed the physical therapy notes and noted he had attended only 3 out of 6 visits. There was a discussion about further physical therapy. Nurse Finnegan then spoke with Sherry Reicken, the nurse case manager for the workers' compensation claim, and discussed with her his progress. Nurse Finnegan thought Petitioner should be ready to return to work now but had been non-compliant with his treatment plan i.e. missing therapy appointments. She noted that he was a no-show for an office appointment. She advised Petitioner she was releasing him to return to work and that if he had any questions or concerns he was welcome to return on an as needed basis. There was no indication for additional treatment or further surgical intervention. She did not think there was any point in resuming physical therapy. She noted that Petitioner became very agitated and started cursing and using inappropriate language loudly yelling at her and throwing paperwork about the office. (PX2, pp. 32-33, 35)

Petitioner followed up with Dr. Kohlmann on July 28, 2014. At that time Petitioner reported feeling much better than before surgery but that he was still having medial knee pain. He had medial knee pain when he slept at night if he kept his knees together, if he was up a lot during the day, and he also noticed swelling in the right knee if he was up for extended periods. A physical examination revealed that Petitioner could walk without a limp. He was wearing shorts. The right knee did not swell. He had a small effusion with tenderness along the medial joint line of the right knee. The range or motion of the right knee was 0 to about 120 degrees before Petitioner experienced quite a bit of medial joint line pain. The operative report was reviewed. The report indicated that the articular cartilage was pristine to the right knee. There was an isolated posterior horn medial meniscus tear with displacement. That portion of the torn meniscus was resected. Dr. Kohlmann assessed persistent right knee pain after surgery with partial medial meniscectomy for isolated medial meniscus tear and no associated arthritic changes. The plan was for Petitioner to take Mobic. A two week follow-up was scheduled. Petitioner was taken off work until his next appointment. It was hoped he would improve significantly with this additional intervention and be able to return to work after the next visit. (PX2, pp. 36-37) An off work slip was issued (PX2, p. 38).

In follow-up visit with Dr. Kohlmann on August 18, 2014 Petitioner continued to complain of medial knee pain. He was currently taking Meloxicam. He gave a history that he went to a tractor pull and carried a cooler full of beverages up the stairs and experienced fairly severe medial knee pain. He did not think he could possibly go back to work in his current state unless there was a light duty position such as holding the flag. A physical exam revealed that Petitioner could walk without a limp. He had a small effusion in the right knee. The right knee motion was back to normal. The right knee did have tenderness along the medial joint line starting about midway from anterior to posterior and the tenderness extended around to the posterior part of the join line on the medial side. He was assessed with post-surgical ongoing symptoms. Treatment options were discussed. Petitioner did not want to consider any steroid injections. He was going to continue taking the Meloxicam and start physical therapy again tomorrow. Dr. Kohlmann advised Petitioner to consider weight loss and an exercise program to assist his recovery. An off work slip was given; however, he could return to light duty work if available (PX2, pp. 40-41, 43)

Petitioner resumed physical therapy on August 19, 2014. (PX 6, pp. 108-110) He attended additional sessions on: August 21, 2014 (he was noted to be mowing his yard); August 25, 2014 (he had fallen over the weekend); August 29, 2014; September 3, 2014; and September 8, 2014. (PX 6, pp. 118 – 119)

In follow-up on September 15, 2014, Dr. Kohlmann noted that Petitioner was still complaining of locking of the right knee and giving out. He continued to have right knee pain. The pain was located along the medial knee. Petitioner indicated he couldn't work. He had been off work since surgery on June 6, 2014. Petitioner walked with a limp. The right knee had a very small trace effusion. The range of motion was 0 to 130 degrees. Petitioner stated he had some pain in the knee especially when it has flexion to 130 degrees. The left knee did not have an effusion and had no pain with range or motion to 130 degrees. Standing x-rays showed a normal right and left knee joint with right medial joint space narrowing as the only abnormality seen. Dr. Kohlmann's assessment was persistent right knee pain post-surgery. He recommended a repeat MRI with contrast. He issued work restrictions. Petitioner was to follow up after the MRI was obtained (PX2, pp. 44-45 and p. 46).

Petitioner attended physical therapy on September 16, 2014 and September 26, 2014. He was discharged from physical therapy as of September 26, 2014 as all goals had been met. (PX 6, pp.111, 124, 130-131)

In follow-up on October 6, 2014 Dr. Kohlmann noted that Petitioner continued to complain of right medial knee pain and swelling. Petitioner didn't feel he could work and noted occasional give away accompanied by pain. Petitioner's physical examination revealed the right knee had trace effusion, at most, and full extension to 0 and flexed to 130 degrees. There was medial joint line tenderness. Lachman's test was negative. It was the same as the right [left] side. Dr. Kohlmann noted that the recent MRI scan revealed evidence of the posterior horn medial meniscectomy, trace effusion, no significant arthritis and no ligament abnormality. Dr. Kohlmann assessed persistent right knee pain with complaints of intermittent instability of uncertain etiology. Petitioner wasn't willing to consider having a steroid injection. He stated that he couldn't possibly work in his current condition. He was willing to have further surgery if there was a chance it would help. Petiotioner did not feel physical therapy had helped and so he didn't want any more of it either. Petitioner did, however, consent to a repeat arthroscopy. (PX2, pp. 61-62) He was not able to return to work (PX 11, pp. 1-2).

Petitioner was examined by Dr. Nogalski on December 9, 2014 at Respondent's request. (RX 9, dep. ex. 2) At the time of the exam Petitioner was not working, having last worked for about two weeks after his employment with Respondent had ended. Dr. Nogalski noted that Petitioner "believed" he hurt himself on May 20, 2013 while picking up two cement blocks when he got his foot caught and felt a pop in his "left knee" as it

was turning to the left. He reportedly fell down and caught himself with the blocks and then set them down. Petitioner was able to walk and worked for 2 ½ more days before being laid off. Petitioner reported being hurt on the job "everyday" and waiting to see if he would get better. He then began working for another construction company but wasn't "100 %." He was walking 6 ½ miles a day and would put out/take down traffic signs and standing to do flagging. He remembered that it was difficult to get his leg up in the truck and he would have to rely on his pant leg to pull the leg up. According to the report, Petitioner went to the doctor in June when he wasn't any better. He didn't have insurance and the cost began to rise so he sought counsel. Petitioner did not recall an accident form being completed but he knew his boss knew about the accident because he was taking the blocks of cement to him. He also reported that he had told his boss before about the straps and that they needed to be removed. He denied any subsequent injuries. When asked about his discussion with Dr. Sadiq about a work slip Petitioner explained that he didn't realize the hall needed one but he wasn't going to sign up for any work at the hall anymore.

Dr. Nogalski further noted in his report that Petitioner eventually underwent surgery which he described as "a piece of cake." He reported doing well thereafter and going to physical therapy for about five weeks. Petitioner reported his knee still hurt but not as bad as before. He was uncomfortable walking on a rough floor and had difficulty rising from a seated position. He further reported difficulty picking up Culligan water bottles or picking up a wheelbarrow and moving it. Petitioner also reported going back to Dr. Kohlmann who had recommended another MRI which was performed in September. Petitioner related asking Dr. Kohlmann about doing exercises like squats but that Dr. Kohlmann told him not to exercise and "that it would be stupid to do squats."

At the time of the examination with Dr. Nogalski, Petitioner's complaints included pain in the front and the top of his knee. He noted popping. His wife, who attended the exam with him, reminded Petitioner that he couldn't walk long distances and that he limped. Petitioner expressed concern about doing anything outside his house because his friends and neighbors had told him he might be on surveillance. According to Petitioner, "his knee just scares him." Petitioner didn't really believe he could work.

Dr. Nogalski reviewed all of the medical records of treatment up to that time, including scans and x-rays, and a surveillance video dated August 18, 2014. Dr. Nogalski described the video as showing Petitioner walking with a slight limp that day and engaged in refueling his vehicle.

Dr. Nogalski also examined Petitioner. Dr. Nogalski's examination showed no significant objective findings. There was no evidence of effusion and Petitioner's knee was stable with full range of motion and no findings of limping, normal strength or atrophy. He noted tenderness with both flexion and extension and grade 5/5 strength. He did not see any specific atrophy when comparing both extremities. Dr. Nogalski's impression was that of status post right knee arthroscopy together with noncompliance with physician follow-up and physical therapy. He noted no mechanical findings within the knee to suggest clinically significant internal derangement. He felt Petitioner had subjective pain without clear clinical correlation. He suggested a Gadolinium enhanced MRI to more clearly assess the situation. Dr. Nogalski noted that Petitioner did not exhibit any objective findings that would "strongly suggest" that an arthroscopic procedure would be beneficial. Dr. Nogalski did not believe Petitioner had ever reported an injury and, furthermore, failed to obtain treatment for six weeks after the claimed event. He wrote, "Operative findings as documented by Dr. Kohlmann strongly suggests that this type of meniscus issue would have prompted further care and would have precluded him from working. When the meniscus is flipped up underneath it is a very painful condition and causes some significant difficulties." He also made reference to an amendment of a note dated July 31, 2013. Dr. Nogalski did not believe the need for a diagnostic or, potentially, therapeutic, arthroscopy was related to the alleged accident. Objectively, he felt Petitioner could return to work and that he reached maximum medical improvement as of

July 25, 2014. Petitioner's prognosis was guarded pending the MRI and given Petitioner's ongoing subjective complaints without correlation. (RX 9, dep. ex. 2)

An MRI with gadolinium, taken on January 19, 2015 revealed post-surgical changes after a meniscal repair of the posterior horn of the medial meniscus with no change since 9/29/14. There was no evidence for any new findings or any avascular necrosis or abnormal fluid collections (PX2, p. 59).

In follow-up visit with Dr. Kohlmann on January 28, 2015 Dr. Kohlmann discussed the MRI results with Petitioner. He noted Petitioner complained of "ongoing really bad medial right knee pain." He stated he couldn't walk very well because his right knee hurt badly and he couldn't even move his leg in certain ways because the pain was severe. His pain was directly at the medial joint line. He did not notice swelling. He had pain radiating down his leg. Petitioner was very disabled and at one point was so upset that he actually cried a little bit as he discussed how badly his knee is affecting his life and his loved ones' lives. A physical examination revealed no limp when going from the chair to the examination table. His right knee did not have effusion. There was mild patellofemoral crepitation as the knee was flexed and extended and described as painful. There was some medial joint line tenderness. There was no instability and the knee had full range of motion. The diagnosis remained unchanged. Dr. Kohlmann discussed losing weight and referred him to Dr. Goding for an evaluation and recommendation (PX2, pp. 65(c) – 65(d)). An off work slip was issued (PX2, p. 65(e)).

Dr. Richard Goding evaluated Petitioner on February 26, 2015 at the request of Dr. Kohlmann. Dr. Goding took a history of Petitioner's injury and subsequent medical treatment including surgery as well as MRI imaging. He conducted a physical examination which did not reveal any abnormality. Dr. Goding did not know what the source of Petitioner's knee pain was. He did not find any correlation between the MRI and Petitioner's physical findings. He had nothing to offer. (PX10).

In follow-up on March 23, 2015 Dr. Kohlmann noted Petitioner continued to complain of right medial knee pain but stated that his strength had gotten better and he was able to get up from a chair and walk around and go up a ladder and do that type of activity without too much trouble. He did have pain but did no feelings of instability. He felt that he was improved enough that he could return to work in early April. A physical examination revealed that Petitioner was able to get up from a chair without a problem and could walk well without a limp. His left knee had a trace effusion and he did have some medial joint line tenderness. There was persistent knee pain. Dr. Kohlmann discussed treatment and other options. He noted that Dr. Goding had no ideas on how to deal with the persistent knee pain. Dr. Kohlmann believed Petitioner had recovered sufficiently to return to work and this could be in early April. Petitioner still had some complaints of pain that could interfere with function and, for that reason, Dr. Kohlmann noted the possibility of a functional capacity evaluation either before or after Petitioner returned to work. For now Petitioner was just ready to return to work in early April and "that is what the plan will be." (PX2, pp. 65(f) -65(g))

Petitioner began working for Cross Construction on May 1, 2015. He worked a total of 135.50 hours. (RX 13) He again began working for Cross Construction on June 1, 2015 and worked 48 hours. Petitioner also went to work for Schomburg & Schomburg Construction as of June 1, 2015 for 8.5 hours. (RX 13)

As of July 1, 2015 Petitioner again worked for Schomburg & Schomburg Construction for 81 hours. On August 1, 2015 he began two jobs – one with Halverson Construction (8 hours) and another with Schomburg & Schomburg Construction (29 hours). On October 1, 2015 he began working for Halverson Construction (69.5 hours) and he started another job for Halverson Construction on November 1, 2015 (9.0 hours). Petitioner worked 32 hours for Superior Labor Solutions as of November 1, 2015. (RX 13)

The evidence deposition of Dr. Michael Nogalski, Respondent's independent medical examiner, was taken on November 2, 2015. (RX 9) Dr. Nogalski testified that 40% of his practice if focused on knees and he is board certified in orthopedic surgery. Dr. Nogalski testified consistent with his written report of an earlier date discussed above.

Dr. Nogalski testified that he would expect an individual with a torn meniscus to have significant difficulty working after experiencing such a tear due to both pain and lack of motion. (RX 9, p. 9) He testified that the post-op MRI performed on September 29, 2014 didn't suggest any new tear of Petitioner's meniscus. (RX 9, p. 21) He further testified that a 49 year old man with a meniscus like Petitioner had should have returned back to full activity anywhere from 2 to 10 weeks post-surgery. He would not have anticipated any need for permanent restrictions either. (RX 9, pp. 21-22)

Dr. Nogalski testified that yellow bruising would be inconsistent with Petitioner's mechanism of injury as a meniscus tear doesn't cause bruising. (RX 9, p. 22)

Dr. Nogalski thought that inconsistent attendance at physical therapy could slow down recovery as far as strength and function goes and it could lead to some increased soreness in the knee because of kneecap or patellofemoral symptoms at the quadriceps (RX9, p. 23).

Dr. Nogalski testified that his physical examination did not reveal any fluid in Petitioner's knee or effusion. There was some tenderness with compression of the kneecap and some tenderness of the inside or medial knee, but not particularly along the joint line. There was some patellofemoral crepitus. There were some intermittent pops of the knee, which appeared to be deep. He could not correlate those with specific medial sided symptoms. Dr. Nogalski testified that Petitioner had an intact exam when ligament stability was tested. He had full knee range of motion. There was a complaint of pain at both full extension and flexion of the knee. He did not show findings that suggested Petitioner was limping or walking with an antalgic gait. He had normal strength and did not appear to have any atrophy in the right leg compared to the left. There were no findings suggestive of a neurologic problem (RX9, p. 23) There was no instability (RX9, p. 25)

Dr. Nogalski testified that he would anticipate some atrophy in the leg if the person had significant right knee problems for a period of six months after surgery (RX9, p. 25).

Dr. Nogalski believed x-rays taken on the day of the exam showed mild to medial joint space narrowing and neutral alignment. There was some increased density of the bone below the tibial plateau on the medial side, which suggested some reactive bone changes from the joint surface cartilage (RX9, Pg. 26). The x-rays did not show anything indicative of an ongoing pathology or a cause for Petitioner's ongoing complaints (RX9, pp. 26-27)

Dr. Nogalski did not believe that Petitioner suffered an injury to his knee at work on May 20, 2013 because there was no consistent thread of complaints or problems that linked back to that claimed event of May 20, 2013. The doctor explained that the type of problem that Petitioner had at the time of the arthroscopy was basically a very painful condition where the meniscus is flipped up underneath the knee. That condition would reasonably have sidelined him right away and the documents provided in the medical treatment notes do not clearly identify a specific thread of complaints and physical findings that validate an injury on May 20, 2013 (RX9, p. 27)

At the time Dr. Nogalski saw Petitioner Petitioner had no mechanical findings within his knee to suggest a clinically significant internal derangement (RX9, p. 28)

Dr. Nogalski believed Petitioner was able to do his regular job without restrictions based upon his review of the records as well as his direct evaluation of Petitioner on December 9, 2014 (RX9, p. 28)

Dr. Nogalski believed Petitioner had reached maximum medical improvement as of July 25, 2014. At that time he would have been able to return to work full duty without restrictions and needed no further medical treatment for his right knee (RX9, p. 29). Dr. Nogalski did not believe that Petitioner's complaints at the time of the exam and, retrospectively, complaints in the medical records, were consistent with some of the objective data (RX9, p. 30).

Dr. Nogalski suggested that further insight might be obtained through a gadolinium arthrogram MRI scan with respect to the knee and if it was normal that would be consistent with his examination and findings. (RX 9, p. 30, RX 9, Exh. 2, p. 10)

Dr. Nogalski opined that Petitioner's subjective complaints appeared to be greater than what he would expect from his physical findings, objective physical findings, x-ray studies, as well as the findings documented by Dr. Kohlmann at the time of the arthroscopy (RX9, p. 31).

On cross-examination Dr. Nogalski admitted that he did not discuss the Illinois Form 45 with Petitioner because he didn't review all his records before the examination (RX9, p. 32).

Dr. Nogalski admitted he did not know why a person's credit report was in his file while doing a medical examination. Dr. Nogalski did not consider it in forming his opinion. He does not normally get a credit report when he does an independent medical examination. Dr. Nogalski didn't even read it. He doesn't know whether the credit report is good or bad. That credit report was over half the size of all the other records in the doctor's file (RX9, p. 33, Ln. 23).

Dr. Nogalski admitted that a twisting motion of the knee could cause a posterior horn medial meniscus tear as Petitioner was diagnosed (RX9, p. 35).

Dr. Nogalski would not admit or deny whether the limp depicted in the surveillance footage was real or feigned (RX9, pp. 36-37). Dr. Nogalski did not get any information at all, including surveillance, showing Petitioner walking without a limp (RX9, p. 37)

Dr. Nogalski performs about 150 to 170 independent medical examinations per year. Most of his examinations come from employees, adjustors and case managers. Dr. Nogalski admitted he did not have board certification in occupational medicine (RX9, p. 42) Dr. Nogalski would not agree that the surveillance footage confirmed Petitioner's subjective complaint about a limp with his right leg (RX9, p. 43)

Dr. Nogalski agreed that Dr. Kohlmann's decision to proceed with surgery was reasonable. (RX 9, p. 39) He felt the MRI findings showed a chronic tear meaning that there had been changes present for some time. When asked if those findings could have been caused by a twisting injury in May of 2013, Dr. Nogalski replied, "If they correlated with adequate documentation of complaints, but they did not, so I do not believe they could." (RX 9, pp. 39-40) He felt the MRI showed a complex tear suggestive of longstanding changes. (RX 9, p. 40)

Dr. Nogalski was also asked how he came to conclude that Petitioner didn't report an injury. He testified

"I think it's significant the findings Dr. Kohlmann identified at the time of the surgery are ones that are very painful ones; in other words, the way the meniscus is flipped up underneath it's a significant issue. It strongly supports the idea and the clinical impression that this condition wasn't present at the time of the claimed injury, or I should say, it wasn't present right after that time because I think it would have limited him from working and walking significantly it would have caused him to have a limp and then some. It would have caused him to favor the leg. It would have caused him to have pain, stiffness and lack of mobility." (RX9, p. 44)

Dr. Nogalski admitted that he did not understand that Petitioner claimed he reported the injury the same day that it happened (RX9, p. 44) He could not recall if he asked him during their meeting if he orally reported the injury to his boss. According to his report, Petitioner implied passively that his boss knew he got hurt.

Dr. Nogalski did not identify in his report that Petitioner told him that he told his boss that he got hurt. He merely implied that his boss knew that he got hurt. Dr. Nogalski didn't see that there was an active statement, and that was not reported to him. He would have been all over Petitioner about whether he reported it and how he reported it. This was all he had in the report which he thought was very important (RX9, pp. 45-46)

Dr. Kohlmann also testified that there was no atrophy in the affected leg which is something might expect if there were a significant problem which had been present in the knee over time. (RX 9, p.)

After Dr. Nogalski's deposition, Petitioner returned to see Dr. Kohlmann on November 24, 2015. At that time Petitioner complained of continued right knee pain. Nothing much else had changed since his last visit. Petitioner reported that he was working but had a lot of pain when doing so. The pain was in the medial knee. The medial right knee still hurt. On that date Petitioner requested a letter from Dr. Kohlmann to document his disability so that he would qualify under certain Federal guidelines to be hired as a disabled person. (PX 11, p. 49)

Petitioner's physical examination revealed he was able to stand and walk pretty well. His right knee was carefully examined for more subtle abnormalities. There might have been a trace effusion. His right knee fully extended to 0 degrees and flexed to probably 130 degrees. The hip had good flexion and rotation and was painless. There was no right knee instability. The left knee exam was similar to the right knee. The right knee was not particularly tender along the medial joint line. Dr. Kohlmann could not palpate any bone spurs and Petitioner certainly had no deformity of the right knee. Dr. Kohlmann's assessment was persistent right knee pain with uncertain etiology. He opined that Petitioner had consistently complained of the same thing for a long time and that the exact pain could "possibly" be related to a medial meniscal tear which was treated surgically. Additional surgical treatment was not indicated. His pain was activity related. The fewer demands he made on his knee the less discomfort he had. A more sedentary work would probably agree with Petitioner. (PX2, pp. 65(h) – 65(i))

Dr. Kohlmann was deposed on April 14, 2016. (PX 11) Dr. Kohlmann is a board certified orthopedic surgeon. As such, he has treated many knee injuries including acute and chronic injuries. Dr. Kohlmann testified consistent with his treatment records as summarized above. He was aware of Petitioner's treatment with Poly Clinic and Dr. Sadiq. In addition, Dr. Kohlmann testified that Petitioner's examination findings when he first saw him were consistent with his injury and history that Petitioner had related to him. (PX11, p. 19) Dr. Kohlmann testified that his diagnosis changed after reviewing Petitioner's MRI as it showed a posterior medial meniscus tear. While Dr. Kohlman had suspected an ACL tear prior to the MRI he based it upon his clinical examination; however, Petitioner was guarding during that examination and it was difficult to examine the knee which is why he ordered the MRI. Dr. Kohlmann was of the opinion that Petitioner's accident at work

caused the posterior horn medial meniscus tear as the lack of problems before the accident along with the twisting mechanism of injury would be consistent with such a diagnosis. (PX11, pp. 20-21)

Dr. Kohlmann initially recommended that Petitioner refrain from prolonged weight bearing on his right leg together with no walking on uneven surfaces. (PX 11, p. 22)

Dr. Kohlmann testified that he then saw Petitioner again six months later at which time he began treating Petitioner. At that time Petitioner was still complaining of medial knee pain and his condition was really unchanged from the first examination. He still recommended surgery and they proceeded with it on June 6, 2014. During surgery Dr. Kohlmann found a complex appearing posterior horn medial meniscus tear. The rest of Petitioner's joint looked very good and in good shape. Dr. Kohlmann was of the opinion that his operative findings were the result of Petitioner's work accident. (PX 11, p. 24)

Dr. Kohlmann took Petitioner off work as of June 9, 2014. Petitioner was doing well post-operatively in July of 2014 when examined by Dr. Packard. (PX 11, p. 26)

Dr. Kohlmann testified that Petitioner was examined by Patricia Finegan on July 25, 2014. He explained that Ms. Finegan is a nurse practitioner in his office. He acknowledged that she returned Petitioner to work at that visit. He didn't recall that she checked with him before doing so. Dr. Kohlmann testified that it would not be out of line to release someone to return to work that soon after surgery if the individual was ready and seemed fine. (PX 11, p. 29)

Dr. Kohlmann testified that he saw Petitioner three days later on July 28, 2014 and noted he was walking without a limp. Petitioner's knee didn't appear swollen but upon closer inspection there was a small effusion in the right knee and some tenderness along the medial joint line. Knee motion was very good with some normal clicking as was to be expected. In light of some "hard findings" and pain complaints (which the doctor believed) he prescribed some medication and took him off work. (PX 11, p. 31)

Dr. Kohlmann testified that Petitioner's missing three days of physical therapy or an earlier appointment with the doctor wasn't hampering his recovery or alter his treatment regimen. (PX 11, p. 31)

Dr. Kohlmann testified that he was familiar with Petitioner's variable type of work. When he saw him in August of 2014 Petitioner was still in pain and had reported carrying a cooler full of beverages up some stairs at a tractor pull which really bothered his knee. At that time Petitioner didn't think he was yet ready to return to work. Petitioner was advised to continue with his medication, go to therapy, and try to lose some weight. Dr. Kohlmann believed Petitioner could work light duty at that time. (PX 11, pp. 32-33)

Dr. Kohlmann further testified that when Petitioner returned to see him in September he was still complaining of knee pain, give away, and locking. The last two complaints had never been mentioned before and were usually not an expected result from the type of surgery Petitioner underwent. Dr. Kohlmann really had no explanation for Petitioner's complaints at that time. His physical examination was relatively benign with just a "very small amount of joint fluid in the joint" and some knee pain when his knee was bent to 130 degrees. Petitioner's knee motion was very good and from a physical point of view, Petitioner's knee looked better than eer. (PX 11, pp. 33-34)

Dr. Kohlmann had Petitioner undergo knee x-rays that showed perhaps some medial joint space narrowing but it was minimal. It could have been due to the resection of the meniscus or some developing arthritis. He acknowledged that it was "possible" those findings could explain Petitioner's ongoing symptoms.

Dr. Kohlmann testified that arthritis can be a long-term result of the type of injury Petitioner had. However, he didn't see any "really obvious evidence of it" just that Petitioner was complaining of knee pain. At that time he felt Petitioner could be performing light duty work. (PX 11, pp. 35-36, 37)

Dr. Kohlmann acknowledged that Petitioner never had any left knee complaints. (PX 11, p. 37)

Dr. Kohmann further testified that he ordered an MRI and it was performed on September 29, 2014. It revealed the surgical changes as well as a small amount of fluid in the knee joint but no evidence of arthritis or ligament abnormalities. Dr. Kohlmann could not find anything to explain Petitioner's ongoing knee pain symptoms. (PX 11, p. 38) He discussed the situation with Petitioner who didn't want any other treatment except for a repeat surgery which would have been done for diagnostic purposes. (PX 11, pp. 38-39) Dr. Kohlmann testified Petitioner was unable to return to work at that time. (PX 11, p. 40)

Dr. Kohlmann testified that he re-examined Petitioner on January 12, 2015 at which time Petitioner still had knee pain. Petitioner told him he had been sent to Dr. Lewis[2] for an independent medical examination and the doctor recommended an MRI with gadolinium. Petitioner was walking with a small limp at that time. Dr. Kohlmann ordered the MRI and it showed the surgical findings with no new findings whatsoever. Thus, in Dr. Kohlmann's opinion, it didn't help explain Petitioner's ongoing pain complaints. Dr. Kohlmann again advised Petitioner to try and lose some weight and referred him to Dr. Goding, an orthopedic surgeon with lots of knee experience. Petitioner remained off work as of January 28, 2015. (PX 11, pp. 40-42)

Dr. Kohlmann testified that he again saw Petitioner on March 23, 2015 after Dr. Goding's appointment with him. He acknowledged that Dr. Goding didn't have much to offer in the way of help. Petitioner seemed much better and the doctor felt he could return to work in early April and learn to deal with the pain when he had it. He also felt an FCE might be helpful. Regardless, Dr. Kohlmann opined Petitioner was at maximum medical improvement at that time. (PX 11, pp. 42-45)

Dr. Kohlmann testified that he didn't see Petitioner again until November 24, 2015 at which time Petitioner reported he was working but experiencing a lot of pain while doing so. On examination the doctor noted a small amount of fluid in his knee but he didn't know what it was due to. He lacked instability and knee motion was normal. He felt Petitioner had persistent right knee pain of uncertain etiology although it was his opinion that the ongoing pain was probably more likely than not related to his injury. (PX 11, pp. 45-46) Dr. Kohlmann recommended sedentary work if that was what was needed to let him work a full day. He, nonetheless, felt Petitioner was able to work at that time. (PX 11, pp. 46-47)

Dr. Kohlmann acknowledged authoring a letter on December 7, 2015 at Petitioner's request regarding a disability determination. In it he indicated Petitioner was suffering from right medial knee pain of uncertain etiology and related to activity. He felt a sedentary occupation would agree with Petitioner. (PX 11, p. 48) Dr. Kohlmann testified that he felt a sedentary job would work for Petitioner because Petitioner felt strongly that it would. (PX 11, p. 49)

On cross-examination Dr. Kohlmann opined that a medial meniscus flipped back up on itself would be expected to cause pain and it would be difficult for one to climb stairs, ladders or scaffolds and one could have pain but it would just depend. The doctor believed one could climb a ladder if one had to (PX 11, Pg. 56, Lns. 1-16). A medial meniscus that folded in upon itself can just hurt whether it is displaced or not terribly

[2] Presumably Dr. Nogalski as no other mention of a "Dr. Lewis" is found in the record.

displaced. He acknowledged that displaced ones (as Petitioner had) can cause significant problems. (PX11, p. 56)

Dr. Kohlmann agreed that Petitioner's medial knee pain complaints were subjective in nature and, objectively, Petitioner had a very good result post-operatively. Dr. Kohlmann obtained a good result from surgery and it was not an overly complex or unusual surgery. It was a fairly routine surgery. Dr. Kohlmann would normally expect someone to be back to work in between 6 to 10 weeks after that (PX11, p. 57)

Dr. Kohlmann was asked to review the July 25, 2014 note. He testified that Nurse Finegan performed an examination that day and it was pretty normal with no sign of effusion and full range of motion. Petitioner's primary complaint was discomfort, a large subjective complaint. Dr. Kohlmann also testified that while Petitioner stated he couldn't walk in his back yard the nurse observed him walking in the reception area and exam room without any difficulty. He also acknowledged that the notes state that after the nurse released him to return to work Petitioner became agitated, cursed, yelled, and threw papers about the office. (PX 11, pp. 58-59) He also acknowledged that when he saw Petitioner three days later, he saw no signs of a limp or swelling. His range of motion was normal. Nothing about Petitioner's condition from an objective basis on July 28, 2014 would have caused him to impose any restrictions. Dr. Kohlmann agreed that any restrictions he imposed after July 28, 2014 were based upon Petitioner's subjective complaints alone. (PX 11, pp. 59-61) He further testified that Dr. Goding saw nothing objectively wrong with Petitioner's knee either. Finally, Dr. Kohlmann testified that any restrictions based on the January 12, 2015 and November 24, 2015 visits were based entirely on Petitioner's subjective complaints. (PX11, pp. 61, 63) Dr. Kohlmann also testified that as of January 12, 2015 and, again on November 24, 2015, Petitioner basically had two normal knees. (PX 11, p. 62)

Dr. Kohlmann testified that it was his opinion that the injury Petitioner sustained on or about May 20, 2013, was the cause of the posterior horn medial meniscus tear on his right leg. (PX 11, p. 20) Dr. Kohlmann acknowledged that his opinion was based largely on the truth, accuracy and completeness of the history provided to him by Petitioner. (PX 11, p. 54)

Dr. Kohlmann testified that when he saw Petitioner on November 24, 2015 Petitioner "definitely" wanted a disability note or report. He acknowledged stating that Petitioner's pain was of uncertain etiology and, to the extent any restrictions were necessary at that time, they were due to Petitioner's subjectively complaints solely. (PX 11, p. 63) Dr. Kohlman never saw any evidence of atrophy in Petitioner's right knee. (PX 11, p. 64)

Petitioner has had no further knee treatment since his last visit with Dr. Kohlmann in November 24, 2015.

Petitioner's case proceeded to arbitration on June 9, 2016. At the time of arbitration Petitioner amended his date of accident from "on or about 5/20/13" to May 22, 2013. (See AX 2) The issues in dispute were accident, notice, causal connection, medical expenses, temporary total disability, and the nature and extent of Petitioner's injury. Petitioner, Ronald J. Stewart and Jason Morgan testified at arbitration.

Petitioner testified that he was employed by Respondent as a union laborer from May 8, 2013 through Friday, May 24, 2013. (see also RX 6) Petitioner was working with bricklayers in the basement of a University building providing them with block, mud and building scaffold. The bricklayers were constructing a basement wall. There were two means of access to the worksite. The workers could either walk down a hill, described by Petitioner as "very steep" or use a ladder, which Petitioner also described as being very steep with 25-30 steps. The parties would go in and out of the basement in this manner at the beginning and end of each day and also for lunch.

Petitioner testified that on May 22, 2013, at some point between 3:30 p.m. and 8:00 p.m., he picked two cement blocks off a pallet, stood up, turned to walk with them and his toe got stuck in a strap causing him to injure his right knee. He testified he felt a pop and a burn in the knee. Petitioner testified that he threw a fit, threw stuff, and cussed because he was mad as the accident could have been avoided. Petitioner continued to work, did not seek medical treatment and did not prepare an Accident Report.

Petitioner testified that he advised his foreman, Jason, of the incident shortly after it occurred, which was sometime between 3:30 and 8:00 p.m. on May 22, 2013. He testified that he had told Jason that he had ". . . done something to my knee and it could have been avoided. I tripped over the band and we talked about resolving that." Petitioner testified that laborers and construction workers get hurt all the time on construction jobs and there was no reason for his foreman, Jason, to think anything was special with respect to the incident described in this claim. Petitioner testified that at the time this occurred, he did not think it was a big deal.

Petitioner finished his shift on May 22, worked on May 23 and May 24, and was laid off as the job was over on Friday, May 24. Petitioner testified that the lay-off was unrelated to any claimed injury.

Petitioner testified he was off work for approximately 2 ½ weeks before securing another job through Laborers' Union 703 at Illiana Construction. Petitioner acknowledged that the union will not dispatch laborers to work unless they are physically 100%. Petitioner testified that he worked for Illiana Construction approximately 13 days before that job ended. Two of those 13 days involved walking six miles and Petitioner was on his feet the majority of the time during the other days. Petitioner did not seek treatment during the 2 ½ weeks prior to being dispatched to the Illiana Construction job.

Petitioner acknowledged that he did not provide Dr. Sadiq with any workers' compensation information as discussed during their office visit. Petitioner testified that his former attorney was supposed to handle that.

Petitioner testified that when Ms. Finegan met with him on July 25, 2014. He testified that she did not physically examine him, did not put her hands on him, and did not even come into the room. On that date Petitioner testified that he had trouble standing up from the toilet and that just walking was a chore.

Petitioner testified that he returned to work as a laborer through Laborers' Local 703. Petitioner testified that he has been referred for jobs and remains on the referral list through Laborers' 703. Petitioner acknowledged that the union will not dispatch workers who have or are under any medical restrictions.

Petitioner acknowledged missing one doctor's appointment post-surgery because he forgot about it. He also acknowledged missing several post-operative physical therapy appointments testifying that he put the wrong date on his calendar and then went on vacation to Florida.

Petitioner testified that he slipped in some ice during the winter after his surgery and "it kind of messed it up a little bit." When asked if it was temporary, Petitioner replied in the affirmative but added that he was still having pain out of it. Petitioner started to say more but was cut off. He denied any "major re-injuries." Petitioner testified that his knee isn't back to one hundred percent. He still has trouble with it and described his pain as a "6-7". When asked when he would experience pain, Petitioner replied that it didn't matter. If he is sitting down it throbs on the inside of his knee. Petitioner testified to feeling pain on the inside of his knee while testifying. He also added that it is painful when he sits and then stands up as it takes awhile for it to straighten out. Petitioner testified to trouble sitting and lifting and performing his daily chores. If he stays off his feet he feels better.

Petitioner testified that Dr. Kohlmann took him off work as of December 12, 2013 and released him to return to work on March 23, 2015. During that time he received some temporary total disability benefits.

Petitioner testified that he has not returned to work as a mason tender because he feels unable to perform the job as it takes a lot of climbing, heavy lifting, and bending which he "just can't do anymore." Petitioner testified that he is looking for work. He has applied for work as a groundskeeper, a maintenance man, and a "gopher" for an electrician. He has also applied for a factory job but isn't "all that cracked up" about that. Petitioner testified to pain up and down his right knee and that it gives away. He also has pain when walking, bending, and squatting. Petitioner testified that most of the time he walks with a limp. He takes Tylenol and Advil if needed and, occasionally, Hydrocodone. Petitioner testified that he can no longer ride a bike or run. He tried walking on the beach after he hurt his knee and he had to turn around and go back to the hotel because he couldn't walk on the sand. Mowing ditches is difficult and he can't push mow anymore. Climbing ladders and walking on unstable ground gives Petitioner problems. He is able to care for himself and perform household chores, however. Petitioner denied full strength having returned to his leg but acknowledged having painful full range of motion.

Petitioner testified that he is trying to get in to see a specialist in Indianapolis regarding his knee.

Petitioner denied telling Dr. Nogalski that he injured his left knee on May 22, 2013. He also denied telling the doctor that he worked a road job and walked 6 ½ miles per day for 2 ½ weeks. At most, it was two days. Petitioner denied telling Dr. Nogalski that he couldn't recall if an accident report was filled out. He didn't tell Dr. Nogalski that he underwent a hernia repair in 1992. Rather, it was 1972. Petitioner denied telling Dr. Nogalski that he was lifting two 80 lb. concrete blocks; rather, they were 8 lb. blocks.

Petitioner denied telling Michelle Cordes at Dr. Sadiq's office to change his medical records.

Petitioner testified, on cross-examination, that the Hydrocodone he has is left over from a year or two before post-surgery.

Petitioner further testified that he was dispatched from the hall to work on the job building basement interior walls. He agreed that he had to be physically 100% to work. He accessed the basement of the building where he worked by walking down a very steep hill or going down a very steep man-made ladder. There were about 25-30 steps. He would go down the hill or steps to start work and go up it to leave. Sometimes they would leave the basement to go and have lunch.

Petitioner testified that Ron Stewart is an acquaintance of his as he lives south of town. They would ride together along with others from town. Petitioner knew his dad having grown up with him. He knew Ron Stewart pretty well from riding together all these years.

Petitioner testified that he thought the accident occurred on a Wednesday. He changed the accident date from May 20th to May 22nd because he really couldn't remember the date and had to look it up on the calendar. He knew he worked two days after the accident. He agreed that his lay-off was unrelated to his accident. The work had been caught up and the second shift was no longer needed.

Petitioner testified that the accident occurred before 8:00 p.m. because he had to climb out of the hole for lunch. Petitioner further testified that Jason was about 14 feet away from him when the accident occurred. He was working "through a doorway and then another 4 feet around the corner." When asked if he told Jason that he twisted his knee, Petitioner testified that Jason turned around and saw him limping and asked what happened

to him to which Petitioner replied that he had just blown his knee out because of the straps being laid on the ground. Petitioner added that they had been having trouble with laborers cutting the bands off and being worried someone was going to trip over them. Petitioner also agreed that he didn't ask to go to the doctor at that time because he would get hurt all the time. Petitioner testified that laborers and construction workers aren't a bunch of sissies so he figured it would work itself out as it had before. Petitioner testified that there was no reason for Jason to believe anything special about that particular incident. He just asked Petitioner what happened and he told him.

Petitioner testified that he didn't know about filling out an accident report because he'd never really had to deal with it and didn't know how to do it. He acknowledged prior workers' compensation claims. On the day of the occurrence he didn't think it was much of a big deal. If someone had brought him a form or told him to fill out an accident report he would have.

Petitioner acknowledged working his remaining shift and that he had an agreement with Garrett Thompson regarding lighter work. According to Petitioner, "they" told Jason what was going on and he didn't care just as long as the work got done. After Petitioner was laid off on Friday he signed up for more work and received another job 2 ½ weeks later. He didn't seek any medical treatment between the two jobs. He then worked for Iliana Construction and walked six miles a day laying reflective tape on the highway. Petitioner testified that the other laborer he was working with knew about his situation and would bend down and put the tape on so that all he had to do was carrying the roll of tape, tear it and hand it to him. He would always be on his feet unless they had to jump in a truck and drive and put traffic control signs up and stuff like that.

Petitioner denied working anywhere else after the Iliana job. He relied upon his savings to live.

Petitioner acknowledged going to work for Cross Construction after Dr. Kohlmann released him in March of 2015. He is still eligible to work out of the hall and his name is on the list.

Petitioner's hobbies include fishing and cutting wood. He just bought some property out in the country and does "a lot there," including walking the trials. He has deer paths that go up and down the property and he walks that. He owns a camper that is towed but everything is push button. Petitioner still fishes but hadn't yet renewed his license. He doesn't hike anymore. He used a wood splitter to split four truckloads of wood back in February of 2016.

Petitioner also acknowledged that when the misunderstanding/mix-up in his therapy occurred, he was vacationing in Panama City Beach and/or at his mother-in-law's in Punta Gorda. When asked if he had gone on any vacations this year, Petitioner replied "Not that I am aware of." When then specifically asked if he went Las Vegas in April, he replied yes. When asked about going to Redondo Beach and Vegas and whether he spent time walking around, he replied that he was pretty much sitting in a bar getting drunk. He also agreed that he had gone to the Lake of the Ozarks over Memorial Day Weekend as his buddy has a house down there and they rewired his boat dock.

Petitioner testified that he uses a riding mower and snow blower.

On redirect examination Petitioner was asked if he injured himself on any of his vacations or while engaged in his hobbies and Petitioner explained that while he was on his honeymoon he tried to walk down the beach and got about ten feet down and had to turn around because he couldn't walk in the sand.

Ronald J. Stewart testified on behalf of Petitioner. Mr. Stewart is a bricklayer. He has known Petitioner three years maybe, give or take. They are not in the same union. They know each other through work. They ride to work together. Mr. Stewart worked on the same project in Urbana with Petitioner in May of 2013. He testified that Petitioner was his carrier and would bring blocks, mortar and other materials. He did the same for Jason. Mr. Stewart worked in close proximity with Petitioner on that project. Mr. Stewart recalled an incident on or about May 22, 2013 when Petitioner had an accident with his right leg. Mr. Stewart was about 5 feet away when the accident occurred. He observed that when Petitioner picked up two 8-inch blocks and turned to walk, his foot got caught under a green plastic strap and when he turned, his foot stayed and he fell into a push up position on the block instead of hitting the floor.

Mr. Stewart further observed that after the incident Petitioner got up and started limping around and said he hurt himself, hurt his knee, and twisted it. Mr. Stewart told Petitioner to go talk to Jason and return to do his job. Mr. Stewart knew Petitioner went down there, but was never in the vicinity of the talk. Mr. Stewart did not observe Petitioner and Jason having any type of discussion after the incident. Mr. Stewart never observed Petitioner with a limp before the accident. As a former mason tender, Mr. Stewart testified it is difficult to do that job with a bad knee. Mr. Stewart never observed Petitioner with a problem with his right leg in the years he knew him before the accident

On cross-examination Mr. Stewart confirmed that Petitioner continued to work until he was laid off. In the interim, he couldn't climb the scaffold. Mr. Stewart labored for him and did the bulk of the labor. Petitioner would hand him blocks here and there but he wasn't climbing up and down the scaffold. As far as he knew Petitioner didn't seek medical treatment at that time. Both Mr. Stewart and Petitioner rode back and forth to work for those last two days.

Mr. Stewart agreed the work they do is heavy in nature and people get bumps and bruises and things happen a lot on the job site. Nothing he saw on the date of this accident lead him to believe Petitioner had a serious injury or that this was something significant but explained that Petitioner was limping, definitely limping. He knew Petitioner was in pain and hobbling.

Respondent called Jason Morgan as a witness. Mr. Morgan was employed by Respondent as a bricklayer foreman. Petitioner was under his supervision on a job site at the University of Illinois in late May of 2013. In his experience there are regular safety meetings on the job site every Friday. Those would take place with all of the local employees or crew. It would be laborers and bricklayers in this case. The requirement of reporting accidents and filling out an accident report is discussed in safety meetings but not at every single meeting.

In terms of getting in and out of the basement as the work area was described, Mr. Morgan described a long gravel ramp that you could walk down, a homemade wooden ladder to climb down, or use of a metal stairwell.

Mr. Morgan agreed that moving heavy block, mud and things of that nature was heavy work. He agreed that people would from time to time would have bumps and bruises and aches and pains and have things occur. He did not recall Petitioner reporting to him that he had suffered an injury to his right knee when his toe caught on a strap and twisted. Had he reported such an accident, Mr. Morgan would have filled out paperwork. Mr. Morgan also would have called the owner of the company and seen him the following day. Petitioner would have been sent to the doctor, if necessary.

Mr. Morgan agreed that people from time to time complain of aches and pains during the course of a work day. As far as he is concerned they are not actually reporting an injury. According to Mr. Morgan, this happens "all the time."

Mr. Morgan had no recollection whatsoever of a conversation with Petitioner at any time on this jobsite wherein Petitioner claimed to have injured his right knee.

Mr. Morgan testified that if this occurred on May 22nd and Petitioner was laid off after the workday on May 24th (which was a Friday) Mr. Morgan would have had occasion to see him on a number of occasions during those days but not physically the whole shift watching him. There were walls between the two. Mr. Morgan testified that he never observed Petitioner limping or in any way appearing injured on this job site during that time.

On cross-examination, Mr. Morgan testified that no one ever advised him that Petitioner had a knee problem before that project. Mr. Morgan admitted he had ample opportunity to observe Petitioner during those first couple of weeks and did not observe any limping or difficulty walking by Petitioner and that Petitioner was performing his job satisfactorily.

Mr. Morgan admitted that Garrett Thompson was another laborer on the project who worked with Petitioner. Mr. Morgan denied he was aware of how Mr. Thompson cut the banding straps to the blocks that Petitioner claims he injured himself on. He had no information that the banding straps were not being cut correctly. He explained that there were several ways to cut the straps but he had no idea how they cut them. The whole purpose was to cut them and get them out of the way. Mr. Morgan denied there were any discussions at any safety meetings about the banding straps.

Mr. Morgan admitted that if an incident is reported to him at work, his responsibility is to report it to the owner and then paperwork is filled out. Mr. Morgan wouldn't be doing his job if he didn't do that. He also admitted that he would suffer no adverse consequences or reprimand if he did not report an accident to the owner.

Mr. Morgan maintained he did not observe Petitioner limping in any way, shape or form in the couple days before he was laid off. Mr. Morgan admitted he did not have much opportunity to observe him after his incident. If he was limping around Mr. Morgan may not have even known it.

Mr. Morgan denied that Petitioner had complained about the way Garrett Thompson was cutting off the banding straps.

Respondent submitted into Respondent's Exhibit 15, which was the member specific skill report for February of 2016. According to this report Petitioner indicated the various skills that he had for hire. While numerous skills are listed, Petitioner did not mark he was available as a mason tender (RX15, p. 3).

Respondent placed into evidence the claims pay-out report identified as Respondent's Exhibit 5. According to this exhibit a claims file was opened on July 31, 2013. A total of $35,072.48 had been paid for temporary total disability compensation. In addition, $24,271.59 had been paid out in past medical expenses (RX5).

The Arbitrator concludes:

Issues (C) and (F) Accident and Causal Connection.

With the exception of issues (N) and (J) all the disputed issues in this case depend upon Petitioner's credibility as a witness and, quite simply, the Arbitrator is unable to find that he was.

Petitioner testified as to the details of an accident when he allegedly caught his toe in a strap while lifting blocks, turning and walking, but he did not recall the time the accident occurred, placing it at some point between 3:30 and 8:00 p.m. on the date in question, nor initially did he recall which day the accident occurred, having amended his Application for Adjustment of Claim to change the accident date from May 20 to May 22, 2013.

There is no real corroboration for Petitioner's account of the accident except for the testimony of Mr. Stewart. However, Mr. Stewart is a co-worker of Petitioner's, they drove back and forth to work together, and Mr. Stewart's father and Petitioner grew up together. Petitioner testified that they got to know one another pretty well riding together over the years. Thus, one could reasonably infer some bias towards Petitioner. Additionally, there were some discrepancies regarding the testimony of Mr. Stewart and Petitioner which leads the Arbitrator to question the veracity of their testimony.

Mr. Stewart testified that Petitioner picked up the blocks, turned to walk and he fell into a push-up position on the block instead of hitting the floor. He then testified that after he fell, he got up and started limping. Mr. Stewart also testified that he told Petitioner to go and talk to Jason and Petitioner "went down there" but he (Mr. Stewart) was never in the vicinity of their conversation. Second, Mr. Stewart testified that Petitioner got hurt on a Thursday (not a Wednesday as Petitioner claimed) and that Petitioner wanted to go home but stayed. He further testified that he "labored" for Petitioner on Friday and performed the majority of the work climbing up and down the scaffold for him.

Petitioner, in contrast, testified he was injured on a Wednesday because he recalled working two more days. Petitioner testified that after the accident he threw a tantrum, threw a fit, threw stuff, and cussed. Mr. Stewart didn't corroborate that. Petitioner further testified that once he was over being mad, he resumed working. He did not testify to wanting to go home. Petitioner also testified that his job duties changed after the accident because he no longer climbed the scaffold to take care of the bricklayers up top; rather, Garrett Thompson was the one who helped him because he was the one who cut the strap off and left it on the ground in the first place. Mr. Stewart testified that he was the one who helped Petitioner out the remainder of the job. He said nothing about Mr. Thompson.

Petitioner did not subpoena Mr. Thompson to testify on his behalf. He could have done so.

Petitioner claims that he gave notice of a work-related accident to his supervisor, Jason, shortly after the accident occurred on May 22, 2013. He indicated the notice was given sometime between 3:30 p.m. and 8:00 p.m. He did not know exactly when the accident occurred or when notice was given within a 4 ½ hour period of time. He indicated that he advised Jason that he had injured his knee and was in pain but acknowledged that laborers on construction sites are hurt all the time and he gave Jason no reason to think anything special had occurred in this particular incident. Petitioner himself did not think the incident was a big deal at the time it occurred. Thus, it isn't clear if there was anything for Petitioner to actually give "notice" of other than the fact he was really mad about the strap.

In contrast, Petitioner's supervisor, Jason Morgan, denied receiving notice of an accident and testified that had an accident been reported, normal protocols would have been followed, which would have included preparation of an Accident Report, a phone call to the owner of the company and a referral, if necessary, of Petitioner for medical treatment. None of this was done in this instance.

The Employer's First Report of Injury reflects the incident was not reported until July 31, 2013, well after the 45-day reporting requirements in Section 4 of the Act, and only after an Application for Adjustment of Claim had been filed, according to the Commission records, on July 19, 2013. (RX 2) That report documents that the accident was "unknown – incident never reported to employer". Petitioner's filing of his Application for Adjustment of Claim occurred the day after his visit with Dr. Sadiq which, coincidentally, happened to be when he was advised that he had no personal health insurance. (PX 2, o/v – 12/12/13)

Petitioner's claim that he suffered a significant injury to his right knee as a result of the alleged accident is contradicted by the fact that he was able to continue working in a very heavy job moments after the accident allegedly occurred and for two more days until he was laid off due to completion of the job. The job required Petitioner to enter and exit the work area by climbing a very steep slope or a very steep ladder for the 2 ½ days after the accident allegedly occurred.

The significance of anything that might have happened on/around May 22, 2013 is further contradicted by Petitioner's failure to seek treatment on the date of the accident. Petitioner's claim is further contradicted by his acknowledgment that at the time this alleged incident occurred, he did not perceive that the incident was "that big of a deal." Also, although he claimed to have told his supervisor, Jason, of the accident, he acknowledged that there was no reason, so far as he knew, for Jason to have thought anything special of this incident based on what he was told or saw. The significance of any alleged event is further diminished and contradicted by Petitioner's failure to seek treatment during the 2 ½ weeks between his lay-off and being dispatched by Laborers' Local Union 703 to another job for Illiana Construction.

Petitioner's claim is further undermined by his ability to work for 13 days at Illiana Construction. While this job involved road construction, as opposed to masonry work, Petitioner was nonetheless on his feet a substantial part of the day and was able, for at least two days, to walk 6.5 miles each day. In order to get that job, he represented himself as 100% physically fit for work. While Petitioner testified that his boss knew about his situation, he provided no corroboration for that. He could have subpoenaed witnesses to verify any alleged problems he was having during that time. However, he didn't.

Petitioner's claim of a significant meniscal tear injury as a result of an event at work is further contradicted by his failure to seek treatment until he presented to his family doctor, Dr. Sadiq, on July 8, 2013, and his failure to follow up by providing workers' compensation information as requested by Dr. Sadiq.

Petitioner and Mr. Stewart testified that Petitioner limped after the alleged accident. Mr. Morgan denied seeing any evidence of limping. The Arbitrator acknowledges that Petitioner was not always in eye sight of Mr. Morgan but given her concerns about the credibility of Mr. Stewart and Petitioner, there was no other corroboration for Petitioner's testimony regarding a limp after the alleged accident.

Petitioner was asked about the gap in treatment between July 8, 2013 and December 12, 2013 (when his new attorney sent him to Dr. Kohlmann for an examination). Petitioner blamed the gap on his prior attorney who, among other things, allegedly failed to send the workers' compensation information to Dr. Sadiq so that his MRI and referral to Dr. Kohlmann could be ordered. That testimony is very different than what Petitioner told Dr. Kohlmann in December of 2013. Dr. Kohlmann wrote:

> His doctor [Dr. Sadiq] ordered an MRI scan, but the worker's [sic] compensation company denied the MRI scan and it was therefore never done. The patient also found out when he went to see Dr. Sadiq that he did not have health insurance. His health insurance had expired in late 2012. (PX 2, o/v of 12/12/13)

Petitioner's motivation in filing a workers' compensation claim the day after his visit with Dr. Sadiq may have been triggered by his lack of personal health insurance. Additionally, the contradictory explanations for Petitioner's lack of treatment between July and December undermine Petitioner's credibility herein.

Petitioner's claim is further contradicted by the history given to Dr. Kohlmann upon initial presentation, on December 12, 2013, that included a claim that his knee was yellow and bruised after this incident. (PX 2, p. 19) Dr. Nogalski's unrebutted testimony was that such a finding would be consistent with a contusion but not with an injury to the meniscus. (RX 9, pp. 22, 28) Dr. Nogalski testified that the MRI scan did not reflect damage to the joint which could have caused bruising. (RX 9, p. 22)

Petitioner's claim of a torn medial meniscus dating to May 22, 2013 is also contradicted by the surgical findings which revealed that the meniscus had been flipped up underneath the knee, a condition which would be very painful and, according to Dr. Nogalski, would have sidelined Petitioner from activities right away. (RX 9, p. 27) Dr. Kohlmann likewise testified that such a displacement could have caused significant problems and can "really, really bother you, yes". (PX 9, pg. 57)

Petitioner's conduct after the surgery in June of 2014 further calls his credibility into question. Petitioner testified he missed a post-operative evaluation with his treating surgeon because he "just forgot all about it". He missed several of the initial physical therapy visits after the surgery because he put them on the calendar on the wrong day and then went on vacation to Florida. Petitioner testified that when he was released without restrictions by Dr. Kohlmann's nurse practitioner, Finegan, she never examined him, never laid hands on him and did not even come into the room. Petitioner indicated at that time he could not stand up to get off the toilet and just walking was a chore. Finegan's note of that day, however, indicated she observed Petitioner walk into the reception area and into the exam room without any difficulty and charted a normal examination. (PX 2, pp. 32-33) Dr. Kohlmann testified that N.P. Finegan did, in fact, examine Petitioner on July 25, 2014. (PX 11, p. 58)

Dr. Kohlmann's testimony that Petitioner's objective findings were essentially normal from July 25, 2014 until the last time he examined Petitioner in November of 2015 also contradicts Petitioner's credibility. On multiple occasions Dr. Kohlmann acknowledged that had Petitioner given him a history that he had never felt better, nothing in his examination would have contradicted such a statement. (PX 9, pp. 60, 63) The absence of any objective basis to support Petitioner's ongoing subjective complaints is further corroborated by the opinions of Dr. Goding and Dr. Nogalski. (PX 10; RX 9)

Also troubling is Petitioner's failure to provide any explanation whatsoever for his lack of treatment with Dr. Kohlmann between December of 2013 and June of 2014. This is further complicated by some of Petitioner's testimony on direct examination that centered around a fall on ice. Petitioner was asked if he re-injured his right knee in any way after his surgery and he replied that he slipped in some ice in the winter after his surgery and "it kind of messed it up a little bit." He was then asked if it was temporary and Petitioner replied, "Yeah. Well, I'm still having pain out of it but--." Petitioner was then cut off and asked if he had any

"major" re-injuries to which he replied "No." Petitioner's surgery was in June of 2014. If, indeed, he fell in the winter-time after his surgery he failed to mention it whatsoever to Dr. Kohlmann or Dr. Goding at any time thereafter. If, indeed, he fell at that time that could have explained his ongoing subjective symptoms during that time. Again, he didn't mention it. The Arbitrator, however, isn't so sure the fall on ice occurred in the winter after his surgery. According to Dr. Sadiq's medical records, Petitioner sought treatment from him on February 20, 2014 after he fell on ice. (PX 3, pp. 66, 68) Petitioner testified that the fall "messed his knee up a little bit." Petitioner's testimony and its related questions raise yet another red flag regarding Petitioner's credibility and what may have truly been going on with regard to Petitioner's knee.

Finally, the Arbitrator notes that Petitioner was, initially, not truthful when asked if he had been on any vacations this year, answering "Not that I am aware of." However, on further questioning, he acknowledged that he was in Las Vegas in April of 2016 and also made trips to Redondo Beach and Lake of the Ozarks over the Memorial Day weekend of 2016 where he "helped a buddy rewire his boat dock." Petitioner's credibility was further lessened by his testimony as to why he didn't seek any treatment for the 2 ½ weeks he was laid off between working for Respondent and going to work for Illiana Construction. Petitioner responded that he didn't have any insurance and just figured it would work itself out. However, Petitioner didn't know he didn't have health insurance at that time as he told Dr. Kohlmann when they initially met in December of 2013 that he didn't find out he lacked health insurance until he presented to Dr. Sadiq on July 8, 2013. (PX 2, o/v 12/12/13)

The Arbitrator further notes that video surveillance was performed on August 18, 2014 and purportedly showed Petitioner limping. In contrast, Petitioner was also examined by Dr. Kohlmann on August 18, 2014 and the doctor noted no evidence of limping. This represents another contradiction and another inconsistency which went unexplained and, again, casts suspicion on Petitioner's credibility and/or motivation herein.

Even assuming, arguendo, that one gives Petitioner the benefit of the doubt on the issue of accident, Petitioner failed to prove the requisite causal connection between his accident and his knee condition. Dr. Kohlmann's opinions, including those with respect to causation, were, by his testimony, based largely on the truth, accuracy and completeness of the history provided to him by Petitioner. (PX 9, pg. 54) Given Petitioner's credibility issues and the completeness of the history provided by him to Dr. Kohlman, including the fall on the ice, Dr. Kohlmann's causation opinion was not persuasive.

For the reasons stated above, the Arbitrator finds that Petitioner's claim lacks credibility and that Petitioner has failed to meet his burden of proof that he sustained an accident on May 22, 2013, that arose out of and in the course of his employment, or that his subsequent injuries and current condition of ill-being in his right knee was causally related to his alleged accident. Petitioner's claim for compensation is denied and no benefits are awarded. All remaining issues are rendered moot.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Nicholas Brown,
Petitioner,
vs.

NO: 14 WC 27393

Packers Sanitation Services, Inc,
Respondent.

18IWCC0041

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, notice, temporary total disability, medical, prospective medical and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 23, 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: JAN 22 2018
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DLG/mw
045

David L. Gore

Stephen Mathis

Deborah Simpson

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

BROWN, NICHOLAS
Employee/Petitioner

Case# **14WC027393**

PACKERS SANITATION SERVICES INC
Employer/Respondent

18IWCC0041

On 5/23/2017, 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 1.05% 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 & EVANS
JAY JOHNSON
4234 MERIDIAN PKWY SUITE 134
AURORA, IL 60504

0264 HEYL ROYSTER VOELKER & ALLEN
JESSICA M BELL
300 HAMILTON BLVD PO BOX 6199
PEORIA, IL 61601

STATE OF ILLINOIS)
)SS.
COUNTY OF Sangamon)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Nicholas Brown
Employee/Petitioner

v.

Packers Sanitation Services, Inc.
Employer/Respondent

Case # 14 WC 27393

Consolidated cases: _____

18IWCC0041

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 **Springfield**, on **April 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. ☒ 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 _____

18IWCC0041

FINDINGS

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

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

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

Timely notice of this accident N/A 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 **$20,529.08**; the average weekly wage was **$394.79**.

On the date of accident, Petitioner was **29** 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** 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

Because Petitioner failed to prove an accident arising out of his employment which was causally related to his current condition of ill-being is related to his employment with Respondent, no benefits are awarded.

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

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

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

D. Dylan McEarth

Signature of Arbitrator

5/16/2017
Date

MAY 23 2017

ICArbDec19(b)

Statement of Facts 18IWCC0041

This case appeared before Arbitrator McCarthy for arbitration on April 24, 2017 in Springfield, Illinois. At the time of arbitration, a Request for Hearing was submitted as Arbitrator's Exhibit 1. Exhibit 1 indicates the issues in dispute are accident, notice, causal connection, medical bills, temporary total disability, temporary partial disability, and prospective medical.

At the time of arbitration, Nicholas Brown ("Petitioner") testified that he was employed as an inedible meat janitor with Packers' Sanitation Services ("Respondent") for a period of time. (Trial Transcript, pg. 55). He initially testified that his employment started in 2012, but later confirmed it started in 2013. (Trial Transcript, pgs. 8, 53). Petitioner's application for adjustment of claim alleges he sustained injuries to both hands/arms as a result of his employment with Respondent as a result of "repetitive trauma." The application for adjustment of claim alleged an accident date of 8/2014, but was later amended by the petitioner to allege an accident date of 9/2013. (Respondent's Exhibit 2).

The petitioner testified regarding the various jobs he performed while employed by Respondent. He testified that he worked in eight different jobs or positions, doing various tasks with each job. (See generally Arbitration Transcript, pgs. 8-52). Respondent's witness, Ruben Mojica, testified that the Petitioner accurately described the Petitioner's job duties, with a few exceptions, which he clarified. (Trial Transcript, pgs. 76-81).

Petitioner testified that the first job he performed when he started with Respondent was working in the "chemical cage." (Trial Transcript, pg. 9). Petitioner testified that his job entailed handing out chemicals and protective equipment to other employees at the start of their shift. Petitioner testified that he experienced some discomfort and breathing issues while working this job and was moved to another position after approximately one month of working. (Trial Transcript, pg. 13). Mr. Mojica indicated working in the chemical cage did not involve the use of the Zamboni machine, nor did it involve any tools or activities that exposed the hands to vibration. (Trial Transcript, pgs. 80-81).

The petitioner testified he next worked "on the ham line," on the second shift. He described this job as consisting of mostly picking up meat that hit the floor during production. He testified that he used a hook or a rake to move the meat so it was not touching the production belt. Petitioner testified he had no preference for one hand over the other while doing this job. (Trial Transcript, pg. 14). Petitioner further testified that his job on the ham line entailed dumping totes of meat product into a larger tote, either 25-30 or 55 gallons in size.

Petitioner testified he would do this task two or three times a day while working on the ham line. (Trial Transcript, pg. 15). Petitioner testified that he worked on the ham line, second shift for approximately two months. (Trial Transcript, pg. 57). Mr. Mojica testified that the Petitioner's job duties were basically as he described with respect to the second shift ham line. However, Mr. Mojica further clarified that the Petitioner was only picking up scraps of meat or toenails that were not caught by the production line, as opposed to picking up every one as the Petitioner seemed to suggest. (Trial Transcript, pgs. 80-81). Mr. Mojica also testified that the second shift ham line did not require the use of a Zamboni machine, nor did it involve anything that exposed the Petitioner to vibration. Mr. Mojica also testified that there was nothing about the second shift ham line that was "repetitive" in nature. (Trial Transcript, pg. 81).

The petitioner testified he next worked on the ham line, but first shift, doing essentially the same job for "a couple months." (Trial Transcript, pg. 20). Petitioner testified he next moved to the "kill floor." He testified regarding a number of job duties he did at this position, starting with picking up toenails. He testified he used a broom or a rake to pick up the toenails, scoop them into a 55 gallon drum, and then wheel the drum over to the dump to be emptied. He testified that the dump had a hydraulic that lifted the 55 gallon drum to be emptied. (Trial Transcript, pgs. 21-24). Petitioner further testified that he had to clean drains while working on the kill floor. He testified that he would manually dump hair and toenails from the drains if the drain clogged. (Trial Transcript, pgs. 26-27). Petitioner testified he also cleaned up lard, picked up squealers, and cleaned off the belt if it broke while working on the kill floor. (Trial Transcript, pgs. 28-31). Petitioner testified he worked on the kill floor for approximately six or seven months. (Trial Transcript, pg. 28).

Petitioner next testified that he moved to the "skinless bellies" after leaving the kill floor. He testified he was "just picking up bellies" while assigned to this position. (Trial Transcript, pg 31). He next testified that he was transferred to a "floater" position where he basically did whatever needed done that day, depending on if someone called off for the day. (Trial Transcript, pg. 31). Petitioner testified he next worked in special production orders, packaging up various items. (Trial Transcript, pgs. 33-34). Petitioner testified he was next moved to the cooler, where his primary task was cleaning. Petitioner testified he worked this job for just a few weeks before no longer returning to work for Respondent. (Trial Transcript, pgs. 34-35).

The Petitioner testified regarding the use of various equipment in his job. He testified that he used something that he described as a power washer, but later explained it was more of a nozzle attachment to a hose for cleaning purposes, and that it was directed with the hands, but mostly maneuvered sitting over the

shoulder/back. (Trial Transcript, pgs. 17-18). He testified that he used a "little box knife" while working as a floater, filling in for any position if someone called off that day. (Trial Transcript, pgs. 32-33). He testified that he used a Zamboni when he was working in the cooler. (Trial Transcript, pg. 34).

Regarding his alleged medical condition, the petitioner first testified that he noticed issues with his hands/wrists at various points during his employment, but later clarified that the specific activity that caused symptoms in his hands was cleaning the drains. (Trial Transcript, pg. 62).

Petitioner testified that he reported his pain or concerns to Andrew Walden, his supervisor. (Trial Transcript, pg. 38). Petitioner also testified that he was aware of Respondent's policy regarding accident/injury reporting. He testified that he received training on the policy and that signs were posted advising employees of the reporting policy. (Trial Transcript, pg. 54-55). Respondent submitted Exhibit 6, PSSI Handbook on "Reporting Accidents and Injuries" explaining the process for reporting work-related injuries. Respondent also submitted Exhibit 7, an accident report documenting the petitioner's complaints regarding his breathing issues while working in the chemical cage. No accident report was submitted to support any reporting by the petitioner of hands/wrists complaints during his employment with Respondent. An Illinois Employers' First Report of injury was submitted as Respondent's Exhibit 1. The form indicates it was completed August 22, 2014 and indicates Respondent was advised of the petitioner's hand/wrist complaints on August 22, 2014, but notes the date and time of the accident is "unknown." (Resp. Ex. 1).

Respondent presented testimony through safety supervisor, Ruben Mojica. Mr. Mojica testified regarding Respondent's accident reporting policy and procedure. (Trial Transcript, pgs. 73-75). Mr. Mojica also testified regarding the Petitioner's reporting of respiratory and rash issues while working in the chemical cage. (Trial Transcript, pg. 75). Mr. Mojica testified that Petitioner never reported any issues with his hands/wrists and no report was ever completed documenting any alleged complaints. (Trial Transcript, pg. 76).

At arbitration, Petitioner initially denied any issues with his hands/arms that predated his employment with Respondent. (Trial Transcript, pg. 37). Upon further questioning, however, he admitted prior issues. (Trial Transcript, pgs. 60-62). The medical records submitted also reveal the petitioner had long-standing issues with his hands/arms. The medical records show the petitioner reported he'd been experiencing those symptoms since as far back as 2007. The medical record in which the petitioner first presented for treatment with Dr. Colen on September 20, 2013 indicates he presented for treatment after experiencing issues while at home. Other than

indicating "Works at Cargill," the medical record from his first visit with Dr. Colen makes no mention of the Petitioner's work activities at all. (See Px. 6; See Rx. 4, pg. 3).

Petitioner sought treatment with Dr. Leutz first in August 2014. Dr. Leutz recommended surgical intervention to address the Petitioner's carpal tunnel condition. At the time of his deposition, Dr. Leutz opined that the Petitioner's employment activities with Respondent caused his CTS condition. (See generally Px. 1).

Petitioner presented to Dr. Williams for an IME on December 3, 2014. Dr. Williams' IME report was submitted as Respondent's Exhibit 4. At the time of the examination, the Petitioner provided Dr. Williams with a detailed history of the various jobs he performed while working for Respondent. (Trial Transcript, pg. 46). Dr. Williams conducted an examination and concluded that the Petitioner did have carpal tunnel syndrome (CTS) and needed surgical intervention. However, Dr. Williams indicated the Petitioner's work activities with Respondent did not contribute to his development of CTS. (Rx. 4).

Arbitrator's Findings

Is Petitioner's current condition of ill-being causally related to the injury and did the Petitioner have an accident arising out of his employment?

In a repetitive trauma claim, the issues of causation and accident are analyzed together. Petitioner must prove that some aspect of his employment was a cause of his injuries. Medical testimony, though not required, is usually relied upon by the Commission in reaching its decision.

The Petitioner testified regarding the various jobs he did while working for Respondent. The Petitioner started working for Respondent in May 2013 and last worked for Respondent August 22, 2014, a period of approximately fifteen months. During that time period, the Petitioner testified he worked eight (8) different jobs. However, because the Petitioner alleged his date of accident is September 20, 2013, it is only relevant to causation the jobs he was doing up to that point, a period of only four (4) months. The Petitioner testified that, as of September 20, 2013, he would have only worked in the chemical cage and on the second shift ham line. Also significant is the fact that on October 7, 2013, nerve studies were performed showing that the Petitioner had moderately severe bilateral carpal tunnel syndrome. (PX 2) Obviously, the work the Petitioner did during those initial five months would be relevant to the issues of accident and causation.

There is no medical evidence to support a finding that the job duties associated with those positions caused or contributed to the Petitioner's development of carpal tunnel syndrome. The Petitioner's own treating physician, Dr. Leutz, testified that he had no formal job description. In fact, Dr. Leutz testified that his understanding of the Petitioner's job comes mostly from the history taken by Dr. Williams, which Petitioner himself tried to discredit at trial as inaccurate and incomplete. Nonetheless, Dr. Leutz testified at his deposition that the Petitioner's work for Respondent caused or contributed to his development of carpal tunnel, despite admitting that he had no independent recollection of the Petitioner's job activities and did not independently verify any of the activities. He went on to place significant emphasis on the Petitioner's use of a power washer in his development of CTS, yet he was unaware of how often he was using a power washer. In any regard, the testimony of the Petitioner himself indicates he was not using any vibratory tools while working in the chemical cage or the second shift ham line, the two jobs he did before he allegedly developed CTS. The Petitioner further attempted to relate his CTS to the use of a box cutter or Zamboni, both of which occurred well after he started treatment and after his alleged accident date of September 20, 2013.

The Arbitrator acknowledges that some of the activities of the second shift ham line could involve gripping, such as the use of a rake or hook. However, there was no evidence that the Petitioner was using those tools for a significant portion of the day, or even on a daily basis. Petitioner's testimony indicates his job was sufficiently varied, moving from manually picking up items, to using tools to do so. He also moved totes to be dumped, but did that only two or three times a day. He further testified that he would use an attachment on a regular hose to spray things off, but irregularly, not even on a daily basis. (Trial Transcript, pg. 19).

By his own admission, the Petitioner stated that the cleaning of drains is the activity that caused his CTS symptoms. (Trial Transcript, pg. 62). However, the Petitioner also indicated that the activity of cleaning the drains was associated with working on the "kill floor," which he did not start doing until *after* his alleged accident date of September 20, 2013, based on his own timeline of his jobs.

The Petitioner's testimony of his job activities suggests his job was extremely varied with respect to the tools used and duties performed. In fact, the Petitioner's alleged accident date of September 20, 2013, is less than four (4) months from the start of his employment. In his report, Dr. Williams indicated that the Petitioner's short duration of employment was a significant factor in finding that his work activities did not cause his CTS. The Arbitrator finds Dr. Williams to be more credible than Dr. Leutz. By his own admission, Dr. Leutz did not

have nearly as much information as Dr. Williams did at the time of his examination. In a case such as this where a thorough understanding of the job duties is essential, the Arbitrator finds he must follow the opinion of Dr. Williams as he was clearly the most informed. As a result, the Arbitrator finds there is insufficient evidence that the Petitioner's work for Respondent caused or contributed to his development of CTS.

The claim is thus denied. All other issues become moot.

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

Robert Corry,
Petitioner,
vs.

NO: 14 WC 16829

State of Illinois, Illinois State University,
Respondent.

18IWCC0042

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of nature and extent, 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 June 15, 2017, is hereby affirmed and adopted.

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

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

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

DATED: JAN 22 2018
o11118
DLG/mw
045

David L. Gore

Stephen Mathis

Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CORRY, ROBERT
Employee/Petitioner

Case# **14WC016829**

SOI/ILLINOIS STATE UNIVERSITY
Employer/Respondent

18IWCC0042

On 6/15/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.10% 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:

0564 WILLIAMS & SWEE LTD
STEVEN R WILLIAMS
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

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

4138 ASSISTANT ATTORNEY GENERAL
WARREN WILKE
500 S SECOND ST
SPRINGFIELD, IL 62706

0903 ILLINOIS STATE UNIVERSITY
1320 ENVIRONMTL HEALTH SAFETY
NORMAL, IL 61790

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

CERTIFIED as a true and correct copy pursuant to 820 ILCS 306/14

JUN 15 2017

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

STATE OF ILLINOIS)
)SS.
COUNTY OF McLean)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Robert Corry
Employee/Petitioner

v.

State of Illinois/Illinois State University
Employer/Respondent

Case # **14** WC **016829**

Consolidated cases: **N/A**

18IWCC0042

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 **Bloomington**, on **5/25/16**. 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 **2/18/14**, 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 **$47,144.82**; the average weekly wage was **$906.63**.

On the date of accident, Petitioner was **65** 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.

The parties stipulated all TTD has been paid.

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $6,987.00 to Central Illinois Orthopedic Surgery, $830.00 to McLean County Anesthesia, $240.00 to Bloomington Radiology, $3,162.35 to OSF St. Joseph Medical Center, and $9,993.00 to Champion Fitness, 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.

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, the Arbitrator finds Petitioner is now permanently and partially disabled to the extent of 70% loss of use of the left leg as provided in Section 8(e) of the Act. Petitioner has sustained serious and permanent injuries in this case that have resulted in an additional 47.5% (53.75 weeks) loss of use of his left leg above and beyond his prior injuries for which the parties stipulated Respondent is entitled to a credit of 22.5% of the left leg. After applying the stipulated credit, Respondent shall pay Petitioner the sum of **$543.98**/week for a further period of **102.13** weeks.

Michael K. Nowak, Arbitrator

5/16/17
Date

JUN 15 2017

FINDINGS OF FACT 18IWCC0042

Petitioner is 67 year old retired Building Mechanic who was employed by Illinois State University between 1984 and August 31, 2014. On February 18, 2014, he slipped on ice and fell forward onto both knees and one hand. The accident is undisputed. Petitioner stated that he immediately felt pain in his knees and sought treatment that day. Notice was provided within the time limits prescribed by the Act. Respondent does not dispute the causal relationship between Petitioner's condition of ill-being and the accident.

On February 18, 2014 Petitioner was seen by Occupational Health. They noted the history of accident as well as swelling to the left knee. He was placed on restrictions. (PX5)

Petitioner was seen by Dr. Keller, an orthopedic surgeon on February 27, 2014. Dr. Keller noted medial joint line tenderness and tenderness over the tibial tubercle. (PX6) When Petitioner followed-up with Dr. Keller on April 1, 2014, his range of motion was limited to 100 degrees flexion and five degrees extension. He had swelling and walked with an antalgic gate. Dr. Keller recommended a total knee replacement. (PX6)

On May 12, 2014 Petitioner underwent a left total knee arthroplasty. The diagnosis was left knee degenerative osteoarthritis. (PX6)

Petitioner followed up with Dr. Keller following his surgery. On May 27, 2014 Petitioner had 100 degrees of flexion and extension was to five degrees. (PX6) On June 19, 2014 Petitioner's flexion was 100 degrees and extension was negative five degrees. (PX6) On July 31, 2014 flexion was 110 and extension was negative two degrees. (PX6) On December 2, 2014 Petitioner's flexion was 120 degrees and extension was zero degrees. The Petitioner still had tenderness at the distal IT band proximal to the lateral femoral condyle. (PX6)

The Petitioner underwent a course of physical therapy at Champion Fitness.

Petitioner was evaluated by Dr. Craig Westin on February 20, 2015 pursuant to section 12 of the Act. Dr. Westin noted Petitioner was able to walk two (2) blocks on level ground before his knee gets sore. He had difficulty going down ladders or stairs. His range of motion of the left knee was zero to 115 degrees while the right knee is zero to 125 degrees. Dr. Westin stated the February 18, 2014 injury caused a permanent aggravation that led to Petitioner's knee replacement. Dr. Westin further stated Petitioner should have a lifting limit of 50 pounds to protect his total knee. Petitioner should have limited bending, squatting and kneeling to avoid irritation to the left knee. Dr. Westin also provided a 25% lower extremity impairment. (PX1)

Dr. Keller authored a letter dated November 13, 2015 in which he opined that Petitioner sustained a tibial tubercle fracture and a grad 1 MCL sprain. He further opined that the injury aggravated pre-existing osteoarthritis which resulted in Petitioner undergoing a total knee replacement on May 12, 2014. Dr. Keller opined there was a causal relationship between the Petitioner's condition of ill-being and his knee replacement. (PX2)

On November 13, 2015 the Petitioner was assessed by Dennis Gustafson. Mr. Gustafson noted the restrictions of Dr. Westin. Mr. Gustafson stated that the Petitioner is unable to resume either building cleaning or maintenance activities based upon documented physical limitations. All such jobs involve more than a

limited amount of bending, squatting and kneeling. Mr. Gustafson stated the Petitioner could work but his wages would be somewhere in the vicinity of $9.00 to $10.50 an hour. (PX3)

At arbitration Petitioner testified that he retired from his position at ISU and that he would not be able to perform the job with the limitations that he had. He further testified that he continues to have a burning sensation in his leg. He has pain when he is on his leg all day. He has difficulty with ladders, stairs and kneeling.

CONCLUSIONS

Issue (J): Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

The Petitioner's medical charges are contained in Petitioner's exhibit number 8. The Arbitrator finds the charges reasonable and necessary. Therefore, Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $6,987.00 to Central Illinois Orthopedic Surgery, $830.00 to McLean County Anesthesia, $240.00 to Bloomington Radiology, $3,162.35 to OSF St. Joseph Medical Center, and $9,993.00 to Champion Fitness, 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 (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 the record contains an impairment rating of 25% of the left leg as determined by Dr. Westin, pursuant to the most current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. 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 loss of range of motion. Because of these limitations, 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 the record reveals that Petitioner was employed as a maintenance worker/building service worker 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 the Petitioner testified that he was not able to perform his past work. The Respondent's examining physician placed restrictions on the Petitioner. Dennis Gustafson evaluated the Petitioner and noted the Petitioner could no longer perform those job duties. Because of these limitations, the Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 64 years old at the time of the accident. Because of the fact that his injury will impact the Petitioner much greater than it would a younger person, 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 that Petitioner's future earning capacity has been impaired by virtue of his injury and resulting restrictions. The Petitioner has permanent restrictions. The permanent restrictions prohibit the Petitioner from performing his past work. The Petitioner could still work based on Mr. Gustafson's comments but at a much lower rate of pay. Because of this, the Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes Petitioner suffered a knee replacement as a result of this injury, the Arbitrator therefore gives *greater* weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator concludes that Petitioner is now permanently and partially disabled to the extent of 70% loss of use of the left leg as provided in Section 8(e) of the Act. The parties agreed that Petitioner received a prior award regarding his left leg which amounted to 22.5% loss of use of the left leg. The result of applying that credit is that Respondent shall pay Petitioner an additional $543.98/week for 102.13 weeks on account of the current claim.

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

Devan Fischer,
Petitioner,
vs.

NO: 16 WC 08061

State of Illinois/Shawnee Correctional Center,
Respondent.

18IWCC0043

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 nature and extent and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed 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.

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: JAN 22 2018
o11118
DLG/mw
045

David L. Gore

Stephen Mathis

Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FISCHER, DEVAN
Employee/Petitioner

Case# **16WC008061**

STATE OF IL/SHAWNEE CORR CENTER
Employer/Respondent

18IWCC0043

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:

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
NICOLE M WERNER
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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 6 - 2017

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

18IWCC0043

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Devan Fischer
Employee/Petitioner

v.

State of Illinois/Shawnee Correctional Center
Employer/Respondent

Case # 16 WC 8061

Consolidated cases: N/A

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Herrin**, on **May 9, 2017.** By stipulation, the parties agree:

On the date of accident, **February 6, 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's earnings were **$64,690.00** and the average weekly wage was **$1,244.04.**

At the time of injury, Petitioner was **28** 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 **$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 bills paid under its group medical plan for which credit may be allowed under Section 8(j) of the Act.

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 **$746.42/week** for a further period of **15** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **3% loss of use of the person-as-a-whole.**

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.

Melinda M. Pope-Gillman

Signature of Arbitrator

6/2/17

Date

JUN 6 - 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Devan Fischer
Employee/Petitioner

Case # 16 WC 8061

v.

Consolidated cases: N/A

State of Illinois/Shawnee
Correctional Center
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he is a Correctional Officer at Respondent's Shawnee facility. The parties stipulated that on February 6, 2016, he sustained accidental injuries at work when he was attacked by an inmate, hit and tackled to the ground, and then shoved into a railing, causing injury to his low back.

At arbitration, Petitioner testified that sitting and standing for long periods of time aggravate his condition. He testified that as a Correctional Officer, he is on his feet approximately six hours per shift. He testified that occasionally he notices pain going down the back side of his right leg and that when this happens, he changes positions. He testified that he also has to try and sit or lay down if he is not at work. He testified that he takes Flexeril as needed or before bed, Meloxicam twice a day and over-the-counter medication as needed for his symptoms. He testified that his hobbies of motorcycle riding and rock climbing have been adversely affected.

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 Massac Memorial Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on February 7, 2016, at which time it was noted that he was attacked by inmates at the correctional facility, that he was punched in the right side of his head and pushed to the floor, and that his right lower back was hurting as well as having a small wound on his left hand. A CT of the head was performed on that date, which was interpreted as negative. A CT of the lumbar spine was performed on that date, which was interpreted as revealing (1) no evidence of acute fracture seen within the lumbar spine; (2) multilevel mild facet arthropathy and mild disc bulge seen within the lower lumbar spine resulting in mild narrowing of the neural foramina bilaterally. X-rays of the left hand also performed on the same date were interpreted as negative. The assessment was noted to be that of head injury, low back pain and an abrasion to the left hand. Petitioner was instructed take Tylenol, increase his hydration, rest for one week, use Neosporin to the left hand and to follow up for further evaluation by a specialist for the low back pain if it did not improve. (PX3).

The medical records of Dr. Nathan Mall were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen on February 9, 2016, at which time it was noted that he was seen for a chief complaint of left hand and lumbar spine complaints after an inmate

altercation that occurred on Saturday night. It was noted that Petitioner stated that he saw his lieutenant get assaulted by an inmate and that as he was watching this, he was hit by an inmate, wrestled with the inmate on the ground and suffered a left hand injury and lumbar spine pain. It was noted that Petitioner complained of right-sided back pain and pain between his ring and small fingers in the left hand where there was a small laceration and abrasion. The assessment was noted to be that of (1) lumbar spine strain; (2) left hand contusion and abrasion. Petitioner was recommended a Medrol Dosepak with an anti-inflammatory in conjunction with physical therapy for his lumbar strain. Petitioner was also recommended to undergo an MRI. It was noted that Dr. Mall thought that the contusion on the left hand should respond well to the medications and physical therapy. (PX4).

The records of Dr. Mall reflect that Petitioner was seen on February 26, 2016, at which time it was noted that he had right-sided lumbar spine pain and pain that went down into his right buttock as well. It was noted that the MRI demonstrated a disc herniation at L5-S1 that was mostly off the right side, which correlated with his symptoms. The assessment was noted to be that of lumbar spine disc herniation. Petitioner was recommended to follow-up with Dr. Gornet. It was noted that the Medrol and physical therapy improved his symptoms substantially. At the time of the April 8, 2016 visit, it was noted that Petitioner had not yet seen Dr. Gornet for his lumbar spine condition and that he stated that his hand was doing much better. The assessment was noted to be that of lumbar spine disc herniation L5-S1. Petitioner was placed at maximum medical improvement for his left hand and was instructed to follow up with Dr. Gornet for further evaluation and treatment of his lumbar spine. (PX4).

The medical records of Auburn Park Imaging were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner underwent x-rays of the left hand on February 9, 2016, which were interpreted as revealing no acute fracture. X-rays of the lumbar spine also performed on that date were interpreted as revealing straightening of normal lumbar lordosis; there is mild disc space narrowing at L5-S1. (PX5).

The medical records of Rehab Unlimited 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 February 12, 2016 through February 25, 2016. At the time of the Initial Evaluation on February 12, 2016, it was noted that Petitioner complained of dull, aching, sharp, stiff pain localized on the right side low back area and that he denied radicular pain, a tingling sensation or any sudden weakness in the bilateral lower extremities. The Discharge Note dated February 25, 2016 noted that Petitioner had met all of his goals. (PX6).

The records of Rehab Unlimited reflect that Petitioner underwent additional physical therapy for the timeframe of March 10, 2016 through April 11, 2016. The Discharge Note dated April 11, 2016 noted that Petitioner reported that his condition was better, that he still had minimal pain and that it was not significant enough to bother him with his activities of daily living. (PX6).

The medical records of MRI Partners of Chesterfield were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The records reflect that Petitioner underwent an MRI of the lumbar spine on February 26, 2016, which was interpreted as revealing (1) central broad-based 5.5 mm protrusion at L5-S1 resulting in dural displacement, mild central canal stenosis, bilateral lateral recess stenosis and mild bilateral foraminal stenosis; (2) short AP pedicular length with mild posterior element hypertrophy at L3-4 and L4-5 resulting in mild central canal stenoses that are predominantly developmental. (PX7).

The medical records of Dr. Matthew Gornet were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The records reflect that Petitioner was seen on April 21, 2016, at which time it was noted that he presented with a chief complaint of low back pain to both sides, particularly the right greater than the left into his right buttock and upper thigh. It was noted that Petitioner stated that he had occasional tingling in his leg at times. It was noted that Petitioner readily admitted to a history of

previous chiropractic care, that he felt that it may have been three visits anywhere from 2-4 years ago, and that he did not recall any significant treatment that could be associated with his current level of symptoms and problems. It was noted that the assessment was that of discogenic low back pain at L5-S1 with an annular tear, that he understood that there may be a subtle problem at L4-5 and that he was trending in a positive direction. It was noted that Petitioner wished to hold off on injections and he was given medications. (PX8).

The records of Dr. Gornet reflect that Petitioner was seen on July 17, 2016, at which time it was noted that he continued to have pain and was working full duty. It was noted that Petitioner continued to have low back, right buttock and right hip pain. It was noted that Dr. Gornet wished to try one steroid injection at L5-S1 right and that if he was not improved, they would need to move forward with discography and MRI spectroscopy. It was noted that Dr. Gornet's working diagnosis was discogenic pain and annular injury at L5-S1. At the time of the September 26, 2016 visit, it was noted that Petitioner was trending positively, that he felt that the medications were helping him and that he was still working. It was noted that Dr. Gornet was reluctant to move forward with discography and MRI spectroscopy. At the time of the April 10, 2017 visit, it was noted that Petitioner still had a level of pain. It was noted that Petitioner had an injection in August and that it had helped him, and that Dr. Gornet thought his best option would be to try and live with his symptoms. It was noted that Petitioner was at maximum medical improvement and was at full duty. (PX8).

The medical records of Orthopedic Ambulatory Surgery Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The records reflect that Petitioner underwent an L5-S1 ILESI with fluoroscopy on August 2, 2015 for a pre- and post-operative diagnosis of right lumbar radiculopathy. (PX9).

The October 25, 2016 Approval Letter from TriStar was entered into evidence at the time of arbitration as Petitioner's Exhibit 10.

The Workers' Compensation Employee's Notice of Injury was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The Supervisor's Report of Injury or Illness entered into evidence at the time of arbitration as Respondent's Exhibit 2. The IDOC Incident Reports were entered into evidence at the time of arbitration as Respondent's Exhibit 3. The Wage Statement was entered into evidence at the time of arbitration as Respondent's Exhibit 4.

CONCLUSIONS OF LAW

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injury, and consistent with 820 ILCS 305/8.1b, permanent partial disability shall be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of Section 8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. No single enumerated factor shall be the sole determinant of disability. *Id.*

With respect to Subsection (i) of Section 8.1b(b), the Arbitrator notes that no AMA rating was offered by either party. The Arbitrator places no weight on this factor when making the permanency determination.

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that the record reveals that Petitioner was employed as a Correctional Officer at the time of the accident and that he has returned to

this position with Respondent. The Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 28 years old on his date of accident. Given the younger age of Petitioner and the fact that the medical records lack any reference to his having been placed under any restrictions, the Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (iv) of Section 8.1b(b), the Arbitrator notes that, following his work injury, Petitioner returned to his position as a Correctional Officer with Respondent. As there was no direct evidence of reduced earning capacity contained in the record, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (v) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that occasionally he notices pain going down the back side of his right leg and that when this happens, he changes positions. He testified that he also has to try and sit or lay down if he is not at work. He testified that he takes Flexeril as needed or before bed, Meloxicam twice a day and over-the-counter medication as needed for his symptoms. He testified that his hobbies of motorcycle riding and rock climbing have been adversely affected. At the time of the April 10, 2017 visit with Dr. Gornet, it was noted that Petitioner still had a level of pain. It was noted that Petitioner had an injection in August and that it had helped him, and that Dr. Gornet thought his best option would be to try and live with his symptoms. It was noted that Petitioner was at maximum medical improvement and was at full duty. (PX8). The Arbitrator concludes that Petitioner's evidence of disability at the time of arbitration, namely his continued complaints and limitations, were somewhat corroborated by his treating records entered into evidence at the time of arbitration. The Arbitrator accordingly places lesser weight on this factor in determining permanency.

The Arbitrator notes that the determination of permanent partial disability benefits is not simply a calculation, but an evaluation of all of the factors as stated in the Act in which consideration is not given to any single factor as the sole determinant. Based on the above factors and the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of **3% loss of use of the person-as-a-whole** as provided in Section 8(d)2 of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Illinois Workers' Compensation Commission,
Insurance Compliance Division,

Petitioner,

vs.

No. 11 INC 00477

Edgar L. Davis, Individually and d/b/a D&D Construction
a/k/a D&D Roofing & Siding,

18IWCC0024

Respondent.

DECISION AND OPINION REGARDING INSURANCE COMPLIANCE

Petitioner, Illinois Workers' Compensation Commission (the Commission), Insurance Compliance Division, brought this action by and through the office of the Illinois Attorney General against the above-captioned Respondent, alleging violations of Section 4(a) of the Illinois Workers' Compensation Act (the Act). Proper and timely notice was given to all parties. An insurance compliance hearing on the merits was held before Commissioner Stephen Mathis on October 11, 2017, in Urbana, Illinois. Respondent did not appear at the hearing despite being properly served with notice of said hearing on September 20, 2017. (PX 1). After considering the entire record and being advised of the facts and law, the Commission finds that Respondent knowingly and willfully violated Section 4(a) of the Act and shall pay a penalty of $500.00 per day for 518 days, plus the sum of $20,940.00, which represents the payout from the Injured Workers' Benefit Fund (the Fund). (PX 2).

Petitioner alleges that Respondent knowingly and willfully lacked workers' compensation insurance coverage for a period of 518 days: from September 5, 2007 to October 27, 2008; from February 9, 2010 to April 11, 2010; and from August 7, 2010 to September 16, 2010. On September 5, 2007, Brian Baker, an employee of Respondent, sustained a work-related injury to his right arm. Mr. Baker filed a workers' compensation case against Respondent, *Baker v. D&D Construction*, 09 WC 045702. The case was tried before Arbitrator Douglas Holland on October 17, 2011, and it was determined that Respondent owed permanent partial disability benefits of $216.00 per week for 25.3 weeks for 10 percent loss of use of the right arm and also that Respondent was liable for medical expenses of $24,880.80. At trial in *Baker v. D&D*

Construction, Respondent Edgar Davis testified that: he was the owner of D&D Construction; Mr. Baker was his employee; and he did not carry workers' compensation insurance for the date of the accident. (PX 6). The Fund ultimately paid out $20,940.00. (PX 2).

On October 11, 2017, Respondent did not appear for the insurance compliance hearing. Petitioner called Michael Cummins, a compliance investigator for the Commission as a witness. Mr. Cummins testified that he has worked as a compliance investigator for the Commission for three and a half years and that prior to that he was a detective with the Chicago Police Department for 21 years. Mr. Cummins was directed to take over this non-compliance case after an award was entered against the Fund. He determined that Respondent's business of general construction, roofing and siding was automatically subject to the provisions of Section 3 of the Act and performed an investigation. Mr. Cummins determined through Mr. Davis's admission at the trial in *Baker v. D&D Construction*, 09 WC 045702 (PX 6) and the confirmation through the National Council on Compensation Insurance (NCCI) (PX 8) that Respondent was not insured on the date of Mr. Baker's work accident. Mr. Cummins also determined based upon the records of the NCCI that Respondent was not insured for the time periods from September 5, 2007 to October 27, 2008, from February 9, 2010 to April 11, 2010, and from August 7, 2010 to September 16, 2010 (PX 8). The NCCI records further show that Respondent maintained proper insurance for the time periods from October 28, 2009 to February 8, 2010, and from April 12, 2010 to August 6, 2010, evidencing that Respondent was aware of the requirement to maintain insurance for his employees. (PX8). Mr. Cummins continued his investigation to determine whether Respondent was self-insured under the Act and received a certification from Maria Sarli-Dehlin of the Commission's Office of Self-Insurance Administration indicating there was no certificate of approval to self-insure issued by the Commission. (PX 10).

The Commission concludes that Respondent knowingly and willfully violated the insurance requirements of Section 4(a) of the Act. Respondent did not appear to provide any defense for the fact that he operated his business for 518 days without the mandated coverage. The Commission hereby assesses a penalty of $500.00 per day for 518 days, equaling $259,000.00. In addition, Respondent is liable to pay $20,940.00, which represents the payout from the Fund.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent Edgar Davis, individually and d/b/a D&D Construction a/k/a D&D Roofing & Siding, pay to the Illinois Workers' Compensation Commission the sum of $279,940.00 pursuant to Section 4(d) of the Act and Section 9100.90 of the Commission Rules. Pursuant to Commission Rule 9100.90(f), payment shall be made by certified check or money order made payable to the Illinois Workers' Compensation Commission. Payment shall be mailed or presented within 30 days after the final order of the Commission or the order of the court on review after final adjudication to:

Workers' Compensation Commission
Insurance Compliance Division
100 West Randolph Street, Suite 8-328
Chicago, Illinois 60601

18IWCC0024

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.

JAN 10 2018

DATED:
d-12/19/2017
SM/sk
44

Stephen Mathis

David L. Gore

Deborah Simpson

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

Amanda Davis,
Petitioner,

vs. No: 12 WC 03377

18IWCC0044

State of Illinois, Vienna Correctional Center,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability, medical benefits, and permanent partial disability, and being advised of the facts and law, modifies the Arbitrator's Decision as discussed below.

The facts of this case were laid out in the Arbitrator's Decision, and the Decision is attached to this for reference. However, on the threshold issue of accident, the Commission disagrees with the Arbitrator's assessment regarding the issue of accidental injury arising out of her employment. The Commission reverses that finding as set forth below; benefits are denied.

To obtain benefits under the Act, an employee must prove her injury arose out of and occurred during the course of her employment. See *e.g. Caterpillar Tractor Company v. The Industrial Commission*, 129 Ill.2d 52, 57, 541 N.E.2d 665 (1989). "In the course of" speaks to time, place, and circumstances of the injury; Petitioner was on duty at the time of the injury, and was clearly in the course of her employment. "Arising out of" speaks to whether a risk encountered by the employee is in fact incidental to the employment. See *e.g. Brady v. Louis Ruffolo & Sons Construction Company*, 143 Ill. 2d 542, 552, 578 N.E.2d 921 (1991) ("This court has previously declined to adopt the positional risk doctrine, believing that the doctrine would not be consistent with the requirements expressed by the legislature in the Act").

18IWCC0044

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). Therefore, it is incumbent on Petitioner to set forth sufficient proof that a fall stems from a work-related cause. Here, Petitioner failed to do so.

Petitioner testified she fell on a raised concrete curb or step several inches high. Tr.28. She testified she was well familiar with the area, having traversed it regularly throughout her tenure at the facility and several times earlier in her shift. Tr.14-15, 28-29. She was not carrying anything. Tr.29. There were no defects in the curb. Tr.30. She was not in a hurry. Tr.37. She also acknowledged that when she filled out the Supervisor's Report of Injury she wrote there were no unsafe acts or conditions in the area. Tr.46. Petitioner offered two potential theories as to the cause of her fall: 1) darkness, and 2) distraction.

Regarding the darkness, Petitioner testified that it was nighttime and that the darkness did affect her vision. Tr.35. However, she did not testify as to the significance to which her vision was affected, and more significantly never testified that any limitations on her vision in fact affected her walking or caused any misstep. As for the distraction, Petitioner testified "I thought I heard the TV in the day room come on, and I had looked up there, and the light was off. I thought an inmate had gotten up, but the light was off, so I started to step back around, and that's when I tripped." Tr.30. However, while investigating a noise was clearly part and parcel of her job duties, she did not actually associate the noise or any distraction with the misstep. Indeed, she was clear that the misstep occurred after she might have heard the noise and never testified that she was distracted at the time of the accident.

Clearly, there are risks a guard on patrol can face. However, the Commission notes that the law holds that "[C]ircumstantial evidence can only support an inference which is reasonable and probable, not merely possible. [citations omitted]. Where the evidence allows for the inference of the nonexistence of a fact to be just as probable as the existence, the conclusion that the fact exists is a matter of speculation, surmise, and conjecture, and the inference cannot reasonably be drawn." *First Cash Financial Services v. The Industrial Commission*, 367 Ill. App. 3d 102, 106, 853 N.E.2d 799 (2006). To find Petitioner fell because she could not see or was somehow distracted would be pure speculation, not a reasonable inference. Further, the evidence adduced clearly shows there was no hazardous condition or workplace defect. The Commission finds a failure of proof of a workplace risk or that the accident arose out of the claimant's employment.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's November 28, 2016 decision is modified as noted above for the reasons stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that since Petitioner failed to prove accidental injuries arising out of her employment, her claim for compensation and medical expenses is hereby denied.

18IWCC0044

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

Pursuant to Section 19(f)(1)(1) of the Act, in this case, where the Respondent is the State of Illinois, the decision of the Commission shall not be subject to judicial review.

DATED: JAN 24 2018

Joshua D. Luskin

o-12/06/17
jdl-mcp
68

Charles J. DeVriendt

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DAVIS, AMANDA
Employee/Petitioner

Case# **12WC003377**

ST OF IL DEPARTMENT OF CORRECTIONS/VIENNA CORRECTIONAL CENTER
Employer/Respondent

18IWCC0044

On 6/20/2016, 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 0.40% 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 B TAYLOR
3 S MAIN SUITE 2
HARRISBURG, IL 62946

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

0558 ASSISTANT ATTORNEY GENERAL
KENTON J OWENS
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 SYSTEMS
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 20 2016

Richard J. Reimer, 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

Amanda Davis
Employee/Petitioner

v.

State of Illinois Department of Corrections/ Vienna Correctional Center
Employer/Respondent

Case # 12 WC 3377

Consolidated cases: n/a

18IWCC0044

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 11, 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 30, 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* causally related to the accident.

In the year preceding the injury, Petitioner earned **$44,254.50**; the average weekly wage was **$851.05**.

On the date of accident, Petitioner was **29** years of age, ***married*** with **3** dependent children.

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

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$567.37**/week for **2 weeks,** commencing **September 1, 2011 through September 14, 2011,** as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the sum of **$510.63**/week for a further period of **8.35 weeks,** as provided in Section 8(e) of the Act, because the injuries sustained caused **5% loss of use of the left foot.**

Respondent shall pay **$2,960.95** for medical services as provided in Sections 8(a) and 8.2 of the Act. Respondent is to hold Petitioner harmless for any claims for reimbursement from any health insurance provider and shall provide payment information to Petitioner relative to any credit due. Respondent is to pay unpaid balances with regard to said medical expenses directly to the providers as stipulated by the parties at the time of arbitration. Respondent shall pay any unpaid, related medical expenses according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner.

Respondent is entitled to a credit for **all 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. Pace-Sullivan

Signature of Arbitrator

6/13/16

Date

JUN 20 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Amanda Davis
Employee/Petitioner

Case # 12 WC 3377

v.

Consolidated cases: N/A

State of Illinois Department of Corrections/
Vienna Correctional Center
Employer/Respondent

18IWCC0044

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that she was not current employed but that she was previously employed by the Vienna Correctional Center as a correctional officer. She testified that she was employed by Respondent on August 30, 2011, at which time she was injured at work.

Petitioner testified that she was in Unit 4 downstairs, coming up from the courtyard area and on to the patio. She testified that she put her right foot up on to the patio, and that her left foot hit part of a raised piece of concrete on the patio and turned under, causing her to fall. She testified that she injured her left ankle in the fall.

Petitioner testified that leading up to the patio that she tripped on, she was walking on a sidewalk and was stepping from the sidewalk to the patio. She testified that this was an area that she would walk through as a regular part of her job duties. She testified that she would walk down this sidewalk approximately 6-8 times per day, and that it was an entrance and exit. She testified that it was located at the correctional center, and that this area was not open to the public and was inside the gates.

Petitioner testified that she sat down at a picnic table after her fall and tried to determine how bad her ankle was hurt. She testified that she signed her books and then went to medical, and did not complete her shift. She testified that her accident was witnessed by another correctional officer by the name of Stanley Brandt. She testified that she later filled out an accident report.

Petitioner testified that prior to August 30, 2011, she did not have any prior injuries to her left ankle. She denied having any history of left ankle pain prior to the accident, and she further denied having missed any work or having to take time off of work for pain in regards to her left ankle prior to the accident.

Petitioner testified that after the fall, she was seen at Hardin County General Hospital. She testified that the physician recommended that she keep the ankle elevated and avoid prolonged standing. She testified that x-rays were taken, and that the emergency room physician said it was really swollen but he did not see a break. She testified that she was told that if the swelling started to go down any and she continued to have pain, she was to see her regular doctor.

Petitioner testified that she then sought treatment from her primary care doctor, Dr. Winkleman, at Primary Care Group. She testified that she was issued an ankle brace and was also taken off work when she initially saw Dr. Winkleman. She denied that she was paid any workers' compensation benefits for the period of time that she was off work.

Petitioner testified that Dr. Winkleman recommended that she undergo physical therapy, which was performed at his office. She testified that she returned to Dr. Winkleman about a week later on September 9, 2011, and that she was continuing to have pain in her ankle. She testified that her doctor kept her off work for another week. She testified that she was required to walk with a cane for a period of time because of the pain in her ankle.

Petitioner testified that she returned to Dr. Winkleman's office on or about September 14, 2011, and that she requested a return to work slip so that she could return to work. She testified that she was out of time, so she went back to her regular job as a corrections officer. She testified that it was painful when she returned to work and that the pain never stopped.

Petitioner testified that she did not undergo any treatment for her left ankle after her physical therapy until early 2014 because of money concerns and other health issues. She testified, however, that she continued to have pain. She testified that she went back to her primary care doctor in January of 2014, and that she was given a PSL shoe for her ankle. She testified that she wore it, but it did not help with the pain. She testified that her doctor then referred her to a podiatrist, and that she saw Dr. Brown at Southern Illinois podiatry on August 14, 2014. She testified that he recommended that she have an MRI of her left ankle, but it was never performed. She denied having any treatment for her left ankle since that date.

Petitioner testified that she continues to have pain in her left ankle, for which she takes Ibuprofen. She testified that she tries not to take it daily. She denied still having to walk with a cane for her left ankle. She testified that she notices the pain the most when she is standing for long periods of time and with increased activity. She testified that it was painful for her to do activities that involved rotation of her ankle, and that standing on it hurt. She testified that walking down stairs caused pain, and that she feels weakness in her left ankle.

On cross-examination, Petitioner testified that she stopped working at Vienna Correctional Center in 2012. She agreed that her no longer working for Respondent had nothing to do with her left ankle.

On cross-examination, Petitioner agreed that in August of 2011, she was working in housing Unit 4. She testified that she was assigned to work 4C and D, which were two separate wings of one building with a breezeway in between. She agreed that she was walking down the sidewalk and encountered the patio at the entrance to building No. 4, and that was when she tripped and fell.

On cross-examination, Petitioner testified that as she was on the sidewalk, when she got to the patio there was a "ledge" that was a couple of inches high that she had to step up onto to get to the patio. She agreed that she had encountered it several times that day already. She testified that she started working at Vienna Correctional Center in 2010, and that it had been like that the entire time she worked there.

On cross-examination, Petitioner testified that history in the record when she saw the podiatrist in 2014 that she twisted the left ankle at work by stepping off a curb was incorrect, and that she stepped up onto it. She denied having been carrying anything in her hands. When asked if anything distracted her as she was stepping up onto the curb, she responded she thought she heard the TV in the day room come on, and that she had looked up and the light was off. She testified that she stepped back around, and that was

when she tripped. She agreed that there was nothing wrong with the curb. She agreed that there was not a hole in the curb, but testified that there were cracks in the concrete.

On cross-examination, Petitioner reviewed Respondent's Exhibit 6. She agreed that her handwriting appeared on the document, and testified that she wrote the description of accident. She agreed that she underwent physical therapy at the Primary Care Group in Harrisburg, and when questioned about the note of September 2, 2011 stating that she was walking on a sidewalk, rolled her ankle over and sustained a sprain to the ankle, Petitioner responded that she told them she twisted her ankle.

On cross-examination, Petitioner testified that on the date of the accident she was wearing "Nike shocks." She testified that at that time, as a correctional officer she could wear whatever shoes she wanted to wear as long as they were not open toe.

On cross-examination, Petitioner agreed that she testified that in 2014 she went back to the Primary Care Group with complaints about her ankle. She agreed that after September 14, 2011, the next time she treated at the Primary Care Group for her ankle was in January of 2014. She agreed that in that timeframe, she treated for other unrelated conditions at the Primary Care Group.

On cross-examination, Petitioner testified that she never underwent an MRI. She testified that she did, however, undergo x-rays of her ankle right after the accident. She agreed that she was told that she did not have a fracture.

On redirect, Petitioner testified that on the date of accident she was working midnight shift, and that the accident occurred at approximately 11:30 p.m. She testified that it was dark outside, and that the darkness affected her ability to see. She testified that at the time of the accident, she had stepped off the patio which went to the sidewalk, and that she went into the grass to look up into the day room to see if an inmate had gone in and that she was stepping back up from the grass and on to the sidewalk. She denied having been in a hurry at the time of her fall.

John Cox was called as a witness by Respondent at the time of arbitration. He testified that he worked for Respondent as a shift supervisor, and that he began working at Vienna Correctional Center in November of 2007. He testified that he has been a shift supervisor at Respondent since 2010. He testified that as a shift supervisor, he was in charge of the security force that assigned officers to the housing units to protect and serve the inmates, as well as the staff inside the institution. He testified that he was the shift supervisor on August 30, 2011.

Mr. Cox testified that he completed a Supervisor's Report of Injury in this case, which was marked as Respondent's Exhibit 3. He agreed that his handwriting was on the form. He testified that he received notice of Petitioner's injury on August 31st. He testified that Petitioner reported that she stepped from the breezeway onto the patio area of housing Unit 4 and twisted her left ankle.

Mr. Cox testified that the patio area of Unit 4 was off the breezeway, and that it was an area where inmates could go during the day and on the 3-11 shift to get out of the units to get some air. He testified that there were picnic tables out there. He testified that the inmates could do sit-ups and general exercise there, and that a lot of them ran around the patio area to get exercise and some fresh air. He denied that the patio area was raised up from the sidewalk.

Mr. Cox testified that the breezeway ran out to the patio area, and that if you were walking down the sidewalk into housing Unit 4, the first thing you would come to was the breezeway. He testified that the breezeway separated wings A and B in housing Unit 4, and then there was a set of stairs that went up

to C and D. He testified that the housing units were shaped like a "U" and that the patio sat in between the U-shaped areas of housing Unit A and B. He testified there was nothing defective about the sidewalk going to the patio near Unit 4. He denied being familiar with any 2-inch gap leading from the breezeway to the patio.

On cross-examination, Mr. Cox denied being present when Petitioner injured her left ankle. He agreed that the report noted a witness by the name of Stanley Brandt, but testified that he no longer worked for Respondent and had been retired for several years. He testified that he was not sure whether Mr. Brandt filled out a witness report, but was shown Respondent's Exhibit 4. He testified that based on the report, Mr. Brandt indicated that he saw Petitioner stumble on the raised concrete of the patio on Unit 4, and that after this she complained of pain in her ankle. He agreed that the statement given by Mr. Brandt noted a mechanism of injury similar to what Petitioner testified to at the time of arbitration.

On redirect examination, Mr. Cox testified that on the Supervisor's Report of Injury he indicated that he observed no any unsafe acts or conditions which contributed to Petitioner's medical condition. He testified that there were no unsafe conditions on housing Unit 4.

The Application for Adjustment of Claim was entered into evidence at the time of arbitration as Arbitrator's Exhibit 2. The Application alleged a date of accident of August 30, 2011, that Petitioner fell at work, and that the body part affected was that of the left ankle. (AX2).

The medical records of Hardin County General Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. Petitioner was seen on August 31, 2011 at 02:00, at which time it was noted that she presented with a chief complaint of left ankle pain. It was noted that Petitioner was at work at one of the prisons in the area, was walking and stepped on an uneven surface, and that she tripped and twisted her left ankle and fell. Petitioner was complaining of severe pain on the left ankle, and also had pain on the left wrist which she tried to use to brace the fall. The assessment was that of left ankle sprain, status-post fall at work. Petitioner was instructed to be off work that day and recommended to follow-up with her own physician in two days. An Ace wrap was used, and Ibuprofen was recommended. X-rays of the left ankle performed on the same date were interpreted as revealing (1) lateral soft tissue edema with no acute bone abnormality; (2) tiny plantar calcaneal spur. X-rays of the left foot performed on the same date were interpreted as revealing (1) no acute bone abnormality; (2) tiny plantar calcaneal spur. (PX1).

The medical records of Primary Care Group (with affidavit dated January 27, 2012) were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. Petitioner was seen on January 2, 2012, but no reference was made as to any complaints or issues involving the left ankle. At the time of the October 31, 2011 visit, no reference was made as to any complaints or issues involving the left ankle. At the time of the October 26, 2011 visit, no reference was made as to any complaints or issues involving the left ankle. At the time of the September 29, 2011 visit, no reference was made as to any complaints or issues involving the left ankle. At the time of the September 23, 2011 visit, no reference was made as to any complaints or issues involving the left ankle. (PX2).

The records of Primary Care Group reflect that Petitioner was seen on September 15, 2011, at which time she was seen for a one week recheck of the left ankle sprain. It was noted that Petitioner was doing well, and that she wanted to return to work and needed a work excuse with no restrictions. It was noted that there was minimal localized swelling and that there was no decrease in range of motion or pain on movements. The assessment was that of "other ankle sprain" and Petitioner was instructed to return to work with no restrictions and to continue physical therapy three times per week. Petitioner was also instructed to elevate her ankle after work to help reduce swelling, and to wear an aircast as needed for support. Petitioner was instructed to follow-up if no improvement or if her symptoms worsened. (PX2).

The records of Primary Care Group reflect that Petitioner was seen on September 14, 2011, at which time no reference was made as to any complaints or issues involving the left ankle. Petitioner was seen on September 9, 2011, at which time it was noted that she was doing well and that she reported continued swelling with moderate discomfort with use. It was noted that Petitioner had an initial evaluation with therapy, and had not yet returned to work. It was noted that there were still some limitations in range of motion, and that she was using a cane if she had to walk any distance. It was noted that the swelling had improved but not resolved, and that she was still having pain especially with walking. The assessment was that of "other ankle sprain" and she was instructed to follow up with therapy and remain off work one additional week. (PX2).

The records of Primary Care Group reflect that Petitioner was seen on September 1, 2011, at which time it was noted that Petitioner presented with a work-related health problems. It was noted that Petitioner was at work and twisted her ankle while walking, and that she stepped on an uneven sidewalk. It was noted that Petitioner was seen in the emergency room and that an x-ray had been done, which showed no fracture. It was noted that Petitioner was supposed to work Friday night and stated that she was not able to work and was still having pain. The assessment was that of "other ankle sprain" and Petitioner was recommended to undergo physical therapy and was issued restrictions of seated work for one week. Petitioner was also instructed to obtain an aircast. (PX2).

Included within the records of Primary Care Group were physical therapy records for the timeframe of September 2, 2011 through October 12, 2011. The Patient Evaluation dated September 2, 2011 noted that Petitioner worked as a prison guard at the Vienna Correctional Facility, and that at approximately 11:30 p.m. Tuesday night, August 30, 2011, she was walking on a sidewalk, rolled her ankle over and sustained a sprain to the ankle and the left anterior talofibular ligament. A stabilizing ankle brace was issued on that date, and it was noted that a single point cane was not issued as Petitioner thought a family member had one at home. At the time of the September 21, 2011 visit, it was noted that Petitioner had been released to full duty work and that going up and down stairs was "killing her." It was noted that Petitioner continued to have tenderness to palpation of the lateral malleolus. At the time of the October 5, 2011 visit, it was noted that Petitioner reported that the pain along the left lateral ankle and leg was improving and that on that date she only had a slight achiness just posterior to the left lateral malleolus. At the time of the October 12, 2011 visit, it was noted that Petitioner continued to report improved range of motion and decreased pain of her left ankle. (PX2).

The medical records of Primary Care Group (with affidavit dated February 12, 2014) were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. Petitioner was seen on January 30, 2014, at which time she presented with ankle pain. It was noted that Petitioner had tripped at work over two years ago and had had intermittent problems since, and that her symptoms included ankle pain, decreased range of motion and difficulty bearing weight. It was noted that Petitioner's pain radiated to the left lower leg to the knee, and that the symptoms were moderate in severity and worsening. It was noted that Petitioner stated she hurt her ankle in 2011 at work where she stumbled over an uneven sidewalk. The assessment was that of bony spur and tendonitis of the foot and ankle. Petitioner was referred to a podiatrist and was advised to wear a PSL shoe. (PX3).

The records of Primary Care Group reflect that Petitioner was seen on November 5, 2013, but no reference was made as to any complaints or issues involving the left ankle. At the time of the August 12, 2013, visit it was noted that Petitioner was tender over the insertion of the plantar fascia in the right heel but no reference was made as to any complaints or issues involving the left ankle. At the time of the February 25, 2013 visit, no reference was made as to any complaints or issues involving the left ankle. At the time of the January 31, 2013 visit, no reference was made as to any complaints or issues involving the left ankle. At the time of the September 17, 2012 visit, no reference was made as to any complaints or

issues involving the left ankle. At the time of the August 31, 2012 visit, no reference was made as to any complaints or issues involving the left ankle. At the time of the May 19, 2012 visit, no reference was made as to any complaints or issues involving the left ankle. (PX3).

The records of Primary Care Group reflect that Petitioner was seen on May 17, 2012, at which time Petitioner reported foot pain and corns, and that her symptoms were located in both feet. It was noted that Petitioner had plantar warts on both feet. The assessment was that of left foot pain, and she was referred to a podiatrist. At the time of the February 10, 2012 visit, no reference was made as to any complaints or issues involving the left ankle. At the time of the February 8, 2012 visit, no reference was made as to any complaints or issues involving the left ankle. At the time of the February 7, 2012 visit, no reference was made as to any complaints or issues involving the left ankle. At the time of the January 27, 2012 visit, no reference was made as to any complaints or issues involving the left ankle. (PX3).

The Off Work Slips from Primary Care Group were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The Work Excuse dated September 15, 2011 noted that Petitioner was seen on September 9, 2011 and was unable to return to work at that time due to injury. The Return to Work/School Note dated September 1, 2011 noted that Petitioner should be excused from any standing work (but may participate in seated work) from September 1, 2011 through September 8, 2011. (PX4).

The medical records of Southern Illinois Podiatry were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. Petitioner was seen on August 14, 2014, at which time it was noted that Petitioner presented as a new patient complaining of left ankle pain and swelling. It was noted that Petitioner had an injury at work on October 30, 2010 and that she twisted her left ankle. It was noted that Petitioner had x-rays done that did not show fracture, that an MRI had not been done, and that she had not had any treatment recently. Petitioner stated that she had several medical issues and had not had any recent treatment to the ankle, and that she stated that the more she walked the more the ankle swelled and hurt. It was noted that x-rays of the left ankle were performed, which revealed no fractures or dislocations; no significant edema or osteopenia; there were no bone erosions, subcutaneous gas or periostitis, and that a subtle line was noted on the oblique view on the posterior tibia but was not able to be seen or confirmed on any other view. The assessment was that of ankle sprain and pain in limb. An MRI was ordered, and it was noted that if the MRI showed any positive findings physical therapy would be ordered, and that if the MRI showed any ligament or tendon injury, Petitioner would be fit for a Triloc ankle brace. (PX5).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 6.

The CMS Summary of Disability was entered into evidence at the time of arbitration as Respondent's Exhibit 1.

The CMS Workers' Compensation Employee's Notice of Injury was entered into evidence at the time of arbitration as Respondent's Exhibit 2. The report was completed on August 31, 2011 and referenced a date of accident of August 30, 2011. It was noted that the place of injury was that of the patio of Unit 4 (A&B), and that Petitioner stepped onto uneven concrete and twisted her ankle. (RX2).

The CMS Supervisor's Report of Injury or Illness was entered into evidence at the time of arbitration as Respondent's Exhibit 3. The report was completed on August 31, 2011 and noted an alleged date of accident of August 30, 2011. The report noted that Petitioner reported that she stepped from the breezeway onto the patio area of Housing Unit 4 and twisted her left ankle. (RX3).

The CMS Workers' Compensation Witness Report was entered into evidence at the time of arbitration as Respondent's Exhibit 4. The report was completed on August 31, 2011 and noted an alleged date of accident of August 30, 2011. The report was completed by Stanley Brandt, who noted that he saw Petitioner stumble on the raised concrete of the patio of Unit 4, after which she complained of pain in her ankle. (RX4).

The CMS Demands of the Job was entered into evidence at the time of arbitration as Respondent's Exhibit 5.

The August 30, 2011 Incident Report was entered into evidence at the time of arbitration as Respondent's Exhibit 6. The report was completed on August 31, 2011 and noted an alleged date of accident of August 30, 2011. It was noted that Petitioner was stepping onto the patio of Unit 4A and when doing so she twisted her left ankle. It was noted that Petitioner was sent to "HVC" for further treatment and upon assessment, was sent home to follow up with her family physician and that worker's compensation was notified. (RX6).

The September 28, 2011 CMS Letter was entered into evidence at the time of arbitration as Respondent's Exhibit 7. It was noted that after conducting a thorough review/investigation of the claim, it had been determined that the claim was not compensable under the provisions of the Illinois Workers' Compensation Act. (RX7).

CONCLUSIONS OF LAW

With respect to disputed issue (C) pertaining to accident, the Arbitrator finds that Petitioner sustained an accident arising out of and in the course of her employment with Respondent on August 30, 2011.

To obtain compensation under the Illinois Workers' Compensation Act, a claimant must show by a preponderance of the evidence that he has suffered a disabling injury arising out of and in the course of his employment. 820 ILCS 305/2; *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill. App. 3d 1010, 1013 (2011); *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 57 (1989). However, the fact that an injury arose "in the course of" the employment is not sufficient to impose liability, for to be compensable, the injury must also "arise out of" the employment. *Id.* at 58.

The "arising out of" component refers to an origin or cause of the injury that must be in some risk connected with or incident to the employment, so as to create a causal connection between the employment and the accidental injury. *Id.* There are three categories of risk to which an employee may be exposed: (1) risks distinctly associated with the employment; (2) risks personal to the employee; and (3) neutral risks, which have no particular employment or personal characteristics. *Springfield Urban League v. Illinois Workers' Compensation Comm'n*, 2103 IL App (4th) 120219WC, ¶ 27; *Young v. Illinois Workers' Compensation Comm'n*, 2014 IL App (4th) 130392WC. Injuries resulting from a neutral risk are not generally compensable and do not arise out of the employment unless the employee was exposed to the risk to a greater degree than the general public. *Id.*

The "in the course of" component refers to the time, place and circumstances under which the accident occurred. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 483 (1989). If an injury occurs within the time period of employment, at a place where the employee can reasonably be expected to be in the performance of her duties, and while she is performing those duties or doing

something incidental thereto, the injuries are deemed to have been received in the course of the employment. *Caterpillar Tractor Co.,* 129 Ill. 2d at 58. "Injuries sustained on an employer's premises, or at a place where the claimant might reasonably have been while performing his duties, and while a claimant is at work, or within a reasonable time before and after work, are generally deemed to have been received in the course of the employment." *Johnson v. Illinois Workers' Compensation Comm'n*, 2011 IL App (2d) 100418WC, ¶21.

In the case at hand, the Arbitrator notes that Respondent has argued that Petitioner has not shown any defect and has not shown any increased risk because of work. The Arbitrator finds, however, that Petitioner, by virtue of her employment, was exposed to that hazard to a greater degree than the general public, particularly given the fact that the area in which Petitioner was injured was not open to the general public as it was inside the grounds of the Vienna Correctional Center. The Arbitrator finds that the frequency with which Petitioner traversed the area in which she fell, when considered with her testimony that the concrete was raised and the fact that the accident occurred in the dark which limited her visibility, are cumulatively supportive facts for the Arbitrator to conclude that Petitioner's accident arose out of and in the course of her employment, particularly when coupled with the fact that the area in which Petitioner was injured was not open to the general public.

As a result thereof, the Arbitrator finds that Petitioner met her burden of proof in establishing that she sustained accidental injuries that arose out of and in the course of her employment with Respondent on August 30, 2011.

With respect to disputed issue (F) pertaining to causation, the Arbitrator notes that Respondent disputed causation as it pertained to accident. (AX1). In light of the Arbitrator's findings as it pertains to accident, the Arbitrator hereby finds that Petitioner's current condition of ill-being is causally connected to the accident of August 30, 2011.

The Arbitrator finds that the evidence in this case was supportive of Petitioner having undergone conservative treatment for a left ankle sprain, although the Arbitrator notes that there was a significant gap in treatment between the time at which Petitioner was returned to full duty work at the time at which she presented to the podiatrist, Dr. Brown, in August of 2014. That having been said, however, the Arbitrator finds that the medical records in this case are supportive of Petitioner having sustained a left ankle sprain as a result of the accident of August 30, 2011.

With respect to disputed issue (J) pertaining to necessary medical services, in light of the Arbitrator's aforementioned conclusions, the Arbitrator finds that Petitioner's care and treatment was reasonable, necessary, and causally related to her work accident of August 30, 2011. As a result thereof, Respondent shall pay all reasonable and necessary medical services as contained in Petitioner's Exhibit 6, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit for all medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

With respect to disputed issue (K) pertaining to temporary total disability benefits, the Arbitrator notes that Petitioner seeks temporary total disability benefits from August 31, 2011 through September 14, 2011. (AX1).

The Arbitrator notes that The Work Excuse dated September 15, 2011 noted that Petitioner was seen on September 9, 2011 and was unable to return to work at that time due to injury. The Return to Work/School Note dated September 1, 2011 noted that Petitioner should be excused from any standing work (but may participate in seated work) from September 1, 2011 through September 8, 2011. (PX4).

No testimony was proffered at the time of arbitration to suggest that Respondent either did or offered to accommodate Petitioner's work restrictions for the timeframe of September 1, 2011 through September 8, 2011. Petitioner testified that she returned to Dr. Winkleman's office on or about September 14, 2011, and that she requested a return to work slip so that she could return to work. As a result thereof, the Arbitrator finds that Respondent shall pay temporary total disability benefits for a period of 2 weeks, commencing September 1, 2011 through September 14, 2011, given the Arbitrator's findings with respect to disputed issues (C) and (F).

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injuries, the Arbitrator notes that Petitioner's injuries occurred on August 30, 2011 and, as such, the Arbitrator will not specifically be addressing the five factors under Section 8.1b of the Act in the determination of permanent partial disability.

The Arbitrator finds that the medical records in this case demonstrate that Petitioner sustained a left ankle sprain for which she underwent minimal conservative treatment. Having reviewed the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of 5% loss of use of the left foot under Section (e) of the Act.

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

Luis Perez,
Petitioner,

vs. NO: 12WC 23240

Labor Solutions,
Respondent,

18IWCC0045

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.

Respondent moved to dismiss Petitioner's Petition for Review on the grounds that Petitioner failed to prosecute his case because he fired his attorney following the timely filing of the Petition for Review and 1) has not hired a new attorney despite being given leave to do so and, 2) did not file a statement of exceptions. There is nothing in the Act, nor in the Administrative Rules prohibiting a Petitioner from pursuing their case *pro se*. Additionally, the appropriate remedy for failure to file a Statement of Exceptions is the denial of oral arguments – as was done in the instant case. *See* 50 Ill. Admin. 9040.70(d). Respondent's Petition to Dismiss Petition on Review is denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 25, 2017 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent's Petition to Dismiss Petition on Review is denied.

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

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

18IWCC0045

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $4,500.00. 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: JAN 24 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

PEREZ, LUIS
Employee/Petitioner

Case# **12WC023240**

LABOR SOLUTIONS
Employer/Respondent

18IWCC0045

On 1/25/2017, 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 0.60% 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:

0147 CULLEN HASKINS NICHOLSON ET AL
JOSE RIVERO
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

1832 KLAUKE LAW GROUP LLC
MARK DINOS
1900 E GOLF RD SUITE 950
SCHAUMBURG, IL 60173

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

Luis Perez
Employee/Petitioner

v.

Labor Solutions
Employer/Respondent

Case # 12 WC 23240

Consolidated cases: N/A

18IWCC0045

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 **December 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 **March 15, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$17,160.00**; the average weekly wage was **$330.00**.

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 may have paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$9,365.71** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$9,365.71**.

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 $220.00/week for 42 4/7 weeks, commencing March 19, 2012 through January 10, 2013, as provided in Section 8(b) of the Act. Respondent shall be given a credit of **$9,365.71** for TTD.

Respondent shall pay reasonable and necessary medical services for treatment to the right shoulder only, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $220.00/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.

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 24, 2017
Date

JAN 25 2017

Statement of Facts

Petitioner had filed a duplicate Application for Adjustment of Claim (12 WC 16375) alleging the same date of accident as the present claim. A voluntary dismissal of 12 WC 16375 was entered on the December 28, 2016 date of hearing (Arb Ex 3). Petitioner's attorney advised the Arbitrator that he would resolve any fee issues with prior counsel. The Arbitrator makes no findings with respect to any fee issue.

Petitioner Luis Perez testified in Spanish through an interpreter. Petitioner testified that on March 15, 2012, he was employed by Labor Solutions. He was working the overnight shift as a packer. His job duties included packing plastic glassware into boxes and stacking the boxes on pallets. He testified that the boxes were about 3 feet long and 2 feet deep. He would stack the boxes up to above shoulder height. He used both hands to lift the boxes. He testified that after 2 to 3 hours he felt weakness in both arms and pain in his right shoulder.

Petitioner testified that he reported this to his employer the next day. He was sent to the clinic. He then chose to treat with his doctor at Herron Clinic, affiliated with Alivio Physical Therapy.

The records of Herron/Alivio Medical Center were admitted as Petitioner's Exhibit 1. Petitioner was first seen on March 21, 2012 by Dr. Barnabas at the facility on Delaware in Chicago. The history provided was that at 4:00 AM, Petitioner was lifting a 70 pound box of plastic glasses and plates above his shoulder to place it on a pallet when he felt pain in his right shoulder. He reported that corporate health diagnosed a right shoulder sprain/strain and returned him to work with restrictions. Petitioner was diagnosed with a right shoulder sprain/strain. He was sent for right shoulder x-ray and referred for therapy and chiropractic to Dr. Bermudez (PX 1, p 37). Petitioner underwent an MRI on March 30, 2012. The MRI found the rotator cuff was intact with mild tendonitis or bursitis (PX 1, p 52). Petitioner continued treatment with Dr. Barnabas and Dr. Bermudez for complaints in the right arm with pain of 5/10 and pain on motion. He was referred to Dr. Sclamberg on April 13, 2012 (PX 1, p 30). Petitioner continued with follow up treatment with Dr. Barnabas and Dr. Bermudez through July 5, 2012. Except for complaints of unrelated low back pain noted on June 6, 2012, Petitioner advanced complaints only in the right arm and shoulder (PX 1, p 4-28).

Petitioner was first seen by Dr. Sclamberg on April 23, 2012. Dr. Sclamberg's records were admitted as Petitioner's Exhibit 2. The hand written history prepared states that the problem is the right shoulder (PX 2, p 4). Dr. Sclamberg records Petitioner's history of lifting boxes and developing pain in the right shoulder. Dr. Sclamberg examined only the right shoulder and diagnosed right shoulder impingement syndrome related to the work related injury. He gave Petitioner an injection, suggested physical therapy and placed Petitioner on a 5 pound lifting restriction, no overhead lifting or repetitive duties (PX 2, p 21). On May 29, 2012, Petitioner advised the injection did not help. Dr. Sclamberg recommended arthroscopic surgery (PX 2, p 20). Petitioner underwent surgery on August 3, 2012. The post-operative diagnoses were right shoulder impingement syndrome, full thickness rotator cuff tear, supraspinatus distribution, hypertrophic synovitis, and distal clavicular hypertrophy (PX 2, p 24-25). Following surgery, Petitioner underwent physical therapy and remained under Dr. Sclamberg's care (PX 2, PX 3). The parties stipulated that Petitioner was no longer temporarily totally disabled relative to the right shoulder after January 10, 2013 (Arb Ex. 1).

On August 27, 2012, Dr. Sclamberg notes that Petitioner is still having pain in the left shoulder (PX 2, p 17). Petitioner testified that from March, 2012 through August 27, 2012 his left arm was bothering him, not as much as the right. He did not report it or complain to a medical provider until August 27, 2012. At the time of the accident, he only told his employer of the injury to the right shoulder. He filled out an accident report only for

the right shoulder. On September 24, 2012, Dr. Sclamberg diagnosed left shoulder impingement syndrome. On October 22, 2012, he provided Petitioner with an injection into the left shoulder and discussed the possibility of left shoulder arthroscopy (PX 2, p 13, 15). On January 25, 2013, Petitioner underwent left shoulder surgery. The diagnoses following surgery were impingement syndrome, left shoulder plus partial thickness rotator cuff tearing, and low grade distal clavicular hypertrophy plus hypertrophic synovitis. (PX 2, p 22-23) Petitioner required physical therapy and home therapy following surgery and eventually was discharged from all care. Treatment from January 25, 2013 through March 22, 2013 was related to the left arm. Petitioner testified that Dr. Sclamberg advised him not to lift over head level.

Petitioner was examined by Dr. Nikhil Verma pursuant to Section 12 of the Act. Dr. Verma testified by evidence deposition taken December 9, 2015 and January 6, 2016 (RX 1). Petitioner was initially examined on April 25, 2012. (RX 1, Dep Ex. 2) Dr. Verma noted Petitioner had only worked for the employer for two days before his right shoulder began to hurt. He opined Petitioner's right shoulder condition was related to the work accident and that he required additional conservative care. Petitioner advanced no left shoulder complaints at that time. Dr. Verma stated that that there was no indication for chiropractic care. Dr. Verma authored an addendum on June 11, 2012, and opined that given Petitioner's failure of conservative care, right shoulder arthroscopic surgery was reasonable. (RX 1, Dep Ex. 3)

Dr. Verma examined Petitioner again on January 10, 2013 (RX 1, Dep Ex. 4). The physical examination notes some loss of range of motion with inconsistent complaints of pain. Strength is rated at 5-/5 with abduction with mild pain complaints with resisted elevation. With respect to the right arm, Dr. Verma opined Petitioner had reached maximum medical improvement and could work without restrictions. Dr. Verma testified that the post surgical treatment received was reasonable and appropriate. Dr. Verma opined that Petitioner's left shoulder condition was not work related. This was based upon Petitioner's reporting the onset of symptoms three or four days after the accident, which is inconsistent with an acute strain or tear, and based upon review of the extensive medical records which document no reporting of left shoulder complaints. Dr. Verma stated that Petitioner's statement that left shoulder treatment was delayed until completion of the right shoulder care is illogical from a medical basis.

Petitioner testified that he has returned to work as a packer. He does not perform overhead work. At the end of an 8-hour work shift, he feels pain in his arms. He testified that he takes aspirin if needed.

Conclusions of Law

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

To obtain compensation under the Act, a claimant must show, by a preponderance of the evidence, that he suffered a disabling injury that arose out of and in the course of the claimant's employment. An injury 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 reported an injury to his right arm while lifting 70 pound boxes in the performance of his job duties as a packer for Respondent. He sought medical treatment and provided a consistent history of this injury to all medical providers and Respondent's examining physician. This activity was performed during the course of his employment. The act of lifting boxes is risk originating with his job as a packer.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that he sustained accidental injuries to his right arm and shoulder arising out of and in the course of his employment with Respondent on March 15, 2012.

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. Petitioner's unrebutted testimony is that he injured his right shoulder on March 15, 2012 while lifting boxes. He reported complaints in the right shoulder to Herron/Alivio Medical Center and Dr. Sclamberg. On April 23, 2012, Dr. Sclamberg diagnosed right shoulder impingement syndrome and noted his opinion that the condition of ill being was related to the work related injury. Dr. Verma also opined that the right shoulder condition and treatment was causally related to the March 15, 2012 work accident. Based upon the unrebutted testimony and medical opinions, the Arbitrator finds that the Petitioner's condition of ill being in the right shoulder is causally connected to the accidental injury.

Petitioner is also alleging that the condition of ill being in his left shoulder, including the treatment and January 25, 2013 surgery, is related to the lifting injury on March 15, 2012. Petitioner only reported an injury to his right shoulder to Respondent. He treated at Herron/Alivio Medical Center, his choice of treater, from March 21, 2012 through July 5, 2012. Despite detailed history and examinations, there is no indication of any left shoulder complaints. The Arbitrator notes that the records detail an instance of unrelated low back complaints, but no left shoulder complaints are recorded. Dr. Sclamberg's records note Petitioner listed only right shoulder complaints even though the questionnaire specifically asks if the problem is on the Right, Left or both. Dr. Sclamberg does not record any left shoulder complaints until August 27, 2012. The Arbitrator finds Petitioner's explanation as to why he did not report the left side earlier in the history to Dr. Verma and in his testimony unpersuasive. The Arbitrator also notes that, while Dr. Sclamberg specifically stated in his records that the right shoulder impingement is causally related to the work related injury, he provides no such causation statement with respect to the left shoulder.

Dr. Verma provides a specific opinion that the left shoulder condition is not related to the accident. His opinion is based upon his own examinations, the medical records and the history received. The Arbitrator finds this opinion credible and persuasive.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that the condition of ill being in his right shoulder is causally connected to the accidental injuries sustained on March 15, 2012. The Arbitrator further finds that the Petitioner failed to prove by a preponderance of the evidence that his condition of ill being in the left shoulder is causally connected to the accidental injuries sustained on March 15, 2012.

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, reasonable and necessary medical bills for treatment for the condition of ill being in the right shoulder would be causally connected to the accident. Treatment for the condition of ill being in the left shoulder would not be causally connected.

Petitioner submitted medical bills as Petitioner's Exhibit 4. The Arbitrator has reviewed the bills and the medical exhibits submitted at PX 1, PX 2 and PX 3. Based upon the exhibits submitted the Arbitrator finds that the unpaid bills claimed for Accredited Ambulatory Care, Advantage MRI, Metro Orthopedics of the North Shore, Metro Milwaukee Anesthesia Associates, and Gray Medical are for treatment to the left shoulder and therefore not causally related to the accident and denied.

PX 4 contains billing dated February 18, 2013 from Herron Medical Center and Alivio PT and Chiropractic for treatment from March 21, 2012 through July 5, 2012. This treatment is for the right shoulder. Dr. Verma opined that chiropractic care was not reasonable in this matter. To the extent the balance reflects chiropractic, the billing would not be reasonable.

PX 4 contains billing dated March 5, 2013 from Waukegan Medical and Rehab for physical therapy from September 6, 2012 through January 15, 2013. The treatment is documented in PX 3. The billing shows payment for treatment through November 28, 2012, with payments made on February 14, 2013. The records do not clearly specify which shoulder was being treated. To the extent that there may remain unpaid treatment for the right shoulder, Respondent would be responsible for payment.

PX 4 contains billing dated May 3, 2013 from Chicago Pain and Orthopedic Institute for the August 3, 2012 and January 25, 2013 surgeries. The statement does not reflect any payments made. The billing for the August 3, 2012 surgery totaling $20,293.08 would be reasonable, necessary and causally related to the accident.

The Arbitrator finds the medical bill exhibit with statements over three years old may not reflect the current state of outstanding balances on the bills for treatment for the right shoulder. This is supported by the lack of dispute on this right shoulder condition by Respondent and further by the Request for Hearing form and cover sheet to PX 4 which reflects different balances due than those shown in the old statements attached. The Arbitrator therefor cannot calculate an exact figure of possible unpaid billing.

Based upon the record as a whole, the Arbitrator finds that Respondent shall pay reasonable and necessary medical services for treatment to the right shoulder only, as provided in Sections 8(a) and 8.2 of the Act.

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

Petitioner's date of accident is after September 1, 2011 and therefore the provisions of Section 8.1b of the Act are applicable to the assessment of partial permanent disability in this matter. Based upon the Arbitrator's finding with respect to Causal Connection, the Arbitrator considers only the condition of ill being in the right shoulder.

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 packer 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 while Petitioner is currently employed as a packer, that he testified that he does not lift above shoulder height. Because of this, the Arbitrator therefore gives some greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 42 years old at the time of the accident. Petitioner therefore will likely perform his job duties including lifting for many years. Because of this, 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 performing the same job duties as he did before the injury. The Arbitrator also notes the low wages he was receiving at the time of the injury. Because of these facts, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner suffered injury to the right shoulder as a result of the accident. Dr. Sclamberg diagnosed right shoulder impingement syndrome related to the work related injury. Petitioner underwent surgery on August 3, 2012. The post-operative diagnoses were right shoulder impingement syndrome, full thickness rotator cuff tear, supraspinatus distribution, hypertrophic synovitis, and distal clavicular hypertrophy. Petitioner followed with post operative care until his release. He testified that Dr. Sclamberg advised him to avoid lifting over head high. Dr. Verma opined Petitioner had reached maximum medical improvement and could work without restrictions. His physical examination did record some loss of motion and strength with complaints of pain. 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 12.5% loss of use of person as a whole pursuant to §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

Maria Vera Amaya,
Petitioner,

vs. NO: 15 WC 16635

Kent Precision Foods Group,
Respondent.

18IWCC0046

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, permanent partial disability, medical expenses, prospective medical expenses, wage rate, penalties and attorney's fees and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission does note that the Decision includes boilerplate 19(b) language noting that a subsequent hearing for further medical benefits or disability is not barred by this decision. Because the claimant failed to prove accident, causal relationship, and notice, the boilerplate language is inapposite. The Commission therefore strikes that sentence from the Decision. All other findings and conclusions are affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 5, 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.

18IWCC0046

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: JAN 24 2018

Joshua D. Luskin

o-01/17-18
jdl/wj
68

L. Elizabeth Coppoletti

Charles J. DeVriendt

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

VERA AMAYA, MARIA
Employee/Petitioner

Case# **15WC016635**

KENT PRECISION FOODS GROUP
Employer/Respondent

18IWCC0046

On 7/5/2016, 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 0.34% 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:

5191 FAJARDO LAW GROUP LLC
TANYA FAJARDO
77 W WASHINGTON ST SUITE 1805
CHICAGO, IL 60602

4800 MICHAEL BEST & FRIEDRICH LLP
DENISE GREATHOUSE
180 N STETSON AVE SUITE 2000
CHICAGO, IL 60601

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
19(b)

MARIA VERA AMAYA
Employee/Petitioner

v.

KENT PRECISION FOODS GROUP
Employer/Respondent

Case # 15 WC 16635

Consolidated cases: _____

18IWCC0046

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 **NEW LENOX AND KANKAKEE**, on **JANUARY 15, 2016 AND JUNE 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. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **MAY 8, 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 $**N/A**; the average weekly wage was $**N/A**.

On the date of accident, Petitioner was **44** 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 $**2,133.12** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $.

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

ORDER

The Arbitrator finds that Petitioner did not sustain and accident arising out of and in the course of her employment with Respondent. All compensation is therefore denied. All other issues are therefore moot.

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

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

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

Robert E Abrams — June 30, 2016

Signature of Arbitrato — Date

ICArbDec19(b)

JUL 5 - 2016

MEMORANDUM OF DECISION OF ARBITRATOR

This matter came before the Arbitrator for hearing on January 15, 2016, with Attorney Denise Greathouse of Michael Best and Friedrich LLP appearing on behalf of Respondent, Kent Precision Foods Group ("Precision Foods"), Attorney Tanya Fajardo appearing on behalf of Petitioner Maria Vera Amaya (Petitioner").

NOW, THEREFORE, upon consideration of the entire record of proceedings before the Arbitrator, as well as all records, files, pleadings, and proceedings filed in this action, the Arbitrator finds as follows:

FACTS

Petitioner, age 44 at the time, worked for Precision Foods as a packer for approximately 8 months prior to her alleged back injury of May 8, 2015. Her job as a packer required her to carry boxes with product ranging anywhere from approximately 8 ounces to approximately 50 pounds. Petitioner testified and reported to the doctors that in the two days prior to the date of injury alleged herein, she had handled numerous 40 lb. boxes. She did nothowever testifiy or relate to her medical providers that this had in any way caused her any discomfort to her lower back. On May 8, 2015, at the start of her shift for the day, Petitioner claims that she bent down to look at a box and as she went to stand up, she felt immediate pain in her lower back. She did not attempt to pick up the box; she simply bent down and stood back up.

After the alleged injury on May 8, 2015, Petitioner was transported to the Bolingbrook Hospital emergency room where she was diagnosed with a lumbar strain and released. (Pet. Ex.

1.) She denied any prior back injuries or problems. She reported pain in the left lumbar sacra area with no radiating pain. She described the pain as dull.

On May 10, 2015, Petitioner was seen by Dr. Ananda Pillai. Petitioner told Dr. Pillai that she was lifting a box when her lower back began to hurt. (Pet. Ex. 2.) Later in the record a history of merely bending over tolook at at a box when pain developed is given. She indicated that she had no prior back problems. On examination Petitioner had a positive straight leg raise on the left and her back range of motion was reduced. (*Id.*) No spasm or tenderness was noted in the paraspinal muscles, no loss of lumbosacral lordosis was noted. (*Id.*) X-rays of the lumbosacral area did not show any fractures, avulsions or dislocations. (*Id.*) Dr. Pillai diagnosed Petitioner with lower back pain. (*Id.*) She was given work restrictions of no lifting over the shoulder greater than 20 pounds, no lifting from waist to shoulder greater than 20 pounds and no lifting below the waist greater than 20 pounds. Restrictions were to stay in effect until May 17, 2015. She was to continue the medications which were provided to her in the emergency room.

Dr. Ronald Gregus saw Petitioner on May 11, 2015 for a follow-up examination of her lower back pain. Dr. Gregus noted that Petitioner reported that she was bent over to lift a box when her lower back began to hurt. There is no indication in this record that Petitioner at any time actually lifted the box. Petitioner again stated that she had no previous back problems. She was able to return to work with restrictions of no lifting over the shoulder greater than 10 pounds, no lifting from waist to shoulder greater than 10 pounds, and no lifting below the waist great than 10 pounds. She was to also wear a back support. These restrictions were to remain in effect until May 18, 2015.

Petitioner return to work for the Respondent on May 11, 2015, the Respondent accommodated her restrictions. Petitioner was labeling which did not require lifting or much movement.

Petitioner saw Phillip Knuth, PA on May 14, 2015 for a follow-up visit of her low back pain. Petitioner reported that her back pain continued to be 10/10. She stated that she was surprised she was not taken off work.

At the hearing, Petitioner testified that after her alleged injury on May 8, 2015 she worked at her other job as a waitress at Saddle Cycle Club on May 17, 2015 for 6 hours and 45 minutes with no lunch break, and without any problems with her back when she was working. (Hrg. Trans. pp. 56-57). Even though Petitioner testified that she went back to the treating physician on May 14, 2015 because of pain, she was able to work May 17, 2015 at Saddle Cycle Club for 6 hours and 45 minutes with no lunch break. (Hrg. Trans. pp. 59-60).

Petitioner was reevaluated on May 19, 2015, this time by Ola Alimi, PA-C. Petitioner reported that her lower back felt better and only had intermittent pain which was normally about 2/10. Ms. Alimi advanced Petitioner to full duty without restrictions effective May 19, 2015. She also released Petitioner from care expecting her to reach maximum medical improvement in 7 days with no impairment.

Dr. Suma Kaki saw Petitioner on May 20, 2015 for continued low back pain. (Pet. Ex. 3.) She indicated that she had a second job as a banquet worker. On examination Dr. Kaki noted that Petitioner was in no acute distress. There was no muscle tenderness and Petitioner had full range of motion. Dr. Kaki advised her to go to physical therapy, continue her current medications and was advised to follow a low fat diet for her obesity. Petitioner was returned to work without restrictions and was told to follow-up in one week.

On May 26, 2015, Petitioner returned to Dr. Kaki for a follow-up visit. Petitioner requested a note stating she was to go back to work on light duty. Dr. Kaki ordered anti-inflammatory medications and physical therapy. She was diagnosed with a lumbosacral sprain. She was given a work excuse with work restrictions.

Petitioner continued to complain of severe low back pain and Dr. Kaki ordered an MRI. Petitioner underwent an MRI of her lumbar spine on July 14, 2015. The MRI revealed degenerative disk disease at L4-5 with right lateral recess stenosis and an annular tear, and a L3-4, L4-5 diffuse disk bulge.

On July 29, 2015 Petitioner was referred to Dr. Laich by Dr. Kaki. Petitioner did not seek any medical treatment again until September 16, 2015 when she first saw Dr. Laich. Dr. Laich diagnosed Petitioner with sacroiliac dysfunction and provided her with a sacroiliac belt and continued physical therapy. Petitioner did not inform Dr. Laich or Dr. Kaki that she had previous back injuries. Dr. Laich prescribed a Sacro back brace/SI joint belt and ordered physical therapy. Dr. Laich ordered her to remain off work for continued rehabilitation – especially to the pelvic floor and SI joint. Petitioner was to follow-up with Dr. Laich once therapy was completed which was anticipated at 8 weeks.

Petitioner underwent an Independent Medical Examination performed by Dr. Cary R. Templin on December 10, 2015. Dr. Templin diagnosed Petitioner with a preexisting lumbar degenerative disk, right-sided L4-5 disc protrusion and lumbar strain injury. (Resp. Ex. R-1, Templin report of 12/10/2015, p. 4.) He opined that the lumbar strain injury was "more likely than not" related to the May 8, 2015 injury. (Resp. Ex. R-1, Templin report of 12/10/2015, p. 4.) Dr. Templin noted that the initial pain was the result of the May 8, 2015 injury, but her pain 7 months later, is not relatable. (Resp. Ex. R-1, Templin report of 12/10/2015, p. 4). Dr. Templin

also noted that based on her Waddell sign, her complaints of pain was inorganic as well as symptom magnification. (Exhibit R-1, Templin report of 12/10/2015, p. 4). Dr. Templin also opined that the sacroiliac belt was not required as Petitioner did not suffer an SI joint dysfunction (Exhibit R-1, Templin report of 12/10/2015, p. 4).

Dr. Templin recommended a Functional Capacity Evaluation, given Petitioner current complaints due to her pre-existing condition, to determine if she can return to work with or without restrictions.

Petitioner testified at the hearing that she could have gone back to work back in September 2015 if she didn't have to do heavy lifting. In fact, she claims she could have gone back to work after she got injured if she had restrictions (Hrg. trans. pp. 83).

After the hearing on January 15, 2016, the Respondent was provided time to obtain medical records concerning Petitioner's prior back injuries. It was later determined that Petitioner had pre-existing problems with her low back that required lengthy treatment dating back to 2008

WITH RESPECT TO ISSUE(C) WHETHER PETITIONER SUSTAINED AN ACIDENT THAT AROSE OUT OF AND IN THE COURSE OF HER EMPLOYEMT WITH RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

At the time Petitioner was injured she reported to her medical providers and testified that she was merely bending over to look at a box. She did not indicate or testify that she was in an unusual or stressed position when she did this, she did not testify that she had anything in her hands or that she had actually picked up anything when this occurred. As she straightened up,

she felt a pain in her lower back. Based on the record as a whole, the Arbitrator finds that Petitioner did not sustain an accident that arose out of and in the course of her employment with Respondent, and notes that while the incident alleged is traceable to a definite time, place and cause, the simple act of bending over to look at a box did not subject the Petitioner to a risk greater than that to which the general public would be exposed, and that there is no risk inherent in her employment which create such a risk. See Board of Trustees v Industrial Commission 44 Ill.2d. 207, 254 NE2d. 522 (1969); Greater Peoria Mass Transit District v Industrial Commission, 81 Ill.2d. 38, 39 IllDec 817, 405 NE2d. 79 (1980). Compensation is therefore denied and all other issues are 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	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MIKE MCGANN,

Petitioner,

vs.

NO: 08 WC 52156
(Consolidated with 10 WC 21559)

CITY OF CHICAGO,

Respondent.

18IWCC0047

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 (TTD), nature and extent, and penalties and attorney's fees, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

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

No bond is required for removal of this cause to the Circuit Court by Respondent. 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.

18IWCC0047

DATED: JAN 25 2018
MJB/pm
1-08-18
052

Michael J. Brennan

Kevin W. Lamborn

DISSENT

The record shows that Petitioner suffered a serious work-related injury with respect to his right hip, among other body parts, on 10/2/08, the subject of claim 08 WC 52156. Petitioner subsequently underwent arthroscopic repair of his right hip at the hands of Dr. Domb on 3/27/09, followed by joint replacement surgery on 5/18/11 and eventual revision of the joint replacement on 12/4/14 – all three procedures, spanning the course of almost six years, having been found to be causally related to the original work-related injury. Yet in spite of this extensive history, and despite the fact that the record evinces no other explanation, the majority of this Commission is unwilling to connect the dots and find that a subsequent infection of the same hip prosthesis is causally related to the original injury and subsequent aggravating incident on 5/11/10, the subject of 10 WC 21559.

The majority's reluctance to make this leap of faith and find causal connection along these lines appears to be based on the fact that no medical opinion was offered into evidence that specifically linked the infection to the heretofore work-related right hip condition. I would argue that no such medical opinion is required, and that a chain of events theory and common-sense interpretation of the facts lead to the reasonable inference that the original work-related injury and subsequent treatment was, at the very least, *a* contributing factor in the ensuing infection. This is particularly true given the warnings of Petitioner's treating orthopedic surgeons that such a risk of infection existed relative to hip replacement surgery. More to the point, I believe that *but for* the original injury there would have been no hip replacement to become infected, and there would have been no need for any subsequent surgeries to address same. It's as simple as that.

As a result, I would reverse the Arbitrator on this point, and award benefits accordingly.

Therefore, I respectfully dissent with respect to that portion of the Commission's decision that finds otherwise.

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

McGANN, MIKE
Employee/Petitioner

Case# **08WC052156**

10WC021559

CITY OF CHICAGO
Employer/Respondent

18IWCC0047

On 3/13/2017, 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 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:

0391 HEALY SCANLON LAW FIRM
PATRICK ANDERSON
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
AUKSE R GRIGALIUNAS
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

STATE OF ILLINOIS)
)
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
REGARDING THE NATURE AND EXTENT OF THE INJURY

Mike McGann

Employee/Petitioner

v.

City of Chicago

Employer/Respondent

18IWCC0047

Case # **08 WC 52156**

10 WC 21559

Consolidated

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 **Milton Black**, arbitrator of the Commission, in the city of **Chicago**, on **December 19, 2016 and December 21, 2016**. The only disputed issue is the nature and extent of the injury. By stipulation, the parties agree on the following items:

- On **October 2, 2008**, the respondent was operating under and subject to the provisions of the Act.
- On this date, the relationship of employee and employer did exist between the petitioner and respondent.
- On this date, the petitioner sustained accidental injuries that arose out of and in the course of employment.
- Timely notice of this accident was given to the respondent.
- In the year preceding the injury, the petitioner earned $ **88,137.40**, and the average weekly wage was $**1,694.95**.
- At the time of injury, the petitioner was **54** years of age, ***married*** with **2** children under 18.
- Necessary medical services have been provided by the respondent.
- The respondent shall pay the petitioner temporary total disability benefits of $ **1,129.97**/week for **2 3/7^{ths}** weeks, from **March 21, 2009** through **April 12, 2009** , which is the period of temporary total disability for which compensation is payable.
- To date, $ **2,744.21** has been paid for TTD and/or maintenance benefits.

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.

This matter was previously heard at the Illinois Workers' Compensation Commission before Arbitrator Jutila on April 9, 2010 in a 19(b) proceeding. Arbitrator Jutila issued a decision on May 20, 2010, finding that the petitioner's current condition of ill-being to his right hip was causally related to the accident of October 2, 2008, and awarded TTD benefits for 2 3/7^{ths} weeks from March 27, 2009 through April 12, 2009 as well as payment for all reasonable and necessary medical bills. The award was paid by the respondent.

The petitioner returned to work on April 13, 2009 and eventually returned to work full duty, performing field work. The petitioner was released at MMI without restrictions for his right hip following arthroscopic surgery which took place on March 27, 2009 with findings of a tear of the labrum, impingement and partial tear of the ligament teres.

As a result of the October 2, 2008 injury, the petitioner sustained tearing of the labrum in his hip, as well as impingement and a partial tear of the ligament teres, which was treated with arthroscopic surgery. The petitioner was able to return to his full duty capabilities as a plumbing inspector for the City of Chicago. As such, the Arbitrator awards benefits in the amount of 43 weeks because the petitioner's injuries caused 20% loss of use of the right leg.

ORDER

- The respondent shall pay the petitioner the sum of $ **664.72**/week for a further period of **43** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **20% loss of use of the right leg**.
- The respondent shall pay the petitioner compensation that has accrued from **March 21, 2009** through **December 21, 2016** 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

March 10, 2017
Date

ICArbDecN&E p.2

MAR 13 2017

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MIKE MCGANN,

Petitioner,

vs.

NO: 10 WC 21559
(Consolidated with 08 WC 52156)

CITY OF CHICAGO,

Respondent.

18IWCC0048

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 (TTD), nature and extent, and penalties and attorney's fees, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission only writes to clarify its affirmation of the Arbitrator's Decision in Claim No. 10 WC 21559.

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.

In Claim No. 10 WC 21559, Respondent disputed liability for the subsequent infection that developed, and which resulted in revision surgery of Petitioner's right hip prosthesis in 2016. The Arbitrator found that Petitioner's right hip infection was a subsequent and intervening injury.

18IWCC0048

In determining causal connection, "[e]very natural consequence that flows from an injury that arose out of and in the course of one's employment is compensable under the Act absent the occurrence of an independent intervening accident that breaks the chain of causation between the work-related injury and an ensuing disability or injury." *Nat'l Freight Indus. v. Ill. Workers' Comp. Comm'n*, 2013 IL App (5th) 120043WC ¶26. "Under an independent intervening cause analysis, compensability for an ultimate injury or disability is based upon a finding that the employee's condition was caused by an event that would not have occurred "but for" the original injury." *Id.*

"For an employer to be relieved of liability by virtue of an intervening cause, the intervening cause must completely break the causal chain between the original work-related injury and the ensuing condition." *Global Products v. Workers' Comp. Comm'n*, 392 Ill. App. 3d 408, 411 (1st Dist. 2009). A work-related 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." (Emphasis in original). *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d, 193, 205 (2003).

As long as there is a "but-for" relationship between the work-related injury and subsequent condition of ill-being, the employer remains liable. *Int'l Harvester Co. v. Indus. Comm'n*, 46 Ill. 2d 238, 245 (1970).

The Arbitrator denied causal connection for Petitioner's right hip condition after February 16, 2015, due to the lack of evidence as to why an infection spread to the right hip and/or the lack of explanation as to whether the right hip would be more prone to infections as a result of the replacement surgery. Specifically, the Arbitrator stated, "There is no opinion in the records supporting the claim that but for the petitioner's hip replacement, he would not have had the infection spread and necessitate two additional surgeries." (Arbitrator's Decision, page 10). The Arbitrator also indicated, "There is no opinion in the records indicating that the strep infection of the right hip was causally related to, or a sequelae of the May 11, 2010 injury." (Arbitrator's Decision, pg. 10).

Petitioner relies on several cases in his brief, the most recent of those cases is *Dunteman v. Ill. Workers' Comp. Comm'n*, wherein the Illinois Appellate Court stated:

> A review of the record in this case demonstrates that there is clearly a "but-for" relationship between the claimant's work-related blister and subsequent infection. Quite simply, even if the claimant's lancing of the work-related blister with a sterilized needle was the immediate cause of his infection, as the Commission found, the infection would not have occurred "but for" the existence of the work-related blister. That is because "but for" the existence of the work-related blister, there would have been no blister to lance. His employment, therefore, remains *a* cause of his current condition of ill-being. 2016 IL App (4th) 150543WC ¶44-45.

A close reading of *Dunteman*, and every case cited by Petitioner, actually provides support for the Arbitrator's Decision in this claim. The cases cited by Petitioner are examples in which our Courts found that the ending condition of each claimant was a natural consequence that flowed from the work-related injury. Further, there was evidence, by way of physician testimony or medical records, to explain and support the causal relationship between the work injury, the subsequent non-work-related event, and the resulting injury.

Here, the evidence demonstrates that following Petitioner's discharge in February 16, 2015, Petitioner's doctors' visits and medical treatment picked up around November 2015. During this time, two things occurred: Petitioner was having rigors and he was having hip pain. The evidence further indicated that in November 2015, x-rays of the right hip and a bone scan revealed "3mm of periprosthetic lucency within the right proximal femur that can be seen with loosening or infection and he says that ever since at the time of his rigors, he started developing significant pain in his right hip that has only progressed." (PX7). Thereafter, Petitioner saw Dr. Kris Alden on December 15, 2015, who noted that Petitioner had been recently hospitalized for a strep/staph infection. (PX8).

Dr. Alden stated, "His recent staph infection complicates his prognosis, although I explained that the chances of infection developing in the prosthesis are low. However, we want to monitor him closely. I told him the only way to know if the hip is infected is an aspiration." (PX8). On January 4, 2016, Petitioner consulted with Dr. Justin LaReau for a second opinion relative to his right hip pain. Dr. LaReau also noted Petitioner had been dealing with bacteremia of unclear etiology. He stated that tests had suggested evidence of potential infection and loosening in the right hip, but there was no definitive proof; like Dr. Alden, Dr. LaReau recommended a right hip aspiration. (PX8). Thereafter, Petitioner underwent another bone scan and two right hip aspirations – all which came back negative for infection. (PX7; PX8). Petitioner underwent the two-part revision surgery, with the final one completed on May 18, 2016. Under "post-operative" diagnosis, "[h]istory of prior right total hip replacement infection, chronic, status post 2-stage revision" was written. (PX6). However, as stated above, the hip was negative for infection.

Respondent's Section 12 examiner, Dr. Jay Levin, conducted his examination on March 21, 2013, and wrote his addendum reports in the latter parts of 2013, so he never addressed causality for the 2016 surgeries.

As it stands, there is no evidence, by way of testimony or the medical records, to indicate that the bacterial infection that arose in November/December 2015 was a natural consequence of the right hip prosthesis. In fact, Petitioner's physician did not know where the bacterial infection came from. The operative reports also do not indicate that Petitioner's need for revision surgery was due to loosening of the implanted hardware. Petitioner's claim is not analogous to *Dunteman* or the other cases cited by Petitioner as there is no evidence to support the causal relationship

between the work injury, the subsequent non-work-related "accident," and the resulting injury. For these reasons, the Commission affirms the Arbitrator's Decision.

Petitioner further indicated that the Arbitrator did not address causal connection relative to Petitioner's cervical and lumbar spine. In this instance, causation between an accident and an employee's condition may be found where a chain of events demonstrate "a previous condition of good health, an accident, and a subsequent injury resulting in disability." *Int'l Harvester v. Indus. Comm'n*, 93 Ill. 2d 59, 63-64 (1982).

Petitioner did have complaints to his spine at the onset, and underwent physical therapy. Dr. Michael Zindrick provided a causal connection opinion for Petitioner's cervical spine condition, stating, "The patient's symptoms do appear to stem from this work related injury back on May 11th. Although he had some underlying disk degeneration, it was aggravated by this fall." As to the lumbar spine, Dr. Zindrick stated that Petitioner initially had back pain after the May 2010 accident, but that within a month, his back had "started to settle down." Dr. Zindrick opined on July 13, 2010 that Petitioner had suffered aggravation of low back pain secondary to physical therapy for his hip. However, Petitioner was not undergoing physical therapy for the hip at this time. (PX8).

After 2010, there is evidence of sporadic, generalized complaints of neck or back pain, the last of which appears in the September 8, 2011 discharge note from ATI Physical Therapy and the March 21, 2013 Section 12 report of Dr. Levin. There is no evidence to support that Petitioner's current condition of ill-being, if any at all, relative to his cervical and lumbar spine, is causally related to the May 11, 2010 accident. (PX5; RX3). Thus, in light of the foregoing, the Commission denies causal connection for the cervical and lumbar spine.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 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.

No bond is required for removal of this cause to the Circuit Court by Respondent. 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: JAN 25 2018
MJB/pm
1-08-18
052

Michael J. Brennan

Kevin W. Lamborn

DISSENT

The record shows that Petitioner suffered a serious work-related injury with respect to his right hip, among other body parts, on 10/2/08, the subject of claim 08 WC 52156. Petitioner subsequently underwent arthroscopic repair of his right hip at the hands of Dr. Domb on 3/27/09, followed by joint replacement surgery on 5/18/11 and eventual revision of the joint replacement on 12/4/14 – all three procedures, spanning the course of almost six years, having been found to be causally related to the original work-related injury. Yet in spite of this extensive history, and despite the fact that the record evinces no other explanation, the majority of this Commission is unwilling to connect the dots and find that a subsequent infection of the same hip prosthesis is causally related to the original injury and subsequent aggravating incident on 5/11/10, the subject of 10 WC 21559.

The majority's reluctance to make this leap of faith and find causal connection along these lines appears to be based on the fact that no medical opinion was offered into evidence that specifically linked the infection to the heretofore work-related right hip condition. I would argue that no such medical opinion is required, and that a chain of events theory and common-sense interpretation of the facts lead to the reasonable inference that the original work-related injury and subsequent treatment was, at the very least, *a* contributing factor in the ensuing infection. This is particularly true given the warnings of Petitioner's treating orthopedic surgeons that such a risk of infection existed relative to hip replacement surgery. More to the point, I believe that *but for* the original injury there would have been no hip replacement to become infected, and there would have been no need for any subsequent surgeries to address same. It's as simple as that.

As a result, I would reverse the Arbitrator on this point, and award benefits accordingly.

Therefore, I respectfully dissent with respect to that portion of the Commission's decision that finds otherwise.

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

McGANN, MIKE
Employee/Petitioner

Case# **10WC021559**

08WC052156

CITY OF CHICAGO
Employer/Respondent

18IWCC0048

On 3/13/2017, 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 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:

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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)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Mike McGann
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **10** WC **21559**

Consolidated case: **08 WC 52156**

18IWCC0048

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 **Milton Black**, Arbitrator of the Commission, in the city of **Chicago**, on **December 19, 2016 and December 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 **May 11, 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* in part causally related to the accident.

In the year preceding the injury, Petitioner earned **$93,512.64**; the average weekly wage was **$1,798.32**.

On the date of accident, Petitioner was **55** years of age, ***married*** with **2** dependent children.

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

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

Respondent shall be given a credit of **$14,044.72** for TTD, **$0** for TPD, **$0** for maintenance, and **$12,145.74** for other benefits (permanency advance), for a total credit of **$26,190.46**.

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

ORDER

The Arbitrator finds that the petitioner's conditions as relate to his right hip condition through February 16, 2015, the petitioner's left knee condition and the petitioner's right shoulder conditions are causally related to the accident of May 11, 2010. The petitioner's right knee condition and seizures are not causally related. As such, the Arbitrator awards the following:

- TTD in the amount of $1,198.88 per week for a period of 10 2/7 weeks from May 31. 2012 through August 10, 2012
- Credit of $14,044.72 for TTD
- Credit of $12,145.74 for nature and extent
- PPD at the maximum rate of $664.72 for 317.5 weeks because the petitioner sustained 50% loss of use of the left leg (left knee injury), 7% loss of use of the person as a whole (shoulder injury) and an additional 35% loss of use of the person as a whole for a job change pursuant to Section 8(d)(2) of the Illinois Workers' Compensation Act (right hip injury).
- Petition for penalties and fees is denied
- Respondent is entitled to a credit for all amounts paid to or on behalf of the petitioner

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.

Walter Black

Signature of Arbitrator

March 10, 2017
Date

MAR 13 2017

FACTS

The petitioner sustained an accident arising out of and in the course of his employment on May 11, 2010. The petitioner stated that he was working and was coming down stairs of an abandoned building. It was raining at the time, and the stairs were slippery. He testified that he fell on the stairs injuring his knees, right hip, right shoulder and head. The petitioner testified that he had no prior right shoulder treatment and no prior knee treatment or pain. This is contradicted by the medical records which indicate that the petitioner had had right knee surgery prior to this accident. The records of Hinsdale Orthopaedics indicated that the petitioner having a history of three arthroscopies previously to the right knee. (PX 8)

Immediately following the accident, the petitioner was seen at the emergency room at Holy Cross Hospital. The petitioner was diagnosed with a right hip contusion, right elbow abrasion and right knee contusion and thoracic spine contusion. The X-ray was to the left knee. The petitioner did not make any complaints that he hit his head at the time of injury, nor was there a loss of consciousness. The medical records state that he denied any head injury and neck pain. (PX 4)

The petitioner was seen following the injury by Dr. Domb on May 13, 2011. (PX 8) The petitioner complained of pain in his right hip, right elbow, right shoulder and left knee. He was diagnosed with injury to the right hip, shoulder and elbow and the left knee. (PX 8, p. 115) Physical therapy was begun at that time. The petitioner was able to return to work in a limited duty capacity immediately following the injury. The petitioner's temporary and eventually permanent restrictions throughout his treatment were always accommodated.

On June 18, 2010, an MRI was performed of the right shoulder which showed a partial thickness supraspinatus tear and a possible labral tear. (PX 8) The petitioner had an injection in his right shoulder on June 22, 2010. The petitioner testified that the injection provided temporary relief.

On August 26, 2010, the petitioner returned to Dr. Domb, who recommended the following treatments for the petitioner: a left knee arthroscopy with medical meniscus repair; regarding right hip the petitioner stated he will try to live with the pain; and regarding the right shoulder, an arthroscopy with SLAP repair was recommended, which was refused by the petitioner. (PX 8) On August 31,

2010, the petitioner called Dr. Domb indicating that his right hip pain is worse, and wanted something done for that. At that time, they decided to proceed with the left knee arthroscopy and then do a right hip replacement four weeks later. (PX 9)

On October 24, 2011, the petitioner was seen by Dr. Durkin at Hinsdale Orthopedics for treatment of the left knee on referral from Dr. Domb (PX 8).

On January 31, 2011, the petitioner underwent a left knee arthroscopy performed by Dr. Durkin. (PX 9) The post-operative findings were left knee medical meniscal tear and chondral defect of the patella.

On May 18, 2011, the petitioner underwent a right hip replacement performed by Dr. Domb. The petitioner was placed at sedentary work only, which was accommodated. (PX 8)

The petitioner underwent physical therapy for his right hip and left knee. The petitioner then was recommended for a partial left knee replacement by Dr. Durkin. That surgery was done on May 30, 2012. (PX 8)

On August 11, 2012, the petitioner was to return to work with sedentary restrictions. (PX 8) On September 14, 2012, the petitioner was placed at MMI with permanent restrictions of "no field work". This restriction was accommodated. The petitioner had one more follow up with Hinsdale Orthopedics on November 19, 2012 providing ongoing sedentary work restrictions and recommendations for a home exercise program.

On March 21, 2013, the petitioner was seen by Dr. Jay Levin. (RX 3) Dr. Levin authored a report dated March 21, 2013 indicating that he needed to review several diagnostic films in order to make an assessment and opine on the questions that counsel for respondent asked. (RX 3)

Dr. Levin was able to review additional reports and diagnostic films and authored a supplemental report dated August 21, 2013. (RX 3) In that report, and at his deposition, Dr. Levin opined that the petitioner's left knee, right hip and right shoulder complaints were causally related to the injury of May 11, 2010. He stated that there were no physical findings, or clinical complaints or

diagnostics taken regarding the petitioner's right knee, and therefore, Dr. Levin found the right knee condition to be not related. (RX 3) Dr. Levin further opined that the petitioner had reached MMI for all of these conditions as of December, 2011. (RX 3) Dr. Levin stated that it would be reasonable for the petitioner to undergo a functional capacity evaluation to determine if it was reasonable to keep him restricted to sedentary duty work.

Dr. Levin authored a supplemental report on November 12, 2013. (RX 3) Dr. Levin indicated that it did not appear that the petitioner underwent a functional capacity evaluation, however based solely on his examination he believed that the petitioner could do more than sedentary work, which was why he had requested a functional capacity evaluation. Dr. Levin believed that the petitioner could return to full, unrestricted work. (RX 3)

Mr. Scott Loeff testified on behalf of the City of Chicago regarding the building department's ability to accommodate restrictions, both temporary and permanent. It is clear and undisputed that, except for the period of May 31, 2012 through August 10, 2012 when the petitioner was completely off of work for his left total knee replacement, that his restrictions had been accommodated over the course of his two years of treatment following the injury. Mr. Loeff testified that they were also able to accommodate the petitioner's permanent restrictions. The reason the water department is able to do so is because all plumbing inspectors have both field work and office work to complete. As such, they are able to shift some responsibilities from some of the field workers to a person who only can do sedentary office work. Mr. Loeff testified that there is currently a plumbing inspector working for the department in a similar capacity as the petitioner would have been.

On May 24, 2013, the petitioner was terminated from his employment with the City of Chicago. The petitioner was working as a plumbing inspector at the time, albeit in a modified position to accommodate his restrictions.

On Feburary 24, 2014, the petitioner met with Ms. Yahaira Tourno of Corvel for an initial vocational rehabilitation interview. (RX 2) The petitioner was able to tell Ms. Tourno about his medical history and work history. He stated that as a plumbing inspector, no lifting was required and it was at the light physical demand level. (RX 2, p. 3) Ms. Tourno opined that the petitioner did not sustain a reduction in earning capacity after the accident and was actually earning the same amount

before and after the injury; he has no loss of job security because he was working in a secure position until he was fired for cause; he did not have vocational rehabilitation in the past; he was trainable due to age, education and occupation; and he had sufficient skills to obtain employment without further training or education.

On May 7, 2014, the petitioner met with vocational counselor James Boyd at the request of his attorney. (PX 17) The petitioner provided Mr. Boyd with a complete work history and medical history. Mr. Boyd stated that the petitioner's restrictions of no field work and no lifting greater than 10 pounds, was at the sedentary level, which is the level the petitioner was working when he was terminated from his employment with the City. (PX 17) Mr. Boyd stated that if the petitioner is restricted to office based work, than the job he was working for the past three years for the City would be appropriate. (PX 17) Mr. Boyd stated that he would also qualify for similar positions in other municipalities.

The petitioner came under the medical care of Dr. Alden at Hinsdale Orthopedics on August 22, 2014. (PX 8) Dr. Alden recommended a right hip replacement revision. That surgery took place on December 4, 2014 and was authorized by the respondent. The petitioner testified that this surgery provided some temporary relief of his pain. The petitioner again completed treatment following this surgery on February 16, 2015. (PX 8)

Around November of 2015, the petitioner had some dental work done. According to the medical records, the petitioner developed some hip pain after following undergoing a tooth filling as an outpatient. (PX 6) The blood cultures that were taken from the petitioner grew the strep virus and the petitioner was provided with antibiotics. Those failed, and the hip was aspirated. The pain continued, and on February 25, 2016 the petitioner underwent surgery consisting of a right total hip arthroplasty, removal of components with extended trochanteric osteotomy, and implantation of antibiotic spacer. According to Dr. Aftab, the petitioner's strep virus was likely started from oral intervention. On May 18, 2016, the petitioner underwent surgical removal of the antibiotic spacer and re-implantation of the right total hip replacement. (PX 6)

The petitioner testified that he now experiences seizures for which he sees Dr. Simon. The petitioner testified that the seizures begin in 2015. According to the history provided in the records of DuPage Medical Group, the petitioner first started experiencing symptoms of behavioral arrest in

June of 2014 (PX 9). Apparently, the petitioner was admitted to Good Samaritan hospital on February 9, 2015 due to seizure. On March 19, 2015, he was diagnosed with temporal lobe epilepsy. The doctor also indicated that in one-third of patients there is no cause and that the petitioner's cognitive difficulties have improved with medication. (PX 9)

According to the report of Dr. Erin Hill, from an evaluation that took place on September 8, 2015, the petitioner told her that when he fell in 2010, he did not report a loss of consciousness or dizziness, headaches or nausea. (PX 10) The petitioner told her that he did not remember hitting his head. According to the records from Holy Cross Hospital, the petitioner reported that he did not hit his head. (PX 4) The petitioner testified that he did injure his head. The results of Dr. Hill's examination were inconclusive as to the cause of the petitioner's mild cognitive disorder. Notably, Dr. Hill indicated that there would have to be a diagnosis of a traumatic brain injury in order for there to be a causal relationship between the 2010 injury and his current condition. (PX 10)

The petitioner testified that he experiences deep pain in his right hip joint, and has increased pain with extended sitting, going up and down the stairs and long stretches of walking. He states that he has left knee pain above and below the knee cap and pain inside the joint. To relieve the pain he uses over the counter medication, physical therapy, and a whirlpool. The petitioner stated that regarding his right shoulder, the pain comes and goes and he cannot lift anything. The petitioner testified that his right knee is fine.

Regarding the petitioner's return to work, Mr. Loeff stated that the petitioner is no longer eligible for a job as a plumbing inspector at the City of Chicago. Mr. Loeff also stated, however, that the petitioner would still be working as a Plumbing Inspector today, but for his termination. The petitioner submitted a few print outs indicating that he has applied for jobs at the City of Chicago as a plumbing inspector. (PX 18) The petitioner stated that he has looked for other jobs including plumbing and mechanical jobs at engineering firms, but did not provide any evidence of written job logs or searches regarding same. The petitioner recalled meeting with James Boyd for a vocational interview.

The petitioner was allowed to be led by his attorney regarding his medical treatment, and agreed with all major points regarding treatment as well as his meeting with vocational counselor

Boyd. On cross examination, however, the petitioner claimed that he did not remember anything. He did not remember a workers' compensation claim against Lenert Plumbing numbered 89 WC 54136 for which he recovered in excess of $100,000.00 in a settlement as a result of a 1989 injury. The settlement was entered on November 11, 1991. (RX 5) When questioned as to whether or not he told the truth to the emergency room doctors, the petitioner replied that he did not know what he told them. The petitioner stated that he did not recall having right knee surgery in 2009, or any problems with the right knee prior to this accident, even though the records are very clear to this fact. The petitioner did not recall seeing Dr. Levin for an independent medical evaluation in 2013. The petitioner also could not recall having dental work in 2015 which led to his strep infection. The petitioner did not recall meeting with Ms. Yahaira Toruno for a vocational assessment at the request of respondent on January 24, 2014. However, according to all medical and vocational records provided, the petitioner was always able to provide an accurate medical and vocational history to all of his treating doctors and counselors.

CAUSATION

The petitioner claims that he sustained injuries to his knees, right hip, right shoulder and head as a result of the May 11, 2010 accident. The respondent has stipulated that the petitioner's condition regardING his left knee, right hip and right shoulder are causally related. The respondent denies liability for the petitioner's right hip infection sustained in November of 2015 and the surgeries associated with same. As such, the only questions regarding causation are for the right knee and the petitioners' claimed seizures. Liability regarding the petitioner's two 2016 right hip surgeries will be addressed in the medical section.

The Arbitrator finds that the petitioner's conditions regarding his left knee, right hip and right shoulder are causally related to the accident. The Arbitrator further finds that the petitioner's conditions regarding his right knee and seizures are not causally related. In support of this decision, the Arbitrator relies on the following facts:

The petitioner testified that when he fell on May 11, 2010 he injured his bilateral knees, right hip, right shoulder and head. The medical records from that date, however, indicate that the petitioner did not hit his head, and that there was no loss of consciousness. The medical records stated that the

petitioner injured his right elbow, right hip and right knee, however all treatment rendered that day and all later notes indicate a left knee injury. Notably, the only diagnostic test performed of either knee was an X-ray of the left knee. Additionally, the petitioner claimed he did not have any prior right knee symptoms, however the medical records show that he had three prior right knee arthroscopies.There are no other medical records near the time of injury, for over a year following the injury, which included right knee complaints. Dr. Levin opined that there are no exam findings, diagnostics or other complaints that would causally relate a right knee condition to the injury. Finally, there is no other causation opinion in the records linking the petitioner's right knee complaints to the injury. Since there is no evidence causally relating the petitioner's right knee injury, except the petitioner's inconsistent and non-credible testimony, the Arbitrator finds that the right knee condition is not related to the injury.

The petitioner's claim that he now has seizures as a result of the accident has no basis in the record either. There was no evidence at the time of injury that the petitioner hit his head or had a loss of consciousness. The petitioner did not begin to have epileptic seizures for over four years following the injury. According to Dr. Hill a diagnosis of traumatic brain injury would be a prerequisite to any claim of a cognitive impact. The petitioner's treating physician for his seizures indicated that there is no clear cut cause for his seizures. There is no opinion in the medical records causally relating seizures to the accident. As such, there is no basis in the record for the Arbitrator to find that the petitioner's seizure condition is causally related to the injury.

For the above-mentioned reasons, the Arbitrator finds that the petitioner's right hip, right should and left knee conditions are causally related to the injury but that the right knee condition and seizures are not causally related to the injury.

MEDICAL

The only medical bills in dispute at this time are those relating to the right hip, and the petitioner's treatment for the right hip following a strep infection, as well as the medical bills for the petitioner's treatment for seizures. The claimed bills that remain outstanding are as follows:

Hinsdale Orthopaedics; Right Hip - 2016; $47,208.00

Hinsdale Hospital; Right Hip - 2016; $189,496.30
Adventist LaGrange Hospital; Right Hip - 2016; $10,470.75
DuPage Medical Group; Seizures 2015-16; $4,232.00

The Arbitrator finds that none of these bills are causally related to the injury in question, and no additional bills are awarded. In support of his decision, the Arbitrator relies on the following facts:

First, regarding the DuPage Medical Group bills for seizures, the Arbitrator has already found that the petitioner's seizure condition is not causally related to the accident. As such, claims for medical bills regarding this condition are denied.

Second, regarding all treatment relating to the petitioner's right hip stemming directly from the infection sustained in late 2015, the Arbitrator finds that the petitioner was at MMI prior to this infection as of February 16, 2015, and therefore, the infection was a subsequent or intervening injury following the petitioner's completion of treatment for his right hip. While the petitioner was ordered to return for follow up, there is no record indicating he did so at any time until he sustained the infection. The medical records show that the petitioner sustained a strep infection as a result of dental work he had done in November of 2015. This infection spread to the petitioner's right hip. There is no opinion in the medical records as to why this infection specifically spread to the right hip, or that the right hip would be more prone to infections as a result of the replacement surgery. There is no opinion in the records supporting the claim that but for the petitioner's hip replacement, he would not have had the infection spread and necessitate two additional surgeries. There is no opinion in the records indicating that the strep infection of the right hip was causally related to, or a sequelae of the May 11, 2010 injury. There is simply no opinion in the records providing support that the infection was causally related to the injury.

The petitioner does have a very significant right hip condition and has undergone surgeries as a result of the accident. Even after the petitioner was terminated, the respondent paid for the petitioner's right hip replacement revision surgery, which was necessitated by the original injury. There may be sequelae of this injury in the future that might or could be causally related to the original injury, and as a result of respondent's stipulation as to causation, the petitioner will have open medical for life for that body. This does not mean, however, that every condition that might or could

occur having to do with the petitioner's right hip will be causally related. It is the petitioner's burden to prove every element of his claim by a preponderance of the evidence. In this case, though it is undisputed that the petitioner sustained a strep infection and that infection spread to the hip, there is no evidence that the condition is causally related to the original injury.

Therefore, due to a lack of evidence causally relating the petitioner's 2016 treatment for his right hip to the original accident, the Arbitrator hereby denies the petitioner's request for payment of medical bills relating to same.

TEMPORARY TOTAL DISABILITY

The petitioner claims two periods of TTD benefits. The first is May 31, 2012 through August 10, 2012. The second is May 25, 2013 through December 19, 2016. The Arbitrator finds that the petitioner is entitled to TTD benefits from May 31, 2012 through August 10, 2012. The Arbitrator denies TTD benefits from May 25, 2013 through December 19, 2016. In support of his conclusions, the Arbitrator relies on the following facts:

Regarding the time period from May 31, 2012 through August 10, 2012, this is when the petitioner was completely off work for his left knee replacement. The petitioner returned to sedentary duty on August 11, 2012. The respondent has accepted liability for the left knee and right hip and therefore, the TTD associated with treatment in the form of surgery to those body parts is awarded.

Regarding the time period from May 25, 2013 through December 19, 2016, the claim for TTD benefits is denied. The petitioner was terminated from his employment with the City of Chicago on May 24, 2013. However, the petitioner had reached MMI on November 19, 2012 and no treatment was undertaken for over a year until the petitioner was referred for a hip replacement revision in 2014. As of November 19, 2012, the petitioner's restrictions were permanent, and those permanent restrictions were being accommodated by the City of Chicago.

Mr. Loeff testified that the petitioner's restrictions were accommodated on a permanent basis, and he would still be working there under those restrictions today but for his termination. That testimony is credible and unrebutted.The petitioner was at MMI having completed treatment over 8

months before his termination, and the petitioner's permanent restrictions were permanently accommodated. As such, no TTD would be warranted for this time period, because the petitioner was not temporarily or totally disabled. The only reason the petitioner was not working or receiving benefits was because he was terminated for cause.

Based upon the foregoing, the Arbitrator finds that the petitioner is entitled to TTD benefits in the amount for 10 2/7^{ths} weeks from May 31, 2012 through August 10, 2012.

NATURE AND EXTENT

The Arbitrator finds that the petitioner is entitled to permanent partial disability benefits in the amount of 317.5 weeks because the petitioner sustained 50% loss of use of the left leg, 7% loss of use of a man as a whole (shoulder injury) and 35% loss of use of a man as a whole for a job change pursuant to Section 8(d)(2) of the Illinois Workers' Compensation Act. In support of so finding, the Arbitrator relies on the following facts:

It is undisputed that the petitioner sustained a significant injury to his left knee as a result of the injury. The petitioner underwent an arthroscopic surgery on that knee, and eventually had a left total knee replacement. Therefore, the Arbitrator awards the 50% loss of use to the right leg.

It also is undisputed that the petitioner sustained an injury to his right shoulder as a result of the accident. The petitioner underwent a conservative course of treatment, and there was a surgical recommendation. The petitioner refused surgery and continues to do so. As such, the petitioner is entitled to 7% loss of use of a person as a whole for the right shoulder injury.

Regarding the petitioner's right hip condition, there is no evidence that the petitioner is medically permanently and totally disabled. There is no evidence that the petitioner is permanently and totally disabled based on the odd-lot theory. The petitioner's own vocational counselor, James Boyd, indicates that the petitioner can return to work in a similar capacity in which he was working for the City of Chicago when they were accommodating his permanent restrictions. The respondent's vocational expert agreed, and did not think the petitioner was a vocational rehabilitation candidate.

The petitioner would still be working for the City of Chicago but for his termination, as indicated by Mr. Loeff.

There also is no evidence that the petitioner would be entitled to wage differential benefits. Both the petitioner's and respondent's vocational experts indicate that he could still be working in either that position, or a similar one for a different municipality, resulting in no wage loss.

The respondent's expert, Dr. Levin, indicated that the petitioner could possibly be performing all of his duties as a plumbing inspector. The petitioner testified that his job duties included walking around and inspecting things. He would be required to climb stairs and walk on uneven surfaces. Taking all of the evidence into consideration, however, it is clear that the petitioner does have significant restrictions as relates to his left knee and right hip and his treating physicians do not believe he should be performing field work. As such, the Arbitrator finds that the petitioner sustained a change in occupation pursuant to Section 8(d)(2) of the Act. The petitioner could still be working as a plumbing inspector, however is restricted from field work, thus reducing his work capabilities. As such, the Arbitrator awards an additional 35% loss of use of a person as a whole pursuant to Section 8(d)(2) for the petitioner's right hip condition.

PENALTIES AND FEES

The petitioner filed a petition for penalties and attorney's fees pursuant to Sections 19(k), 19(l) and 16. Based on the Arbitrator's decision regarding TTD and medical, no penalties are awarded.

TEMPORARY TOTAL DISABILITY CREDIT

The respondent claims that it paid $14,044.72 in TTD in this case. This amount is not disputed. As such, the respondent is entitled to a credit against TTD paid in the amount of $14,044.72.

PERMANENCY ADVANCES CREDIT

The final issue is whether or not the respondent is allowed a credit against permanency for advancements it has made in the past to the petitioner. The respondent issued a permanency

advancement in October of 2013 in the amount of $7,145.74, the equivalent of 5% loss of use of a leg. The respondent also issued a permanency advancement of $5,000.00 in February of 2014. Total monies already advanced to the petitioner equal $12,145.75. This amount is stipulated, and the Arbitrator finds that the respondent is entitled to a credit against permanency totaling $12,145.75.

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)
☒ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DeLawrence D. Dillard,

Petitioner,

vs. NO: 13 WC 13334

DS Waters of America Inc.,

Respondent.

18IWCC0049

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 issues of accident, causal relationship, temporary total disability, medical expenses, and nature and extent of permanent disability and being advised of the facts and law, modifies the Corrected Decision of the Arbitrator as stated below and otherwise affirms and adopts the Corrected Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission strikes the chain of events analysis in the Corrected Decision of the Arbitrator, pages 26 through 28. 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 in certain circumstances. *International Harvester v. The Industrial Commission*, 93 Ill. 2d 59, 442 N.E.2d 908 (1982). The Commission finds those circumstances are not present in this case as "[c]ases involving aggravation of a preexisting condition concern primarily medical questions and not legal ones." *Long v. The Industrial Commission*, 76 Ill. 2d 561, 565, 394 N.E.2d 1192 (1979). The Commission affirms the Arbitrator's finding that a causal relationship exists between the accidental injuries Petitioner sustained on January 28, 2013 and his cervical condition of ill-being based on Petitioner's testimony and the medical opinions of Dr. Cybulski and Dr. Coe, which the Commission finds persuasive.

The Commission modifies the Arbitrator's award of the contested medical bills relative to Issue "J" as follows:

1) Industrial Pharmacy Management in the amount of $833.40;
2) Dr. Giressan in the amount of $400.00;
3) Pronger Smith Medical Center in the amount of $549.00;
4) ATI in the amount of $1281.75;
5) Clearing Clinic in the amount of $635.09;
6) Northwestern Memorial Hospital in the amount of $47,417.86;
7) Northwestern Medicine (Medical Group) in the amount of $32,364.72; and
8) Accelerated/Athletico in the amount of $1281.75.

The medical bills are awarded pursuant to §8(a) and §8.2 of the Act, which allows for the rate as paid by Petitioner's group health insurance carrier, BC/BS, to represent the negotiated rate. To the extent any balances remain regarding the awarded bills which stem from Petitioner's deductible, co-payments and/or co-insurance, the Respondent shall reimburse Petitioner accordingly pursuant to §8(a) of the Act. The Commission strikes from the Arbitrator's Corrected Decision relating to issue "J" pages 29, 30 and 31 and the medical expenses as ordered on the Decision page.

The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Corrected Decision of the Arbitrator filed September 12, 2016 is 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 $580.10 per week for a period of 65 weeks, that being the period of temporary total incapacity for work pursuant to §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the sum of $84,763.57 for the reasonable, necessary and related medical expenses pursuant to §8(a) of the Act, subject to the Medical Fee Schedule pursuant to §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $522.09 per week for a period of 200 weeks, pursuant to §8(d)2 of the Act, for the reason that the injuries sustained caused the permanent disability of the person as a whole to the extent of 40%.

18IWCC0049

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 $8,950.29 in temporary total disability benefits.

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

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

DATED: JAN 25 2018
LEC/maw
o12/13/17
43

L. Elizabeth Coppoletti

Joshua D. Luskin

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

DILLARD, DeLAWRENCE D
Employee/Petitioner

Case# **13WC013334**

DS WATERS OF AMERICA INC
Employer/Respondent

18IWCC0049

On 9/12/2016, 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 0.47% 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:

1987 RUBIN LAW GROUP LTD
ARNOLD G RUBIN
20 S CLARK ST SUITE 1810
CHICAGO, IL 60603

1296 CHILTON YAMBERT PORTER LLP
DANIEL T CROWE
303 W MADISON ST SUITE 2300
CHICAGO, IL 60606

18IWCC0049

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION

DeLawrence D. Dillard
Employee/Petitioner

v.

DS Waters of America, Inc.
Employer/Respondent

Case # **13 WC 13334**

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 **Chicago**, 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. [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 present 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 1/28/2013, 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 **$45,247.81** ; the average weekly wage was **$870.15**.

On the date of accident, Petitioner was **47** years of age, ***married*** with **1** dependent children.

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

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

Respondent shall be given a credit of **$8,950.29** for TTD, **$-0-** for TPD, **$-0-** for maintenance, and **$-0-** for other benefits, for a total credit of **$8,950.29**.

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

ORDER

- The Respondent shall pay the Petitioner temporary total disability benefits of **$580.10**/week for **65 weeks**, from **1/29/2013** through **4/28/2014**, which is he period for which compensation is payable.

- Respondent shall pay for the medical bills reflecting total charges of **$132,081.52**. The medical bills awarded include medical bills from Industrial Pharmacy Management ($833.40), Dr. Gireesan ($400.00), Pronger Smith Medical Center ($304.00), ATI ($3,336.10), Clearing Clinic ($635.09), Northwestern Memorial Hospital ($84,682.93), Northwestern Medicine (Medical Group) ($6,132.00), Northwestern Medicine/Medical Group ($31,197.00) and Accelerated/Athletico ($4,561.00). These medical bills are awarded subject to payment pursuant to Section 8(a) and Section 8.2 of the Act. The payment shall be sent directly to Petitioner's attorney in accordance with Section 7080.20 of the Rules Governing Practice Before the Illinois Workers' Compensation Commission. Respondent shall receive credit for payments it has made in connection with the causally connected medical bills. Respondent shall not receive credit for payments made by Petitioner's wife's group insurance carrier since those payments do not represent a negotiated rate. Rather, all the medical bills are awarded pursuant to Sections 8(a) and 8.2 of the Act.

- Respondent shall pay Petitioner the sum of **$522.09**/week for a further period of **200** weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained to the cervical spine caused a **40%** loss of use of the person as a whole.

- Respondent shall pay Petitioner compensation that has accrued from **4/29/2014** through **4/21/2016** and shall pay the remainder of the award, if any, in weekly payments.

- The Arbitrator adopts the Rider to the Arbitration Decision attached hereafter.

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.

Brent Thom
Signature of Arbitrator

9-12-2016
Date

Arbitrator Decision Paragraphs

SEP 12 2016

DeLawrence D. Dillard v. DS Water of America, Inc.
Case Number: 13 WC 13334
Date of Accident: 1/28/2013

18IWCC0049

RIDER TO THE CORRECTED ARBITRATION DECISION

I. INTRODUCTION

Evidence in the above-captioned claim was presented to Arbitrator Cronin on April 21, 2016. On that date, the Arbitrator heard the testimony of Petitioner and several witnesses. The Arbitrator also received into evidence various exhibits, which included: 1) a photograph of a 5-gallon water bottle; 2) various medical records; 3) diagnostic study reports; 4) operative reports; 5) reports of Dr. Cybulski, Dr. Coe and Dr. Mather; 6) transcript of the evidence depositions of Dr. Cybulski, Dr. Coe and Dr. Mather; 6) various medical bills; 7) Petitioner's written statement; 8) job description; and 9) SC News period print out.

Following the conclusion of the hearing, Petitioner filed a Motion to Re-Open Proofs. Petitioner sought to submit the AMA Impairment Report of Dr. Coe into evidence. The Arbitrator rejected Petitioner's argument and declined to re-open proofs in order to allow the AMA Impairment Rating into evidence. The Impairment Report is a rejected exhibit.

The Arbitrator is considering the disputed issues of accident, medical causation, payment of medical bills, payment of temporary total disability benefits and nature and extent of the injury. Petitioner has elected to receive his permanent partial disability benefits pursuant to Section 8(d)2 of the Act.

Before making conclusions of law in connection with this case, the Arbitrator makes the following findings of fact:

II. FINDINGS OF FACT

Petitioner testified before the Arbitrator on April 21, 2016. The Arbitrator finds that Petitioner's testimony was credible. The Arbitrator also finds that Petitioner's testimony was consistent with the histories, treatment and objective findings documented in the medical records, which were offered into evidence at the time of the hearing. Specifically, the histories regarding the accident were consistent

throughout Petitioner's medical treatment. Additionally, Petitioner's testimony was not rebutted by the testimony of Respondent's witnesses. In fact, Petitioner's testimony was corroborated by Respondent's witnesses.

A. Background

Petitioner testified that on January 28, 2013, he was employed by Respondent as a sales consultant. Petitioner had been employed as a sales consultant for Respondent for approximately nine (9) years. Petitioner is left-handed.

Petitioner testified regarding his job duties for Respondent as a sales consultant. Petitioner solicited new accounts. Petitioner provided customers with promotional details, signed up customers, conducted credit checks and provided customers with equipment. Petitioner provided customers with hot and cold machines, cases of water, and five (5) gallon bottles of water. He also serviced customers. Petitioner delivered water and machines to customers. The machines weighed approximately fifteen (15) to twenty (20) pounds each. Water came in a 24 pack. Each container in the 24-pack contained 16.9 fluid ounces of water. Petitioner also delivered "baby water." Baby water came in a three-pound container. He delivered five (5) gallon jugs of water. The five (5) gallon jug of water was illustrated in the photograph submitted into evidence as Petitioner's Exhibit 1. The five (5) gallon jug of water weights approximately 43 pounds. (RX 4)

Petitioner lifted and carried objects when he was loading his truck. Petitioner testified that the type of water cases or supplies that he loaded into the truck depended on the order that he was filling. Petitioner would locate and carry the objects, such as 24 pack of water or a five (5) gallon jug of water, to the truck. When loading the truck, the five (5) gallon jugs are stored in "cubby holes" in the side of the truck.

Respondent submitted a job description into evidence. (RX 4) The job description was consistent with the job duties described by Petitioner. Further, Respondent's witnesses corroborated Petitioner's testimony regarding his job duties.

B. Prior Medical Treatment

Petitioner testified that prior to January 28, 2013 he received medical treatment for his cervical spine. Petitioner testified that in December of 2006 he picked up a five (5) gallon bottle of water and injured his neck. He sought medical treatment at Pronger Smith Medical Center for his cervical spine. (RX 2) Petitioner also received physical therapy from PTSIR. Petitioner was referred to Dr. Goldberg for medical treatment. (RX 3) Petitioner underwent a cervical MRI on January 12, 2007. (PX 3) Petitioner underwent cervical surgery on May 3, 2007. (PX 4) He underwent a cervical fusion from C5-C7. (PX 4) Petitioner underwent an FCE on September 6, 2007. (PX 5) The FCE set forth that Petitioner could perform work at a heavy physical demand level. (PX 5) Accordingly, Dr. Goldberg released Petitioner to return to work with no restrictions on September 24, 2007. (PX 6) Petitioner returned to work for Respondent without restrictions. Petitioner did not receive any additional medical treatment for his cervical spine from Dr. Goldberg.

Petitioner sought medical treatment for his cervical spine in 2012, more than four (4) years since his last office visit with Dr. Goldberg. On January 13, 2012, Petitioner was examined at Pronger Smith Medical Center for neck pain. (RX 2) On November 6, 2012 and November 14, 2012, Petitioner complained of right-sided pain radiating to the right arm at Pronger Smith. (RX 2) On November 14, 2012, the physician at Pronger Smith Medical Center set forth that Petitioner could return to work with the restriction of no lifting more than fifteen (15) pounds for two (2) weeks. (RX 2); (RX 5) Petitioner continued to work for Respondent. He was provided a helper for two (2) weeks at work. After two (2) weeks, Petitioner testified that he resumed his normal unrestricted work activities.

On December 31, 2012, Petitioner was examined at Pronger Smith Medical Center. (RX 2) On this date, he was seen by Dr. Shing Yen. The Pronger Smith Clinic record from December 31, 2012 states: "pain in right side of neck since weight lifting on 12/22. Patient complains of pain to neck which radiates down right arm. Patient states he has been lifting weights. Patient has seen Dr. Markus for similar pain." Dr. Yen's record from 12/31/12 states that Petitioner reported his pain level at 7-8. Dr. Yen entered a

diagnosis of cervical radiculopathy. At trial, the petitioner denied that he had been lifting weights; Petitioner testified that he attempted to lift weights, but could not.

Petitioner followed up with the physician at Pronger Smith Medical Center on January 7, 2013. (RX 2) Petitioner complained of neck pain radiating into his right shoulder. (RX 2)

From January 12, 2012 to January 27, 2013, Petitioner did not lose any time from work relating to his cervical spine condition. Further, other than the office visits at Pronger Smith Medical Center and medication, Petitioner did not receive any medical treatment for his cervical spine condition. From January 13, 2012 to January 27, 2013, no physician recommended an MRI study of the cervical spine or recommended that Petitioner undergo surgery for the cervical spine.

Petitioner testified that Dr. Markus provided him a work status note on November 14, 2012. The note stated that he could not lift more than fifteen (15) pounds for two weeks. Petitioner provided that note to Scott Hurley on November 15, 2012. Respondent accommodated Petitioner's work restrictions. Petitioner testified that his restrictions were accommodated for two (2) weeks. Petitioner does not recall ever bringing Mr. Hurley a note releasing him from the work restrictions. During the two (2) weeks of restrictions, the sales consultant did all the loading. Following the two (2) week period, Petitioner started loading the van without assistance. After he completed the light duty work for two (2) weeks, Petitioner resumed his normal job duties. Petitioner testified that various individuals rode with him following the light duty period. There could be two (2) or three (3) sales consultants riding together. The sales consultants did not help him lift or load the truck.

C. Work-Related Accident of January 28, 2013

Petitioner testified that on January 28, 2013, he arrived at work for Respondent at approximately 8:45 in the morning. He was preparing to give a presentation at a school on 111th and Laflin. Petitioner was preparing for the presentation by himself at a warehouse located at 6055 South Harlem. Petitioner loaded hot and cold machines, cases of water and five (5) gallon bottles of water into his truck. Petitioner started loading the materials into the truck at approximately 9:15 in the morning. He spent approximately twenty (20) minutes loading the materials into his truck. Petitioner loaded approximately twelve (12) to fourteen

(14) hot and cold machines into the back of the truck. He then loaded twenty (20) cases of water into the truck. Finally, Petitioner started to load the five (5) gallon jugs of water into the truck. The five (5) gallon jugs weighed 43 pounds. Petitioner had loaded approximately seven (7) or eight (8) jugs onto the truck. As Petitioner lifted the last jug, Petitioner placed his right hand on the neck of the jug and his left hand on the bottom of the jug. Petitioner then grabbed the jug and with his left hand and flipped it onto his right shoulder. After Petitioner placed the jug on his right shoulder, he felt pain shoot down his right arm. The pain in his right arm caused him to drop the 43-pound jug of water. Petitioner experienced pain in the right side of his neck, down the right shoulder and into his right hand. Petitioner testified that the pain he experienced following the accident of January 28, 2013 was worse than he experienced prior to January 28, 2013.

Petitioner stopped working following the accident. He contacted his supervisor, Scott Hurley, and reported the accident. Mr. Hurley advised Petitioner to seek medical treatment at the Clearing Clinic, Respondent's company clinic.

The Statement that Petitioner provided to Respondent dated January 28, 2013 was admitted into evidence. (RX 6) The Statement provided that Petitioner was in the warehouse loading five (5) gallon bottles of water when pain started shooting down his right arm from the neck. (RX 6) Petitioner completed the statement prior to going to the Clearing Clinic for medical treatment.

D. Medical Treatment

Following the work-related accident of January 28, 2013, Petitioner sought medical treatment. Petitioner was initially examined at the Clearing Clinic on January 28, 2013. (PX 7); (RX 7) The physician documented a history that Petitioner was loading water onto a truck and experienced pain, which shot down his right arm. (PX 7) The physician recommended medication and work restrictions of no lifting over 10 pounds and no driving a company vehicle. (PX 7)

On January 28, 2013, Petitioner was also examined at Pronger Smith Medical Center. (PX 9) It was recommended that Petitioner remain off work and undergo an MRI of the cervical spine. (PX 9)

Petitioner was again examined at the Clearing Clinic on February 1, 2013. The physician set forth that Petitioner's cervical radiculopathy and cervical sprain was causally related to the work related activities. (PX 7) Petitioner was released to return to work with restrictions of no lifting over ten (10) pounds and no driving the company vehicle. (PX 7) Petitioner was prescribed medication and an MRI study. (PX 7)

Petitioner underwent the recommended MRI study on February 6, 2013 at Chicago Ridge Radiology. (PX 17) The MRI study revealed that Petitioner was status post-surgical fusion of C5-C7, moderate spinal canal stenosis at C4-C5 with severe right and moderate to severe foraminal stenosis due to disc osteophyte complex, C3-C4 mild spinal stenosis in the central region and mild to moderate left foraminal stenosis due to disc osteophyte complex and C7-T1 mild spinal canal stenosis in the right paracenteral region and severe bilateral foraminal stenosis due to disc osteophyte complex. (PX 17)

On February 11, 2013, the physician at the Clearing Clinic referred Petitioner to Dr. Zelby for a consultation. (PX 7) The physician set forth a diagnosis of multilevel foraminal stenosis due to disc osteophyte complex, status post C5-C7 fusion. (PX 7)

Petitioner was examined by Dr. Andrew Zelby on February 22, 2013. (PX 8); (RX 9) Dr. Zelby documented a history that Petitioner was injured at work on January 28, 2013 while loading a five (5) gallon jug of water into his truck and felt pain in his neck and right arm. Dr. Zelby diagnosed Petitioner with a herniated disc at C4-C5. Dr. Zelby recommended that Petition undergo physical therapy for four (4) weeks, use Naproxen, Carisopodol and Tamadol and return to work with a lifting restriction of twenty (20) pounds occasionally, ten (10) pounds frequently and limited over the shoulder work. Dr. Zelby stated that Petitioner may require an anterior cervical decompression and fusion at C4-C5 if his symptoms did not resolve. Petitioner underwent the recommended physical therapy at Accelerated. (PX 20) On March 25, 2013, Dr. Zelby confirmed that Petitioner wanted to proceed with the recommended surgery. (PX 8)

On April 11, 2013, Petitioner was examined at Pronger Smith Medical Center. (PX 9) It was recommended that Petitioner undergo the surgery recommended by Dr. Zelby. (PX 9)

Petitioner was examined by a physician of his own choice, Dr. Geri Gireesan, on May 6, 2013. (PX 10); (RX 10) Dr. Gireesan documented a history that Petitioner was lifting bottles of water at work on January 28, 2013 when he experienced pain in the neck with radiation to the right shoulder. (PX 10) Dr. Gireesan recommended that Petitioner undergo a two (2) level anterior cervical discectomy and interbody fusion. (PX 10) He referred Petitioner to Dr. Cybulski, a neurosurgeon, and set forth that Petitioner should remain off work. (PX 10)

Petitioner was examined by Dr. Cybulski on May 6, 2013. (PX 11) Dr. Cybulski documented that Petitioner was lifting a large water bottle and sustained an injury to his neck. (PX 11) He set forth a diagnosis of C4-5 herniated disc radiculopathy secondary to a work-related injury. (PX 11) Dr. Cybulski recommended an anterior cervical discectomy and fusion. (PX 11).

Petitioner underwent the recommended surgery on May 10, 2013 at Northwestern Memorial Hospital. (PX 12). The post-operative diagnosis was C4-C5 herniated disc with radiculopathy. (PX 12). Dr. Cybulski performed a revision of the anterior cervical discectomy, removal of the top portion of the plate and a C4-C5 discectomy and fusion with peek cage and anterior plating. (PX 12).

On May 13, 2013, Petitioner was admitted to the emergency room at Northwestern Memorial Hospital. (PX 13). Petitioner had post-operative vomiting and aspiration. (PX 13). Petitioner had difficulty swallowing. (PX 13).

Petitioner remained under the post-operative care of Dr. Cybulski. (PX 11). Post-operative care included follow-up office visits, physical therapy, medication, and activity modification. (PX 11). Petitioner participated in physical therapy at ATI Physical Therapy. (PX 21).

On January 6, 2014, Dr. Cybulski recommended that Petitioner be evaluated for peripheral neuropathy. (PX 11). He set forth that Petitioner could return to work with the restrictions of no lifting more than fifteen (15) pounds. (PX 11).

On January 10, 2014, Petitioner was examined by Dr. Senda Ajroud-Driss. (PX 16). Dr. Driss set forth that Petitioner had mild sensory loss. (PX 16). Dr. Driss recommended an EMG, labs, diet change,

proper foot care and Gabapentin and Elavil. (PX 16). On May 9, 2014, Dr. Driss set forth a diagnosis of small fiber neuropathy. (PX 16). Petitioner underwent the EMG on May 12, 2014. (PX 16).

Petitioner was last examined by Dr. Cybulski on August 4, 2014. (PX 11). Dr. Cybulski set forth that Petitioner had reached MMI and set forth that Petitioner could return to work with a 25 pound lifting restrictions. (PX 11).

E. Medical Opinions of Dr. Cybulski

The narrative report of Dr. George Raymond Cybulski prepared on January 13, 2014 was admitted into evidence. (PX 14). Dr. Cybulski is a board-certified neurosurgeon. Dr. Cybulski reviewed multiple medical records, including the report of Dr. Mather, Respondent's Section 12 physician. (PX 14). On physical examination, Dr. Cybulski documented that Petitioner had a Spurling's maneuver consistent with a cervical nerve root compression and set forth a diagnosis of C4-C5 herniated disc secondary to a work-related injury. (PX 14). Dr. Cybulski opined that carrying heavy water bottles on Petitioner's neck would increases the stress that occurs at the C4-C5 disc space and would produce the C4-C5 disc herniation. (PX 14). Dr. Cybulski noted that on January 28, 2013, Petitioner's symptoms increased and were intense and unremitting enough to be consistent with a herniated disc. (PX 14). He set forth that the symptoms three (3) weeks prior were not related to the accident and were not consistent with a herniated disc. (PX 14). If Petitioner had sustained a herniated disc prior to January 28, 2013, Dr. Cybulski stated that Petitioner would not have been able to work on January 28, 2013. (PX 14). As of January 13, 2014, Dr. Cybulski stated that Petitioner could return to work with a lifting restriction of fifteen (15) pounds. (PX 14). He recommended an FCE. (PX 14).

The evidence deposition of Dr. Cybulski was taken on February 13, 2014. (PX 15). Dr. Cybulski testified that he is a board certified neurological surgeon. (PX 15 at 5). Dr. Cybulski is an associate professor at Northwestern University School of Medicine. (PX 15 at 7). He is also an attending neurosurgeon at Northwestern Medicine. (PX 15 at 9).

Dr. Cybulski testified that he provided medical care and treatment to Petitioner from May 16, 2013 to the date of the deposition. (PX 15 at 12). Dr. Cybulski was provided a history that in the course of

delivering bottled water, Petitioner incurred cervical radiculopathy. (PX 15 at 16). Dr. Cybulski was provided a history of prior medical treatment in January 2013. (PX 15 at 17). The prior medical treatment included right-sided cervical radicular symptoms. (PX 15 at 17). Dr. Cybulski also testified that since the accident of January 2013, Petitioner's cervical radiculopathy was persistent. (PX 15 at 18). Persistent symptoms meant that the cervical nerve root was inflamed and the source of Petitioner's pain. (PX 15 at 18).

Dr. Cybulski set forth a diagnosis of C4-C5 disc herniation causing cervical radiculopathy. (PX 15 at 20-21). Petitioner also had spondylosis and a bulging disc at C3-C4. (PX 15 at 21). Based on the cervical radiculopathy, persistent symptoms and herniated disc at C4-C5, Dr. Cybulski recommended that Petitioner undergo an anterior C4-C5 discectomy and fusion. (PX 15 at 21-22). Petitioner underwent the surgery on May 10, 2013. (PX 15 at 22). Dr. Cybulski testified that the entire C4-C5 disc was removed and replaced with a spacer. (PX 15 at 24). Petitioner continued under the post-operative care of Dr. Cybulski. (PX 15 at 25).

Dr. Cybulski last examined Petitioner on January 6, 2014. (PX 15 at 26). Dr. Cybulski set forth that Petitioner's diagnosis was cervical radiculopathy status post anterior cervical discectomy and C4-C5 fusion, chronic cervical radiculopathy related to the prior anterior cervical discectomy and fusion at C5-C7. (PX 15 at 28). Dr. Cybulski testified that he could not distinguish between the radiculopathy at C4-C5 and C5-C7. (PX 15 at 29). Dr. Cybulski testified that the current condition of ill-being at the C4-C5 level was a causative factor in the cervical radiculopathy. (PX 15 at 30). Dr. Cybulski based his opinion on the fact that there was a herniated disc at C4-C5, which is a competent cause of cervical radiculopathy. (PX 15 at 30).

Dr. Cybulski testified that Petitioner was temporarily totally disabled from performing his job duties on January 28, 2013. (PX 15 at 39). Petitioner would have been able to work at a sedentary level lifting less than fifteen (15) pounds in early fall of 2013. (PX 15 at 39). As of August 12, 2013, Petitioner would probably be able to return to sedentary work in approximately six (6) weeks. (PX 15 at 39).

Dr. Cybulski testified that Petitioner would reach maximum medical improvement approximately one (1) year from the date of surgery. (PX 15 at 32-33). Dr. Cybulski set forth that Petitioner would require permanent restrictions. (PX 15 at 31). The basis for his opinion was that Petitioner had diminished, but lingering, symptoms of cervical radiculopathy. (PX 15 at 31). As of the date of the deposition, Petitioner had not reached maximum medical improvement for the cervical condition. (PX 15 at 34). He set forth that Petitioner had restrictions of no lifting greater than fifteen (15) pounds. (PX 15 at 35).

Dr. Cybulski opined that the work-related accident of January 28, 2013 caused a C4-C5 herniated disc, which produced cervical radiculopathy and required surgery to remove the herniated disc and fuse the spine. (PX 15 at 36). The basis of his opinion was Petitioner's symptoms, physical examination, MRI study, knowledge of having water delivered and the previous medical records. (PX 15 at 36-37). Dr. Cybulski described how the accident could cause the herniated disc at C4-C5. (PX 15 at 37). He stated that when the bottle is cradled on the shoulder between the arm and the neck, the neck is forced to one side and that imparts trauma to the disc space. (PX 15 at 37).

Dr. Cybulski testified that the prior medical records form Dr. Goldberg supported his opinion. (PX 15 at 38). Dr Cybulski noted that the previous C5-C7 fusion would require the space above the fusion to absorb new forces and increase the stress placed on the C4-C5 disc space. (PX 15 at 38).

Dr. Cybulski testified that the prior medical records from Pronger Smith Medical Center did not have any effect on his opinions regarding medical causation. (PX 15 at 71). Dr. Cybulski testified that the medical records from Pronger Smith did not document that Petitioner had a herniated disc prior to the work-related accident of January 28, 2013. (PX 15 at 71). Further, there were no recommendations for an MRI study prior to January 28, 2013. (PX 15 at 71). Dr. Cybulski testified that the previous surgery at C5-C7 would cause cervical radiculopathy and the medical records from Pronger Smith do not point to a specific C4-C5 disc herniation. (PX 15 at 71). Rather, the records point to general symptoms of cervical radiculopathy. (PX 15 at 71-72). Accordingly, Dr. Cybulski noted that the disc herniation at C4-C5 was a new finding based on the history of accident. (PX 15 at 72). Dr. Cybulski noted that while Petitioner was working for Respondent and treating at Pronger Smith in 2012, he did not have evidence of a

herniated disc. (PX 15 at 74). If Petitioner had a herniated disc, then he would not have been able to work. (PX 15 at 74). Dr. Cybulski clarified that it was possible to have cervical radiculopathy without a herniated disc. (PX 15 at 75).

Dr. Cybulski testified that the medical treatment that he provided to Petitioner was reasonable and necessary. (PX 15 at 41). Dr. Cybulski testified that he had no reason to doubt Petitioner's credibility. (PX 15 at 44). Dr. Cybulski noted that the symptoms that Petitioner experienced in his legs are not related to the cervical spine condition. (PX 15 at 50).

F. Medical Opinions of Dr. Coe

Petitioner was examined by Dr. Jeffery Coe on December 22, 2014. (PX 18). Dr. Coe performed a physical examination of Petitioner and reviewed medical records. (PX 18 at 10). Dr. Coe also reviewed the evidence deposition of Dr. Mather, Respondent's Section 12 physician, and Dr. Cybulski. (PX 19 at 26). Petitioner provided Dr. Coe with a history that on January 28, 2013 he was loading a jug of water into his truck when he felt a sharp shooting pain radiating from his neck to his right arm. (PX 18).

Dr. Coe stated that Petitioner experienced onset of right-sided neck and arm pain, numbness and tingling, while moving a jug of water at work on January 28, 2013. (PX 18). Dr. Coe opined that Petitioner's work-related accident of January 28, 2013 caused the current neck and arm symptoms. (PX 18). The injury caused permanent partial disability to the person as a whole due to cervical pain, stiffness and residual right upper extremity radiculopathy. (PX 18). He set forth permanent restrictions including no lifting more than 25 pounds below shoulder height. (PX 18).

The evidence deposition of Dr. Coe was taken on June 15, 2015. (PX 19). Dr. Coe is board-certified in occupational medicine. (PX 19 at 6). Dr. Coe physically examined Petitioner and reviewed medical records. (PX 19 at 14). The medical records that Dr. Coe reviewed included medical records from prior to January 28, 2013. (PX 19 at 15).

Dr. Coe noted that Petitioner had trigger points on physical examination. (PX 19 at 22). Dr. Coe noted that a trigger point is a subjective complaint of pain, but objective in the localization of the pain. (PX 19 at 23). Dr. Coe noted the objective range of motion measurements of the neck which included

flexion of 35 degrees, normal being 45, extension of 25, normal being 35, left lateral rotation of 45 degrees and right of 50, normal being 65, lateral bending of 25 on the left and 25 on the right, normal being 35. (PX 19 at 23-25). Petitioner experienced pain with extreme range of motion. (PX 18). Petitioner experienced some dysesthesia at the tips of his right second and fifth fingers with sensory testing. (PX 18). Dr. Coe testified that the stiffness in Petitioner's cervical spine was moderately severe and in all directions tested. (PX 19 at 25). The objective measurements were consistent with a history of cervical surgery and the treating physician's records. (PX 19 at 25). Dr. Coe testified that range of motion is both subjective and objective measurements. (PX 19 at 25).

Dr. Coe set forth a diagnosis of post two cervical surgeries, the most recent following a herniated disc at C4-C5, with post-surgical residual cervical stiffness and myofascial discomfort and radiculopathy. (PX 19 at 27). Dr. Coe testified that the current condition of ill-being of the cervical spine was causally related to the work-related accident of January 28, 2013. (PX 19 at 29). Specifically, the work-related accident aggravated degenerative changes in the cervical spine and caused a new herniation of the C4-C5 disc that required surgery. (PX 19 at 29). Dr. Coe's opinions were based on the history, medical records, opinions of the physicians and physical examination. (PX 19 at 29).

The medical records from prior to January 28, 2013 did not change his medical opinions. (PX 19 at 31-32). Specifically, Dr. Coe noted that Petitioner's condition changed post-accident. (PX 19 at 32). Dr. Coe stated that the prior medical records from Pronger Smith were not significant because they did not document specific acute and severe pain. (PX 19 at 46). Further, following the accident of January 28, 2013, Petitioner's condition was severe sharp pain in his neck with significant radiculopathy symptoms. (PX 19 at 46). Based on the treatment and medical records, Petitioner experienced a significant and dramatic change in his condition following the events of January 28, 2013. (PX 19 at 46).

Dr. Coe noted that Petitioner would require restrictions due to his cervical spine. (PX 19 at 32). The restrictions would include limitations in lifting of light to medium physical demand level, or 25 pounds occasionally and staying below shoulder height. (PX 19 at 32-33). Dr. Coe opined that the work restrictions were related to the work-related accident of January 28, 2013. (PX 19 at 33). His

recommendation for restrictions was not related to the peripheral neuropathy. (PX 19 at 33-34). Dr. Coe opined that Petitioner's condition was permanent. (PX 19 at 34).

G. Medical Opinions of Dr. Mather, Respondent's Section 12 Physician

The evidence deposition of Dr. Steven E. Mather was taken on February 7, 2014. (RX 1). Dr. Mather is a board-certified orthopedic surgeon who specializes in adult spinal disorders. (RX 1 at 5).

Dr. Mather examined Petitioner on April 22, 2013 at the request of Respondent. (RX 1 at 7). Dr. Mather reviewed medical records and the films from the MRI study. (RX 1 at 8). He testified that the MRI study revealed a large disc herniation at C4-C5 and a smaller bulge at C3-C4. (RX 1 at 8). Dr. Mather testified that Petitioner provided him a history that his symptoms began on January 28, 2013 while he was lifting a five (5) gallon jug of bottled water and that he was fine prior to January 28, 2013. (RX 1 at 9). Petitioner advised Dr. Mather of the prior cervical fusion. (RX 1 at 9). Dr. Mather reviewed the prior medical records from January 2013. (RX 1 at 10). Dr. Mather reviewed medical records that he had not previously seen, including the medical records from Dr. Markus. (RX 1 at 12-13).

Dr. Mather set forth a diagnosis of C4-C5 disc herniation. (RX 1 at 16). He stated that Petitioner's current condition of ill-being in his neck was not causally connected to the work-related accident of January 28, 2013 since Petitioner had symptoms consistent with cervical radiculopathy prior to the accident date. (RX 1 at 16). Dr. Mather stated that there was no other reason to have cervical radiculopathy other than the C4-C5 disc herniation. (RX 1 at 17). He set forth that Petitioner had the neck condition since August 2012. (RX 1 at 18). Dr. Mather testified that an anterior cervical discectomy and fusion would be reasonable medical treatment. (RX 1 at 18).

Dr. Mather testified that Petitioner had cervical radiculopathy prior to January 28, 2013. (RX 1 at 20). He noted that he had other patients that could work with a disc herniation. (RX 1 at 20). Dr. Mather testified that the peripheral neuropathy was not causally connected to the C4-C5 disc herniation. (RX 1 at 21). Dr. Mather clarified that the radicular complaints are related to the C4-C5 disc herniation. (RX 1 at 23). However, Dr. Mather admitted that there is more than one cause for cervical radiculopathy. (RX 1 at 26). Possible causes of radiculopathy are bone spurs, disc herniation and synovial cyst. (RX 1 at 26).

There were no MRI studies other than the MRI performed in February 2013. (RX 1 at 27). Further, prior to January 28, 2013, no doctor specifically diagnosed Petitioner with C4-C5 disc herniation. (RX 1 at 27).

Dr. Mather was not sure whether Petitioner had reached maximum medical improvement at the date of the deposition. (RX 1 at 23). He would want to know whether the fusion was solid. (RX 1 at 23). Dr. Mather also agreed that one (1) year from the date of surgery would be reasonable time frame for determining permanent restrictions. (RX 1 at 25). Dr. Mather had not reviewed the operative report as it relates to the instant case. (RX 1 at 26).

Dr. Mather admitted that on a quick report, he had initially marked that the condition was casually related to the accident and then crossed it out and stated that the condition was not related to the work-related accident. (RX 1 at 28). He does not recall if he originally believed that the cervical condition was related to the accident of January 28, 2013. (RX 1 at 29).

Dr. Mather admitted that the disc level above a fusion could increase stress on the disc space below the fusion. (RX 1 at 29). He further admitted that the incident of January 28, 2013 could provide the physical force to cause a disc herniation at C4-C5. (RX 1 at 29-30). He further acknowledged that the medical records from Clearing Clinic were consistent with Petitioner sustained a work-related accident of lifting a heavy bottle on January 28, 2013. (RX 1 at 30). He testified that Petitioner did not have any indication of malingering. (RX 1 at 31).

Dr. Mather testified that Petitioner sustained the C4-C5 disc herniation prior to January 28, 2013. (RX 1 at 38). Dr. Mather noted that at a minimum Petitioner strained his neck when he lifted a bottle of water. (RX 1 at 34). He noted that Petitioner had neck pain after lifting. (RX 1 at 34). He stated that Petitioner could have been a surgical candidate prior to January 28, 2013. (RX 1 at 38). However, the surgical recommendation would be based on pain and no one can document the veracity of pain. (RX 1 at 37-38). He admitted that no doctor had recommended surgery prior to January 28, 2013. (RX 1 at 38). He also testified that the disc herniation at C4-C5 could have been aggravated as a result of the accident of January 28, 2013. (RX 1 at 39).

H. Medical Bills

Petitioner submitted several medical bills into evidence. Petitioner requested that the medical bills be paid pursuant to Section 8(a) and the Medical Fee Schedule. Petitioner acknowledged that the Petitioner's wife's group insurance carrier made payments as it relates to the medical bills. The following medical bills were submitted into evidence as Petitioner's Exhibit 22:

- Industrial Pharmacy Management- $833.40
- Dr. Gireesan- $400.00
- Pronger Medical Care- $304.00
- ATI (paid by Group Insurance)- $3,336.10 (current balance $429.77)
- Clearing Clinic- $635.09
- Northwestern Memorial Hospital (paid by Group Insurance)- $84,682.93 (current balance
- $37, 283.12)
- Northwestern Medical Group- $6,132.00
- Northwestern Medicine (paid by Group Insurance)- $31,197.00 (current balance $7,788.26)
- Accelerated/Athletico- $4,561.00

The total charges of the medical bills are $132,081.52. (PX 22). The payment record of Blue Cross Blue Shield was admitted into evidence. (PX 22). The payment records reflect that Blue Cross Blue Shield, Petitioner's wife's group insurance carrier, paid $19,947.83 in connection with medical treatment related to the instant case.

I. Testimony of Respondent's Witness, Meg Karolczak

Respondent presented the testimony of Meg Karolczak. Ms. Karolczak has been employed by Respondent since 2000. She has been the human resource manager since 2007. Her job responsibilities include employee relations, benefits and anything related to Respondent's associates. Mr. Karolczak testified that the job description for a sales consultant included the essential functions of the job. (RX 4).

Ms. Karolczak testified that Dr. Markus' restrictions were accommodated by Respondent. She testified that the restrictions were to remain in place until Respondent received a release that Petitioner no longer required restrictions. Ms. Karolczak stated that Respondent did not receive a release and it was her understanding that Petitioner's restrictions remained in place on January 28, 2013.

Ms. Karolczak identified Respondent's Exhibit 11 as the new customers for sales consultants. She noted that Petitioner obtained new customers. (RX 11).

Ms. Karolczak testified that Petitioner was a good employee. He had good sales and his attendance was good. She testified that she has never observed Petitioner performing his job duties. She agreed that Petitioner would lift up to 43 pounds in performance of his job duties. Ms. Karolczak had no reason to disagree that Petitioner was preparing for a presentation on January 28, 2013 or that he was loading the truck with water and machines from the warehouse. Ms. Karolczak admitted that Dr. Markus' note stated that Petitioner could return to work in two (2) weeks. Further, she had no personal knowledge as to how Petitioner was performing his job from November 28, 2012 through January 28, 2013. She testified that her understanding of Petitioner's restrictions and what he was actually doing after November 29, 2013 could be different. Further, Ms. Karolczak agreed that Respondent did not have enough trucks for its sales consultants so the employees double or tripled up in the van. She did not have any personal knowledge as to whether the co-employees would assist Petitioner with lifting. She had no personal knowledge that Petitioner was not performing his full range of duties from November 29, 2012 through January 28, 2013.

J. Testimony of Respondent's Witness, Scott Hurley

Respondent presented the testimony of Scott Hurley. Mr. Hurley had been employed by Respondent since 1988. Mr. Hurley has been a sales manager for Respondent since 2009. He was Petitioner's direct supervisor. He testified that Petitioner provided him with notice of the accident on January 28, 2013 and completed an accident report for him.

Mr. Hurley testified that he was familiar with the work status note from Dr. Markus advising of a fifteen (15) pound lifting restrictions. He testified that Respondent would have continued to

accommodate Petitioner's restrictions until Respondent received a release that Petitioner could return to work without restrictions. Respondent did not receive any documentation that released him to return to full-duty work. He testified that people were assigned to ride with Petitioner to accommodate his restrictions.

Mr. Hurley testified that Petitioner complained of neck pain prior to January 28, 2013. However, he did not recall how often he complained of pain. He testified that the accident of January 28, 2013 caused increased neck pain from the prior neck injury. He testified that Petitioner was one of his best sales people. He agreed that Petitioner would be required to lift and carry water. Further, Petitioner would do the initial set up for customers. This would include delivery of 43 pound bottles of water and 24 cases of water. He did not have knowledge as to whether someone would be driving with Petitioner on January 28, 2013. He did not have reason to doubt that Petitioner would be loading his own vehicle. Mr. Hurley considers Petitioner to be an honest person. He acknowledged that Petitioner could have been lifting and carrying the water bottles between November 29, 2012 and January 28, 2013. He did not have any personal knowledge that Petitioner was not performing his full job duties for Respondent on January 28, 2013. He testified that Petitioner did not miss time from work due to his neck condition prior to January 28, 2013.

K. Petitioner's Post Accident Work Status

Petitioner testified that he returned to work on April 29, 2014 with a different company. Petitioner testified that in January of 2014, he took the work status note of Dr. Cybulski to Meg, a human resource representative for Respondent. He brought the note to 6055 South Harlem. Petitioner did not see Meg when he dropped off the note. However, Petitioner left the note at the facility. Petitioner did not ever speak to a representative of Respondent. Further, he was not offered employment by Respondent in his restrictions. Petitioner testified that he tried to call Meg, but was not able to reach her. He left her several voicemail messages.

On April 29, 2014, Petitioner returned to work at St. James Hospital in environmental services ("EVS"). Petitioner cleaned the hospital. Petitioner lifted and carried sheets and pillowcases. He

testified that the sheets and pillowcases were very light. Petitioner worked for St. James Hospital for approximately one (1) year.

Petitioner then went to work for Manor Care. He worked for Manor Care for approximately six (6) months. Following his job at Manor Care, he was hired by Aramark. Petitioner delivered uniforms and mats for Aramark. Petitioner worked for Aramark for three (3) to four (4) months. Petitioner testified that he was not able to perform his job duties for Aramark. He experienced pain in his neck. Petitioner testified that he did not sustain any new accidents or injuries involving his cervical spine or right arm while working for Aramark.

Petitioner then began working for Uber and Lyft. He picked up customers and drove them to designated locations. As a driver, Petitioner did not perform any lifting or carrying. Petitioner testified that since January 28, 2013 he has not sustained any accidents of injuries involving his cervical spine, neck or right arm.

L. Current Subjective Complaints

Petitioner testified regarding his current subjective complaints. Petitioner testified that when he turns his head, he experiences a shooting pain down his arm. He also experiences a shooting pain down his right arm when he sleeps. Petitioner testified that while driving for Uber and Lyft, he feels pain when he makes a hard turn. The pain is located in the center of his neck and into his hands. Petitioner soaks and lets hot water hit his body when he is in pain. Petitioner takes over the counter pain medication.

III. CONCLUSIONS OF LAW

In support of the Arbitrator's decision relating to issue "C," did an accident occur that arose out of and in the course of the Petitioner's employment with Respondent, the Arbitrator makes the following conclusions:

The Arbitrator concludes that Petitioner sustained an accidental injury that arose out of and in the course of his employment with Respondent on January 28, 2013. In support of the decision, the Arbitrator relies on Petitioner's testimony, which was corroborated by the medical records and the accident report. Further, the Arbitrator notes that despite Respondent presenting the testimony of Ms. Karolczak and Mr. Hurly, Petitioner's testimony is unrebutted regarding his accident. Accordingly, the Arbitrator finds Petitioner's testimony to be credible and unrebutted.

The Arbitrator finds that Petitioner has met his burden of proof and has established that he sustained accidental injuries arising out of and in the course of his employment. "For an injury to arise out of one's employment, it must have an origin and some risk connected with or incidental to the employment, so that there is a causal connection between the employment and the injury." *Lakeside Architectural Metals v. Industrial Commission,* 267 Ill.App.3d 1058, 642 N.E.2d 796 (1st Dist. 1994). Thus, to be covered, the employee must be exposed to a risk greater than that of the general public. *Caterpillar Tractor Company v. Indus. Com'n*, 129 Ill.2d 52, 541 N.E.2d 655 (1989). "If the risk of hazard is so increased by employment, it does not matter that the injury is unusual or unexpected, or that it is not particular to the employment." *Bommarito v. Industrial Commission*, 82 Ill.2d 191, 412 N.E.2d 548 (1980), citing *C.A. Dunham Co. v. Industrial Commission*, 16 Ill.2d 102, 156 N.E.2d 560 (1959).

The Arbitrator notes that the Commission has also found that accidents arise out of the employment where the accident occurs as a result of a risk associated with the employment. For example, the Commission has found there was an increased risk where the claimants were lifting or carrying objects. *Gertgen v. New Horizon*, 09 IWCC 1338, 2009 WL 5458128 (IWCC Dec. 11, 2009). The Supreme Court had held that the unrebutted testimony of Petitioner is sufficient to establish a work-related accident. *Thrall Car Manufacuring Co. v. Industrial Commission*, 64 Ill.2d 459, 356 N.E.2d 516 (1976).

In the instant case, Petitioner sustained an accidental injury that arose of out and in the course of his employment. Petitioner's unrebutted testimony established that he injured his neck while lifting a 43-pound, five (5) gallon jug of water. Petitioner testified that he grabbed the jug and with his left hand and flipped it onto his right shoulder. As Petitioner was placing the jug in the truck, he felt pain shoot down his right arm. The pain in his right arm caused him to drop the jug of water. Petitioner experienced pain in the right side of his neck, down the right shoulder and into his right hand.

Petitioner was furthering the business of Respondent by lifting and loading the five (5) gallon jug into his truck. Petitioner faced the risks, which were solely a part of his employment and greater than that of the general public, of loading a heavy object into a truck, maneuvering in the truck and repetitively lifting heavy objects. It is clear that Petitioner sustained accidental injuries that arose out of his employment since he was faced with a risk greater than that of the general public and unique to his employment with Respondent.

Petitioner's unrebutted testimony established that he sustained a work-related accident on January 28, 2013. Petitioner's testimony is unrebutted by Respondent's witnesses. All of the medical records admitted into evidence contained a history that was consistent with Petitioner sustaining a work-related accident while lifting a jug of water at work. Moreover, Petitioner reported the work-related injury on the date of accident and completed an accident report following the accident. The accident report corroborated Petitioner's testimony.

The Arbitrator notes that Respondent did not present any testimony to rebut Petitioner description of the accident. "Where a witness who has knowledge of the facts and is accessible to a party is not called by the party, a presumption arises that his testimony would be adverse to that party." *Tonarelli v. Gibbons*, 121 Ill.App.3d 1042, 460 N.E.2d 464 (3d 1984). Respondent did not present any testimony that Petitioner was not performing his job duties for Respondent or that Petitioner was not loading his truck on January 28, 2013.

Respondent's witnesses testified that they believed Petitioner to be on modified work on January 28, 2013. However, both Respondents' witnesses testified that they had no personal knowledge of how

Petitioner was performing his job duties on January 28, 2013. Further, they agreed that lifting a five (5) gallon jug would be part of Petitioner's job duties. They also testified that the work status note that they were relying on stated that Petitioner was on restricted work for two (2) weeks. The two (2) week period had lapsed many weeks prior to the work-related accident of January 28, 2013. Respondent's witnesses also corroborated Petitioner's testimony that multiple sales persons could use a truck at the same time. Respondent did not present any evidence that Petitioner was not lifting a five (5) gallon jug on January 28, 2013. Accordingly, the Arbitrator finds that Petitioner's unrebutted testimony established that he sustained an accidental injury to his neck that arose out of his employment with Respondent on January 28, 2013.

Additionally, Petitioner was clearly in the course of his employment since, when the injury occurred, he was performing his job duties for Respondent within the time period of his employment. Petitioner was also performing his job duties were he could reasonably been expected to perform his duties.

The Arbitrator finds that Petitioner was performing his job duties for Respondent. Petitioner was involved in a task that was solely for the benefit of Respondent and performing activities that exposed him to a risk greater than that of the general public. Thus, Petitioner has established that he sustained a compensable accident on January 28, 2013.

In support of the Arbitrator's decision relating to issue "F," whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator makes the following conclusions:

On November 14, 2012, Petitioner informed Dr. Robert Markus that he had been experiencing pain in his neck that radiated down his right arm for four months. Petitioner also complained of numbness in his right fingers. Petitioner rated his pain scale at 6. He had a positive Spurling's sign. On November 14, 2012, Dr. Markus placed Petitioner on work restrictions of no lifting over 15 pound, for two weeks. Respondent accommodated these restrictions and provided Petitioner with a sales consultant to help him.

On the issue of the duration of these restrictions, Petitioner could not recall whether Mr. Hurley told him on November 15, 2012 that he needed to tender a note from his physician releasing him to full duty

before he would be allowed to return to full-duty work. Both Mr. Hurley and Ms. Karolczak testified that these restrictions were to remain in place until Petitioner was released by his physician. Yet, the only document in Respondent's possession that reflected this light duty release was Dr. Markus' note in which he limited such light-duty restrictions to a duration of 2 weeks.

Petitioner returned to the Pronger Smith Medical Center on December 31, 2012. On this date, he was seen by Dr. Yen. Dr. Yen's record from that date states that Petitioner had pain in his neck since weight lifting on December 22, 2012. On that date, Petitioner rated his pain at the 7-8 level.

Petitioner denied that he told Dr. Yen he was lifting weights. Petitioner testified on cross-examination that on December 22, 2012, he attempted to lift weights but could not.

None of the physicians who saw Petitioner after January 28, 2012, other than Dr. Markus, received a true pre-1/28/13 medical history from Petitioner.

Dr. Sorokin's record of January 28, 2013, indicates Petitioner's numbness started on that date. Yet, Petitioner was experiencing right hand numbness since, at least, November 14, 2012 when Dr. Markus diagnosed him with cervical radiculopathy. Under cross-examination, Petitioner denied that he told Dr. Sorokin on January 28, 2013 that he had only been experiencing numbness since that date. However, Dr. Sorokin's records from February 1, 2013 and February 11, 2013 each indicate that the numbness in Petitioner's right hand and arm started on January 28, 2013.

Dr. Zelby's report of February 22, 2013 states that Petitioner underwent an anterior cervical fusion in 2007 and he was doing well with no complaints of pain until this flare-up. When Petitioner testified at trial, he stated that he had no discussion with Dr. Zelby of his condition prior to January 28, 2013. Yet, Dr. Zelby was aware of the 2007 fusion. Further, the restrictions set by Dr. Zelby in February of 2013 were not as stringent as those set by Dr. Markus on November 14, 2012.

Dr. Mather testified that Petitioner reported to him that his symptoms started on January 28, 2013. Petitioner testified that Dr. Mather did not discuss his pre-2013 medical history with him on the date of the examination.

Dr. Cybulski testified that Petitioner did not report his treatment at Pronger Smith Medical Center when he saw him for the first time on May 6, 2013. Petitioner testified that he did not discuss his treatment prior to January 28, 2013 with either Dr. Cybulski or Dr. Gireesan. Dr. Cybulski testified that it is significant to know a patient's true history when making a diagnosis, especially in situations where there is a legal-medical causation issue.

On January 28, 2013, Dr. Sorokin wrote in his notes that Petitioner reported a pain level of 0/10. Further, on January 28, 2013, Dr. Sorokin performed the Spurling maneuver and reported that it was negative. With respect to work, Dr. Sorokin released Petitioner to return to work, no lifting over 10 pounds.

When Petitioner saw Dr. Markus later in the day on January 28, 2013, he reported a pain level at 10. Dr. Markus' physical examination revealed a positive Spurling maneuver on the right. Petitioner did not report an accident on January 28, 2013 to Dr. Markus, only that his pain was getting worse. Dr. Markus stated a diagnosis on January 28, 2013 of cervical radiculopathy, recurrent.

Dr. Coe was not aware of the fact that Petitioner had been placed on restrictions by Dr. Marcus on November 14, 2012, and could not recall Petitioner's medical histories from November of 2012 through January 28, 2013 and did not feel that such histories were significant.

Notwithstanding the foregoing paragraphs that address this issue, the Arbitrator finds, by a mere preponderance of the evidence, that Petitioner's current condition of ill-being of his neck, which includes the C4-C5 disc herniation that resulted in the C4-C5 cervical fusion as well as the bulging disc at C3-C4, is casually connected to the accident of January 28, 2013.

The Arbitrator notes that Petitioner is not claiming that the neuropathy in his feet is causally related to the accident of January 28, 2013.

The Arbitrator relies on the testimony of Petitioner, the medical records admitted into evidence and the medical opinions of Dr. Cybulski. The Arbitrator also notes the testimony of Dr. Coe. The Arbitrator also finds it significant that the physician from Clearing Clinic sets forth that Petitioner's cervical spine condition was causally related to the work-related accident of January 28, 2013. The Arbitrator accords

less weight to the medical opinions of Dr. Mather, Respondent's Section 12 physician, than he does to those of Dr. Cybulski.

To recover under the Act, an employee must show that there is a causal connection between the claimant's employment and the injury. In *Sisbro, Inc. v. Industrial Commission*, 207 Ill.2d 193, 797 N.E.2d 665 (2003), the Illinois Supreme Court held that "even though an employee has a preexisting condition which may make him more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor." *Id.* The accident "need not be the sole causative factor, nor even the primary causative factor, as long as it was *a* causative factor in the resulting condition of ill-being." *Id.* (emphasis in original).

A. Medical Opinions of Dr. Cybulski

Petitioner established medical causation in connection with his neck condition through the medical records and opinions of Dr. Cybulski. The Arbitrator finds the opinions of Dr. Cybulski to be persuasive and accords such opinions more weight. *See International Vermiculite Company v. Industrial Commission*, 77 Ill.2d 1, 394 N.E.2d 1166 (1979) (holding that the Commission may accord greater weight to the medical opinions of the claimant's treating physician).

Dr. Cybulski set forth that Petitioner's diagnosis was cervical radiculopathy status post anterior cervical discectomy and C4-C5 fusion and chronic cervical radiculopathy related to the prior anterior cervical discectomy and fusion at C5-C7. Dr. Cybulski opined that the work-related accident of January 28, 2013 caused a C4-C5 herniated disc, which produced cervical radiculopathy and required surgery to remove the herniated disc and fuse the spine. The basis of his opinion was Petitioner's symptoms, physical examination, MRI study, knowledge of having water delivered and the pervious medical records.

Dr. Cybulski described how the accident could cause the herniated disc at C4-C5. Dr Cybulski noted that the previous C5-C7 fusion would require the space above the fusion to absorb new forces and increase the stressed placed on the C4-C5 disc space. Dr. Cybulski opined that carrying heavy water bottles on Petitioner's neck would increases the stress that occurs at the C4-C5 disc space and would

produce the C4-C5 disc herniation that occurred. He stated that when the bottle is cradled on the shoulder between the arm and the neck, the neck is forced to one side and that imparts trauma to the disc space.

Dr. Cybulski testified that the prior medical records from Pronger Smith did not have any effect on his opinions regarding medical causation. Dr. Cybulski testified that the medical records from Pronger Smith did not document that Petitioner had a herniated disc prior to the work-related accident of January 28, 2013. Further, there were no recommendations for an MRI study prior to January 28, 2013. Dr. Cybulski testified that the previous surgery at C5-C7 would cause cervical radiculopathy and the medical records from Pronger Smith do not point to a specific C4-C5 disc herniation. Rather, the records point to general symptoms of cervical radiculopathy. Accordingly, Dr. Cybulski noted that the disc herniation at C4-C5 was a new finding based on the history of accident. Dr. Cybulski noted that while Petitioner was working for Respondent and treating at Pronger Smith, he did not have a herniated disc. If Petitioner had a herniated disc, then he would not have been able to work. Dr. Cybulski testified that it was possible to have cervical radiculopathy without a herniated disc.

Dr. Cybulski noted that on January 28, 2013, Petitioner's symptoms increased and were intense and unremitting enough to be consistent with a herniated disc. He set forth that the symptoms three (3) weeks prior were not related to the accident and were not consistent with a herniated disc.

B. Medical Opinions of Dr. Coe

The Arbitrator finds it significant that both the physician at Clearing Clinic and Dr. Cybulski have opined that Petitioner's current condition of ill-being in his cervical spine was causally related to the work-related accident of January 28, 2013.

Although he is neither an orthopedic spine surgeon nor a neurosurgeon, Dr. Coe, a medical doctor who specializes in occupational medicine, provided a medical causation opinion. Dr. Coe opined that Petitioner's work-related accident of January 28, 2013 caused Petitioner's current neck and arm symptoms. Dr. Coe set forth a diagnosis of post two cervical surgeries, the most recent following a herniated disc at C4-C5, with post-surgical residual cervical stiffness and myofascial discomfort and radiculopathy. Dr. Coe testified that the current condition of ill-being of the cervical spine was causally

related to the work-related accident of January 28, 2013. Specifically, the work-related accident aggravated degenerative changes in the cervical spine and caused a new herniation of the C4-C5 disc that required surgery. Dr. Coe's opinions were based on the history, medical records, opinions of the physicians and physical examination.

Dr. Coe testified that the medical records from prior to January 28, 2013 did not change his medical opinions. Specifically, Dr. Coe noted that Petitioner's condition changed post-accident. Dr. Coe stated that the prior medical records from Pronger Smith were not significant because they did not document specific acute and severe pain. Further, following the accident of January 28, 2013, Petitioner's condition was severe sharp pain in his neck with significant radiculopathy symptoms. Based on the treatment and medical records, he opined, Petitioner experienced a significant and dramatic change in his condition following the events of January 28, 2013.

B. Chain of Events Analysis

The Arbitrator further concludes that Petitioner's current condition of ill-being in connection with his neck, including the C4-C5 disc herniation causing cervical radiculopathy and spondylosis and a bulging disc at C3-C4 resulting in the C4-C5 cervical fusion, was casually connected to the work-related accident of January 28, 2013, through the "chain of events" analysis. Proof of prior good health and change immediately following and continuing after an injury may establish that the impaired condition was due to injury. *Ill. Power Co. v. Indus. Com'n*, 176 Ill.App.3d 317, 530 N.E.2d 617 (4th Dist. 1988).

In *Kawa v. Illinois Workers' Compensation Commission*, 372 Ill.Dec. 123, 991 N.E.2d 430 (1st Dist. 2013), the Appellate Court reaffirmed the chain of events analysis. The Court found that the claimant established a "causal nexus between the accident and his condition of ill-being" based on the evidence that the claimant's condition had begun no sooner than the work-related accident and continued with no intervening cause that broke the chain of events. *Id.*

In the instant case, Petitioner testified he had sustained a prior accident to his neck in 2006. Petitioner underwent surgery performed by Dr. Goldberg. Petitioner was eventually released to return to work without restrictions on September 24, 2007. Petitioner returned to work for Respondent.

Following his release from medical care by Dr. Goldberg, Petitioner sought medical treatment for his cervical spine on approximately four (4) occasions in 2012. On November 14, 2012, the physician at Pronger Smith Medical Center set forth that Petitioner could return to work with the restriction of no lifting more than fifteen (15) pounds for two (2) weeks. Petitioner continued to work for Respondent. He was provided a sales consultant for two (2) weeks at work. According to Petitioner, and consistent with Dr. Markus' note, after two (2) weeks he was to return to work without restrictions. Petitioner was also seen at Pronger Smith Medical Center for neck pain on December 31, 2012 and January 7, 2013. From January 12, 2012 to January 27, 2013, Petitioner did not lose any time from work relating to his cervical spine condition. Further, other than the office visits at Pronger Smith Medical Center and medication, Petitioner did not receive any medical treatment for his cervical spine condition. From January 13, 2012 to January 27, 2013, no physician recommended an MRI study of the cervical spine or that Petitioner undergo surgery for his cervical spine condition.

Immediately following the work-related accident of January 28, 2013, Petitioner began a course of medical care for his neck. Following the accident, Petitioner has experienced constant, intense and persistent pain in his neck. Further, Petitioner has undergone a course of medical treatment, including office visits, physical therapy, diagnostic studies and surgery. Petitioner was also unable to continue working for Respondent. Petitioner's ongoing symptoms in his neck are well documented in the medical records. Further, since the accident of January 28, 2013, Petitioner has not sustained any new accidents to his neck.

The Arbitrator concludes that based on the medical evidence, including the medical records of Pronger Smith, Dr. Zelby, Dr. Gireesan and Dr. Zelby and the credible, and unrebutted testimony of Petitioner, that Petitioner was not under active medical treatment, did not experience any persistent symptoms in his neck and was able to work for Respondent prior to January 28, 2013. However, following the work-related accident of January 28, 2013, Petitioner received consistent medical treatment for his neck. Further, the Arbitrator finds that following the accident of January 28, 2013, the symptoms that Petitioner experienced in his neck were worse, more intense and persistent. Accordingly, the

Arbitrator finds that the work-related accident of January 28, 2013 caused Petitioner's current condition of ill-being as it relates to his neck based on the chain of events analysis.

C. Medical Opinions of Dr. Mather, Respondent's Section 12 Physician

The Section 12 reports of Dr. Mather were admitted into evidence. The Arbitrator has considered the opinions of Dr. Mather, and in this case, he accords less weight to his opinions than he does to Dr. Cybulski's opinion. *See International Vermiculite Company,* 77 Ill.2d 1. The Arbitrator finds it significant that Dr. Mather testified that the disc herniation at C4-C5 could have been aggravated as a result of the accident of January 28, 2013. Further, Dr. Mather's testified that the mechanism of accident as described by Petitioner could have caused the C4-C5 herniation.

Dr. Mather set forth a diagnosis of C4-C5 disc herniation. He stated that Petitioner's current condition of ill-being in his neck was not causally connected to the work-related accident of January 28, 2013 since Petitioner had symptoms consistent with cervical radiculopathy prior to the accident date. He set forth that Petitioner had the neck condition since August 2012. Dr. Mather testified that Petitioner had cervical radiculopathy prior to January 28, 2013.

However, the Arbitrator finds it significant that in a quick report, Dr. Mather initially marked that the condition was casually related to the accident and then crossed it out and stated that the condition was not related to the work-related accident. Dr. Mather does not recall if he originally believed that the cervical condition was related to the accident of January 28, 2013.

Further, Dr. Mather agreed that the disc level above a fusion could have increased the stress on the level above or below the fusion. He further testified that the incident of January 28, 2013 could provide the physical force to case a disc herniation at C4-C5. He acknowledged that the medical records from Clearing Clinic were consistent with Petitioner sustaining a work-related accident of lifting a heavy bottle on January 28, 2013. He also acknowledged that the only MRI study in the case was performed in February 2013. Further, prior to January 28, 2013, no doctor specifically diagnosed Petitioner with C4-C5 disc herniation. He admitted that there was no surgical recommendation prior to January 28, 2013. It

is also significant that Dr. Mather had not reviewed the operative report from the surgical procedure performed on May 10, 2013.

The Arbitrator notes that Dr. Mather testified that the accident could have caused or aggravated the herniated disc at C4-C5. Further, he acknowledged that all recommendations for medical treatment were made following January 28, 2013. Lastly, the Arbitrator notes that Dr. Mather may have changed his opinions regarding medical causation. Accordingly, the Arbitrator relies on the persuasive opinions of Dr. Cybulski that the current condition of ill-being as it relates to Petitioner's cervical spine was causally related to the work-related accident of January 28, 2013.

In support of the Arbitrator's decision relating to issue "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 makes the following conclusions:

The Arbitrator concludes that the medical services provided to Petitioner in connection with the cervical spine injury were reasonable and necessary and that Respondent is liable for payment of the medical bills admitted into evidence as Petitioner's Exhibit 22, totaling $126,850.32. The medical bills are awarded pursuant to the Section 8(a) and 8.2 of the Act. The Arbitrator finds that Respondent is liable for the following medical bills:

- Industrial Pharmacy Management- $833.40
- Dr. Gireesan- $400.00
- Pronger Smith Medical Care- $304.00
- ATI (paid by Group Insurance)- $3,336.10 (current balance $429.77)
- Clearing Clinic- $635.09
- Northwestern Memorial Hospital (paid by Group Insurance)- $84,682.93 (current balance $37,283.12)
- Northwestern Medical Group- $6,132.00
- Northwestern Medicine (paid by Group Insurance)- $31,197.00 (current balance $7,788.26)

- Accelerated/Athletico- $4,561.00

These bills total $132,081.52.

The payment record of Blue Cross Blue Shield was admitted into evidence. The payment records reflect that Blue Cross Blue Shield, Petitioner's wife's group insurance carrier, paid $19,947.83 in connection with medical treatment related to the instant case.

The Arbitrator awards payment of the above-listed medical bills, which have been found to be compensable, in accordance with Section 8(a) and subject to Section 8.2 of the Act. The Arbitrator orders Respondent to make payment of the medical bill to Petitioner's attorney pursuant to Section 7080.20 of the Rules Governing the Practice Before the Illinois Worker's Compensation Commission. Respondent shall indemnify and hold Petitioner harmless from any claims made by group insurance as it relates to payment of the above listed causally connected medical bills.

The Arbitrator rejects Respondent's argument that its liability is limited to the group insurance rate paid by the group insurance carrier of Petitioner's wife. Respondent relies on the holding in *Tower Automotive v. Illinois Workers' Compensation Commission*, 407 Ill.App.3d 427 (1st Dist. 2011). In *Tower Automotive*, the Court held that the employer was liable for payment of medical expenses in the amount that was paid to the provider, not the amount incurred for medical services. *Id.* The Court stated that by reimbursing the claimant for payments made to the provider, the employer has complied with Section 8(a) of the Act and provided and paid for the medical services. *Id.* The Court rejected the claimant's argument that the employer is not entitled to a write off for payments made by a group health carrier that the employer did not make contributes to. *Id.* The claimant's argument was based on the collateral source rule, which states: "Benefits received by an injury party from a source wholly independent of, and collateral to, the tortfeasor will not diminish damages otherwise recoverable from the tortfeasor." *Id.*

However, the holding of *Tower Automotive* is not applicable to the instant case. The holding in *Tower Automotive* only applies to accidental injuries that occurred prior to February 1, 2006. *Id.* The Court specifically noted that that its decision "is of limited future significant, as the legislature has seen fit

to amend section 8(a) of the Act to provide that employers are obligated to provide and pay the 'negotiated rate, if applicable, or the lesser of the health care provider's actual charges or accordingly to a fee schedule.'" *Id.* The Court acknowledged that the amount of payments has been limited to the negotiated rate, actual charges or fee schedule amount. *Id.*

Determining the meaning of "negotiated rate" is a matter of statutory interpretation. When determining the meaning of a statute, it is important to give effect to the intent of the legislation. *Dodaro v. Ill. Workers' Compensation Comm'n*, 403 Ill.App3d 538, 950 N.E.2d 256 (1st Dist. 2010). "The best indication of this intent is the plain and ordinary language of the statute itself." *Id.* To determine the plain language of the statute, courts can consult a dictionary if the word is not defined in the statute. *Id.*

Section 8(a) does not define "negotiated rate." The Rules of Practice Before the Illinois Workers' Compensation Commission state that when an employer or insurance company negotiate a contract with a medical provider for medical services, the rate negotiated in the contract shall prevail. Section 7110.90(d). According to Black's Law Dictionary, "negotiate" means "to communicate with another party for the purpose of reaching an understanding" or "to bring about by discussion or bargaining." BLACK'S LAW DICTIONARY (8TH Ed. 2004). "Rate" means the amount paid or charged for a good or service. *Id.*

Based on the case law, definition of negotiated and language of the Act, the Arbitrator finds that he negotiated rate must be an actual rate negotiated between the employer or employer's group insurance carrier and the medical provider. The Arbitrator notes that there was no negotiation between the employer or a party of the case and the medical provider. Therefore, the Arbitrator finds that the negotiated rate was not the amount paid by Petitioner's wife's group insurance. Accordingly, the Arbitrator awards all medical bills pursuant to the medical fee schedule.

In support of the Arbitrator's decision relating to issue "K," temporary total disability benefits, the Arbitrator makes the following conclusions:

The Arbitrator concludes that Petitioner is entitled to temporary total disability benefits from January 29, 2013 through April 28, 2014, the day before Petitioner returned to work within his restrictions for another company. The Arbitrator relies on Petitioner's unrebutted testimony and the medical records of Dr. Zelby, Dr. Gireesan and Dr. Cybulski. The Arbitrator also relies on the testimony of Dr. Cybulski, and to some degree, Dr. Coe. The Arbitrator notes that Respondent's only defense to payment of temporary total disability benefits is medical causation. Dr. Mather agreed that the cervical fusion of C4-C5 was reasonable and necessary and that Petitioner could reach maximum medical improvement approximately one (1) year from the date of surgery, which was May 19, 2013. Having found that Petitioner's current condition of ill-being in connection with the cervical spine condition was causally related to the work-related accident of January 28, 2013, the Arbitrator awards payment of temporary total disability benefits for the period of January 29, 2013 through April 28, 2014.

In *Freeman United Coal Mining Company v. Industrial Commission*, 318 Ill.App.3d 170, 741 N.E.2d 1144 (2001), the Court set forth that "a claimant is entitled to TTD when a 'disabling condition is temporary and has not reached a permanent condition.'" (quoting *Manis v. Industrial Commission*, 172 Ill. Dec. 95, 595 N.E.2d 158 (1st Dist. 1992)). The dispositive test for determining whether a claimant is entitled to TTD is whether the condition has stabilized. *Id.* In *Freeman United Coal Mining Company*, the Court held that the condition of the claimant's knee had not stabilized and that the petitioner was thus entitled to TTD benefits. *Id.* The Court based its decision on the fact that the claimant had not been released to full-duty work and future medical care was being considered by the claimant's treating physicians. *Id.*

In the instant case, Petitioner was initially examined at the Clearing Clinic and Pronger Smith Medical Center on January 28, 2013. The physician at Clearing Clinic found Petitioner could return to work with restrictions and the physician at Pronger Smith found that Petitioner was unable to work. Respondent did not accommodate the work restrictions of Clearing Clinic. Following the examinations of

January 28, 2013, Petitioner remained under medical care with Dr. Zelby, Dr. Gireesan and Dr. Cybulski. Medical treatment included office visits, physical therapy and surgery. Petitioner was not released to return to work for Respondent while he was under active medical care. Dr. Cybulski testified that Petitioner would reach maximum medical improvement approximately one (1) year following surgery. On April 20, 2014, Dr. Cybulski released Petitioner to return to work with restrictions. Petitioner returned to work within his restrictions for another company on April 29, 2014. Accordingly, the Arbitrator finds that Petitioner reached maximum medical improvement effective April 28, 2014.

Based on the medical records and medical opinions of Dr. Cybulski, the testimony of Petitioner, as well as the opinions of Dr. Coe, the Arbitrator finds that Petitioner is entitled to payment of temporary total disability benefits from January 29, 2013 through April 28, 2014. The Arbitrator relies on *Freeman United Coal Company (supra)* in support of his decision.

In support of the Arbitrator's decision relating to "L," what is the nature and extent of the injury, the Arbitrator makes the following conclusions:

A claimant is entitled to an award under Section 8(d)2 of the Illinois Workers' Compensation Act "if, as a result of the accident, the employee sustains serious and permanent injuries" which "partially incapacitate him from pursuing the duties of his usual and customary line of employment but do not result in an impairment of earning capacity." 820 ILCS 305/8(d)2.

Pursuant to Section 8.1(b) of the Act, the Arbitrator must consider certain factors and criteria in assessing permanent partial disability, including, the level of impairment under the AMA Guides, the occupation of the injured worker, the age of the injured worker, the future earning capacity of the injured worker and evidence of disability corroborated by the treating medical records. The Act provides that no single enumerated factor shall be the sole determinant of disability. Therefore, the Arbitrator considers the relevance and weight of the following five factors:

A. Level of Impairment under the AMA Guides

The Arbitrator finds that neither Petitioner nor Respondent submitted a report setting forth an AMA impairment rating. The Court in *Corn Belt Energy v. Illinois Workers' Compensation Commission*, 2016 IL App (3d) 150311WC (3d Dist. 2016), held that an AMA Impairment Rating is not required for the Arbitrator to award permanent partial disability benefits. Accordingly, the Arbitrator will not consider this factor as it relates to the nature and extent of the injury.

B. Occupation of Petitioner

At the time of the accident, Petitioner was employed as a sales consultant for Respondent. Petitioner's job required him to lift and load water into a truck. He was required to lift five (5) gallon jugs of water that weighed 43 pounds. Accordingly, Petitioner job duties were physically demanding. Following the work-related accident, Dr. Cybulski released Petitioner to return to work with a lifting restriction of 25 pounds. Accordingly, as a result of the work-related accident of January 28, 2013, Petitioner was unable to perform his pre-injury job. The Arbitrator finds this factor to be relevant and gives it major weight.

C. Age of Petitioner

The Parties stipulated that on the date of the accident, Petitioner was 47 years old. (AX 1) The Arbitrator finds this factor to be relevant and gives it gives it minor weight

D. Future Earning Capacity

No evidence was presented regarding Petitioner's future earning capacity. Therefore, the Arbitrator gives no weight to this factor.

E. Evidence of Disability Corroborated by the Treating Medical Records

The medical records of Dr. Zelby, Dr. Gireesan and Dr. Cybulski and the report of Dr. Coe establish that Petitioner sustained a C4-C5 disc herniation causing cervical radiculopathy and spondylosis and a bulging disc at C3-C4 resulting in the C4-C5 cervical fusion and permanent restrictions which prevented Petitioner from returning to his pre-injury job for Respondent. The diagnosis was corroborated by the diagnostic studies, operative reports and objective evidence. The Arbitrator finds it significant that even

Respondent's Section 12 physician, Dr. Mather, agreed that Petitioner did sustain a C4-C5 disc herniation, which required a cervical fusion.

The medical records of Dr. Cybulski document Petitioner's subjective complaints. Petitioner's testimony regarding his subjective complaints was consistent with the complaints documented in the medical records.

The medical records of Dr. Cybulski and the report of Dr. Coe document objective findings. Petitioner had objective loss of range of motion. The Arbitrator finds that Petitioner's subjective complaints and objective findings were corroborated by the medical records of Dr. Cybulski, Petitioner's treating physician.

Further, Dr. Cybulski recommended that Petitioner return to work with permanent work restrictions of no lifting more than 25 pounds.

The Arbitrator finds this factor to be relevant and gives it major weight.

Accordingly, based the above five factors, the Arbitrator finds that Petitioner sustained a permanent loss of use, person as a whole, to the extent of 40% thereof since he experienced a loss of occupation as provided for in Section 8(d)2 of the Act.



9-12-2016

Brian T. Cronin
Arbitrator

Date

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 as to PPD award to award wage differential	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify ON REMAND FROM THE APPELLATE COURT	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Anthony R. Holstine,

Petitioner,

vs.

NO: 12 WC 21071

Affordable Roofing,

Respondent.

18IWCC0050

DECISION AND ORDER ON REMAND FROM THE APPELLATE COURT

This matter had previously been heard and the Decision of Arbitrator Falcioni had been filed February 11, 2014-(corrected decision). The Arbitrator found that Petitioner sustained accidental injuries arising out of and in the course of his employment with Respondent on May 28, 2010; that Petitioner established a causal connection between these accidental work related injuries and his condition of ill-being; that Petitioner was entitled to an award of 97-3/4 weeks of temporary total disability benefits (6/14/10-4/25/12) at a rate of $1,051.34 per week under §8(b) of the Act ($102,768.48 total TTD) and 29-2/7 weeks of temporary partial disability-(TPD)-(5/1/12-11/21/12) at $814.97 per week (total TPD =$23,866.98)***; that Petitioner was entitled to an award of $-ALL PAID- for reasonable and necessary medical expenses under §8(a) of the Act; that Petitioner is entitled to an award of 50% loss of use of Petitioner's person as a whole under §8(d)(2) of the Act (250 weeks at $664.72 per week =$166,180.00 total PPD).
-Both parties filed for Review and the Commission affirmed and adopted the decision of the Arbitrator.
-Petitioner appealed to the Circuit Court who affirmed the Commission decision.
-Petitioner appealed to the Appellate Court who remanded the case back to the IWCC only for determination of wage differential-(PPD award of 50% loss person as a whole vacated)), with their finding Petitioner proved entitlement to wage differential; all else was affirmed.

18IWCC0050

- At the initial hearing, Petitioner testified he was a 45-year-old employee of Respondent, who described his job as a roofer. Petitioner had been employed by Respondent on May 28, 2010; Petitioner had been working for Respondent for about eight years at that time. He had previously worked for Respondent first in 1984 and but for 2-3 years, Petitioner worked for Respondent from 1984; he had left and then returned to Respondent. Petitioner was a foreman roofer at Respondent. Petitioner's duties included climbing ladders, tearing off roofs, installing roofing, carrying the materials and doing mop work-(with hot tar). The mop full of tar weighed 35-40 pounds. Petitioner testified they had to dispose of the demolished roofing and they put the materials in a wheel barrel (smart carts about twice the size of a regular wheel barrel) and walk it over and dump it off of the roof. Petitioner testified one of the smart carts full weighed 250-300 pounds. The carts were used mostly on the roof, but also some on the ground. On the date of accident, May 28, 2010-(Friday), Petitioner testified he was working for Respondent and he was getting some materials out of the back of the truck and he jumped out of the back of the truck to the ground and he hurt his right hip. Petitioner testified when it occurred he felt pain in his right hip. Petitioner testified after he finished his shift that day he did not report the occurrence that day. Petitioner testified that he did report the accident the following week to Bill Triscila a partner/owner at Respondent. Petitioner testified that he told Mr. Triscila that Petitioner had the hip pain and Mr. Triscila asked if Petitioner could work that day and Petitioner stated he told him Petitioner did not know. Petitioner testified that Mr. Triscila asked Petitioner how it happened and Petitioner stated he had advised him of the event as Petitioner explained it occurred jumping down from the truck. Petitioner had continued to work and he eventually sought treatment at Dreyer Clinic as that was where Respondent sends the employees for pain-related injuries. Petitioner testified he had previously sustained injuries on the job for Respondent and they had sent him to Dreyer Clinic in the past. Petitioner first sought medical treatment at Dreyer Medical on June 14, 2010 (about 2 weeks after the event).

- Petitioner testified that while he had worked for Respondent he was also then employed at Community of Christ Church where he mowed, weed whacked, and did building maintenance/janitor; church property, church camp grounds. Petitioner had continued working for the church after he was injured and continued working for Respondent. Petitioner testified when he went to Dreyer they took x-rays and eventually took him off of work and to non-weight bearing with the second doctor-(Dr. Johnson or Johnston) he saw there. Petitioner testified that they ordered an MRI of his hip and then advised Petitioner that he had a subacromial fracture of the femoral head and advised him off work. Petitioner, (per Respondent records) last work for Respondent on a roof June 11, 2010. Petitioner worked light duty in Respondent office after that for about a week. Petitioner believed about June 18, 2010 he saw a Dr. Pellegrin who had confirmed the break and Petitioner was then off work completely. Petitioner testified he was treated conservatively at Dreyer, no surgery, and he went through physical therapy for a period of time that had been recommended by Dr. Rabin there. The therapy was transitioned at the end of October 2010 to work hardening after about 12 weeks of therapy. During that time Petitioner also had a steroid injection to his right hip, and due to Petitioner's ongoing pain complaints, Dr. Rabin had Petitioner evaluated by Dr. Jacobs-El on March 11, 2011 at Dreyer. Petitioner

18IWCC0050

indicated the referral was made because the doctor was having trouble determining what was wrong with Petitioner's hip and wanted another opinion. Petitioner agreed Dr. Jacobs-El saw and examined Petitioner-(that one time) and had released Petitioner then to full duty. Petitioner testified that exam involved Petitioner laying on the table and lifting his leg and putting it to his chest and moving it left and right and then back down. Petitioner stated that doctor asked how Petitioner felt and Petitioner stated he told the doctor that he was still in a lot of pain and the doctor said he felt Petitioner was able to go back to full duty work. Petitioner testified that during the course to that time, Petitioner had been in communication with a representative from Respondent's carrier-(Mr. Underwood). Petitioner had been referred by the carrier for an evaluation by Dr, Nho (Respondent IME) and that was done about March 11, 2011. Petitioner testified when he left Dr. Nho's office Petitioner had no knowledge of the doctor's impression or recommendations. At the recommendation of the doctors at Dreyer, Petitioner had a functional capacity evaluation-(FCE) about March 14, 2011 and he was not given the results at the end of that evaluation; he later learned of the results of the FCE when he called Marcia Underwood at Respondent's carrier and asked for a copy of the FCE report and the report of Dr. Nho; he did subsequently receive those reports. Petitioner testified that subsequent to the reports being sent, Petitioner had a phone conversation with Ms. Underwood. Petitioner stated he started by asking about the Dr. Nho exam and why she did not inform Petitioner when she received the report and she told Petitioner she did not think Petitioner wanted surgery because it was against Dr. Rabin who said he did not want surgery, and Petitioner stated that was not accurate. Petitioner stated it was Dr. Rabin advice that the doctor did not think that Petitioner needed surgery and that was near when they were ending treatment so Petitioner had followed Dr. Rabin's instructions. Petitioner had also received the FCE report and he believed in the conversation it was she suggested coming to the house to discuss it further. Petitioner stated she drove to his house and spoke to Petitioner about the results of the two tests and she had indicated it was Petitioner's right to get a third opinion and Petitioner told her that was what he would do was get another opinion. Petitioner stated she asked Petitioner not to take the Dr. Nho report and the FCE report to that doctor's appointment to see if that other opinion would come with the same diagnosis as their doctor did.

- Petitioner first sought medical attention for that other opinion at Castle Orthopedics in Aurora, but he did not see a doctor there; he stated they told Petitioner they did not do that type of surgery and they recommended Petitioner try Dr. Domb at Hinsdale Orthopedics and Petitioner pursued that treatment. Petitioner first saw Dr. Domb about June 20, 2011 and the doctor reviewed the initial MRI and made the diagnosis of the fracture and that there was also evidence of a right hip labral tear. The doctor then recommended treatment of therapy and then to have surgery. Petitioner had the surgery at Weiss Memorial Hospital about August 10, 2011 and had a labral tear debridement femoral-plasty and capsular release to his right hip. They then continued restricting Petitioner from work, no weight bearing. Petitioner continued to treat with Dr. Domb post surgery and went through further therapy that started relatively quickly after surgery. Petitioner then saw the doctor monthly and symptomatically thereafter. He had the therapy at ATI and eventually had ultrasound guided injections to the hip due to his continued pain issues. Petitioner testified that Dr. Domb eventually had Petitioner transition to work hardening at ATI about January 8, 2012.

Petitioner had a second ultrasound guided injection to his hip February 3, 2012. On February 19, 2012 they determined Petitioner had plateaued in work hardening and they recommended an FCE which was then done at ATI. Petitioner testified that they did not have a job description for the FCE regarding his roofer job duties. Petitioner testified that FCE was a routine FCE similar to his prior FCE. Petitioner testified it was not discussed his job things like mopping with 35 pounds and that was not tested. Petitioner stated he was tested for three steps but not ladder work and they did not test him for carrying 250-300 pounds with a wheel barrel. They had tested with a roping wheel that was a wheel that hooks on the top rung of the ladder to help you use the material and with that there are 1-2 guys on the ground with a rope and they hook material up and pull the one side of the ladder up to the roof, but you have to hold it out from the roof for it to work; the worker on top actually suspends it; like a dumbwaiter, and they did not test Petitioner for that activity. Petitioner testified that when he worked as a roofer it involved ladder work and height and that varied time to time. The frequency up and down the ladder varied as did the height. As to height, Petitioner indicated it could be anywhere from 10 to a 40 foot ladder and he had to get off of the ladder on top and then go back down the ladder; sometimes it was 4 times per day but it could be 12-15 times per day depending on the job and who was on the job. Petitioner testified there were times he had to carry tools or materials up; mainly materials and tools and sometimes equipment like shovels, blades, spades, brooms; he stated none of that had been tested with that FCE in 2012. Petitioner testified that at the time of the FCE and afterwards he stated he noticed pain and he believed he then had a 2nd injection just about 3 weeks before the FCE. After the FCE Petitioner had returned to see Dr. Domb and he asked about the results of the FCE and then Dr. Domb placed restrictions on Petitioner of nothing heavier than 40 pounds and Petitioner believed it was occasional bending and squatting and very occasional ladder work' Petitioner testified that he followed those restrictions.

- Petitioner testified that he did not attempt to return to work at Respondent to see if they could accommodate the restrictions after February 28, 2012 because they had fired Petitioner October 2010. Petitioner testified that after the FCE his TTD benefits were terminated. Petitioner testified that prior to that time he had returned to work for the camp ground and that work had conformed to the restrictions placed by Dr. Domb; at that time the camp ground was the only job Petitioner was working. Petitioner testified that when he learned that he was not going to get any vocational assistance, Petitioner conducted an independent search for work and he did eventually find work about November 21, 2012 at Loving Arms Daycare Center; a branch of the Cross Lutheran Church in Yorkville; it is just a day care center, like a pre-school in the morning, 6 weeks to 6th grade. Petitioner does maintenance for them plus he did the mowing and weed-whacking at the camp ground. It does require occasional ladder work, maybe every two to two and a half months to change a light bulb in exit signs on an 8 foot ladder with 4-5 steps. Petitioner did not have to go up a ladder 40 feet. Petitioner currently still did work for both of those places. He worked about 20 hours a week at Loving Arms and paid there 12.50 per hour and at the campground $14.50 per hour about 25 hours per week. Petitioner testified that at no time was he offered job placement services by Respondent's carrier. Petitioner had returned to Hinsdale Orthopedics in early 2013 and saw one of Dr. Domb's assistants and the restrictions were raised to 50 pounds from 40 pounds, but no changes regarding the other

noted restrictions. Petitioner testified that currently with his right hip he still had a great deal of pain at times depending on the activities that he did that day and how long he did the activities for. He does take over-the-counter Aleve.

The Commission notes Petitioner testified that while he had worked for Respondent he was also then employed at Community of Christ Church where he mowed, weed whacked, and did building maintenance/janitor; church property, church camp grounds. Petitioner had continued working for the church after he was injured and continued working for Respondent. Petitioner testified when he went to Dreyer they took x-rays and eventually took him off of work and to non-weight bearing with the second doctor-(Dr. Johnson or Johnston) he saw there. Petitioner testified that they ordered an MRI of his hip and then advised Petitioner that he had a subacromial fracture of the femoral head and advised him off work. Petitioner, (per Respondent records) last work for Respondent on a roof June 11, 2010. Petitioner worked light duty in Respondent office after that for about a week. Petitioner believed about June 18, 2010 he saw a Dr. Pellegrin who had confirmed the break and Petitioner was then off work completely. Petitioner testified he was treated conservatively at Dreyer, no surgery, and he went through physical therapy for a period of time that had been recommended by Dr. Rabin there. The therapy was transitioned at the end of October 2010 to work hardening after about 12 weeks of therapy. During that time Petitioner also had a steroid injection to his right hip, and due to Petitioner's ongoing pain complaints, Dr. Rabin had Petitioner evaluated by Dr. Jacobs-El on March 11, 2011 at Dreyer. Petitioner indicated the referral was made because the doctor was having trouble determining what was wrong with Petitioner's hip and wanted another opinion. Petitioner agreed Dr. Jacobs-El saw and examined Petitioner-(that one time) and had released Petitioner then to full duty. Petitioner testified that exam involved Petitioner laying on the table and lifting his leg and putting it to his chest and moving it left and right and then back down. Petitioner stated that doctor asked how Petitioner felt and Petitioner stated he told the doctor that he was still in a lot of pain and the doctor said he felt Petitioner was able to go back to full duty work. Petitioner testified that during the course to that time, Petitioner had been in communication with a representative from Respondent's carrier-(Mr. Underwood). Petitioner had been referred by the carrier for an evaluation by Dr, Nho (Respondent IME) and that was done about March 11, 2011. Petitioner testified when he left Dr. Nho's office Petitioner had no knowledge of the doctor's impression or recommendations. At the recommendation of the doctors at Dreyer, Petitioner had a functional capacity evaluation-(FCE) about March 14, 2011 and he was not given the results at the end of that evaluation; he later learned of the results of the FCE when he called Marcia Underwood at Respondent's carrier and asked for a copy of the FCE report and the report of Dr. Nho; he did subsequently receive those reports. Petitioner testified that subsequent to the reports being sent, Petitioner had a phone conversation with Ms. Underwood. Petitioner stated he started by asking about the Dr. Nho exam and why she did not inform Petitioner when she received the report and she told Petitioner she did not think Petitioner wanted surgery because it was against Dr. Rabin who said he did not want surgery, and Petitioner stated that was not accurate. Petitioner stated it was Dr. Rabin advice that the doctor did not think that Petitioner needed surgery and that was near when they were ending treatment so Petitioner had followed Dr. Rabin's instructions. Petitioner had also received the FCE report and he believed in the conversation it was she suggested coming to the house to discuss it further. Petitioner stated she drove to his house and spoke to Petitioner about the results of the two tests and she had indicated it was Petitioner's right to get a third opinion and Petitioner told her that was

what he would do was get another opinion. Petitioner stated she asked Petitioner not to take the Dr. Nho report and the FCE report to that doctor's appointment to see if that other opinion would come with the same diagnosis as their doctor did.

The Commission notes that Petitioner first sought medical attention for that other opinion at Castle Orthopedics in Aurora, but he did not see a doctor there; he stated they told Petitioner they did not do that type of surgery and they recommended Petitioner try Dr. Domb at Hinsdale Orthopedics and Petitioner pursued that treatment. Petitioner first saw Dr. Domb about June 20, 2011 and the doctor reviewed the initial MRI and made the diagnosis of the fracture and that there was also evidence of a right hip labral tear. The doctor then recommended treatment of therapy and then to have surgery. Petitioner had the surgery at Weiss Memorial Hospital about August 10, 2011 and had a labral tear debridement femoral-plasty and capsular release to his right hip. They then continued restricting Petitioner from work, no weight bearing. Petitioner continued to treat with Dr. Domb post surgery and went through further therapy that started relatively quickly after surgery. Petitioner then saw the doctor monthly and symptomatically thereafter. He had the therapy at ATI and eventually had ultrasound guided injections to the hip due to his continued pain issues. Petitioner testified that Dr. Domb eventually had Petitioner transition to work hardening at ATI about January 8, 2012. Petitioner had a second ultrasound guided injection to his hip February 3, 2012. On February 19, 2012 they determined Petitioner had plateaued in work hardening and they recommended an FCE which was then done at ATI. Petitioner testified that they did not have a job description for the FCE regarding his roofer job duties. Petitioner testified that FCE was a routine FCE similar to his prior FCE. Petitioner testified it was not discussed his job things like mopping with 35 pounds and that was not tested. Petitioner stated he was tested for three steps but not ladder work and they did not test him for carrying 250-300 pounds with a wheel barrel. They had tested with a roping wheel that was a wheel that hooks on the top rung of the ladder to help you use the material and with that there are 1-2 guys on the ground with a rope and they hook material up and pull the one side of the ladder up to the roof, but you have to hold it out from the roof for it to work; the worker on top actually suspends it; like a dumbwaiter, and they did not test Petitioner for that activity. Petitioner testified that when he worked as a roofer it involved ladder work and height and that varied time to time. The frequency up and down the ladder varied as did the height. As to height, Petitioner indicated it could be anywhere from 10 to a 40-foot ladder and he had to get off of the ladder on top and then go back down the ladder; sometimes it was 4 times per day but it could be 12-15 times per day depending on the job and who was on the job. Petitioner testified there were times he had to carry tools or materials up; mainly materials and tools and sometimes equipment like shovels, blades, spades, brooms; he stated none of that had been tested with that FCE in 2012. Petitioner testified that at the time of the FCE and afterwards he stated he noticed pain and he believed he then had a 2nd injection just about 3 weeks before the FCE. After the FCE Petitioner had returned to see Dr. Domb and he asked about the results of the FCE and then Dr. Domb placed restrictions on Petitioner of nothing heavier than 40 pounds and Petitioner believed it was occasional bending and squatting and very occasional ladder work' Petitioner testified that he followed those restrictions.

The Commission notes that Petitioner testified that he did not attempt to return to work at Respondent to see if they could accommodate the restrictions after February 28, 2012 because they

18IWCC0050

had fired Petitioner October 2010. Petitioner testified that after the FCE his temporary total disability-(TTD) benefits were terminated. Petitioner testified that prior to that time he had returned to work for the camp ground and that work had conformed to the restrictions placed by Dr. Domb; at that time the camp ground was the only job Petitioner was working. Petitioner testified that when he learned that he was not going to get any vocational assistance, Petitioner conducted an independent search for work and he did eventually find work about November 21, 2012 at Loving Arms Daycare Center; a branch of the Cross Lutheran Church in Yorkville; it is just a day care center, like a pre-school in the morning, 6 weeks to 6th grade. Petitioner does maintenance for them plus he did the mowing and weed-whacking at the camp ground. It does require occasional ladder work, maybe every two to two and a half months to change a light bulb in exit signs on an 8-foot ladder with 4-5 steps. Petitioner did not have to go up a ladder 40 feet. Petitioner currently still did work for both of those places. He worked about 20 hours a week at Loving Arms and paid there $12.50 per hour and at the campground $14.50 per hour about 25 hours per week. Petitioner testified that at no time was he offered job placement services by Respondent's carrier. Petitioner had returned to Hinsdale Orthopedics in early 2013 and saw one of Dr. Domb's assistants and the restrictions were raised to 50 pounds from 40 pounds, but no changes regarding the other noted restrictions. Petitioner testified that currently with his right hip he still had a great deal of pain at times depending on the activities that he did that day and how long he did the activities for. He does take over-the-counter Aleve.

The Commission finds from the Illinois Workers' Compensation Act-§8(d)1: Wage Differential

1. If, after the accidental injury has been sustained, the employee as a result thereof becomes partially incapacitated from pursuing his usual and customary line of employment, he shall, except in cases compensated under the specific schedule set forth in paragraph (e) of this Section, receive compensation for the duration of his disability, subject to the limitations as to maximum amounts fixed in paragraph (b) of this Section, equal to 66-2/3% of the difference between the average amount which he would be able to earn in the full performance of his duties in the occupation in which he was engaged at the time of the accident and the average amount which he is earning or is able to earn in some suitable employment or business after the accident. For accidental injuries that occur on or after September 1, 2011, an award for wage differential under this subsection shall be effective only until the employee reaches the age of 67 or 5 years from the date the award becomes final, whichever is later.

   'To qualify for a wage-differential award, the claimant must prove a partial incapacity that prevents him from pursuing his usual and customary line of employment and an impairment of earnings.' In order to recover under subdivision (d)(1) of this section, claimant was required to prove his actual earnings for a

substantial period before the accident and after he returned to work, or, if he was unable to return to work, he was required to prove what he was able to earn in some suitable employment. Petrie v. Industrial Commission 160 Ill. App. 3d 165, 111 Ill. Dec. 858, 513 N.E.2d 104 (3 Dist. 1987).

The Commission finds (on Remand from the Appellate Court) that Petitioner had a valid functional capacity evaluation-(FCE) done post-surgery and that result indicated Petitioner at a very heavy demand level. The FCE clearly does not include work activities specific to Petitioner's job description or any 'job description', but is a generic test to judge a person's general capabilities at that time. Petitioner's treating doctor, Dr. Domb, considered the FCE and Petitioner's ongoing complaints and underlying condition and placed Petitioner on permanent restrictions at a medium level, with lifting restrictions of 50 pounds and also restrictions of no ladder climbing. The restrictions would clearly prevent Petitioner from returning to work as a roofer at a very heavy demand level and involving significant ladder climbing and working on angled roofs. Dr. Domb indicated Petitioner may need further care and possible hip replacement at some time in the future and also noted in testimony that the very heavy work would likely quicken the arthritic deterioration in the hip and need for treatment sooner. Respondent's Dr. Nho found a causal relationship with his only examination and agreed Petitioner needed the surgery and restrictions before surgery. Dr. Nho then reviewed the operative report and FCE and essentially based on the FCE opined Petitioner could return to work as a roofer at the very heavy demand level. Dr. Nho did agree at deposition that heavy work in such cases can speed up the arthritic changes, so his opinion does not consider Petitioner's ongoing complaints and potentially working in discomfort and pain at that very heavy level, or even the consideration of speeding up the degenerative changes working at that level, to be considered as persuasive. Dr. Nho's and the FCE opinions appear based on insufficient data as they only knew a roofer was a very heavy demand job but had no real idea of the specific activities involved on a daily basis.

The Commission finds, per testimony, that Petitioner had worked concurrent, part time employment, prior to the injury. Petitioner, subsequent to surgery, only pursued the two-part time positions, making much less in only the part time positions. A question can be therefore raised that if the part time maintenance/lawn work type part time jobs are 'suitable employment' and therefore whether Petitioner mitigated the wage loss sufficiently as there were no full time positions even pursued, such that Petitioner did not establish a wage loss. A petitioner does not have to show a diligent job search for wage loss-(while a diligent job search may be a way of showing wage loss), but a petitioner does have to evidence impairment of wages as a result of the injury. Petitioner did perform a couple side jobs and had also declined side jobs per the testimony. Clearly, even per the restrictions of Dr. Domb, Petitioner is capable of at least a medium demand level job. Petitioner's pursuit of the two-part time jobs appears to evidence suitable employment and appears to be an effort to mitigate his wage loss, albeit, with no other evidence to prove he cannot obtain higher wage work within his medium restrictions with his apparent experiences and expertise in his prior employment, however, the evidence finds that Petitioner meet the burden of proving entitlement to a §8(d)(1) wage loss award, per the remand from the Appellate Court.

18IWCC0050

The Commission finds that Petitioner did have hip surgery with the right hip arthroscopy including labral debridement, femoroplasty, and capsular release. Petitioner does have ongoing subjective complaints and the valid FCE that found Petitioner at a very heavy demand level, but Dr. Domb maintained restrictions on Petitioner at a medium level with no ladder climbing clearly preventing him from returning to his former employment and career. At time of the injury average weekly wage-(AWW) was stipulated as $1,577.01. Respondent did not stipulate separately, on the Request for Hearing form, as to Petitioner's earnings regarding concurrent employment, and Petitioner's testimony does not show amounts earned as concurrent employment so presumably the stipulated AWW took that into consideration. Petitioner's unrebutted testimony was that he currently worked about 20 hours a week at Loving Arms and was paid $12.50 per hour ($250.00 AWW) and at the campground, $14.50 per hour for about 25 hours per week-($362.50 AWW); no exhibits were presented to either support or rebut those wages.

The Commission notes that Petitioner 'calculated' and requested $682.51 per week as wage loss-(in their Statement for the 2015 Review), but it is not clear how they arrived at that figure other than they indicated the parties 'stipulated' Petitioner earned $573.25 from the 2 jobs, but that does not arrive at that figure either.

The Commission finds, therefore, based on Petitioner's unrebutted testimony, his current AWW has been $612.50, combining the two-part time positions. That yields $964.51 less earnings per week, so 66.66% of that finds a wage loss award of **$643.00** per week beginning November 21, 2012 for the duration of the disability under §8(d)(1).

The Commission notes that the Appellate Court affirmed all other issues other than for this issue on remand regarding reversing the prior decision as to PPD award and here for determination of wage differential.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $643.00 per week beginning November 21, 2012 for the duration of the disability under §8(d)(1) as a wage differential.

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.

18IWCC0050

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: JAN 25 2018
d-12/14/17
DLG/jsf
045

David S. Gore

David Gore

Stephen J. Mathis

Stephen Mathis

Deborah L. Simpson

Deborah Simpson

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

Mercy Hargis,
Petitioner,
vs.

NO: 08WC 7176

Dollar General,
Respondent.

18IWCC0051

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, 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 8, 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 $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: JAN 2 6 2018

o012318
MJB/jrc
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HARGIS, MERCY
Employee/Petitioner

Case# **08WC007176**

DOLLAR GENERAL
Employer/Respondent

18IWCC0051

On 5/8/2017, 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 0.97% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4888 LAW OFFICE KEITH SHORT
1355 N BLUFF RD
UNIT C-D
COLLINSVILLE, IL 62234

1886 LEAHY EISENBERG & FRAENKEL
PETER SINK
33 W MONROE ST SUITE 1100
CHICAGO, IL 60603

18IWCC0051

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

MERCY HARGIS
Employee/Petitioner

v.

DOLLAR GENERAL
Employer/Respondent

Case # 08 WC 07176

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 **July 25, 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 _____

18IWCC0051

FINDINGS

On **July 8, 2007**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$15,514.05**; the average weekly wage was **$315.00**.

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 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 **$30,038.20** under Section 8(j) of the Act.

ORDER

The Arbitrator finds that the Petitioner has failed to prove, by the preponderance of the evidence, that she sustained accidental injuries arising out of and in the course of her employment on July 8, 2007. She has therefore also failed to prove that her low back condition is causally related to a July 8, 2007 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.

Paul V. Collins

Signature of Arbitrator

3/23/16

Date

MAY 8 - 2017

STATEMENT OF FACTS

The Petitioner, 42 years old at the time of the alleged accident, testified that she has worked as an assistant store manager at various locations for Respondent for over 10 years. Her job duties include stocking shelves, working the cash registers, managing other workers, maintaining cash drawers, scheduling shifts, dealing with customers and general store cleaning. Of note, Petitioner has not lost time from work throughout this claim and has been able to continue to work without restrictions.

While working at Respondent's Godfrey location on 7/8/07, the Petitioner alleges that she and a co-worker, Ruth Ford, were putting Christmas decorations onto a high shelf. Ms. Ford was on the upper portion of a ladder, and the Petitioner was handing boxes up to her. She testified that, while handing what she estimated to be a 40 to 50 pound box of wrapping paper up to her, Ford lost control and the box started to fall. Petitioner testified she held onto the box to prevent it from falling into the aisle, twisted and felt sharp low back pain. The box ended up falling and breaking open. She finished the last half hour of her shift and completed the task.

The Petitioner testified that she was under no work restrictions at that time and had no prior low back problems that required medical or chiropractic care. She did have a yearly physical in 2005 and indicated that her doctor believed she had left foot weakness that could have been due to her back and sent her to another doctor. On cross exam she did agree that she had years of back pain, but indicated it was never as bad as it was after the alleged accident date.

Petitioner's supervisor at the time was Donna Garrett. Petitioner testified that she told Ms. Ford that she hurt her back. She also testified that she completed an accident form on the day of the occurrence and put it into her work file because Ms. Garrett was on vacation at the time. She planned to give it to her upon her return. She testified that she discussed the injury with Ms. Garrett when Garrett returned a day or two later.

Petitioner testified that while discussing her back with Ms. Garrett, a customer in line who worked for a back doctor told Petitioner that if she called a back doctor: "they're going to tell you to take Aleve for a week . . . before they even want to see you and I'm like, ok, I guess I'll try that so I took Aleve and then I called my doctor." The Petitioner testified that she did not seek treatment at this time. Both Garrett and Ford have since retired according to Petitioner, and neither party called either one to testify at the hearing.

An undated Accident and Injury Report Petitioner submitted into evidence indicated a 7/8/07 date of accident and the following: "I was helping another clerk put Christmas trees on the ledge to get them out of the back room. She was on the ladder and I was handing up the trees and I hurt my lower back." As to the date she reported it to her supervisor, it states: "7-10-2007 – I told her my back was hurt but didn't think it was going to be serious." Asked if she sought treatment and where, the Petitioner indicated Dr. Stabell, chiropractor Dr. Smith and Dr. Buenger. (Px19). Petitioner first saw Dr. Stabell for her back on 8/22/07, and did not see Drs. Buenger or Smith until after that.

Dr. Stabell is the Petitioner's family doctor, and the Petitioner testified she did not seek any medical care or call him until a few weeks later, after she was walking through the store and was unable to bring her left foot forward, noting she had to pull on her pants leg to move that leg forward to ambulate. She also said she reported increasing pain to Ms. Garrett.

On 8/22/07, Petitioner sought treatment with Dr. Stabell and saw his nurse practitioner. Petitioner provided a history of injuring her back 3 to 4 weeks prior with increasing pain in the left hip into the groin. It appears x-rays were obtained which showed mild degenerative disc disease. On 8/28/07 Petitioner was seen by Dr. Stabell and complained of increased low back pain, left hip pain and sciatica in the left leg. A history of lumbar problems in 2005 was noted, as well as that a lumbar MRI was obtained, apparently indicating some thecal sac impingement at L4 to S1, with occasional mild low back pain since. The Petitioner testified that her pain never went below her knee. Dr. Stabell recommended physical therapy and discussed the possibility of epidural injections. (Px6). Asked about reporting pain going back 3 to 4 weeks, which would have been after the alleged accident date, Petitioner testified, "I don't remember what I told them word for word, it was a long time ago, but I know I told them I hurt my back at work."

The Petitioner's prior medical records indicate that Petitioner had an evaluation of her low back in 2005 when it appears she was having some difficulty with foot-drop on the left. At that time, Dr. Stabell referred Petitioner to Dr. Burger for evaluation of Petitioner's left foot and low back. Dr. Burger was concerned that a lumbar pathology was responsible for the Petitioner's left lower extremity pain. He prescribed a 9/28/05 lumbar MRI that showed evidence of degenerative disc disease at L4/5 and L5/S1 with small central disc protrusions at both levels, and mild impingement on the thecal sac. There also was evidence of a synovial cyst extending from the right L4/5 facet joint and impinging on the thecal sac. (Rx8) Dr. Burger ordered an EMG/NCV to assess Petitioner's leg pain and two plus years of left foot pain. The 7/29/05 testing revealed left tibial CMAP and left tibial neuropathy at the ankle causing axonal loss. (Rx15). This appears to the Arbitrator to be a finding very similar to the left foot/leg symptoms the Petitioner testified led her to seek treatment with Dr. Stabell in August 2007.

Petitioner recalled that Dr. Stabell prescribed an MRI and muscle relaxers, and referred her to Dr. Buenger for pain management. She indicated her mother had treated with Dr. Buenger in the past for her back, and Petitioner was afraid to see him because she knew he would give her injections. She instead sought treatment with chiropractor Dr. Smith at Wood River Chiropractic Center. (Px9) Petitioner testified she had never seen a chiropractor before this accident. On 9/27/07 Petitioner gave a history to Wood River of injuring her low back when she was lifting overhead at work. She admitted that she had had back "issues" previously but did not require any treatment. The Petitioner testified she didn't recall reporting Dr. Smith on 10/2/07 that she tripped and fell down, or telling him on 10/19/07 that the only idea she had as to how she injured her back was lifting boxes and bending at work. She also did not recall telling Dr. Smith on 10/26/07 that her back went out while lifting merchandise at WalMart. Dr. Smith did not note any history of the alleged 7/8/07 accident. She testified Dr. Wood's treatment provided no relief and a few months later she went to Dr. Buenger.

A 10/26/07 lumbar MRI indicated an annular tear at L4/5, a grade I isthmic spondylolisthesis at L5/S1 and a foraminal disc herniation at L5/S1. (Px3). On 10/31/07 Dr. Stabell noted Petitioner had been to pain management and had epidural injections with only moderate relief. On 11/8/07, Dr. Stabell noted that Dr. Buenger performed a left L5 transforaminal epidural steroid injection. On 12/5/07, Petitioner had left sided medical blocks at L4, L5 and S1. (Px7).

Petitioner testified that the initial epidural provided only temporary relief, she did get relief with therapy, and that multiple radiofrequency ablation procedures, starting in December 2008, did help for 3 or 4 months. She also testified that she continued to work full duty, including cashier, stocking, sweeping and lifting of various weights up to 50 pounds, with no medical restrictions. She stated that she was still in constant pain during Dr. Buenger's treatment, but had to work to pay her bills. She took Aleve and testified that Dr. Stabell prescribed Flexeril.

From 1/10/08 through April, 2008 Petitioner participated in physical therapy. She did not miss any work during this time. During therapy she was noted to have left low back and left-sided pain at 7 out of 10 level. On 1/18/08 the therapist noted that Petitioner was having difficulty using her left leg. On 3/21/08, however, Dr. Buenger released the Petitioner to return as needed, as she noted only 1 out of 10 pain.

The Petitioner could not recall what she told Dr. Stabell's nurse practitioner at the initial visit, but that she did say she hurt her back at work. She sought treatment because she was getting worse and she couldn't move her leg forward. She again testified that while Dr. Stabell indicated in 2005 that she might have a back problem, this was based on her examination of the Petitioner's foot. As to reporting her pain was caused by lifting heavy objects at work, she indicated this meant the wrapping paper. She "should" have told Stabell she got hurt lifting heavy objects at work "because that's what happened", meaning the wrapping paper.

The Petitioner testified that she hasn't seen Dr. Gornet, or any other physician, for her back since 2012, and that he indicated there was nothing more he could do for her outside of surgery. She said she hadn't made up her mind about it at that point in time. She has seen Dr. Stabell for unrelated conditions. Nevertheless, she testified that she has continued to have back pain.

Petitioner was not working at the time of the hearing, testifying that this was for unrelated reasons, though she remained a Respondent assistant manager. Prior to going off work she continued to work her regular job with pain. Her left leg pain is not as bad as it was, but it still sometimes travels down her leg to the knee. She is unable to take Aleve due to being on blood thinners, but testified she continues to take Flexeril via Dr. Stabell. Her pain is worse in the evenings, she uses ice or heat, and she is able to use stairs with difficulty.

Petitioner testified that she is currently employed at a different Dollar General store in East Alton, Illinois, noting she would still be working full duty if she wasn't off work for an unrelated issue. She agreed she hadn't had any lost time due to her back. Petitioner agreed that her job as an assistant manager continued to involve setting up display merchandise inside and outside of the store, and bringing everything back in at the end of the day. Video was presented by Respondent reflecting the Petitioner performing her daily work duties with Respondent. The Arbitrator's review of these videos (see Rx22, 23 and 24) reflects the Petitioner performing some fairly physical work without any obvious low back or left leg problems. The Arbitrator notes that these videos cover several days in both January and March of 2014 and March of 2016.

CONCLUSIONS OF LAW

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

The Arbitrator finds that the Petitioner failed to prove that she sustained accidental injury to her low back on 7/8/07 which arose out of and in the course of her employment with Respondent. Overall, this was a close case with regard to the issue of accident, but the Arbitrator believes that the preponderance of the evidence indicates that the Petitioner has failed to prove this key issue.

A significant factor in this determination, in the view of the Arbitrator, is the accident report and the facts surrounding a verbal report to her supervisor, as well as the delay in treatment. The accident report itself belies the Petitioner's testimony that she provided this notice. While she testified she completed it on the alleged date of accident, in the section requesting treatment information, the document lists Dr. Stabell, Dr. Buenges and Dr.

Smith, all of whom the Petitioner testified she did not see until 8/22/07 and thereafter. The document itself is undated. However, it makes no sense that she could have prepared this document and indicated on it that she saw doctors that she had not yet seen. This definitely impacts the Petitioner's credibility in a negative way in this case. Additionally, she testified that her supervisor was on vacation when she completed the report, so she put it in her own file, and was going to tell her supervisor when she returned. It doesn't make sense to the Arbitrator that someone would put an accident report into their own file without first providing it to their supervisor. It also seems a little too convenient that the supervisor happened to be gone the day that this alleged incident happened.

The Petitioner also sought no treatment after this alleged injury until 8/22/07, which is over six weeks after the alleged accident date. The Petitioner then reported to Dr. Stabell's assistant that she was injured at work 3 or 4 weeks prior, which is inaccurate based on the alleged accident date, and failed to indicate with any specificity how she was injured. This becomes all the more relevant when you review the note of chiropractor Dr. Smith which appears to indicate that the Petitioner wasn't certain how she was injured at work, but that the only idea she had was lifting boxes and bending at work. The first time the records reflect a specific incident like the Petitioner testified to was in the October 2007 physical therapy records. This seems to coincide with a time where the Petitioner had seen the medical providers she listed on the accident report (Px19). Thus, the Arbitrator believes the preponderance of the evidence would indicate that it was at this time that the Petitioner determined that an alleged prior incident was causing her current problems. The Arbitrator also notes that there is some discrepancy

The Arbitrator also finds it relevant that in 2005 she was worked up for what appeared to be a left foot drop. This included an MRI and EMG/NCV. At that time Dr. Buenger noted a two year history of this problem. This indicates not only that it appeared to be a chronic condition, but also that the Petitioner had seen Dr. Buenger before. When she was referred there after the accident date, she testified that she went to Dr. Smith instead because she was afraid of needled, and that Buenger had previously treated her mother with injections. Again, this doesn't make sense given it appears that she herself had seen Dr. Buenger prior to 2007.

The Petitioner, since the alleged accident date, has continued to work her full duties for Respondent, other than being off work for unrelated issues. The evidence in this case, particularly the extensive video of her working at the store, indicates that she has continued to perform fairly physical work duties since the alleged accident date. Taking all of the evidence as a whole, the picture in this case appears to be more one of the Petitioner having had ongoing low back problems, which included radicular symptoms in the left leg and foot, since 2003, and that nothing very significant changed about her condition in July 2007 other than a flare up. Given she has failed to prove an accident, the flare up does not appear to the Arbitrator to be causally related to any specific work accident.

The explanations the Petitioner offers regarding the noted discrepancies in this case are simply far too convenient in the Arbitrator's view to be credible. Part of the dilemma in this case is the Petitioner was testifying about events from almost 10 years prior to the hearing. However, this does not relieve the Petitioner of her burden of proof. Taking all of the evidence in this case as a whole, the number and degree of inconsistencies are significant and consequential. The Arbitrator finds that the clear preponderance of the evidence indicates that the Petitioner failed to prove she sustained accidental injuries arising out of and in the course of her employment on 7/8/07.

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

Based on the same facts noted above with regard to the accident issue, the Arbitrator also finds that the Petitioner failed to prove that she provided timely notice to the Respondent pursuant to Section 6(c) of the Act. First, the Arbitrator has determined that she failed to prove accident. Secondly, the Arbitrator does not find the Petitioner's allegation that she prepared an accident report on the date of accident to be credible given the information contained therein, as noted above.

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

Given that the Petitioner failed to prove a compensable accident, there is no accident to which to causally related the Petitioner's lumbar condition. As such, the Arbitrator finds that the Petitioner has failed to prove causation of her low back condition to an alleged 7/8/07 accident.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's findings with regard to accident and causation, 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 with regard to accident and causation, this issue is moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Timothy F. Monahan,

Petitioner,

vs. NO: 15WC 21247

State of Illinois Healthcare & Family Services,

18IWCC0052

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, 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 May 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.

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: JAN 26 2018
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MJB/jrc
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

MONAHAN, TIMOTHY F
Employee/Petitioner

Case# **15WC021247**

ST OF IL HEALTHCARE & FAMILY SERVIICES
Employer/Respondent

18IWCC0052

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:

2427 KANOSKI BRESNEY
KATHY A OLIVERO
2730 S MacARTHUR BLVD
SPRINGFIELD, IL 62704

5002 ASSISTANT ATTORNEY GENERAL
JOSEPH P BLEWITT
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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

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

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

MAY 11 2017

DONALD A. RARRIA, Acting Secretary
Illinois Workers' Compensation Commission

18IWCC0052

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Timothy F. Monahan
Employee/Petitioner

Case # 15 WC 21247

v.

Consolidated cases: _____

State of Illinois Healthcare & Family Services
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Edward Lee, Arbitrator of the Commission, in the city of Springfield, on March 30, 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 : prospective medical care

FINDINGS

On **April 10, 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 $104,306.50; the average weekly wage was $2,005.89.

On the date of accident, Petitioner was **50** years of age, ***married*** with **0** dependent children.

Petitioner ***has not*** received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $0.00 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 $1,894.16 under Section 8(j) of the Act.

ORDER

- Respondent shall pay Petitioner compensation that has accrued from 4/10/15 through 3/30/17, and shall pay the remainder of the award, if any, in weekly payments.
- Respondent shall pay the further sum of **$2,389.56** for necessary medical services, pursuant to the medical fee schedule, as provided in Section 8(a) and 8.2 of the Act, and shall be given a credit for payments made by the group medical plan, and shall hold Petitioner harmless from any and all claims by any provider 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 the bilateral carpal tunnel releases Dr. Ma has recommended for Petitioner's hands, consistent with the fee schedule in 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.

Gus Lee
Signature of Arbitrator

5/9/17
Date

MAY 11 2017

18IWCC0052

The Arbitrator hereby makes the following Findings of Facts on all issues:

Petitioner has been employed by the State of Illinois since February of 1983, holding positions with the Secretary of State and the Dept. of Public Aid, n/k/a Healthcare & Family Services. As of 1997, Petitioner held the position of Executive I in Healthcare & Family Services and performed the duties of web development and graphic design for multiple websites. To perform his duties as an Executive I, Petitioner typed on 3 computers for 7 hours per work day, 5 days per week, as well as 7-8 hours of overtime on Saturdays. Petitioner described the manner in which he typed as his shoulders were elevated, his palms were down, and his wrists flexed, and he used his right hand to operate the mouse.

In 2008, Petitioner became a Public Service Administrator (PSA) in Healthcare & Family Services and performed the duties of web development, graphic design, and Local Area Network (LAN) administration. To perform the duties of LAN administrator, Petitioner installed, fixed, and worked on computers in other offices, and typed reports for every LAN certification issue. As a PSA, Petitioner typed on several computers and used the mouse at least 7 hours per work day, 5 days per week, as well as 7-10 hours of overtime each week. Petitioner described the manner in which he typed as a PSA as the same manner as he did as an Executive I.

Petitioner noted PX 4 did not accurately describe the duties he performed as a PSA. PX 4 described the essential functions of a PSA, including conducting extensive research and resolving program and administrative problems and noted the percentage of time to perform those functions, but did not describe the physical requirements to perform the various functions.

As a PSA, the number of computers Petitioner interacted with daily varied and while Petitioner worked with other hardware including printers and monitors, Petitioner still had to type on a keyboard. Petitioner described the printers used as large printers installed by Xerox as there are not a lot of small local printers used anymore. Petitioner works with approximately a dozen software programs and fixes computers remotely from his computer. Petitioner identified his primary computer as the one he does his work on, another computer as the one where list serves are run which has to be separated because of HIPPA violations or breaches, and the remaining computer is used to remote in and out of other places, and these computers are used all the time going back and forth.

Petitioner acknowledged he has a laptop at home he uses to pay bills, but because of the amount of time he is on the computer at work, he uses his laptop for only a small amount of time but not long enough to experience symptoms in his hands.

Petitioner identified PX 7 as photographs of his work station as a PSA and noted there were 4 monitors with 3 keyboards. These photographs show two keyboards and 3 mouses on a desk and another keyboard on a small file cabinet (PX 7). Petitioner types on the 3 keyboards n the manner he described and noted he had never used an ergonomic keyboard and/or an ergonomic mouse in the performance of his duties. Petitioner has worked with Christine Yucaneer, another PSA for Respondent, since 2009.

Petitioner is right hand dominant. Before Petitioner began his employment with the State of Illinois, Petitioner had never sustained any injuries to his right and left hands, had never seen any medical provider for any complaints involving his right and left hands, and had not experienced any symptoms in his right and left hands. In January of 2014, as Petitioner was typing and using the mouse in the

18IWCC0052

performance of his duties as a PSA, Petitioner noticed a little pain and numbness in his right arm. Petitioner saw his primary care physician, Dr. Morton, who did not do anything medically for these complaints and Petitioner did not report this to Respondent, as Petitioner did not think it was bad enough.

In April of 2015, as Petitioner was performing his duties as a PSA, Petitioner noticed increased symptoms in his right hand as well as symptoms in his left hand. Petitioner again sought treatment for these complaints with his primary care physician, Dr. Morton, and discussed with Dr. Morton the duties he performs on computers.

The records of Springfield Clinic reported Petitioner was seen on 4/10/15 by Dr. Morton for both upper extremities, it had been ongoing for a very long time, it was unbearable, and Petitioner had a lot of numbness and tingling in his forearms and into all of his digits, and Petitioner wakes up at night with shooting pain into both hands and numbness, and Petitioner had done computer entry work for many years (PX 1, p. 1). On physical examination, Petitioner had a positive Tinel's and Phalen's at the wrists, a positive Tinel's at the elbows bilaterally, and his strength was a bit diminished bilaterally. Dr. Morton assessed Petitioner as likely having carpal and cubital tunnel syndrome that was likely aggravated by his profession, gave Petitioner bilateral wrist splints to use and scheduled Petitioner for an EMG/NCV study of the upper extremities with Dr. Gelber (PX 1, p. 1).

The EMG/NCV study was performed on 4/20/15 and it was reported Petitioner was a state worker with complaints of numbness and tingling in the hands and pain in the wrists (PX 1, p. 2, 20-23). This study showed bilateral carpal tunnel syndrome, mild on the left and moderately severe on the right. Petitioner completed a Notice of Injury Report following his appointment with Dr. Gelber and noted he was working on computer/keyboard/mouse at the time of injury (PX 5, p. 1). A Supervisor's Report completed by Richard Foxman noted the unsafe act or condition was typing (PX 5, p. 3).

Dr. Morton then referred Petitioner to Dr. Ma, an orthopedic surgeon. Petitioner discussed his duties as a PSA with Dr. Ma noting he performed computer work most of the day. The records of Springfield Clinic reported Petitioner was seen on 5/1/15 by Dr. Ma for evaluation of numbness and tingling in both hands, Petitioner has an office job, Petitioner developed numbness and tingling in both hands many years ago, the symptoms in both hands have progressed, Petitioner has more numbness and tingling in the left hand but both hands fall asleep easily, and the symptoms are aggravated with working with computers at work (PX 1, p. 3, 10). On examination, Dr. Ma found the left upper extremity demonstrated a positive Tinel sign at the carpal tunnel, a Durkan test, a Phalen test, decreased sensation in the median nerve distribution, and slight weakness of intrinsic muscles of the left hand (PX 1, p. 5). Dr. Ma further found the right upper extremity demonstrated decreased sensation in the median nerve distribution, a positive Tinel sign at the carpal tunnel, a Durkan test, a Phalen test, and there was a mass lesion on the dorsal aspect of the right wrist (PX 1, p. 6). Dr. Ma reviewed the EMG/NCV studies and diagnosed Petitioner with carpal tunnel syndrome and a dorsal wrist ganglion, and discussed surgical intervention with Petitioner which he noted would be scheduled once approval from workman's compensation insurance was obtained. An Order Comments Report dated 5/6/15 noted the surgery was not authorized due to the claim being denied as compensable (PX 1, p. 7).

The records of Springfield Clinic reported Petitioner was seen by Dr. Ma on several occasions after 5/1/15, including 1/22/16, 5/24/16, and 11/23/16 (PX 1, p. 24-26, 30-33, 34-36). At each of those visits,

18IWCC0052

Petitioner continued to complain of numbness and tingling in the bilateral hands as well as weakness, the examinations by Dr. Ma continued to have similar physical findings of the bilateral hands, and Dr. Ma administered steroid injections on both sides and also prescribed new bilateral cock-up splints at the visit of 11/23/16 (PX 1 p. 34-36).

Petitioner was also seen by Dr. Ma on 1/17/17, who reported the steroid injection and bracing Petitioner received in November, did not provide much relief to Petitioner, Petitioner's hands fall asleep several times a day, Petitioner's pain was 7/10, Petitioner types at least 6 hours per day, Petitioner has to work with multiple keyboards and computers, and Petitioner's symptoms are really aggravated with activities at work (PX 1, p. 37). Dr. Ma's findings on physical examination of Petitioner's bilateral hands were the same as before, and Dr. Ma noted Petitioner would benefit from surgical release of both carpal tunnels and in the meantime, to continue activity modification, bracing, and nonsteroidal anti-inflammatory medications (PX 1, p. 38-39). Petitioner expressed to Dr. Ma he wanted to proceed with the surgery and expressed he still wants to proceed with the surgery Dr. Ma has recommended for him as there has been no change in his symptoms.

Petitioner saw Dr. Naam at the request of Respondent and completed paperwork for Dr. Naam's office in PX 8 but was not asked to explain any information in the paperwork he completed. The Worker's Compensation Information form asked for a description of current work activities and Petitioner replied LAN administrator and he is responsible for maintaining and organizing the local area network for Healthcare and Family Services office and staff in Springfield and Chicago, installing LAN network components, tracking inventory, installing software and equipment, monitoring LAN performance, upgrading hardware and software, trouble shooting computer and software problem, and installing large groups of new computer (PX 8, p. 8-9). This form also asked for a description of work related incident or injury and Petitioner replied years of working on a computer keyboard – mouse (PX 8, p. 8). PX 8 also contained a Therapy Evaluation Form that noted Petitioner presented with a moderate weakness of the left upper extremity and a significant weakness of the right upper extremity and the rapid exchange grip was higher on the 2nd position on the right indicating decreased effort and only slightly high on the left (PX 8, p. 2).

Dr. Naam did not ask Petitioner how much time he spent daily typing on the computer, did not ask Petitioner the manner in which Petitioner typed on the computer, and did not ask Petitioner to demonstrate the manner in which Petitioner typed on the computer. Petitioner actually saw 3 individuals in Dr. Naam's office and spent only 5 minutes with Dr. Naam. Petitioner described his demeanor during the 5 minutes he spent with Dr. Naam as normal, maybe a little nervous because he is shy and quiet, but no different than his dealings with Drs. Morton, Gelber, and Ma. Petitioner denied he became hostile during his examination by Dr. Naam and reported he gave maximal effort during the testing performed by Dr. Naam's staff.

PX 9 is a printout of information about Carpal Tunnel Syndrome from Southern Illinois Hand Center and notes the cause of it is increased pressure within or on the carpal tunnel resulting in decreased blood flow and oxygen delivery to the median nerve. This printout further provides that tasks that require rapid, repetitive use of the hands, vibrating tools, or a prolonged power grip are associated with carpal tunnel and non-operative management includes reducing repetitive or strenuous use of the hand, keeping the wrists in a neutral position, taking resting breaks for the hands, and altering grasp to use the whole hand.

18IWCC0052

Christine Yucaneer has been employed by the Dept. of Healthcare & Family services as a LAN Services Coordinator which is also known as a Public Service Administrator since 2009 and works with Petitioner. Ms. Yucaneer performs similar duties to Petitioner but noted Petitioner has extra duties Ms. Yucaneer does not. Ms. Yucaneer described her work station as comprised of several monitors and keyboards in front of her and reported she spent 85% of her day typing on these keyboards and her normal work day was 7 ½ hours. Ms. Yucaneer has observed Petitioner performing his duties as a PSA and reported Petitioner spent the same amount of time as she did typing on the computers if not more (A. 32-33). Ms. Yucaneer described the desks she and Petitioner use as ones where there is no drop down keyboard and this requires them to reach across the desk, but she had not observed the position of Petitioner's wrists or hands when he was typing.

PX 3 contained the medical bills incurred by Petitioner at Springfield Clinic and these bills totaled the sum of $5,711.40. This exhibit showed payments by group health insurance totaled the sum of $1,894.16, group health insurance adjustments totaled the sum of $1,427.68, Petitioner made payments of $177.00, and there was a balance of $2,212.56 due and owing.

Dr. Ma is an orthopedic surgeon who did his residency at Wake Forest University, an upper extremity fellowship at Duke University, and joined Springfield Clinic in 2012 where he specializes in the upper extremity and regularly treats patients with carpal tunnel syndrome (PX 2, p. 5-7). Dr. Ma is licensed to practice medicine in Illinois and North Carolina and is also board certified (PX 2, p. 6).

Dr. Ma first saw Petitioner as a patient on 5/1/15, as a referral from Petitioner's primary care physician, Dr. Morton, and reported Petitioner complained of numbness and tingling with the left hand worse than the right hand, and a ganglion cyst of the right hand (PX 2, p. 7-8). Dr. Ma explained a ganglion cyst is a mass on the dorsal side and carpal tunnel syndrome is numbness/tingling in the thumb, index, middle, and half of the ring fingers resulting from compression of the median nerve (PX 2, p. 8). Dr. Ma noted carpal tunnel syndrome was the most common nerve compression and explained when the wrist is flexed there is increased pressure in the carpal tunnel and this is very common for people with repetitive motion (PX 2, p. 8-9). Petitioner told Dr. Ma this problem developed over a course of years, and Petitioner used a computer and mouse all the time and Petitioner's symptoms were aggravated with typing on the computer and using the mouse (PX 2, p. 9). Dr. Ma did not think Petitioner demonstrated to him the position of his hands as he typed or used the mouse (PX 2, p. 9-10, 28-29).

On physical examination, Dr. Ma found decreased sensation in the median nerve distribution, a positive Tinel's sign, and a positive Durkan test (PX 2, p. 10). Dr. Ma reviewed the EMG/NCV testing that showed mild carpal tunnel syndrome on the left and moderately severe carpal tunnel syndrome on the right, and noted the degree of carpal tunnel syndrome on electrodiagnostic testing does not necessarily correlate with the symptoms an individual has, and explained he does not make his decision based solely on the diagnostic findings (PX 2, p. 10-11). Dr. Ma did not find anything in Petitioner's medical history, surgical history, or family history, that was significant with respect to Petitioner's complaints and a risk factor for the development of carpal tunnel syndrome (PX 2, p. 11-12, 25, 29).

Dr. Ma diagnosed Petitioner with bilateral carpal tunnel syndrome and a dorsal wrist ganglion and recommended surgery for Petitioner to be scheduled once there was approval from workers' compensation (PX 2, p. 12-13). Dr. Ma was subsequently informed by his office that workers' compensation did not approve Petitioner's surgery (PX 2, p. 13). Dr. Ma saw Petitioner again on 1/22/16,

18IWCC0052

and noted Petitioner symptoms had progressed and provided Petitioner with injections to the carpal tunnel (PX 2, p. 14). Dr. Ma explained the lidocaine in the injection numbs the nerve and temporarily relieves the symptoms and the steroid in the injection calms the inflammation to partially relieve the symptoms (PX 2, p. 14-15). Dr. Ma did not think the injections were ideal treatment for Petitioner because Petitioner's symptomatology was very significant but it was a good option before surgery is scheduled (PX 2, p. 15).

Dr. Ma reviewed his clinic note of 5/24/16, and noted the question is this work related is for internal use in determining whether workers compensation has been approved and surgery can be scheduled, and does not have to do with the issue of causation (PX 2, p. 16-17). At the visit of 5/24/16, Petitioner had complaints involving his right elbow and Dr. Ma diagnosed this as lateral epicondylitis and noted this is very different than carpal tunnel syndrome but can also be due to repetitive motion of the elbow and Petitioner had not had any further complaints involving the elbow since it was injected (PX 2, p. 17-18).

Dr. Ma saw Petitioner on 1/17/17, and Petitioner expressed his symptoms were getting worse as Petitioner had symptoms beyond the numbness and tingling he initially complained of (PX 2, p. 18-19). Petitioner told Dr. Ma he types on multiple keyboards for 6 hours per day in his job and this aggravated his symptoms and caused his hands to fall asleep easily (PX 2, p. 19-20). On physical examination, Dr. Ma had findings consistent with previous examinations of Petitioner but the ganglion cyst had gone away, and the diagnosis remained bilateral carpal tunnel syndrome and Dr. Ma again recommended surgery for Petitioner's bilateral carpal tunnel syndrome (PX 2, p. 20-21).

Based on a reasonable degree of medical and surgical certainty, Dr. Ma opined the work activities Petitioner performed for a number of years definitely aggravated the conditions of bilateral carpal tunnel syndrome diagnosed in Petitioner, but could not opine these work activities caused the bilateral carpal tunnel syndrome (PX 2, p. 21-22). Dr. Ma explained an aggravation means the condition was there and made worse and causation means the condition was not there (PX 2, p. 27). Dr. Ma also thought it was possible Petitioner experienced a temporary aggravation of his symptoms at work in the beginning but over time multiple aggravations can cause pathological or permanent change (PX 2, p. 27, 31-32). Dr. Ma understood Petitioner had worked for Respondent for multiple years and opined given that length of time, Petitioner's bilateral carpal tunnel syndrome had been significantly aggravated by the performance of his work duties and further opined this was not a temporary aggravation (PX 2, p. 32-33).

Dr. Ma did not know what other duties Petitioner performed besides using the keyboard and what hand Petitioner used to manipulate the mouse but assumed it was Petitioner's dominant right hand (PX 2, p. 27-28). Dr. Ma explained a basis for his opinion was scientific evidence which showed with repetitive motion the pressure is increased within the carpal tunnel and can cause compression of the median nerve and then symptoms (PX 2, p. 22). Dr. Ma explained it is common sense when the pressure is increased within the tunnel the nerve is squeezed and the blood supply is cut off so the nerve will not get enough nutrient and that causes dysfunction which is why there is numbness and tingling (PX 2, p. 22). Dr. Ma noted the activities that cause this increased pressure within the carpal tunnel include flexion and extension of the wrists (PX 2, p. 23).

Dr. Ma also opined Petitioner was in need of surgery for both the right and left hands with respect to his carpal tunnel syndrome (PX 2, p. 23). Dr. Ma noted Petitioner had never shown a hostile attitude during the numerous encounters he had with Petitioner, as Petitioner was a very pleasant patient, and Petitioner

had never shown any signs of symptom magnification (PX 2, p. 24). Dr. Ma indicated he would not order a repeat nerve conduction study on Petitioner as the diagnosis has already been confirmed and it would not change the treatment needed by Petitioner (PX 2, p. 24-25). Dr. Ma did not think he had reviewed any of the records of Dr. Morton before he began treating Petitioner (PX 2, p. 26). Dr. Ma heard Petitioner had been seen by Dr. Naam as Petitioner may have mentioned Dr. Naam's conclusion but had not seen any report (PX 2, p. 30-31).

Dr. Nash Naam examined Petitioner on June 28, 2016 and prepared a report which expressed opinions based on a reasonable degree of medical certainty (RX 3, p. 4-5, 16). Dr. Naam discussed Petitioner's job duties and concluded there was no relationship between Petitioner's work activities and carpal tunnel syndrome or the ganglion cyst on the dorsal aspect of the wrist (RX 3, p. 5-6). Dr. Naam explained Petitioner told him his job was to set and install computers, and Dr. Naam thought it seemed like Petitioner did several things with his hand, not just one thing over and over, and his job did not come to the level it would cause carpal tunnel syndrome (RX 3, p. 6). Dr. Naam did not believe Petitioner's work duties contributed to the development of the cyst because most ganglions on the dorsal aspect of the wrist are idiopathic in nature and while they sometimes can result from trauma, there was no history of trauma and nothing in Petitioner's work activities predisposed Petitioner to develop the ganglion (RX 3, p. 6-7).

Dr. Naam acknowledged his office sent various paperwork to Petitioner to complete before the examination, and initially stated he could not identify that paperwork as it is sent by his business office but then confirmed Petitioner had been sent a letter, a Workers' Compensation information form, a patient information form, a medical history form, a notice of privacy practices and patient consent for use of disclosure of protected health information form, and information on insurance plans accepted (RX 3, p. 16-18). The Workers' Compensation form asked Petitioner to describe his current work activities and Petitioner noted the repetitive use of his hands on a frequent basis when installing LAN network components, and Dr. Naam thought it said something about tweeting and software equipment, and then performance, upgrading, and monitoring, and not all of this information was contained within his written report (RX 3, p. 18-19). Dr. Naam acknowledged he did not review Petitioner's written description of the job duties with him, but simply asked Petitioner to express what he did (RX 3, p. 19-20).

Dr. Naam also received previous medical records concerning Petitioner and a cover letter dated 6/9/16 in association with his examination of Petitioner but did not receive any written job description for Petitioner's position, a physical demands analysis for Petitioner's position, any photographs of the work station where Petitioner performed his duties, and any photographs of the keyboards and mouses used by Petitioner (RX 3, p. 20-21). Dr. Naam acknowledged he was not provided with any medical records from Dr. Morton and did not mention the records of Dr. Ma in his written report (RX 3, p. 21-22). Dr. Naam explained he reviews the medical records before the examination of the individual but was unable to state the amount of time he spent reviewing the records of Petitioner as there were a lot of duplicate records he had been provided and then estimated it took him 1 ½ hours to review the records (RX 3, p. 22).

Dr. Naam acknowledged that besides work related activities, there are other risk factors for the development of carpal tunnel syndrome and explained carpal tunnel syndrome is a multifactorial entity and most of the carpal tunnel syndrome diagnosed is idiopathic (RX 3, p. 7). Dr. Naam noted some of the multiple causes of carpal tunnel syndrome include metabolic causes, including diabetes and

hypothyroidism, trauma, any space occupying lesion inside the carpal tunnel, anything that narrows the carpal tunnel, and anything that causes pressure or compression, and noted Petitioner did not have any of those risk factors for the development of carpal tunnel syndrome (RX 3, p. 7-8). Dr. Naam noted the presence of pain or any symptoms related to the performance of an activity does not mean the activity is responsible for causing an entity and provided an example where a person who has a fracture of the right hand has his hand shaken and the hand hurts (RX 3, p. 8).

Dr. Naam expressed in his report Petitioner had a somewhat hostile attitude at the beginning of the evaluation and explained patients with Workmen's Comp have an uncomfortable attitude but then stated he did not really pay a whole lot of attention to that (RX 3, p. 9-10). Dr. Naam also explained what he meant by symptom augmentation in his report in that Petitioner did not give his maximal effort when his grip strength was evaluated and noted he sometimes sees that for whatever reason but again stated he did not pay attention to that until he was asked specifically about Petitioner's behavior (RX 3, p. 10).

Dr. Naam estimated the physical examination of Petitioner including the involvement of the therapist took about an hour and the therapist reported the grip strength and active range of motion findings (RX 3, p. 23-24). Dr. Naam explained the patient is tested using a Jamar dynamometer and there is a specific pattern seen with normal grip strength measurements, i.e. the bell shaped curve, and then the rapid exchange grip is performed to see if there is any discrepancy between the rapid exchange grip strength and the normal grip strength (RX 3, p. 11). Dr. Naam noted the rapid exchange should be lower because the patient gets tired from repeating the grips and if there is a significant discrepancy the conclusion is the patient was not giving his maximal effort (RX 3, p. 12). Dr. Naam did not know the other readings for Petitioner as nothing else was recorded (RX 3, p. 13).

Dr. Naam indicated an EMG/NCV is sort of valid for about 3 years (RX 3, p. 26). Dr. Naam acknowledged some patients with carpal tunnel syndrome complain of numbness in all digits (RX 3, p. 12). Dr. Naam diagnosed Petitioner with bilateral carpal tunnel syndrome and opined Petitioner was in need of surgical releases for his conditions of ill-being and agreed Petitioner did not have any systemic conditions associated with carpal tunnel syndrome (RX 3, p. 26-27).

Dr. Naam acknowledged increased pressure within the carpal tunnel results in decreased blood flow and oxygen delivery to the median nerve and this can cause carpal tunnel syndrome but disagreed that increased pressure on the carpal tunnel results in decreased blood flow and oxygen delivery to the median nerve and this can cause carpal tunnel syndrome (RX 3, p. 27). Dr. Naam was unaware the latter statement was on the website for his office and confirmed the question asked of him was word for word consistent with the information on the website (RX 3, p. 27-28). Dr. Naam agreed typing on the computer with the wrists and hands in a flexed position throughout the day can cause increased pressure within the carpal canal and therefore lead to carpal tunnel syndrome but noted it is the flexion of the wrist that is important rather than the typing (RX 3, p. 28). Dr. Naam recalled asking Petitioner to demonstrate the manner in which he typed on the computers but acknowledged he did not mention that anywhere in his report and the manner in which Petitioner demonstrated he typed is a significant factor (RX 3, p. 29-30). Dr. Naam did not ask Petitioner how many computers he had in front of him throughout the day or the manner in which Petitioner worked on the keyboards for each computer but Petitioner told him there were quite a few computers (RX 3, p. 30-31). Dr. Naam agreed Petitioner told him when installing various equipment, he had to place his wrists in awkward positions but he did not think this was done for any sustained period of time like 4-6 hours, so it had no significance but acknowledged flexion of the

18IWCC0052

wrists for 4-6 hours per day is significant (RX 3, p. 31-32). Dr. Naam did not know the amount of time Petitioner spent typing on computers but then indicated Petitioner did not sit for 4-6 hours continuously everyday to type as Petitioner fixes the computers daily but acknowledged this information was not contained in his report (RX 3, p. 36-37).

Dr. Naam is of the opinion a person who rests their wrists on a table does not cause increased pressure within the carpal canal and explained pressure from the outside is not enough to go through the transverse carpal ligament or the bones to cause increased pressure within the canal, unless there is a fall or crushing injury, but when the wrists are flexed the transverse carpal ligament increases the pressure inside the canal to go to 90 mm (RX 3, p. 33-35).

Therefore, the Arbitrator concludes as follows:

1. Petitioner sustained an accident arising out of and in the course of his employment on 4/10/15. Petitioner credibly testified to the extent of typing activities he has performed daily as well as during overtime hours he normally has worked each week since 1997, and the manner in which he physically performed those typing activities with his wrists flexed. The extent of typing activities performed by Petitioner was corroborated by Petitioner's co-worker, Christine Yucaneer, who has worked with Petitioner since 2009. In addition, the record of Dr. Morton for 4/10/15 reported Petitioner had done computer entry work for many years, the initial medical record of Dr. Ma reported Petitioner performed computer work most of the day, and Dr. Ma's last medical record reported Petitioner has to type at least 6 hours per day on multiple keyboards and computers. The photographs of Petitioner's work station corroborated the amount of keyboards and computers used by Petitioner as a PSA. The only contradictory evidence on the extent of typing activities performed by Petitioner as well as the manner in which Petitioner typed was the testimony of Dr. Naam. However, that testimony is not credible and persuasive for several reasons including that the written report of Dr. Naam did not reference the extent and manner of typing performed by Petitioner nor did any of the records from Dr. Naam's office reference this (RX 2). In addition, Petitioner denied Dr. Naam asked him about the time he spent typing on the computer, the manner in which Petitioner typed on the computer, and that he had demonstrated the manner in which he typed on the computer to Dr. Naam. Finally, when Dr. Naam testified about Petitioner's job, it is apparent Dr. Naam was not relying on information provided by Petitioner but rather his thoughts about what Petitioner's job entailed, including tweeting, and Dr. Naam admitted he did not review Petitioner's written description of his job duties with him. Petitioner sustained a repetitive trauma injury to his right and left hands that manifested on 4/10/15 when Petitioner was seen by his primary care physician, Dr. Morton, for complaints in his bilateral hands which Dr. Morton opined was likely aggravated by his profession.

   Petitioner's condition of ill-being of bilateral carpal tunnel syndrome is causally related to the accident of 4/10/15. Petitioner informed his primary care physician, Dr. Morton, he had performed computer entry work for many years, and Dr. Morton opined Petitioner's conditions of ill-being were likely aggravated by his profession (PX 1, p. 1). In addition, Dr. Ma opined the work activities Petitioner performed for a number of years definitely aggravated the bilateral carpal tunnel syndrome diagnosed in Petitioner. Dr. Ma further opined that given the length of time Petitioner had been performing these work activities, this was not a

temporary aggravation, but one that had significantly aggravated Petitioner's carpal tunnel syndrome. Dr. Ma explained when the wrist is flexed, there is increased pressure in the carpal tunnel and this is very common for people with repetitive motion and this was supported by scientific evidence. Even Dr. Naam acknowledged typing on the computer with the wrists and hands in a flexed position throughout the day can cause increased pressure within the carpal canal and therefore lead to carpal tunnel syndrome and that flexion of the wrists for 4-6 hours per day is significant. The opinion of Dr. Naam there was no relationship between Petitioner's work activities and carpal tunnel syndrome is not credible for the reasons previously noted, as well as the finding made on accident.

2. Medical bills incurred by Petitioner in treatment of his condition of ill-being of bilateral carpal tunnel were reasonable, necessary and medically appropriate, and Respondent is liable for payment of these bills. Respondent had no objection to the reasonableness and necessity of these bills. The medical records supported the treatment Petitioner had received was reasonable and necessary. In addition, Dr. Naam opined the treatment Petitioner had received thus far was reasonable and necessary (RX 2).

3. Respondent is entitled to a credit of $1,894.16 pursuant to Section 8(j) of the Act. PX 3 contained the medical bills incurred by Petitioner at Springfield Clinic and showed payments by group health insurance totaled the sum of $1,894.16. This amount was not disputed by Respondent, as if offered no evidence on this issue.

4. The surgery recommended by Dr. Ma for Petitioner's bilateral carpal tunnel syndrome is reasonable and necessary in the care and treatment of Petitioner's condition of ill-being, and Respondent shall authorize this surgery and pay the reasonable and customary charges for said surgery, consistent with the medical fee schedule in Section 8.2 of the Act. Both Drs. Ma and Naam opined Petitioner was in need of surgery for his bilateral carpal tunnel syndrome (RX 2). The medical records reported Petitioner's complaints are worsening and Petitioner has not responded to the conservative treatment received to date, including bracing and injections to the areas. Petitioner has expressed he wants to proceed with this surgery.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Patrick A. Wilkison,

Petitioner,

vs. NO: 03WC 53825

City of Chicago - Department of Water,

Respondent.

18IWCC0053

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, temporary total disability, vocational rehabilitation, maintenance benefits, fees, 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 September 28, 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.

18IWCC0053

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: JAN 26 2018
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KWL/jrc
042

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

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

WILKISON, PATRICK A
Employee/Petitioner

Case# **03WC053825**

CITY OF CHICAGO-DEPT OF WATER
Employer/Respondent

18IWCC0053

On 9/28/2016, 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 0.42% 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:

0152 LINN CAMPE & RIZZO LTD
JOHN J RIZZO
215 N MARTIN L KING JR AVE
WAUKEGAN, IL 60085

0766 HENNESSY & ROACH PC
DANIEL WELLNER
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

18IWCC0053

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)/8(a)

Patrick A. Wilkison
Employee/Petitioner
v.
City of Chicago-Dept. of Water
Employer/Respondent

Case # 03 WC 053825

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 **November 20, 2014**. 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. [ ] 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 **Vocational Rehabilitation ?**

18IWCC0053

FINDINGS

On the date of accident, **8/8/2003**, 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 **$70,412.16**; the average weekly wage was **$1,354.08**.

On the date of accident, Petitioner was **47** years of age, ***married*** with **4** dependent children.
Petitioner has received all

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

Respondent shall be given a credit of **$168,686.88** for TTD, **$0** for TPD, **$120,953.14** for maintenance, and **$15,416.62** for other benefits (PPD advances), for a total credit of **$305,056.66**. The Parties agreed that all TTD/Maintenance benefits due before April 5, 2013 had been paid.

ORDER

Respondent shall pay Petitioner **temporary total disability benefits of $902.72 per week for 8-1/7 weeks**, commencing **4/5/2013 through 5/31/2013**, as provided in **Section 8(b) of the Act**.

Respondent shall pay reasonable and necessary medical services of **$28,468.75**, as provided in **Sections 8(a) and 8.2 of the Act**.

Respondent shall be given **a credit of $6,259.55** 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 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(l) 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

September 26, 2016
Date

SEP 28 2016

FINDINGS OF FACT

Petitioner testified that he was employed by Respondent as an operating engineer (hoisting engineer?). He began work for Respondent in 1990 in the Streets and Sanitation Department. He transferred to the Water Department three or four years later. Petitioner worked out of Respondent's South District facility, located at 1040 West 95th St. in Chicago. In the Water Department, Petitioner laid water mains. He used a backhoe and ram hoe to break up concrete and dig in grass to install water mains and make repairs. He would also operate front loaders, compressors and thawing rigs. In this job, Petitioner would frequently lift 35 pounds and occasionally lift 100 pounds. The job would expose him to abnormal variations in temperature. (PX 2)

The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on August 8, 2003. As Petitioner was filling a hole, the road collapsed and the machine that he was operating fell into the hole. The machine fell to the left hand side and Petitioner struck his left side on the machine. Petitioner was jostled around in the fall and wrenched his back and pulled something in his lower back. (PX 1)

Petitioner was taken via ambulance to Little Company of Mary Hospital, where he was treated in the emergency room. Petitioner complained of low back and left hip pain. He had a history of chronic back pain. The pain today was said to be more intense. X-rays showed minimal degenerative changes. Petitioner was diagnosed with a lumbar strain and was released. (PX 15)

Petitioner was referred by Respondent to its clinic, Mercy Works. Petitioner started a course of treatment through Mercy Works that lasted through April 9, 2013. (PX 16)

Petitioner was first seen at Mercy Works, by Dr. Homer Diadula, on August 10, 2003. Petitioner complained of low back pain, radiating to the left leg. Dr. Diadula diagnosed a low back strain. Petitioner was taken off work due to a work related condition, prescribed medications and instructed regarding a home exercise program. Physical therapy was later begun and Petitioner underwent a Lumbar MRI on September 3, 2003. The MRI showed disc degeneration with a focal right sided annular tear and minor disc bulge at L4-L5 and partial degeneration of the disc at L5-S1. (PX 17) Dr. Diadula diagnosed an L4-L5 annular tear and continued Petitioner off work. Petitioner was referred to Dr. Wehner by Mercy Works. Dr. Wehner's report is not in evidence, but she apparently released Petitioner to work at full duty as of October 8, 2003. Petitioner continued to complain of low back pain radiating to the left leg greater than the right. Petitioner was kept off work by Mercy Works and was referred to Dr. Phillips at Midwest Orthopedics at Rush for a second opinion. (PX 16)

Dr. Phillips saw Petitioner on October 16, 2003 and thought that the MRI revealed facet arthritis at L4-L5 and L5-S1, giving rise to foraminal stenosis, without evidence of acute disc herniation or acute pathology. Therapy and ESI's were recommended. Petitioner was not a current surgical candidate and could work at full duty. (PX 18)

Petitioner returned to work on October 9, 2003 and noticed an increase in low back pain later that month. He was seen at Mercy Works and taken off work, beginning October 29, 2003. (PX 16) He continued treatment with Mercy Works, Dr. Phillips and had injections by Dr. Fillmore. Dr. Phillips thought that it was safe for Petitioner to return to work as of February 27, 2004. If Petitioner's symptoms became really severe, decompression could be considered. Petitioner was seen by Dr. Phillips on May 4, 2004 and it

was noted that the injections had provided only short-lived relief. Petitioner was inquiring about surgery. A CT/Myelogram was recommended. Petitioner could continue to work at full duty. On June 24, 2004, it was noted by Dr. Diadula that Petitioner decided not to undergo the surgery that had been proposed by Dr. Phillips. Petitioner was given medication, reminded regarding a HEP and was released from care and to full duty work. (Px 16, 18)

In December of 2004, Petitioner sought treatment with his PCP, Dr. Oliver at Pronger Smith Clinic for complaints of pain and stiffness in his knees, ankles and back. Petitioner was said to have chronic back pain and degenerative disc disease. Petitioner had osteoarthritis. Treatment recommendations included PT and orthopedic consultation. Petitioner did not pursue this treatment, although he returned periodically to Dr. Oliver for these complaints from 2004 to 2006. The records from the PCP show several charted complaints of low back pain beginning in May of 2000 after a MVA on 5/24/2000. The records show that Petitioner was said to have chronic back pain in January of 2003 and was to be seen in orthopedics. On June 10, 2003, it was noted that Petitioner had low back pain, radiating down the left hip and leg. The pain was said to limit Petitioner's ADL's and his work. (PX 24, RX 1)

Petitioner worked for Respondent at light duty and full duty from March 2, 2004 through March 2, 2006.

On March 2, 2006, Petitioner presented to Mercy Works, advising that he now wished to pursue the surgery that Dr. Phillips offered. Petitioner was taken off work and was referred back to Dr. Phillips. Dr. Phillips ordered a discogram, which he thought was negative. Dr. Cupic at Mercy Hospital thought that the discogram was equivocal. Dr. Phillips recommended injections. Dr. Cupic performed a second discogram on November 9, 2006. The study was said to show a fissure at L3-L4, a small leak of contrast material at L4-L5 and concordant pain at L5-S1. (Px 16, 17, 18)

Petitioner was referred by Mercy Works to Dr. Mirkovic for another opinion. Dr. Mirkovic performed an L4-S1 posterolateral fusion with bone graft and instrumentation on March 1, 2007. Petitioner remained under Dr. Mirkovic's care through May 28, 2013. Follow-up radiographic studies were interpreted by Dr. Mirkovic as showing a solid fusion with no appreciable disc pathology. An FCE was performed on February 6, 2008, per the recommendation of Dr. Mirkovic. The FCE results showed that Petitioner could return to work at a light duty capacity. Dr. Mirkovic released Petitioner to return to work, per the FCE. Dr. Diadula noted that Petitioner was restricted to limited duty, at MMI and discharged from care as of March 31, 2009. (PX 16, 19)

Petitioner was paid TTD from March 3, 2006 through March 31, 2009. He was paid Maintenance benefits from April 1, 2009 through May 31, 2010. In May of 2010, Respondent made work available for Petitioner with restrictions of lifting, carrying, pushing, pulling 5 to 10 pounds frequent and up to 30 pounds occasionally between the waist and shoulders, sitting, standing, walking 60 to 90 minutes, bending, twisting and turning occasionally and avoid situations where a quick agile response is required. (PX 19) Thereafter, Petitioner worked light duty from June 1, 2010 to July 22, 2010. He was then off work and paid maintenance from July 23, 2010 through December 16, 2011. Respondent provided vocational services to Petitioner, through Genex, from February 2, 2010 through June 30, 2011. Petitioner did not obtain new employment through the voc efforts. (PX 26)

In December of 2011, Respondent invited Petitioner back to work in the Water Department, South Yard. Petitioner would drive a compressor truck, or a thawing truck. He would drive the trucks short distances, so they could be used on jobs by laborers. The time spent driving was about ½ hour at a time. Sometimes he would be uncomfortable with the jostling of the truck. He had treatment by Dr. Oliver and

followed up with Mercy Works. (PX 16, RX 1) Petitioner worked in this modified duty position for Respondent from December 17, 2011 through April 4, 2013.

Respondent sent Petitioner for a §12 exam by Dr. Noren on October 9, 2012. Petitioner drove himself to the exam and said that the trip took about two hours. Dr. Noren opined that Petitioner was at MMI and further interventional treatment was unwarranted. Petitioner could work full duty (within the FCE restrictions) and the restrictions were thought to be permanent. (PX 25, RX 4)

On April 4, 2013, Petitioner was working for Respondent and noticed increased low back pain and pain down his left leg when he drove a truck over railroad tracks. He was sent to Mercy Works by his supervisor, where they diagnosed a low back strain. X-rays did not show acute pathology. Petitioner was taken off work due to "work related condition" and prescribed Ibuprofen. Petitioner was seen at Mercy Works by Dr. Diadula on April 9, 2013. He was authorized off work and referred back to Dr. Mirkovic. Mercy Works closed their file as of April 9, 2013. (PX 16)

Petitioner was seen by Dr. Mirkovic on May 7, 2013. Dr. Mirkovic's impression was: Lumbar spondylosis, status post L4-S1 fusion. A repeat MRI was ordered and Petitioner was prescribed Medrol Dosepak, Prilosec and Norco. Dr. Mirkovic excused Petitioner from work at that time. Petitioner was seen by Dr. Mirkovic for review of the MRI on May 21, 2013. Dr. Mirkovic thought that the MRI showed degenerative changes without significant pathology. Petitioner reported that his symptoms were reduced. Petitioner was referred to therapy and released to full duty without restrictions (the Arbitrator believes the release was likely meant to be to RTW at the prior restrictions that Petitioner had worked with from 12/11/2011 through 4/4/2013). He was given a script for Mobic and Prilosec. Petitioner was last seen by Dr. Mirkovic on May 28, 2013. It was noted that Petitioner had been offered work within the restrictions that he had been working under (per the May 12, 2010 memo from Respondent), but at a different location where Petitioner would have to drive an hour to get to. This location was at Respondent's North District facility, on the Northside of Chicago and was not an easy location for Petitioner to get to from his home on the Southside of Chicago (10122 S. Washtenaw). Petitioner lived about 10 or 15 minutes away from Respondent's South District facility. Dr. Mirkovic provided Petitioner with restrictions of driving only 30 minutes to work and to continue to work within the restrictions placed by Dr. Noren. The restrictions were said to be permanent. It was also recommended that Petitioner see a physiatrist at RIC. Petitioner was released, PRN, pending the RIC evaluation. (PX 19) Petitioner did not pursue the therapy or the RIC consult.

In the summer of 2013, Petitioner received three injections by Dr. Bitar, who saw Petitioner on a referral from Dr. Oliver. Dr. Bitar noted noncompliance with therapy. His diagnosis was: postlaminectomy syndrome with neuropathic pain in the lower extremities, radiculopathy, facet arthritis, herniated disc at L3-L4 (later changed to bulging disc at L3-L4) and DDD. The ESI's were performed at L3-L4 and there was no follow up after the last injection, which took place on August 13, 2013. (PX 23)

No TTD benefits were paid subsequent to Petitioner being taken off work be Mercy Works on April 4, 2013. PPD advances were made, totaling $15, 416.62. (RX 5) Petitioner has not worked anywhere since April of 2013.

When Petitioner attempted to return to work at South District on May 22, 2013, he was advised that there was no longer a position for him at that facility. A position within the work restrictions was available at Respondent's North District facility at that time. Petitioner thought that traveling to the Northside facility would involve a commute of over an hour and he did not think that he could drive that far, so he sought

additional restrictions from Dr. Mirkovic, which were given on May 28, 2013 (no more than ½ hour commute).

Petitioner never tried to drive to the North District facility. Respondent did not offer Petitioner other work. The last time that Petitioner contacted Respondent regarding return to work within the restrictions given by Dr. Mirkovic was with Marisol at Respondent's personnel department about 2 or 3 months before trial. She said that she would try to help Petitioner, but she did not get back to him. Petitioner would like to return to work at Respondent, if the restrictions set by Dr. Mirkovic (including the commuting limitation) will be abided.

Respondent presented the testimony of Marsha Simmons. She was a 30 year employee of Respondent and has been a Hoisting Engineer Foreman for 14 years. She works at the South District facility. She was Petitioner's supervisor. After Petitioner went off work due to the railroad crossing incident in April of 2013, Simmons could not give him his previous job on the compressor truck because of staff changes and lack of personnel at the South District. Respondent could not accommodate Petitioner's restrictions at the South District because they needed hoisting engineers that were capable of full duty work. Petitioner could go to the North District, where compressor truck jobs were available. Petitioner did not try to go to the North District facility to work the compressor truck driver job there. At the time of trial, Respondent could not accommodate Petitioner's restrictions at the South District. Simmons did not know whether a compressor truck driver position was available at the North District as of the date of trial. She had no knowledge as to whether the compressor driver job was available at the North District after the summer of 2013.

Respondent had Petitioner examined by Dr. Daniel Troy, pursuant to §12, on December 3, 2013. Dr. Troy opined that Petitioner had suffered an aggravation to pre-existing degenerative changes in his lumbosacral spine from the injury of August of 2003. The fusion surgery was to address the long-standing, pre-existing, DDD at L4-L5 and L5-S1. The diagnosis was status post fusion at L4-S1 with subjectively based symptomatology without any type of discrete objective evidence. There was no evidence of neurological loss. The causality for accepting the surgery (done in 2007 by a physician within the chain of referrals from Respondent's clinic) was thought to be highly questionable. The 30 minute driving restriction does not appear appropriate. An FCE could be done to fully evaluate the commuting time restriction. Petitioner was at MMI as of February of 2008. Petitioner could return to work, per the February, 2008 FCE. (RX 3)

The Parties agreed that all TTD and Maintenance due Petitioner had been paid through April 4, 2013. Petitioner sought TTD from April 5, 2013 through the date of trial.

Petitioner submitted unpaid medical bills as Exhibits 6 through 14.

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

The Arbitrator finds that Petitioner's current condition of ill-being regarding his lower back (status post aggravation of degenerative disc disease and spondylosis condition as a result of a machine accident on August 8, 2003, leading to eventual L4-S1 fusion with resultant limitations per FCE and subjective complaints) is causally related to the injury, based upon the testimony of Petitioner and the medical records.

The Record establishes that Petitioner had prior complaints of low back pain, since at least May of 2000, for which he had treatment by his PCP. In fact, it is noted that Petitioner had low back pain on June 10, 2003 (less than 2 months before the accident in the present case), with pain radiating down the left hip and leg, said to be limiting his ADL's and work. Additionally, Dr. Troy's opinion is that Petitioner suffered a minor aggravation of the longstanding degenerative condition of his lumbar spine that had resolved by the spring of 2004 as a result of the accident. Causality on the surgery was highly suspect. Petitioner's current condition regarding his lumbar spine was related to the preexisting condition and not the accident.

While there was no formal causal connection opinion submitted by Petitioner, it is noted that documents from Mercy Works and Dr. Mirkovic do state that Petitioner's condition is work related. Further, the chain of events and medical treatment after the accident do support a finding of causal connection. There were gaps in treatment where Petitioner had returned to work at full duty, but it is documented that Petitioner did not want to undergo surgery when it was first offered and wanted to continue working-a choice that should be respected by the Commission. The gaps in treatment, noted to be with physicians within the chain of referral from Respondent's clinic, are not such that the Arbitrator can find that there is no causal connection. It is significant that when Petitioner would seek treatment after ceasing treatment previously he would return to Mercy Works where his complaints and presentation were obviously thought to be valid such that he would be referred to a specialist, ending up with Dr. Mirkovic who did the fusion surgery and who endorses permanent restrictions.

If there was a legitimate question on causal connection, the physicians at Mercy Works would have raised it. They did not. Dr. Troy's opinion on causal connection is not persuasive based upon the above and the fact that he did not examine Petitioner prior to the surgery. Finally, there was no evidence of any lost work time due to back problems and no recommendation regarding back surgery before the accident. Considering the Record as a whole, Petitioner's current condition of ill-being with respect to his lumbar spine is causally related to the accidental injuries of August 8, 2003.

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 treatment that was provided to Petitioner was reasonable and was necessary to cure or relieve the effects of the injury. The treatment was causally related to the injury.

Petitioner's claimed medical bills were entered into evidence as Petitioner's Exhibits 6-14. The Parties agreed that Respondent was entitled to a §8(j) credit for payments on some of the bills in the amount of

$6,259.55. Petitioner attached a spreadsheet regarding the claimed bills as RFH Attachment 1. Respondent's dispute regarding the claimed bills was as to liability, based upon its causal connection dispute.

Based upon the Arbitrator's finding above regarding reasonableness and necessity and regarding causation, above, the claimed bills are awarded as follows:

PROVIDER	DOS	AMOUNT
Dr. Mirkovic (PX 6)	5/7/2013-5/28/2013	$1,577.00
NW Mem Hosp MRI(PX 7)	5/11/2013	4,840.00
Metro South (PX 8)	6/25/2013	5,960.50
BI Anesthesia (PX 9)	6/25/2013	900.00
Metro South (PX 10)	7/23/2013	6,219.75
BI Anesthesia (PX 11)	7/23/2013	1,000.00
Metro South (PX 12)	8/13/2013	5,546.50
BI Anesthesia (PX 13)	8/13/2013	900.00
Dr. Bitar/Pronger (PX 14)	9/2012-8/2013	1,525.00
	TOTAL:	$28,468.75

Regarding the Dr. Bitar/Pronger bill, the services billed for 5/22/2013 ($224.00) were for Type II DM and Esophageal Reflux and are not awarded.

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:

Causal connection has been established.

At issue is TTD benefits after April 4, 2013. Petitioner was authorized off work by Mercy Works and Dr. Mirkovic from April 5, 2013 to May 22, 2013. On May 22, 2013, Petitioner received a full duty release to return to work from Dr. Mirkovic (treated by the Parties as releasing Petitioner back to work with the prior restrictions under which he had worked from December 11, 2011 to April 4, 2013) and Petitioner was advised that such a position was not available at Respondent's South District facility. Modified duty work for Petitioner was available at the North District facility. Petitioner did not attempt to return to work at the North District facility. Instead, he saw Dr. Mirkovic on May 28, 2013 and received further work restrictions, re-stating the prior restrictions and limiting Petitioner to ½ hour commuting.

Simmons testified that modified duty work was not available for Petitioner at the South District facility in late May of 2013. No such position was available at the time of trial. Work was available at the North District facility for Petitioner in late May of 2013. Petitioner never attempted to drive to the North District facility after being advised that modified duty work was available. There was no evidence as to whether modified duty work was available for Petitioner at the North District Facility at the time of trial. The Record does not contain documentation advising Petitioner to report to modified duty work at the North District facility on a specified date.

The Arbitrator finds that Petitioner's condition of ill-being stabilized, i.e.: he reached MMI, as of the last visit with Dr. Mirkovic (May 28, 2013). The palliative care received from Pronger is just to ease

Petitioner's pain complaints, which have stabilized. Petitioner did not get the recommended follow up care at RIC, so there was no reason to see Dr. Mirkovic after May 28, 2013. Given the holding in Interstate Scaffolding, Inc., TTD benefits are not owed after this date. Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Commission, 236 Ill.2d 132 (2010) Given the Record herein, the Arbitrator finds that TTD benefits are due through May 31, 2013. Petitioner was clearly medically authorized off work after April 4, 2013. Thereafter, he was given the defective release to full duty of May 22, 2013. Giving Petitioner the benefit of the doubt, TTD benefits should not be stopped based on the release of May 22, 2013. Thereafter, Petitioner received the revised restrictions from Dr. Mirkovic on May 28, 2013. While the commuting restriction is rendered by a treating physician within the chain of referrals from Respondent's clinic, it does not bind Respondent and the Arbitrator is not convinced that it is a valid restriction, given that Petitioner had worked the compressor truck/thawing truck driver position (driving a large truck in the City of Chicago [albeit in ½ hour trips]) for 1 ½ years after returning to work December 17, 2011. Petitioner should have tried to drive to the North District facility. He failed to do so. A reasonable time for Petitioner to have tried this trip would be up to May 31, 2013. The Arbitrator cannot support an award of TTD after May 31, 2013

WITH RESPECT TO ISSUE (M), SHOULD PENALTIES BE IMPOSED UPON THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Given the Record herein, the Arbitrator declines to award Penalties.

Perhaps Respondent would be liable for §19(l) penalties for the non-payment of compensation benefits for the time period of April 5, 2013 to May 31, 2013. However, Respondent did make two PPD advances (totaling $15, 416.62). The dates of the advances are not set forth on Respondent's Exhibit 5 and there was no evidence of when these payments were made, so it cannot be determined how late the payments are in order to figure §19(l) penalties.

§19(k) penalties are not appropriate in this case. There was no evidence of a demand for the payment of the medical bills. Respondent has a good faith dispute on liability for TTD after May 31, 2013, given Petitioner's failure to try to drive to the North District facility. §16 attorney's fees are likewise not merited.

WITH RESPECT TO ISSUE (O), VOCATIONAL REHABILITATION, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner has failed to prove that he is entitled to an award of vocational rehabilitation in this case. No evidence of the appropriateness of vocational rehabilitation services at the time of trial was adduced. The Genex records (PX 26) and the letters from Respondent contained in Petitioner's Exhibit 4 do not persuade the Arbitrator on this issue. No award for vocational rehabilitation services is made.

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

Gerald Monroe,
Petitioner,
vs.

NO: 16WC 14011

18IWCC0054

Dynegy Midwest Generation,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 3, 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 $47,100.00. 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: JAN 26 2018
o012318
KWL/jrc
042

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MONROE, GERALD
Employee/Petitioner

Case# **16WC014011**

DYNEGY MIDWEST GENERATION
Employer/Respondent

18IWCC0054

On 8/3/2017, 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 1.13% 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:

0969 RICH RICH & COOKSEY PC
THOMAS C RICH
6 EXECUTIVE DR SUITE 3
FAIRVIEW HTS, IL 62208

0299 KEEFE & DePAULI PC
NEIL A GIFFHORN
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

18IWCC0054

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

GERALD MONROE
Employee/Petitioner

v.

DYNEGY MIDWEST GENERATION
Employer/Respondent

Case # **16** WC **14011**

Consolidated cases: _____

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Collinsville**, on **November 30, 2016**. By stipulation, the parties agree:

On the date of accident, **October 29, 2015**, 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 $**65,228.80**, and the average weekly wage was $**1,254.40**.

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.

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

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 $752.64/week for a further period of **62.5** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **12.5% loss of use of the body as a whole.**

Respondent shall pay Petitioner compensation that has accrued from **September 14, 2016** through **November 30, 2016**, 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

August 2, 2017
Date

AUG 3 - 2017

STATE OF ILLINOIS)
) SS
COUNTY OF MADISON)

18IWCC0054

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT

GERALD MONROE
Employee/Petitioner

v.

Case #: 16 WC 14011

DYNEGY MIDWEST GENERATION
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The parties stipulated that on October 29, 2015, Petitioner sustained an accident which arose out of and in the course of his employment with Respondent, resulting in an injury to his right shoulder. The parties further stipulated that the only issue in dispute was the nature and extent of Petitioner's permanent partial disability.

On the date of accident, Petitioner was 45 years old, married, and had two dependent children. He was employed as an Auxiliary Operator. On that date he was using a large, heavy valve wrench to open a valve to drain a tank. Petitioner testified that the process was cumbersome and took about 45 minutes, and that he had to stand on the rung of the safety railing to get high enough to get the to the valve, as it was over his head. During the process of opening the valve, he injured his right shoulder.

Petitioner initially sought treatment for his injury at Midwest Occupational Medicine. Examination was positive for limited range of motion, discomfort, and tenderness. PX3. An MRI was performed, which revealed a SLAP tear with tendinopathy and AC joint pathology. PX5. Based on these findings, Petitioner was referred to Dr. Mark Miller, who saw him on January 20, 2016, and recommended surgery. PX4.

On March 15, 2016, Dr. Miller performed surgery, which showed a near circumferential labral tear, articular sided tendinopathy of supraspinatus, impingement syndrome, and an AC joint torn meniscoid disc. Surgery consisted of diagnostic arthroscopy, eight-anchor capsulolabral reconstruction, rotator cuff debridement, subacromial decompression, and AC joint debridement. PX6. Following surgery, Petitioner underwent physical therapy and work hardening and it was noted he had difficulty regaining his range of motion. PX4.

Petitioner's final visit with Dr. Miller was September 14, 2016. At that time Dr. Miller noted the final work hardening report, which indicated that Petitioner's job requirements were at the medium work demand level and that he was functioning at the heavy physical demand level. Dr. Miller stated, "The patient has done very well with his work conditioning program. He has far exceeded the demands of work. He is a bit uncomfortable with overhead movements but he is tolerant. He has displayed all of the capabilities for return to work with full duty. He is released. I do not need to see him back unless there are setbacks." PX4.

The following day, on September 15, 2016, Petitioner was examined at Midwest Occupational Medicine by Physician's Assistant Andy Colon. PA Colon documented a decreased range of motion and strength of the right shoulder. He further noted that Petitioner reported that Dr. Miller assured him that this was normal and that he would increase his strength and range of motion in the next few months to a year. PX3.

Petitioner testified that he currently continues to experience soreness and stiffness in his right shoulder, as well as limited range of motion. At trial he demonstrated what he believed was a lack in range of motion in his right shoulder, as compared to the left. He stood against a wall and stretched out both arms against the wall. The Arbitrator observed that his right arm did not straighten out quite as much, and did not go quite as far up the wall as the left arm. Petitioner testified that he has increased pain if he moves his right shoulder further than that demonstrated. He testified that he has soreness and stiffness when he wakes up every morning, and that he sometimes has trouble sleeping if he accidentally sleeps on his right shoulder. He has difficulty turning valves at work at shoulder height or above his head and testified he has to "think twice about everything" that he does to avoid re-injuring his shoulder. He testified he now attempts to do 95% of his work with his left arm, especially for overhead activities. He takes Ibuprofen on a daily basis, usually when he wakes up. Petitioner acknowledged that he was back to work in the same capacity with no job performance issues and that he was earning more than he was prior to the injury.

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. The only issue in dispute at the time of hearing was the nature and extent of the permanent partial disability. With regard to the nature and extent of disability, for accidents occurring on or after September 1, 2011, pursuant to Section 8.1b of the Act, in determining the level of permanent partial disability the Arbitrator must look at the following five factors.

In regard to factor **(i) the reported level of impairment pursuant to Subsection (a)**, although Petitioner's date of accident was after the effective date of Section 8.1b of the Act, neither party offered into evidence a reported level of impairment pursuant to Subsection (1). As such, the Arbitrator gives no weight to this factor.

In regard to factor **(ii) the occupation of the injured employee**, the record reveals that Petitioner was employed as an Auxiliary Operator at the time of the accident and that he was able to return to work in that capacity without any restrictions or limitations as a result of said

injury. Petitioner testified he is able to perform all of his job duties, though has difficulty with shoulder-height or overhead activities such as turning valves. The medical records, including Dr. Miller's final note, show that Petitoner's occupation is at the medium demand level and that he was performing at the heavy demand level upon testing during work hardening. The Arbitrator gives some weight to this factor.

In regard to factor **(iii) the age of the employee at the time of the injury**, Petitioner was 45 years old at the time of the accident. He has been able to return to his prior position without limitation. He can be expected to work about 20 more years and will have to work with his condition for a long period of time. Over time his condition could improve, stay the same, or get worse. The Arbitrator gives greater weight to this factor.

In regard to factor **(iv) the employee's future earning capacity**, Petitioner returned to his prior position full duty and has since received an increase in pay. There was no evidence that Petitioner's future earning capacity has been or will be impacted as a result of his injury. Accordingly, the Arbitrator places no weight on this factor.

In regard to factor **(v) evidence of disability corroborated by treating medical records**, the Arbitrator notes that Petitioner sustained an injury to his right shoulder. He underwent surgery, which showed a near circumferential labral tear, articular sided tendinopathy of supraspinatus, impingement syndrome, and an AC joint torn meniscoid disc. Surgery consisted of diagnostic arthroscopy, eight-anchor capsulolabral reconstruction, rotator cuff debridement, subacromial decompression, and AC joint debridement. Petitioner testified he had continued soreness, stiffness, and reduced range of motion and takes Ibuprofen on a daily basis. Dr. Miller's note following Petitioner's final visit of September 14, 2016, indicated Petitioner was functioning at the "heavy demand" level.

The Arbitrator notes that consideration of the factors enumerated in Section 8.1b does not simply require a calculation, but rather a measured evaluation of all five factors, of which no single factor is the sole determinant on the issue of permanency. Taking the above five factors into consideration and based on the record in its entirety, the Arbitrator finds that Petitioner has sustained a 12.5% loss of use of the person as a whole (62.5

weeks) pursuant to Section 8(d)2 of the Act. The parties stipulated that Petitioner's average weekly wage was $1,254.40. The Arbitrator finds his permanent partial disability rate is $752.64.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LONNIE LAMASTER,

Petitioner,

vs. NO: 15 WC 34224

ZENNOH GRAIN CORP., d/b/a CGB ENTERPRISES, 18IWCC0055

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice provided to all parties, the Commission, after considering the issues of accident, manifestion date, causation, temporary disability, medical expenses, and permanent disability, and being advised of the facts and law, provides additional discussion and corrections as set forth below, but otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

In its Statement of Exceptions and at oral argument, Respondent vigorously challenged January 8, 2015 as a proper manifestation date. Respondent argued Petitioner did not testify he discussed his work activities with PA Friday on that date; the medical records do not document Petitioner discussed his work activities and/or any aspect of his job or a work accident/injury occurring on January 8, 2015; and the January 8, 2015 visit was for a thyroid level recheck. Respondent further posited Petitioner's testimony that PA Friday diagnosed him with carpal tunnel syndrome on January 8, 2015 is inconsistent with the medical record, as that documents a diagnosis of median neuropathy and an order for an EMG. The Commission finds Respondent's arguments to be unavailing.

Firstly, the January 8, 2015 medical record demonstrates Petitioner complained of hand problems and "reports he uses hand tools a lot and worse the more he uses them." PX2. The Commission finds this certainly evidences Petitioner discussed his work activities with PA Friday on January 8, 2015. Secondly, the Commission finds it disingenuous for Respondent to

18IWCC0055

suggest the sole purpose of the appointment was Petitioner's thyroid condition when the record identifies chief complaints of both "check up" and "hand issues" and the History of Present Illness reads, "Pt here to get thyroid level rechecked. Pt also here due to ongoing numbness and pain to his hands for the past year." PX2. Thirdly, while it is true the record does not reflect a diagnosis of carpal tunnel syndrome on January 8, 2015, it does demonstrate a diagnosis of median neuropathy along with an order for diagnostic workup with an EMG. The Commission observes carpal tunnel syndrome is a neuropathy caused by compression of the median nerve and would come under the umbrella of median neuropathy, but irrespective of that, the law is clear the ultimate diagnosis is not a prerequisite to the assignment of the manifestation date. See *General Electric Co. v. Industrial Comm'n*, 190 Ill. App. 3d 847, 857, 546 N.E.2d 987 (1989) (A formal diagnosis is not required. The manifestation date is not the date on which the injury and its causal link to work became plainly apparent to a reasonable physician, but the date on which it became plainly apparent to a reasonable employee.) Moreover, Petitioner's testimony that PA Friday diagnosed "possible carpal tunnel syndrome" on January 8, 2015 is corroborated by the February 2, 2015 record: Nurse Note states "Patient is here today to go over carpal tunnel testing on both wrists," and History of Present Illness is "here to discuss results of carpal tunnel studies." PX2.

It is well-settled the date of manifestation of a repetitive trauma injury is subject to a "flexible standard" that "ensures a fair result for both the faithful employee and the employer's insurance carrier." *Three 'D' Discount Store v. Industrial Commission*, 198 Ill. App. 3d 43, 49, 556 N.E.2d 261 (1989). Our courts typically uphold various factors which set the manifestation date as "either the date on which the employee requires medical treatment or the date on which the employee can no longer perform work activities." *Durand v. Industrial Commission*, 224 Ill. 2d 53, 72, 862 N.E.2d 918 (2006). Petitioner, whom the Commission finds credible, testified his hand symptoms progressed until the "pain got so bad" he sought treatment on January 8, 2015; during that evaluation, he was told he had possible carpal tunnel syndrome, and an EMG was ordered to confirm the diagnosis. The next day, Petitioner reported the connection between his work duties and his hand problems to his supervisor. The Commission affirms the finding Petitioner sustained repetitive trauma injuries manifesting on January 8, 2015, and further affirms Petitioner's conditions of ill-being are causally related to the January 8, 2015 accident. The Commission, like the Arbitrator, finds Dr. Vender had a significant misunderstanding of Petitioner's work duties, and therefore, the doctor's contrary causation opinion is afforded no weight. See, *e.g.*, *Sunny Hill of Will County v. Illinois Workers' Compensation Commission*, 2014 IL App (3d) 130028WC, ¶36 (Expert opinions must be supported by facts and are only as valid as the facts underlying them.) The Commission instead relies on Dr. Greatting's opinions, which it finds most comport with the evidence regarding Petitioner's work activities and most persuasive.

The Commission corrects the following typographical errors in the Arbitrator's decision:

1 - The Commission affirms the award of 6 6/7 weeks of temporary total disability benefits but corrects the termination date to read October 2, 2016 (Dr. Greatting released Petitioner to return to work "as of October 3, 2016." PX4. The period from August 16, 2016 through October 2, 2016 is 48 days or 6 6/7 weeks).

18IWCC0055

2 - The Commission affirms the Arbitrator's Section 8.1b(b) analysis and permanence finding (10% loss of use of the right arm, 10% loss of use of the right hand, and 12.5% loss of use of the left hand), but notes the Order contains computational errors. The Commission corrects the Order to reflect an award of $382.31 per week for 68.05 weeks under Section 8(e).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 9, 2017, as amended above, 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.

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: JAN 30 2018

L. Elizabeth Coppoletti

LEC/mck

O: 12/6/17

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L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LAMASTER, LONNIE D
Employee/Petitioner

Case# **15WC034224**

18IWCC0055

ZENNOH GRAIN CORP B/B/A CGB ENTERPRISES INC
Employer/Respondent

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:

2934 BOSHARDY LAW OFFICES PC
JOHN V BOSHARDY
1610 S 6TH ST
SPRINGFIELD, IL 62703

5033 LAW OFFICE CAPUANI & SCHNEIDER
EDWARD JANUSZKIEWICZ
135 S LASALLE ST SUITE 2950
CHICAGO, IL 60603

18IWCC0055

STATE OF ILLINOIS)
)
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

Lonnie Lamaster
Employee/Petitioner

Case # **15** WC **34224**

v.

Zenoh Grain Corp. d/b/a CGB Enterprises, Inc.
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Springfield**, 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 present 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 _____

18IWCC0055

FINDINGS

On **January 8, 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 $ **33,133.36**; the average weekly wage was $ **637.18**.

On the date of accident, Petitioner was **38** 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 for $**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 $ **424.79**/week for

6 & 6/7 weeks, commencing **August 16, 2016** through **Ocotber 3, 2016**, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $ **382.30**week for 66.25 weeks, because the injuries sustained caused 10 **% loss of use of the right arm, 12.5 % loss of the left hand and 10% loss of use of the right hand.** as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner compensation that has accrued from **January 28, 2015** through **April 18, 2017**, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay $ **23,911.25** for medical services, as provided in Section 8(a)and 8.2 of the Act. Respondent is entitled to credit for any actual related medical expenses paid by any group 8(j) health provider and Respondent is to hold Petitioner harmless for any claims for reimbursement from said group health insurance provider and shall provide payment information to Petitioner relative to any credit due. Respondent is to pay unpaid balances with regard to said medical expenses directly to Petitioner.

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. Dglas McEnty

Signature of arbitrator

5/5/2017
Date

MAY 9 - 2017

Lonnie Lamaster vs. Zennoh Grain Corp. d/b/a CGB Enterprises, Inc.
IWCC No. 15 WC 34224

ATTACHMENT C and F

In support of the Arbitrator's findings on the issue of **(C) Did an accident occur that arose out of and in the course of the petitioner's employment by the respondent? and (F) Is the petitioner's present condition of ill-being causally related to the injury?,** the Arbitrator finds the following facts:

Petitioner was employed by Respondent beginning in April 2007. He performed many different jobs which will be discussed below. Petitioner and Marc Mueller, Respondent's Terminal Operations Manager testified in this matter.

Mr. Mueller was called by Respondent and testified that he directly supervised Petitioner from 2007 through 2010. Mr. Mueller admitted that he did not directly supervise the Petitioner after 2010.

Mr. Mueller created the job descriptions and explained that the descriptions described the tasks that were performed by the job title and had a bullet mark next to each task. Mr. Mueller agreed that the job descriptions were supposed to indicate the percentage of time that a worker in that classification might perform the task listed but the job descriptions did not indicate how much time a worker might perform a certain task.

Mr. Mueller also stated that he had no training in ergonomic studies. Mr. Mueller agreed that the job description for a Deckhand did not indicate that the worker had to manually open fiberglass doors or pulling a cable and chain up with their hands. Mr. Mueller further agreed that the Tower Operator and Grader Tester job all required use of the hands to perform. The job descriptions for a Deckhand, Tower Operator and Grader Tester did not include any details explaining the physical activity required to perform the respective tasks required of the positions. Respondent operates a grain elevator along the Illinois River in Naples, Illinois. Petitioner first began working for the Respondent as general laborer in April of 2007. Petitioner normally works 40 hours per week. During harvest, from September through December the Petitioner works seven days a week and 12 hours a day.

From April of 2007 through 2010, Petitioner worked exclusively cleaning the Respondent's premises. Cleaning was described as sweeping and shoveling grain that had fallen onto the floor of Respondent's facility. Petitioner stated that there was enough grain to require eight hours of sweeping and shoveling. Mr. Mueller stated that shoveling for eight hours was not normally required but would depend on need.

Petitioner stated that schedules were created daily where his tasks for the next day were set out. Petitioner stated that the tasks scheduled might change during the day and the schedules would not necessarily indicate the tasks he actually performed on a given day. Mr. Mueller agreed that work schedules might change during the day based on Respondent's business needs.

Petitioner used two foot wide push brooms, hand brushes and shovels to push and scoop up grain. Petitioner estimated that a shovel full of grain weighed 20 pounds and he used his arms and hands to sweep and shovel. Petitioner had to grip the shovel and brooms fairly hard. A job description was admitted into evidence that states the physical requirements of a General Laborer. Petitioner stated that the job description for General Laborer described the tasks he performed cleaning. The Job Description for General Laborer stated that the position required continuously pushing and lifting 40 pounds. (Respondent's Group exhibit 3)

In 2010, additional duties were added including being a deckhand. A job description was admitted into evidence which detailed the tasks to be performed by a deckhand but there was no description of the physical activity Petitioner performed as a deckhand. (Respondent's Group exhibit 3) Mr. Mueller helped to create the job descriptions which were admitted as Respondent's Group Exhibit 3.

Petitioner described that as a deckhand he had to manually open large fiberglass doors on the barges. Petitioner also had to pull a three quarter inch cable through, pull the chains through the cable and hook the chains to the cable. Petitioner had to use a lot of force to pull the cable. As a deckhand Petitioner had to tie ropes. Petitioner's testimony about the physical activity required of a deckhand was unrebutted.

Petitioner could not estimate how much of his time was spent between the various job duties of working as a deckhand and cleaning. Some weeks there would be barges to load and he would work as a deckhand. Other times there would be no barges and he would perform cleaning duties.

After one year of cleaning and performing the work of a deckhand, additional duties were added to his work activities including barge loading duties in 2011. After 2011 Petitioner's deckhand duties were replaced by loading barges in a position called a Tower Operator. For a six month period of time beginning in April 2013, Petitioner went to one of Respondent's facilities in Louisiana and worked exclusively as a laborer, using a shovel, broom and hoe-type scraper cleaning grain bins. He said that this job required him to use a lot of grip force. He went on to explain that since November 2013 through the time when he sought treatment for his conditions in January 2015, he worked exclusively as a Tower Operator and/or a general laborer.

The barge loader, or Tower Operator, controls the flow of grain through a conveyor chute into the barge door holes. Petitioner stated that he used both hands in performing the duties of a Tower Operator loading barges.

Petitioner held a joystick continuously in his hand as he was loading a barge. Petitioner stated that he operated the joy stick which had a little tension on it. He said that he held the joystick with a closed fist, unlike

the example depicted in RX 4, photograph 6. Petitioner used both hands to operate the joystick but not at the same time.

Petitioner maneuvered the joy stick constantly because the barge would move for various reasons, requiring him to re-position the chute above the barge door hole. Petitioner described that the barge moved because of wind, the river current and because it sunk in the water as the grain being loaded added weight to the barge. Petitioner demonstrated how his hand would move when holding the joy stick. Maneuvering the joy stick required Petitioner to repeatedly bend, twist and rotate his hand and wrist.

A panel to the left of Petitioner contained knobs that he would have to twist, buttons to push and toggle switches that would be moved during the barge loading process. Petitioner stated that operating the toggle switches required twisting the wrist and the toggles that operate the winches took some work to operate because the barges move a lot.

Petitioner also stated that it might take 15 minutes to fill one door hole with grain. He would use the joystick to move the chute to another door. The grain doors are depicted in RX 4, photograph number 2, 3, 7 and 8.

Finally, Petitioner acknowledged that occasionally he would be assigned to task of a Grader Tester where he would have to test grain in a lab. Petitioner poured 500 grams of grain into a bucket, with 250 grams of water, placed the grain mixture in a bag and shook it with his hands. Petitioner stated that of the entire eight years before he developed the conditions of ill being at issue here he may have performed the work of a Grader Tester for approximately three months out of the eight years he worked for Respondent before January 8, 2015.

Petitioner stated that there was no set amount of division between his work loading barges as a Tower Operator and cleaning and General Labor duties. One week, he would be loading barges as a Tower Operator filling barges and the next week there may be no barges and he would be cleaning. Once a barge was filled Petitioner would return to his cleaning activities. A work schedule was created to show what duties Petitioner might be assigned to perform on a given day. However, Petitioner and Mr. Mueller agreed that the work schedule might be abandoned due to the needs of Respondent's business that might change during the day. Petitioner stated this happened frequently.

Petitioner sought treatment from his primary care doctor's physician assistant Danny Joe Friday on April 14, 2014 complaining of right arm pain. Petitioner denied any recent trauma or overuse and the doctor diagnosed Petitioner with right arm pain and prescribed Tramadol. (PX 2) An arterial Doppler study was performed and was negative for deep vein thrombosis. (PX 3) No further treatment was rendered to Petitioner and he did not return for additional treatment. (PX 2)

On January 8, 2015 Petitioner sought treatment from Physician's Assistant Friday complaining of numbness and pain in both hands for the previous year and that the symptoms were worsening. (PX 2)

Petitioner told PA Friday that he used hand tools and the symptoms were worse with using the hand tools. (PX 2) PA Friday noted the Petitioner worked for Respondent. Petitioner was diagnosed with median neuralgia, and was prescribed Naproxen and Prednisone. PA Friday also ordered an EMG/NCS. (PX 2)

An EMG was performed in January 26, 2015 by Dr. Mukteshwar Mehra. (PX 7) Dr. Mehra noted that Petitioner had numbness and tingling in both hands, but his left was worse than the right and he was dropping objects. (PX 7) The EMG was positive for bilateral carpal tunnel syndrome and Dr. Mehra recommended surgery as soon as possible. (PX 7)

Petitioner returned to Danny Joe Friday PA on February 2, 2015. Petitioner was advised to continue working and wear wrist splints. (PX 2) PA Friday referred Petitioner to Dr. Kanthilal for surgery. Dr. Kanthilal referred Petitioner back to PA Friday so that he could refer Petitioner to a different surgeon. (PX 2) Petitioner was referred by PA Friday to Dr. Ma at the Springfield Clinic. Instead of seeing Dr. Ma Petitioner was treated by Dr. Mark Greatting. (PX 2, 4)

Dr. Greatting examined Petitioner for the first time on November 9, 2015. Petitioner described his work activities to Dr. Greatting and noted Petitioner's hands had bothered him for more than a year and recently had right elbow pain. (PX 4) Petitioner told Dr. Greatting that for the previous three weeks he had been repairing vehicles but his normal job for the previous eight years was cleaning grain. Petitioner read the history he gave to Dr Greatting and felt it accurately described what he did at work. (PX 4)

Dr. Greatting examined Petitioner and reviewed the EMG study. Dr. Greatting diagnosed Petitioner as suffering from bilateral carpal tunnel syndrome, and right lateral epicondylitis. (PX 4) Dr. Greatting injected Petitioner's right elbow and recommended surgery for bilateral carpal tunnel syndrome. (PX 4)

Petitioner was sent for a Section 12 examination with Dr. Michael Vender. (RX 5, Dep. Ex. 2)

Petitioner stated that Dr. Vender did not question him in detail about his work activities. Dr. Vender did not believe that Petitioner's carpal tunnel condition or right lateral epicondylitis were causally related to Petitioner's work activities and Respondent refused to authorize Petitioner's surgeries. (RX 5, Dep. Ex. 2) Petitioner stated that Dr. Vender looked at his hands asked him what he did at work. Petitioner told Dr. Vender that he scooped and swept grain and then he left the room. Dr. Vender did not ask him to review any job descriptions.

On July 20, 2016 Petitioner was examined by Dr. Greatting where it was noted Petitioner's symptoms were worsening. (PX 4) Dr. Greatting noted that workers' compensation authorization was denied and that Petitioner chose to proceed with treatment using Petitioner's insurance. (PX4)

On August 16, 2016 Dr. Greatting performed a right lateral epicondylectomy and a right carpal tunnel release. (PX 4) Petitioner's arm was casted from just below his shoulder to his hand.

On August 29, 2016 Petitioner returned to Dr. Greatting in follow-up of his right lateral epicondylectomy. Dr. Greatting removed his cast and scheduled Petitioner's left carpal tunnel release. (PX 4)

Petitioner's left carpal tunnel release was performed on September 16, 2016. (PX 4) Dr. Greatting noted Petitioner had excruciating pain after let carpal tunnel surgery and prescribed additional pain medications. (PX 4)

Petitioner returned to Dr. Greatting on September 28, 2016 for suture removal and was advised that he could return to work on October 3, 2016. (PX 4)

Petitioner retuned to Dr. Greatting for a final visit on November 17, 2016. Dr. Greatting noted Petitioner had resolution of the numbness and tingling in both hands but continued to have intermittent cramping in his hand. Dr. Greatting noted weakness in Petitioner's hands but suspected it would improve over time. Dr. Greatting released the Petitioner from his care and told him he could return if he felt it was necessary. (PX 4) Petitioner has not felt the need to return for further treatment.

Dr. Michael Vender is a board certified orthopedic surgeon from Arlington Heights, Illinois with added qualifications of hand surgery. (RX 5, p. 4-5)

Dr. Vender stated that he examined Petitioner on April 21, 2016 at the request of Respondent for which he created a narrative report of his opinions. (RX 5, p. 8, Dep. Ex. 2) Dr. Vender stated that he performed a clinical examination and noted normal range of motion of the wrists and right elbow, lateral elbow pain with firm gripping, local tenderness around the lateral epicondyle. (RX 5, p. 10) Dr. Vender diagnosed Petitioner with bilateral carpal tunnel syndrome and right lateral epiconcondylitis. (RX 5, p. 11)

Dr. Vender stated that he discussed Petitioner's job activities with him but he was not provided with "…all that much". (RX 5, p. 12) Dr. Vender stated that Petitioner denied a specific injury and Petitioner "…didn't identify in particular what he thought was responsible". (RX 5, p. 12) Dr. Vender further stated that Petitioner did describe "shoveling or moving grain, but he didn't give me an understanding of his overall job as to how many different types of activities he performed…" (RX 5, p. 12) Dr. Vender stated that based on Petitioner's description of his job activities he did not believe that the job activities caused, aggravated or accelerated Petitioner's bilateral upper extremity conditions. (RX 5, p. 20, 21) Dr. Vender stated that there was nothing in the descriptions provided to him by Petitioner to indicate that the risk factors for carpal tunnel and epicondylitis were present in Petitioner's case. (RX 5, p. 21)

Dr. Vender stated that in looking at work as a cause of carpal tunnel syndrome he looks for forceful gripping on a persistent basis intermittently throughout the day. (RX 5, p. 13-14) Dr. Vender felt that the job descriptions that he reviewed led him to believe that Petitioner's work activities were more supervisory in nature. (RX 5, p. 14)

Dr. Vender reviewed written job descriptions, but agreed that Respondent never provided him with any ergonomic studies of any of the job classifications performed by Petitioner. (RX 5, p. 23) Dr. Vender agreed

that apart from the description provided by Petitioner to him at his exam he had no other information concerning the physical activities required of Petitioner. (RX 5, p. 23-4)

Dr. Mark Greatting testified in this matter and is a board certified orthopedic surgeon from Springfield, Illinois with added qualifications in hand surgery. (PX 5, p. 7, Dep. Ex 1)

Dr. Greatting testified that Petitioner did not have any systemic conditions that he associated with carpal tunnel syndrome except for a thyroid condition which was being treated. (PX 5, p. 11) Dr. Greatting stated that as long as the thyroid condition was being treated it should not contribute to problems with the median nerve. (PX 5, p. 11) Dr. Greatting noted that Petitioner was not diabetic and quit smoking seven years before. (PX 5, p. 11) Dr. Greatting noted Petitioner was obese and there is a higher incidence of carpal tunnel syndrome among the obese. (PX 5, p. 12) Dr. Greatting stated that it was his opinion that the work activities the Petitioner described to him were a significant contributing factor to Petitioner's carpal and lateral epicondylitis. (PX 5, p. 14, 27)

Dr. Greatting was given a hypothetical question describing Petitioner's work activities that included the Tower Operator duties along with the cleaning duties Petitioner performed as a General Laborer, and stated that the Petitioner's work activities as described were a significant factor in the development of his carpal tunnel syndrome and lateral epicondylitis. (PX 5, p. 21, 27)

Dr. Greatting felt having to grip a large shovel or scoop, and large push broom, and repeatedly regularly over a period of years was the activity that he felt was the significant contributing factor. (PX 5, p. 27) Dr. Greatting felt that he did not believe the Petitioner performed the shoveling and sweeping 100 percent of the time but it was his assumption Petitioner did this the majority of the time. (PX 5, p. 27-8) Dr. Greatting stated that for the shoveling and sweeping to be a significant causative factor it would have to be performed for several hours per day, or five to six per day. (PX 5, p. 32)

Respondent provided Dr. Greatting with a hypothetical description of Petitioner's work activities and asked Dr. Greatting whether he considered the activities he described as being repetitive. (PX 5, p. 30) Dr. Greatting stated that the hypothetical did not provide a lot of detail but that he felt the activities sounded repetitive and could also contribute to the problem. (PX 5, p. 30-31)

The Arbitrator notes that Petitioner's work activity of gripping and pushing a broom or a shovel to lift grain required forceful gripping. Dr. Greatting agreed. (PX 5 at 10) The Arbitrator also notes that the Petitioner performed those duties when working as a General Laborer, which was the only job he performed throughout his entire seven year period of work for the Respondent prior to becoming symptomatic. In fact, from 2007 until 2010 and again from April through October 2013, that was his only job. Respondent argues that the Petitioner did a variety of jobs and, as such, nothing that he did could be classified as forceful and repetitive. However, the Petitioner established that he did the laboring job the majority of the time he was employed. As stated above,

there were periods of time when that was all that he did. The Petitioner said that he worked as a laborer at times for his entire shift. Mr. Mueller, who was also familiar with the laboring job, simply said that for the most part, laborers did not clean all day. Dr. Greatting related the Petitioner's injuries to his work duties as a laborer. Dr. Vender agreed that forceful gripping can cause carpal tunnel and epicondylitis. Dr. Vender's opinion that there was no causal relationship between the Petitioner's work and his conditions was flawed as it was based on the assumption that he did all of his jobs on a rotational basis throughout each day of work. The fact is that he only worked as a Tester occasionally, totaling only three months of testing during his seven plus years of work. In addition, he stopped working as a Deck Hand by his estimation sometime in 2011. While he did combine the Laborer job with that of a Tower Operator after November 2013, there is nothing in the evidence to rebut the proof that he used a shovel and/or broom to clean up grain several hours a day. There was no evidence offered by Respondent that it sought to provide Dr. Vender with a description of the physical activities of Petitioner's job duties. There was no evidence that Dr. Vender questioned Petitioner for more details regarding Petitioner's work activities. Clearly, Dr. Vender did not have a clear understanding of the work activities performed by Petitioner and his opinions against a finding of causal relationship are given less weight as a consequence.

Based on the foregoing, the Arbitrator finds Petitioner's employment required repetitive work with the hands which included repeated forceful gripping, lifting, twisting and bending of the wrists. The Arbitrator finds the Petitioner carried his burden of proving that he sustained accidental injuries that arose out of and in the course of his employment as a result of the repetitive duties required of his employment on January 8, 2015.

The Arbitrator further finds that Petitioner has carried his burden of proving that his bilateral carpal tunnel and right lateral epicondylitis were causally related to the accident of January 8, 2015.

ATTACHMENT J

In support of the Arbitrator's findings on the issue of **(J) Were the medical services that were provided to the petitioner reasonable and necessary?**, the Arbitrator finds the following facts:

The findings of fact stated in other parts of this decision are adopted and incorporated by reference here.

The Arbitrator finds the medical care provided to Petitioner was causally related to the accident, reasonable and necessary. The Arbitrator denies all medical bills submitted into evidence with a date of service before January 8, 2015 as being unrelated to the accidental injuries at issue. The Arbitrator finds the medical bills listed below as causally related to the accident and orders Respondent to pay the related medical bills, subject to the fee schedule, as follows:

Medical bills:

Elmer Hugh Taylor Clinic, 2/2/15-6/14/16	$ 688.00
Springfield Clinic, 11/9/15-9/16/16	$22,314.25
Physicians Group Associates, 1/26/15	$ 909.00
Total:	**$23,911.25**

Respondent is entitled to credit for any actual related medical expenses paid by any group 8(j) health provider and Respondent is to hold Petitioner harmless for any claims for reimbursement from said group health insurance provider and shall provide payment information to Petitioner relative to any credit due.

ATTACHMENT K

In support of the Arbitrator's findings on the issue of **(K) What amount of compensation is due for Temporary Total Disability?**, the Arbitrator finds the following facts:

The findings of fact stated in other parts of this decision are adopted and incorporated by reference here.

Petitioner was removed from work by Dr. Mark Greatting after his first surgery from August 16, 2016 to October 16, 2016. (PX 4) Having found the Petitioner's condition of ill-being to be causally related to his accident, the Arbitrator finds that Petitioner was temporarily and totally disabled from August 16, 2016 through October 3, 2016, a period of 6 and 6/7 weeks.

ATTACHMENT L

In support of the Arbitrator's findings on the issue of **(L). What is the nature and extent of the injury?** the Arbitrator finds the following facts:

The findings of fact stated in other parts of this decision are adopted and incorporated by reference here. Under the amended Illinois Workers' Compensation Act the Arbitrator notes that the Commission shall base its Decision on five enumerated factors. All of the factors need not be present to award permanent partial disability.

(i) the reported level of impairment;

(ii) the occupation of the injured employee;

(iii) the age of the employee at the time of injury;

(i) the employee's future earning capacity;

(ii) evidence of disability corroborated by medical records.

Therefore:

With regard to (i) of Section 8.1(b) of the Act:

Neither party offered an Impairment rating report pursuant to the Guides for the Evaluation of Permanent Impairment Sixth Edition. The Arbitrator does not consider this factor.

With regard to (ii) of Section 8.1(b) of the Act:

Petitioner was released without restrictions and continues to work for the Respondent in a different position. Some of his duties involve gripping small parts, and his notices problems because of his decreased grip strength. The Arbitrator gives moderate weight to this factor.

With regard to (iii) of Section 8.1(b) of the Act:

The Petitioner was 38 years old at the time of injury. The Arbitrator notes that the Petitioner has significant remaining work life. Petitioner returned to work for the Respondent where he has been transferred to a new position as a mechanic. He is required to use hand tools, socket wrenches and requires assistance to break some bolts loose as he cannot accomplish the task on his own. The Arbitrator gives great weight to this factor.

With regard to (iv) of Section 8.1(b) of the Act:

The Arbitrator concludes that the Petitioner's future earning capacity has not been impacted by the injury. No weight is attached.

With regard to (v) of Section 8.1(b) of the Act:

Petitioner continues to experience pain in both hands and his right elbow but it has lessened since the surgery. Petitioner notices that he continues to have occasional cramping and the grip in both hands is reduced. During his last visit with Dr. Greatting on November 17, 2016, he was noted to have a little tenderness in the left palm with good bilateral strength. The doctor indicated his condition could improve over the next six months. (PX 4) Moderate weight is attached to this factor.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SAMUEL VIRES,

Petitioner,

vs. NO: 15 WC 31947

PAXTON HEALTHCARE & REHAB,

Respondent.

18IWCC0056

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation, temporary disability, medical, and prospective medical, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof, with the change set forth 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 penultimate sentence of the fifth paragraph of the Conclusions of Law section is amended to read: "Dr. Butler's report establishes that in fact Petitioner had a long history of lumbar complaints, documenting several dates on which Petitioner called off work because he 'hurt his back' or 'threw his back out,' the most recent occasion being just four months prior to his accident."

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 23, 2017, as amended above, is hereby affirmed and adopted.

18IWCC0056

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 $1,500.00. 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: JAN 30 2018

L. Elizabeth Coppoletti

LEC/mck

O: 12/5/17

43

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

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

VIRES, SAMUEL
Employee/Petitioner

Case# **15WC031947**

PAXTON HEALTHCARE & REHAB
Employer/Respondent

18IWCC0056

On 5/23/2017, 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 1.05% 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 & EVANS
RUSSELL HAUGEN
4234 MERIDIAN PKWY SUITE 134
AURORA, IL 60504

2593 GANAN & SHAPIRO PC
TIMOTHY STEIL
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

18IWCC0056

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Samuel Vires
Employee/Petitioner

v.

Paxton Healthcare & Rehab
Employer/Respondent

Case # **15WC 31947** _____

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Springfield**, on **April 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 _____

18IWCC0056

FINDINGS

On the date of accident, **8/30/2015**, 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 partially causally related to the accident.

In the year preceding the injury, Petitioner earned **$17,505.08**; the average weekly wage was $397.84

On the date of accident, Petitioner was **48** 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 **$7,754.46** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$11,457.98** for other benefits, for a total credit of **$19,212.44**.

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

ORDER

Petitioner failed to prove his current condition of ill being for which Dr. Butler has proposed surgery is causally related to the accident. Petitioner has proven that he sustained an acute back injury on August 30, 2015 in the nature of a sprain.

Petitioner's request for medical care per the recommendation of Dr. Butler is denied as not being reasonably required to cure or relieve him from the effects of his accidental injury.

Medical bills incurred after April 3, 2016 are denied as not being reasonably required to cure or relieve Petitioner from the effects of his accidental injury.

Respondent shall pay reasonable and necessary medical services incurred prior to said date as contained in PX 4, pursuant to the Fee Schedule.

. Petitioner is entitled to TTD for 1/7 weeks for September 3, 2015 at a TTD rate of $265.23 pursuant to Section 8(b). Respondent is entitled to credit for TTD already 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.

18IWCC0056

Signature of Arbitrator

5/19/2017
Date

ICArbDec19(b)

MAY 23 2017

FACTS OF CASE

I. Petitioner's testimony

Petitioner was employed by Respondent on the date of his accident of August 30, 2015. (T.9) Petitioner was employed as a certified nursing assistant. (T.10) On August 30, 2015, Petitioner was transferring a resident from a wheel chair into a dinning chair and upon transferring the resident, Petitioner lost his balance and turned when his back popped. (T.11) Petitioner immediately felt a sharp burning pain in his lower back. (T.11)

Petitioner testified he did not have any back pain prior to his accident and working for full duty for Respondent. (T.11) Petitioner testified he had not undergone any prior treatment to his lower back. (T.11)

Petitioner was transported to Gibson Hospital via ambulance on August 30, 2015. (T.12) Petitioner was taken off work. (T.12) Petitioner was then seen by Nurse Practitioner Sullivan at Family Healthcare on August 31, 2015. (T.12) Petitioner was kept off of work until September 4, 2015. (T.13) Petitioner returned back to work for Respondent with light duty restrictions as of September 4, 2015. (T.13) Petitioner underwent a course of physical therapy as recommended by Nurse Practitioner Sullivan through November 2015. (T.14)

At the referral of Nurse Practitioner Sullivan, Petitioner was initially seen at GAH Orthopedics on December 3, 2015. (T.14) Petitioner underwent a second course of Physical therapy at Gibson Hospital from December 2015 through January 2016. (T.15) On January 7, 2016, GAH Orthopedics recommended a lumbar spine MRI. (T.15) On February 10, 2016, Petitioner underwent a lumbar MRI. (T.16) On February 25, 2016, GAH Orthopedics recommended an epidural steroid injection. (T.16) On March 31, 2016, Petitioner returned to GAH Orthopedics requesting a 90 pill refill. (T.17) On May 20, 2016, Petitioner underwent an epidural steroid injection. (T.17) On June 9, 2016, Petitioner was seen by Dr. Jesse Butler for an initial consultation as a treating physician. (T.17)

At the June 9, 2016 visit, Dr. Butler recommended a laminectomy and fusion to the lumbar spine. (T.18) Petitioner testified he wanted to proceed with that surgery. Petitioner has continued to be prescribed pain medication for his back by Nurse Practitioner Sullivan from August 2016 through January 2017. (T.18)

Petitioner worked light duty for Respondent from September 4, 2015 through July 13, 2016. (T.19) Petitioner worked answering phones, receptionist, charting vitals and into computer network and passing ice water. (T.19) Petitioner was working 35 to 40 hours a week during that time. (T.19) Petitioner was terminated by Respondent on July 14, 2016. (T.19) Petitioner was terminated as he failed a drug test. (T.20) Petitioner has not worked anywhere else since his termination. (T.20)

Petitioner testified he was still in pain and had good days and bad days. (T.21)Since his accident, there has never been a point Petitioner has not been in pain. (T.21) Petitioner's pain varied from a 4 all the way up to on a 10 on a 0 to 10 pain scale depending on the activities he does during the day. (T.21) Pain medication, heating pad and soaking in hot tubs of water helped relieve his pain. (T.22)

Petitioner suffered a right hip fracture on December 6, 2016 and is not claiming any benefits as it relates to that injury. (T.22) Petitioner testified he has never filed any prior workers' compensation claims in the past. (T.22)

On cross-examination, Petitioner testified he has only seen Dr. Butler in January 2016 and of June 2016. (T.23) Petitioner does smoke marijuana on occasion. (T.25) Petitioner could not recall filing a workers' compensation

claim for a date of accident of May 2, 1989. (T.26) After further questioning, Petitioner did recall his prior case going to trial. (T.28) Petitioner did recall having a prior right foot claim that went to trial. (T.28)

Petitioner did not remember calling in to be taken off of work for any prior back issues. (T.30) Petitioner did not recall in April 2015 that he had called off work because of issues concerning his back. (T.30) Petitioner also did not recall calling off of work on July 25, 2012 or September 8, 2011. (T.34-35)

Prior to April 2, 2016 and April 3, 2016, Petitioner testified he had a 10 pound lifting restriction. (T.39) Petitioner testified he was present during the deposition of Dr. Butler on November 11, 2016. (T.39)

During the deposition and afterwards, Petitioner testified he did have an opportunity to review the video surveillance taken of him on April 2, 2016 and April 3, 2016. (T.40) Petitioner testified he had no reason to disagree that he was seen in the video surveillance. (T.41) Petitioner testified that the video fairly and accurately showed the activities he performed on those days. (T.42)

Petitioner testified the deep freezer he was seen moving in the video had no motor or anything in there as it was an old junk freezer. (T.49) The freezer was empty. (T.49) The guts were torn out of the freezer and that is why it was scrap. (T.49) Petitioner testified the freezer weighed probably 40 pounds. (T.49) Petitioner testified the largest item not including the deep freezer that he picked up was a box full of knickknacks that weighed approximately 10 to 15 pounds. (T.50) Petitioner testified he was wearing a back brace underneath his clothes. (T.50) Petitioner testified he was taking pain medications at the time of the video. (T.51) Petitioner testified he did have discomfort in his back while doing the activities on that date. (T.51)

Petitioner testified he did not weigh the chest freezer. (T.53) Petitioner testified it was just his guess as to the chest freezer weighing 40 pounds. (T.53) Petitioner testified the chest freezer was made of tin metal. Petitioner testified it was not steel as it was a newer model. (T.53)

II. Exhibits Introduced at Trial

After the accident, Petitioner presented to the Gibson Hospital ER on August 30, 2015 with complaints of back pain after lifting a patient. (Px-1) The impression was no acute osseous abnormality of the lumbar spine with degenerative disc and joint disease most pronounced at L5-S1.

On August 31, 2015, Petitioner presented to FNP Sullivan as referred by ER. He was unable to sit upright due to severe back pain. (Px-1) There was tenderness and muscle spasm of the lower back with gait disturbance. He was excused from work and advised to follow up.

Petitioner continued to follow up with FNP Sullivan through November 18, 2015. (Px-1) At the November 18, 2015 visit, Petitioner reported no improvement after six physical therapy visits. He felt worse after therapy. There was tenderness to palpation of the mid lumbar/sacral area and to the right sacroiliac joint. He was referred to the spine clinic. Therapy was discontinued.

On December 3, 2015, Petitioner was seen by Glenett Barrett, NP, with lower back pain that radiated into the right buttock. (Px-2) He was able to bend forward finger tips below the knees. Backward bending was very limited. He was able to toe walk and had difficulty with heel walking. He was able to squat and rise. The CT and x-rays were reviewed. He was referred to physical therapy. If not improvement, then an MRI would be the next step.

On December 4, 2015, x-ray of the lumber spine showed no acute osseous abnormality; multilevel degenerative disc and joint disease. (Px-2)

Respondent scheduled an IME with Dr. Jesse Butler on January 15, 2016. (Rx-3) At the time of the examination, Petitioner complained of continuing to have severe low back pain that radiated only to the buttock. Petitioner has taken multiple medications with modest control of pain. Petitioner was frustrated and continued to be miserable. Petitioner's neurologic exam was normal. Petitioner's musculoskeletal exam revealed moderate tenderness with no swelling and normal sensation. Straight leg raising test negative as well as reverse straight leg raising test and Waddell's test. Dr. Butler reviewed Petitioner's lumbar spine x-ray of December 3, 2015 which showed severe disc degeneration as L5-S1 level and approximate levels were normal. Petitioner's CT of the lumbar spine on August 30, 2015 showed degenerative collapse of the L5-S1 level with left and right sided foraminal stenosis, moderate facet degeneration, spinal canal centrally without stenosis and the proximal levels were normal.

Dr. Butler diagnosed Petitioner with lumbar strain with aggravation of underlying degenerative disc disease. (Rx-3) Dr. Butler causally related Petitioner's spine condition to his work incident. Dr. Butler indicated a CT exam showed degenerative findings at L5-S1 consistent with Petitioner's complaints of subjective pain. Physical therapy was found to be reasonable as well as an MRI. These recommendations were causally related to the work incident. Dr. Butler opined Petitioner had not reached MMI. Dr. Butler opined Petitioner was not currently capable of working with restrictions. Petitioner had incapacitating back pain that limited his ability to stand, walk and sit for any period of time. Once the MRI reviewed, further discussion could be completed regarding treatment options.

After the IME, Dr. Butler became Petitioner's treating physician.

On February 25, 2016, Petitioner followed up with Ms. Barrett. (Px-2) Petitioner described his back pain as severe. Exacerbating factors consisted of lying flat, movement, prolonged sitting, raised legs in supine position, squatting, standing and walking. Petitioner stated he would like to leave spinal fusion as a last resort and that discussion was had for an injection. Petitioner stated he would like to try an epidural steroid injection.

On March 22, 2016, Petitioner was provided with work restrictions by Ms. Barrett of walking or standing occasionally, lifting ten pounds maximum and frequent lifting or carrying of objects such as small tools. (Px-2)

On March 25, 2016, Dr. Butler prepared an addendum which was introduced into evidence. (RX 4, Exhibit 3) He wrote that he had reviewed the lumbar spine MRI of February 10, 2016 and opined it showed severe collapse of the L5-S1 disc space with left-sided foraminal stenosis and lateral recess narrowing from posterior spurring of the end plates coupled with facet hypertrophy. (Rx-4, Ex-3) The proximal lumbar levels were normal. Dr. Butler again found Petitioner had not reached MMI. Dr. Butler stated Petitioner may consider an epidural injection to see if there was any reasonable reduction in the radicular component of pain. Surgical option of decompression and fusion at L5-S1 would be reasonable if the spinal injection did not provide reasonable sustained improvement. MMI with injections producing relief would potentially occur in two to three months. Surgery would require seven months to reach MMI. Petitioner is to remain off of work. Modified duty may be considered if injections provided relief.

On March 25, 2016, Petitioner presented to Dr. Charles Martin at Hoopeston Regional Health Center. (Px-5) Petitioner reported "my back is killing me" since October. Petitioner reported lower, middle and right sided back pain. Petitioner out of Vicodin and not able to get refill. Petitioner was informed to go to ER. Petitioner was prescribed Flexeril and Norco.

On March 31, 2016, Petitioner presented to Ms. Barrett. (Px-2) Petitioner reported his symptoms were moderate-severe. Petitioner's symptoms were aggravated by ascending stairs, bending, coughing, daily activities, descending stairs, driving, exercise, extension, flexion, jumping, lateral bending, lying/rest, rolling over in bed, rotation, sneezing, sports, standing, twisting and walking. Petitioner reported that sometimes 60 pain pills a month does not last. Petitioner did much better with 90 pain pill prescription. Petitioner was waiting for approval for epidural steroid injections. Ms. Barrett stated Petitioner was not abusing his medication and she would prescribe him 90 pills a month.

On May 20, 2016, Petitioner underwent a lumbar epidural steroid injection. (Px-3)

On June 9, 2016, Petitioner followed up with Dr. Butler. (Px-2) Petitioner reported the epidural steroid injection did not help at all. Petitioner had right leg pain and back pain. Petitioner complained of shoulder blade pain. Dr. Butler offered a laminectomy and fusion to which Petitioner expressed his wish to proceed with.

III. Dr. Butler Deposition

Dr. Jesse Butler's deposition was taken on November 11, 2016 with Petitioner present. (Rx-4) Dr. Butler spoke with Petitioner's counsel prior to the deposition about the potential for some surveillance video and if that might affect his opinions. (Rx-4, T.6)

Dr. Butler reviewed some x-rays of the lumbar spine and a CT scan. (Rx-4, T.11) The x-ray from December 3, 2015 showed severe disc degeneration at L5-S1 and the proximal levels were normal. The CT scan from August 30, 2015 showed degenerative collapse of the L5-S1 disc with left and right-sided foraminal stenosis, moderate facet degeneration, no central stenosis in the upper levels, upper levels of the back were normal. At the time of Dr. Butler's examination, Petitioner described an injury to the lower back on August 30 while performing a patient transfer. Petitioner stated he developed acute and severe low back pain that radiated to the right leg. Petitioner stated the leg pain had improved with medication, time and therapy but continued to have severe back pain with radiation to the buttock. Petitioner was also taking multiple medications with some modest control of pain.

When Dr. Butler performs an IME or when he is treating a patient, he relies on the patient to be truthful and honest when they are relating subjective complaints. (Rx-4, T.12) It is important for a patient to be truthful when describing subjective complaints as decisions for treatment are based upon correlating objective findings of the imaging studies with the subjective reports of pain. If information is either left out or misrepresented, a physician can make treatment decisions that might put the patient in harm's way.

Dr. Butler diagnosed Petitioner with lumbar sprain and lumbar degenerative disc disease. (Rx-4, T.19) Dr. Butler opined Petitioner's work activity of performing this patient transfer aggravated the underlying degenerative disc disease at L5-S1.

Dr. Butler recommended physical therapy. (Rx-4, T.20) Dr. Butler also recommended an MRI scan. Petitioner could continue with medication. Dr. Butler also recommended Petitioner to remain off work and was not at MMI.

Dr. Butler's opinion was based on Petitioner being truthful and honest about his subjective complaints of pain at the time Dr. Butler saw him. (Rx-4, T.21) Dr. Butler took Petitioner off of work was based on Petitioner's subjective complaints of pain.

Dr. Butler reviewed the video surveillance from April 3, 2016. Dr. Butler reviewed Petitioner's attempts to move and lift the chest freezer onto a truck on the video surveillance. Dr. Butler described either the wires or the flexion from the tailgate, plastic on the top of the tailgate was making it difficult for the chest freezer to slide and Dr. Butler could see Petitioner was limited in the strength he could put into this and there were limitations to his bending. (Rx-4, T.34) Dr. Butler could see Petitioner walk away from it and believed it was apparent that it was not an easy task for Petitioner.

Dr. Butler testified he could see Petitioner limping as he was walking around from the refrigerator at 11:08 on April 3. (Rx-4, T.36)

Dr. Butler indicated Petitioner's activities in the video did not appear to aggravate Petitioner's back. (Rx-4, T.39) Dr. Butler testified Petitioner's activities after lifting and pushing in the chest freezer did not necessarily appear to have aggravated Petitioner's back. Dr. Butler indicated Petitioner was still walking with a stiff gait that he has had and Petitioner did not appear to be overtly in duress.

Dr. Butler did not know whether Petitioner's walking pattern as seen on the video could be Petitioner's normal walking pattern regardless of Petitioner's back issues. (Rx-4, T.40) Dr. Butler testified the only activity in the video that he saw that was somewhat inconsistent was Petitioner pushing the freezer into the truck bed. With the way Petitioner was doing it, the action required probably about 40-50 lbs. of push/pull force to get the freezer into the bed of the pickup truck.

Dr. Butler testified that during his exam of Petitioner, Petitioner was able to comfortably bend down to 45 degrees so the bending as seen in the video is not inconsistent with what he saw on physical exam. (Rx-4, T.41) Dr. Butler indicated the video he saw was just a short period of time and on one single date and that he did not have any follow up as to whether Petitioner was taking extra pain medication to be able to complete this or took extra pain medication after doing this. Dr. Butler indicated the video did not give him a complete picture. Dr. Butler testified that if Petitioner was seen doing this for four to eight hours, it would tend to cast some shadow about the reliability.

Dr. Butler testified the video showed Petitioner as doing more than what he should be doing but it did not necessarily change his opinion. (Rx-4, T.41) Dr. Butler did not know if the video necessarily changed his opinion as it concerned the veracity of Petitioner's pain complaints.

Dr. Butler was then asked whether the video had any impact as to his opinions on treatment. (Rx-4, T.46) Dr. Butler indicated reviewing a video is challenging and it is difficult to analyze these things to make sweeping generalizations when a patient's examination findings are essentially normal. When Dr. Butler saw Petitioner, the only issue Petitioner had on physical exam was discomfort in bending past 45 degrees and everything else was fine.

Dr. Butler testified Petitioner pathology, i.e. degenerative disc disease, is one which people can have without symptoms. (Rx-4, T.47) Petitioner's symptoms can wax and wane. Dr. Butler conceded Petitioner was doing an activity on the video that was more than what he should be doing and Petitioner never really claimed that he didn't do these types of activities but this is something that would cause Petitioner pain.

When a patient tells Dr. Butler that they have 7/10 pain, he would not expect the patient would be able to lift a chest and bend down as frequently as seen in the video. (Rx-4, T.49) If a patient describes 5/10 pain, Dr. Butler would expect a patient to be able to lift a chest and bend down as frequently as seen in the video. Dr. Butler testified Petitioner's condition was one that he would expect to wax and wane over time.

When asked if it was possible Petitioner's condition had plateaued as of April 3, 2016 and Petitioner's condition thereafter would not be related to his work accident, Dr. Butler testified Petitioner had just gotten a fresh prescription of 90 pain pills and Petitioner may have taken extra pain medication to complete the task as seen in the video. (Rx-4, T.50) Dr. Butler stated he would need to see a trend of increasing activity and increasing function over time in maintaining that to say that there was no longer a causal relationship between the accident that Petitioner had in August and what he saw Petitioner doing in April.

Dr. Butler testified if there is a lumbar sprain and an aggravation, many of those things do tend to resolve by six months after the incident and on the longer end about a year. (Rx-4, T.50)

Dr. Butler felt surgery was a reasonable option given the information he had. (Rx-4, T.53) Dr. Butler testified the surgical recommendation was related to both Petitioner's pre-existing condition and the accident of August 30, 2015. After review of the video, Dr. Butler believed the prognosis of proceeding with surgery was reasonable. Petitioner did have some risk with smoking and depression.

Dr. Butler testified surgery was based on Petitioner's persistence of pain and it is a subjective call. (Rx-4, T.54) Dr. Butler did not have a problem based on what he saw in the video to recommend surgery.

IV. Dr. VanFleet Deposition

Petitioner was seen by Dr. VanFleet for an IME on January 18, 2017 at Respondent's request. (Rx-1) Dr. VanFleet reviewed video surveillance from April 3, 2016. (Rx-2, T.12) Dr. VanFleet reviewed video at 11:07 AM mark and indicated Petitioner appeared to be in really good physical condition. (Rx-2, T.12) Petitioner did not look like he was having any trouble getting up and down from the cab of a truck. Petitioner was picking up a pretty large chest freezer that had to be heavy and Petitioner was moving it around without much of a problem. Dr. VanFleet believed Petitioner did not look like anybody who had a back injury. (Rx-2, T.13)

Dr. VanFleet believed the chest freezer would weigh at least 75-100 pounds. (Rx-2, T.14) In review of the video, Dr. VanFleet could see Petitioner was pushing the chest freezer and rocking his hips back and forth as well to try to push the freezer and Petitioner was flexing and extending his pelvis without moving his legs and trying to generate upper body strength in order to push the chest further was all coming through the lumbar spine and did not seem to pose any problem for Petitioner.

Dr. VanFleet did not see anything in the video that would give him the slightest impression Petitioner had a back problem. (Rx-2, T.15)

During portions of the video, Dr. VanFleet noticed there appeared to be no pain behaviors on Petitioner's part. (Rx-2, T.17) Petitioner was not listed over holding his back, Petitioner was walking pretty normally without any kind of limp or any kind of antalgic gait and was in no distress and appeared to be tolerating activities without much of a problem.

Dr. VanFleet observed the most compelling part of the video surveillance were the issues where Petitioner was pushing the cab off of the back of the truck, then moved the spare tire in the back of the truck and then jumped up into the truck without any problem. (Rx-2, T.19) Petitioner could bend over without problems. Petitioner was moving the deep freezer from ground level on his own up into the pickup truck without any problem. Dr. VanFleet opined a person with a back problem to the degree where he is off work and on Norco and on a ten pound restriction does not do these kinds of activities. Dr. VanFleet would release the patient from his care without any treatment if an individual is doing these kinds of activities. Dr. VanFleet stated Petitioner would not be his patient based on the video because it was obviously disingenuous and obviously misstates the level of

pain and dysfunction and interference with the quality of life Petitioner proclaimed to have at that point. It was completely not medically possible for a back problem to which Petitioner described to do these types of things that he did.

Dr. VanFleet conducted a physical exam of Petitioner. (Rx-2, T.22) Petitioner had a diffuse and superficial tenderness to palpation across the lumbar spine. With forward flexion, Petitioner indicated he could not bend very well forward. Petitioner had pain with simulated truncal rotation which is kind of a non-organic pain manifestation as is the superficial tenderness to palpation across the spine. Axial pain or pain with axial compression of the head and shoulders which is consistent with kind of a non-organic pain manifestation presentation and also symptom magnification. Dr. VanFleet believed Petitioner had symmetric strength in the lower extremities, but Petitioner had give way on the right side, but that was the side Petitioner had hip surgery. There was no evidence of any tension signs.

Dr. VanFleet reviewed the MRI from February 10, 2016, which showed evidence of degenerative disc disease at L5/S1, bone-on-bone changes. (Rx-2, T.23) Petitioner had some narrowing on the left side of the neural foramina with disc osteophyte protrusion extending out.

Dr. VanFleet testified the MRI findings in and of themselves do not necessarily suggest or indicate that a patient needs or requires lumbar surgery. (Rx-2, T.24) The findings were degenerative changes and people will develop degenerative changes which do not provide an indication for surgery.

Dr. VanFleet's diagnosed Petitioner's lumbar condition as non-specific low back pain with lumbar degenerative disc disease. (T.25) Dr. VanFleet opined Petitioner's subjective complaints and perceived physical limitations did not appear consistent with what was seen on the video surveillance as the video surveillance showed a person that seemed to be able to do whatever it was he wanted in terms of lifting and bending and twisting.

Dr. VanFleet opined Petitioner was not a surgical candidate as Petitioner was a smoker and there was nothing in his examination that would lead Dr. VanFleet to believe Petitioner's back pain was a result of the disc changes at L5/S1. (Rx-2, T.28) Dr. VanFleet testified Petitioner had a lot of red flags pointing in the direction of a failed operation or leading to a failed back syndrome. The red flags Dr. VanFleet saw were: Petitioner is a smoker, workers' compensation was involved and the video surveillance.

Dr. VanFleet testified Petitioner had basically non-organic pain manifestations on exam and therefore the surgical outcome will likely fail. (Rx-2, T.29) Dr. VanFleet testified Petitioner was not to be believed based on examination and if Petitioner was his patient, he would have been released from care. Dr. VanFleet saw no reason to believe Petitioner was a fusion candidate and Petitioner has zero percent chance of improvement with surgery.

Dr. VanFleet did not believe Petitioner was a surgical candidate and there was too many things pointing to a secondary gain. (Rx-2, T.30) Dr. VanFleet testified that the mere fact Petitioner developed back pain after the accident does not mean he is a surgical candidate, it means Petitioner has back pain as a result of the mechanism of lifting.

Dr. VanFleet opined Petitioner had reached MMI approximately eight to ten weeks following the injury. (Rx-2, T.31) Based on Dr. VanFleet's review of the video surveillance, Dr. VanFleet opined Petitioner did not require any work restrictions. Based on Dr. VanFleet's own examination, Petitioner did not require any work restrictions. During the examination, Dr. VanFleet did identify signs of symptom magnification.

Dr. VanFleet testified the signs of symptom magnification on exam were the superficial tenderness to palpation, pain with simulated truncal rotation, and pain with axial compression of the head and shoulders (Rx-2, T.32) Pain with axial compression of the head and shoulders is generally speaking when pressure is put on the top of the head that is not going to cause back pain as there is no pressure on it, not pushing pressure on it, however, Dr. VanFleet is kind of providing a level of pressure at the top of the head and it fools the patient into thinking that they are pushing down on top of them. It is more or less kind of like a tap, when you tap them and they believe you are pushing on them, you are not applying any load to that mechanism does not cause back pain. When Dr. VanFleet put his hand on Petitioner's head, Petitioner reported pain across the back.

When Dr. VanFleet described Petitioner was tender to palpation diffusely and superficially across the lumbar spine, he is applying a pinching of the skin that is not really doing anything to the patient's back. (Rx-2, T.33) With a diagnosis of degenerative disc disease Dr. VanFleet testified, a pinching of the skin will not have any affect on that. If a patient has discogenic pain, it will be localized to the left or right and it is not going to be up in the right side of the upper back or in the left side. Superficial and diffuse pain does not subscribe to any kind of clinical entity as far as degenerative disc disease is concerned. When Dr. VanFleet noted Petitioner had pain with simulated truncal rotation from a clinical standpoint it is when Dr. VanFleet puts his hands on a patient's hips and then rotates the whole pelvis so everything is moving together as a unit. There is not any motion going through the lumbar spine and this should not hurt because the spine is not being moved.

On cross-examination, Dr. VanFleet disagreed with Dr. Butler's testimony after reviewing the video that Petitioner walked with an antalgic gait throughout the video. (Rx-2, T.49)

Secondary gain would be somebody who is injured in an accident who may have persistent pain and continues to seek treatment for the sole purpose of extending that patient role and perhaps to have a payout at the end. (Rx-2, T.50) Dr. VanFleet's opined Petitioner would subject himself to a fusion with the risk associated with that for the purposes of a secondary gain.

Conclusions of Law

With respect to (F.) and (J) Is Petitioner's current condition of ill-being causally related to the injury and is the proposed treatment of Dr. Butler consisting of lumbar fusion surgery reasonably necessary to cure or relieve the Petitioner from the effects of his accidental injury, The Arbitrator finds as follows:

The real issue in this claim is whether the surgical treatment prescribed by Dr. Butler is reasonably necessary to cure or relieve the Petitioner from the effects of his accidental injury. In order to address the issue, the Arbitrator feels it appropriate to discuss what injuries are and are not causally related to said accident, based upon the trial evidence.

First of all, Dr. Butler at his initial visit with the Petitioner diagnosed his condition as that of a lumbar sprain with degenerative disc disease. He noted the CT scan taken on the date of the accident as showing extensive degeneration of the lumbar spine at the level of L5-S1. He explained in his report that the accident did aggravate the degenerative condition and that his condition on that examination date was causally related to the accident.

The Arbitrator agrees with Dr. Butler's assessment made on January 15, 2016. It is supported by the continuous and consistent treatment and examination findings that the Petitioner received from the date of accident forward.

However, the Arbitrator does not believe that Dr. Butler's proposed surgery is reasonably required based upon the evidence. Dr. Butler explained in detail during his deposition that his surgical recommendation depended

largely upon the Petitioner's credibility with respect to the severity of his pain and not upon the objective findings seen in his exam and on the various diagnostic studies which had been performed. Dr. Butler explained that the Petitioner had no neurologic crisis which required surgical treatment. (RX 4 at 48) He showed no deficits in strength or sensation (Id at 18) He basically said that the Petitioner was unable to work and needed surgery because of his ongoing complaints of pain. (See RX 4 at 16, 21) He noted that the Petitioner indicated that he could only lift 20 pounds. (Id at 16) The surgery, he said, was based upon the Petitioner's persistent pain. (Id at 54)

The Arbitrator does not find the Petitioner credible. First of all, there's the videotape of April 3, 2016 which was reviewed by both Drs. Butler and Van Fleet. While the Arbitrator does agree with some of the points made by Dr. Butler that a short video does not really reflect the Petitioner's capabilities, it does contradict some of Petitioner's testimony concerning the severity of his pain. The Petitioner maintained that his pain level was in the neighborhood of 5 to 7 on a 10 point scale but that it increased to 10 when aggravated by the activities of bending and lifting, activities which he was clearly doing on April 3. The Arbitrator viewed the video and it certainly didn't appear that those strenuous activities, particularly lifting and pushing on a freezer weighing at least 40 pounds, caused any noticeable change in the Petitioner's symptoms. More important than the video, however, are the inconsistencies between fact and the Petitioner's testimony concerning his prior back symptoms. As stated above, on direct examination and later to Dr. Van Fleet, the Petitioner flat out denied having any lower back symptoms or treatment prior to his accident. Dr. Butler's report establishes that in fact the Petitioner had a long history of lumbar symptoms with treatment, the most recent being only four months prior to his accident. (See RX. 3 and RX. 4 at 10) When given this information during cross examination, the Petitioner simply said he did not recall those instances.

The lack of credibility directly effects whether the surgical proposal is reasonable, as it is being based upon the Petitioner's veracity with respect to his symptoms. For the reasons referenced above, the Arbitrator does not believe the propose surgery is a reasonable treatment option, and the request for authorization is denied.

Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; and (L.) What temporary benefits are in dispute? The Arbitrator finds as follows:

The attached order explains the period of TTD owed which is one day. It also explains the Respondent's obligation to pay the medical incurred through April 3, 2016.

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 DU PAGE)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☒ Modify down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Raymond Mason,

Petitioner,

vs. NO: 14 WC 18256

Lowery Tile Co.,

Respondent.

18IWCC0057

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of 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.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner has been a Union Tile Setter for 32 years.

2. On November 12, 2013, he was working for Respondent at Hillside South High School. He was grouting 1x1 unglazed floor tile in a 600 square feet area with epoxy. Normally epoxy is a two man job, but a co-worker did not show up that day, so Petitioner was working mostly alone. Epoxy requires three products to be mixed together into one stiff mixture, which is difficult to smear into the tile cracks.

3. Petitioner was consistently getting up to fill 5-gallon buckets with warm water, and pulling and smoothing epoxy with a float. He also used Scotch Brite pads to scrub in a

circular motion to clean extra grout from the tiles.

4. Near the end of the job, Petitioner noticed his left shoulder getting more and more stiff. He also had sharp pain in his neck and left arm.

5. The following day, Petitioner returned to work and reported his shoulder issues to Respondent.

6. Over the next few days Petitioner's pain increased, to the point where he sought medical care. He underwent x-rays, was placed in a shoulder immobilizer and was referred to an orthopedic surgeon.

7. On November 19, 2013, Petitioner's primary care physician recommended a left shoulder MRI and placed him on light duty.

8. Petitioner worked light duty for a couple of days, but Respondent did not approve the MRI. Several days later Petitioner's primary care physician released him to full duty. Petitioner worked for two more weeks and then the work ran out.

9. Subsequently, Petitioner was placed with another company, working with them for six to seven months. Throughout this time period he was in pain at the top of his shoulder and along the side of his neck.

10. In June 2014 Petitioner treated with his primary physician and was again recommended for an MRI. The results revealed tendinosis, but the MRI was compromised due to movement. Subsequent to the MRI, Petitioner was given a shoulder injection, placed on light duty and prescribed therapy.

11. In December 2014 Petitioner was referred to an orthopedic surgeon, Dr. Staron.

12. A repeat MRI was performed in January 2015, which revealed impingement, moderate tendinosis and a partial thickness rotator cuff tear.

13. In February 2015 Dr. Staron reviewed the MRI and diagnosed a partial thickness rotator cuff tear and a SLAP tear. Surgery was then recommended.

14. On January 5, 2016 Dr. Coe performed an Independent Medical Examination (IME) on Petitioner. Petitioner complained of left shoulder pain, worse when reaching, lifting, pushing or pulling. He also complained of left shoulder weakness. Dr. Coe opined an impairment rating of 7%.

15. Petitioner has yet to undergo surgery. He needs 35 years of service to retire at the age of 60. Any disruption in service of 6 to 8 months would cause him to work until the age of 64 before he would be able to retire. There is also no guarantee that after surgery, Petitioner would even be able to continue in his employment. Moreover, Petitioner is a diabetic and if he were off work for longer than 3 months he would lose his health

insurance, which he needs to afford his insulin and pills.

16. At the time of trial Petitioner complained of daily pain He suffers from left arm cramps when he holds a phone up to his ear. He is an outdoors person, living in a gated community with several lakes and a golf course. He has five children and six grandchildren. Due to his condition, he no longer water skis, fishes or golfs. He also is an avid hunter, but can no longer hold a rifle up. He testified that he takes six Aleve daily.

17. Petitioner now works with tools 60% of the time at work, and supervises the other 40% of the time. He earns the same amount as he did pre-accident, but must work more hours overall to earn the same pay.

The Commission notes the Arbitrator's findings addressing the factors listed in §8.1b of the Act with respect to an award for nature and extent.

The Arbitrator assigned significant weight to the impairment rating of 7% offered by Dr. Coe.

The Arbitrator noted that Petitioner was a full-time Tile Setter for Respondent at the time of accident.

Petitioner was 53 years old at the time of accident.

There was no evidence that Petitioner had suffered an impairment of his ability to earn wages in the future. However, Petitioner is now required to work longer hours to earn the same amount of pay as he was pre-accident. He also now serves in more of a supervisory capacity, tiling 60% of the time and supervising 40% of the time.

Petitioner underwent conservative treatment, including therapy and injections in his left shoulder. Arthroscopic rotator cuff repair surgery was eventually recommended., along with a possible labral repair and open sub pectoral biceps tenodesis to address the partial thickness rotator cuff tear and SLAP tear.

Petitioner suffers from pain daily, whether he is working or not. He is no longer as active as he used to be, and has difficulty even holding a phone to his ear with his left arm without cramping. No malingering or exaggeration was noted and no contrary medical opinion was offered by Respondent.

The Commission acknowledges the above findings, but views them slightly different than does the Arbitrator, and hereby modifies the Arbitrator's award down from a 12.5% loss of a man to a 10% loss of a man.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $721.66 per week for a period of 50 weeks, as provided in §8(d)(2) of the

18IWCC0057

Act, for the reason that the injuries sustained caused a 10% loss of use of Petitioner's person as a whole.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $45,200. 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.

JAN 30 2018

DATED:
O: 12/14/17
DLG/wde
45

David L. Gore

Stephen Mathis

Deborah L. Simpson

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
NATURE AND EXTENT ONLY

Raymond Mason
Employee/Petitioner

v.

Lowery Tile Co.
Employer/Respondent

Case # 14 WC 18256

Consolidated cases: N/A

18IWCC0057

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 **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Wheaton**, on **August 30, 2016**. By stipulation, the parties agree:

On the date of accident, **November 12, 2013**, 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 **$88,774.40**, and the average weekly wage was **$1,707.20**.

At the time of injury, Petitioner was **53** years of age, ***married*** with **no** dependent children.

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

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

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

ORDER

As explained in the Arbitration Decision Addendum, Respondent shall pay Petitioner permanent partial disability benefits of $721.66/week for 62.5 weeks, because the injuries sustained caused the 12.5% loss of use of the person as a whole (left shoulder), as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

October 17, 2016
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*
NATURE AND EXTENT ONLY

Raymond Mason
Employee/Petitioner

v.

Lowery Tile Co.
Employer/Respondent

Case # **14** WC **18256**

Consolidated cases: **N/A**

FINDINGS OF FACT

Background 18IWCC0057

Raymond Mason (Petitioner) testified that he worked for Lowery Tile Co. (Respondent). Petitioner testified that he has been a union tile setter with Union Local 67 (newly Local 21) since 1988. Petitioner testified that he worked for Respondent as a tile setter on and off for three years. Prior to the date of accident, Petitioner had not injured his left shoulder or neck, received any medical care to either body part, or did he miss any work due to medical problems related to either body part. Petitioner is right-handed.

Petitioner sustained an undisputed accident at work on November 12, 2013. He explained that he arrived at 6:00 a.m. to work on a locker room in a high school that was under new construction. Petitioner was supposed to be working with another gentleman to grout one by one inch tiles and there were a lot of cracks to fill with epoxy over 600 square feet of space.

Petitioner explained that epoxy grout comes in a three-part form. The three products are mixed together and the mixture is very stiff making it difficult to smear into the cracks. Petitioner also explained that the application requires a specific tool, a grout float, to apply the grout. Generally, applying epoxy grout is a two-person job and it requires use of a lot of water during the process.

On the date of accident, Petitioner testified that the other person that was supposed to work with him did not show. Once informed that the other person did not appear, the owner of the company told Petitioner that he would be back to work with him. However, Petitioner testified that he almost completed the job by himself by the time the owner was able to assist him. To accomplish this, Petitioner testified that he constantly had to get buckets of water, use a large amount of scrub sponges in a circular motion to clean up the extra grout, and at the end he was using both arms to use the grout float.

Petitioner testified that while performing this work, his left shoulder was stiff and he felt pain in his arm and shoulder. That evening, he continued to feel stiff and sore so he iced his shoulder and sat in a hot tub to alleviate his pain. However, the following day, Petitioner was also set to work for Respondent at another project where he was performing different activities using a chipping hammer to take out tile. Petitioner reported problems with his shoulder to Respondent and his pain became excruciating over the following four to five days.

Medical Treatment

On November 17, 2013, Petitioner presented at St. Catherine Hospital emergency room. PX2 at 3-10. He reported worsening pain after working hard the past week in the left side of the neck, left arm, and left hand. Id. Petitioner was diagnosed with acute left sided cervical radiculopathy, a strain of the left trapezius muscle, and a left shoulder strain. Id.

Petitioner testified that he continued working for Respondent and the medical records reflect that on November 19, 2013, Petitioner's family physician, Dr. Brett Brechner (Dr. Brechner) ordered an MRI of the left shoulder for arm pain. PX3 at 4-6. Petitioner testified that he was released to full duty work on November 21, 2013.

Petitioner returned to work for Respondent and worked there for approximately two weeks after which Respondent had no more work for him. Petitioner testified that he then called the union hall and went to work for another shop. During the following 6-7 months, Petitioner was working for another employer, Five Star Tile. Petitioner testified that he felt pain in the top of his shoulder, along the side of his next, sometimes on the bicep of the arm. He has not been back to work for Respondent.

Petitioner then returned to see Dr. Brechner on June 26, 2014. PX3 at 7-9; PX4 at 3. Dr. Brechner again ordered a left shoulder MRI and reiterated that a shoulder injection should be considered. Id.

On September 8, 2014, Petitioner underwent the recommended left shoulder MRI at Advanced Imaging Center. PX3 at 30. The interpreting radiologist noted a signal alteration in the rotator cuff tendon most likely due to tendinosis, although a partial tear was not excluded. Id. The radiologist also noted that the MRI was compromised due to movement. Id. Dr. Brechner reviewed Petitioner's MRI on October 1, 2016, at which time he diagnosed Petitioner with shoulder pain and administered a cortisone injection into the left shoulder. PX3 at 10-12. Dr. Brechner also referred Petitioner for physical therapy. Id.

Petitioner participated in a physical therapy program from October 6, 2014 through January 20, 2015 at ATI Physical Therapy. PX5. He then returned to see Dr. Brechner on December 30, 2014 at which time he administered another left shoulder cortisone injection. PX3 at 13-15. Dr. Brechner also referred Petitioner to an orthopedic specialist for evaluation. Id.

On January 5, 2015, Petitioner was examined by Jeffrey Scott Staron, M.D. (Dr. Staron), an orthopedic specialist. PX6 at 3-5. Dr. Staron diagnosed Petitioner with a left rotator cuff tear and recommended an arthroscopic rotator cuff repair surgery. Id. In addition, Dr. Staron suggested that Petitioner obtain a repeat MRI of his left shoulder because of motion artifact that was evident on the first MRI. Id. Petitioner underwent the repeat MRI at Advanced Imaging Center on January 17, 2015. PX6 at 7. The interpreting radiologist found noted impingement, moderate tendinosis, and a partial thickness rotator cuff tear. Id.

Petitioner returned to Dr. Staron on February 5, 2015 at which time he reviewed the new MRI images and diagnosed Petitioner with a partial thickness rotator cuff tear and a SLAP tear. PX6 at 8-10. Once again, Dr. Staron recommended surgery including an arthroscopic rotator cuff repair, possible labral repair, and open subpectoral biceps tenodesis surgery. Id. In the interim, Petitioner also continued to see Dr. Brechner. See PX3.

PPD Impairment Rating – Dr. Coe

At Respondent's request, Petitioner underwent a medical evaluation with Jeffrey Coe, MD (Dr. Coe) on January 5, 2016 for the purpose of issuing an AMA Guides PPD Impairment Rating. RX1; RX1 (Dep. Ex. 2). Dr. Coe took a history from Petitioner, performed a physical examination, reviewed treating medical records, and issued a report. *Id.*

At the time of this evaluation, Petitioner complained of some pain in his left shoulder that was generally worse if he reached, lifted, pushed or pulled. RX1 at 13-14. He also reported that his pain was particularly noticeable if he tried to do things with the left arm above shoulder height. Id. Petitioner further reported feeling as if there was some weakness in his left shoulder. Id. Dr. Coe noted that at the time of his examination, Petitioner was at maximum medical improvement and he had declined surgical intervention. RX1 at 12, 16.

After explaining the calculation process using the 6th Edition of the AMA Guides, Dr. Coe ultimately concluded that Petitioner had a PPD impairment rating of 7% of the left upper extremity. RX1 at 22-29.

Continued Medical Treatment

Petitioner returned to see Dr. Brechner on February 29, 2016 at which time he administered a third cortisone injection into Petitioner's left shoulder. PX3 at 23-25.

On April 28, 2016, Petitioner was examined by Dr. Brechner for the last time prior to the hearing. PX3 at 26-28. Dr. Brechner noted that Petitioner still had left shoulder pain with radiating pain to the arm elbow and neck. Id. Petitioner also complained of warmth, weakness, and a burning sensation in his left shoulder. Id. Petitioner reported that his discomfort increased with external rotation and lifting. Id. On physical examination, Dr. Brechner noted decreased shoulder abduction and internal rotation. Id. Dr. Brechner again provided Petitioner with a left shoulder cortisone injection. Id.

Additional Information

Petitioner testified that he worked for Five Star Tile for the majority of his treatment during which time he performed supervisory functions 40% of the day and the remaining 60% of the day he worked with tools performing tiling services. On cross examination, Petitioner testified that his job duties changed after the accident. He explained that he knows how to run and set up jobs because he used to run a company with 30 employees, so the companies at which he works now overlook the fact that he has an injury because he can use his knowledge to teach younger workers. Petitioner maintained that he still works with tools about 60% of the time and he supervises about 40% of the time. Prior to his injury, Petitioner explained that he worked with tools 100% of the time. Petitioner further testified that his income has not decreased and he makes the same amount of money, but he now works more hours to have the same salary. He explained that generally work hours are from 7:00 a.m. to 3:00 p.m., but as a supervisor he may also work nights and weekends to reach his prior salary.

Petitioner also testified that he has declined the recommended surgery at this point. He explained that he has not had the surgery recommended by the physicians because of his retirement plans. Petitioner testified that he needs 35 years of service in the union to retire at 60 years of age and disruptions of six months or more create a problem to retire as expected. Petitioner also testified that there was no guarantee that he would be able to perform his job if he underwent the recommended surgery. In addition, Petitioner explained that he is diabetic

and when he is not active his blood sugar spikes, so he does not want to increase his insulin or medication usage.

Regarding his left shoulder current condition, Petitioner testified that he is in pain every day whether he is working or not. He cannot perform the simplest functions such as holding a phone to his ear. Petitioner explained that he moved to Indiana to a location with four lakes and an 18-hole golf course so that he could go water-skiing, fishing and golfing. However, he can no longer water-ski, operate a fishing boat, or golf. Petitioner also testified that he cannot go hunting as he did before. Petitioner has five children and six grandchildren. Petitioner also testified that he takes six Aleve pills every day. Petitioner testified that he never had any of these problems before his accident at work and he has not sustained any other injuries to his left shoulder or neck and he has not missed work.

CONCLUSIONS OF LAW

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. In assessing the nature and extent of Petitioner's injury, the Arbitrator notes the following:

Section 8.1b of the Illinois Workers' Compensation Act ("Act") addresses the factors that must be considered in determining the extent of permanent partial disability for accidents occurring on or after September 1, 2011. 820 ILCS 305/8.1b (LEXIS 2011). Specifically, Section 8.1b states:

> For accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the following criteria:
>
> (a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.
>
> (b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors:
>
> (i) the reported level of impairment pursuant to subsection (a);
> (ii) the occupation of the injured employee;
> (iii) the age of the employee at the time of the injury;
> (iv) the employee's future earning capacity; and
> (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. *Id.*

Considering these factors in light of the evidence submitted at trial, the Arbitrator addresses the factors delineated in the Act for determining permanent partial disability.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that the permanent partial disability impairment report of Dr. Coe was offered into evidence. Dr. Coe determined that Petitioner had impairment of 7% of the left upper extremity. The Arbitrator finds that the uncontroverted PPD impairment rating provided by Dr. Coe is relevant to the determination required pursuant to subsection (i) of §8.1b(b) and assigns significant weight to this factor.

With regard to subsections (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that Petitioner was employed as a full time tile setter at the time of his accident and had been so employed by Respondent for several months prior to his accident preceded by a work history of approximately 30 years as a tile setter. The Arbitrator finds the uncontroverted fact that Petitioner was employed as a full time tile setter for Respondent to be relevant to the determination required pursuant to subsection (ii) of §8.1b(b) and assigns significant weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 53 years old at the time of the accident. The Arbitrator finds the uncontroverted fact that Petitioner was 53 years old at the time of his injury to be relevant to the determination required pursuant to subsection (iii) of §8.1b(b) and assigns significant weight to this factor.

With regard to subsections (iv) of §8.1b(b), the future earning capacity of the employee, the Arbitrator notes that there is no evidence indicating that Petitioner has suffered an impairment of his ability to earn wages in the future. However, there is evidence that Petitioner is required to work longer hours in order to receive the same salary that he previously received as a tile setter as a result of his injury at work. Petitioner gave credible, uncontroverted testimony that he continues to work as a tile setter, but now does a portion of his work in a supervisory capacity. Petitioner explained that he performs supervisory functions 40% of the day and he spends the remaining 60% of the day performing tiling services. Thus, the Arbitrator finds the foregoing to be relevant to the determination required pursuant to subsection (iv) of §8.1b(b) and assigns significant weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner underwent conservative medical treatment including physical therapy and several injections into the left shoulder as a result of his injury. Petitioner's orthopedic surgeon also recommended a surgery including an arthroscopic rotator cuff repair, possible labral repair, and open subpectoral biceps tenodesis surgery to address Petitioner's partial thickness rotator cuff tear and SLAP tear. Petitioner testified that he has refused surgery because he wishes to retire at 60 years of age and because no guarantee could be made that he would be able to perform his work as a tile setter post-operatively, which could impact his ability to retire. Thus, Petitioner continued to receive conservative medical care until his last visit with Dr. Brechner and he was able to modify his work duties to limit the tile setting work to 60% with the remaining 40% attributable to supervisory duties.

Petitioner testified that he is in pain every day whether he is working or not and that he can no longer perform the simplest functions such as holding a phone to his ear. Also, he can no longer engage in activities involving use of his left arm such as water-skiing, operating a fishing boat, golfing or hunting. Petitioner was also evaluated at the request of Respondent's counsel by Dr. Coe. The medical records reviewed by Dr. Coe were consistent with those submitted into evidence. Dr. Brechner, Dr. Staron and Dr. Coe all noted ongoing symptoms at the time of their respective physical examinations as a result of Petitioner's work-related injury.

No physician found that Petitioner had malingered, exaggerated or that his subjectively reported symptoms were incongruent with objective medical evidence or clinical observations, and no contrary medical opinion was offered into evidence regarding Petitioner's diagnoses with the exception of the medical analysis performed by Dr. Coe solely for the purpose of rendering a PPD impairment rating pursuant to the AMA Guides.

The findings of Petitioner's treating physicians as reflected in the medical records are uncontroverted and persuasive and, thus, more relevant to the determination required pursuant to subsection (v) of §8.1b(b) than simply the AMA impairment ratings analysis performed by Dr. Coe. Thus, the Arbitrator assigns significant weight to this factor.

Based on all of the foregoing, and in consideration of the factors enumerated in Section 8.1b, which does not simply require a calculation, but rather a measured evaluation of all five factors of which no single factor is conclusive on the issue of permanency, the Arbitrator finds that Petitioner has established permanent partial disability to the extent of 12.5% loss of use of the person as a whole (left shoulder) pursuant to §8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Aubrey J. Prince,
Petitioner,
vs.

NO: 13 WC 42617

State of Illinois, Illinois/Illinois Department of Revenue,
Respondent.

18IWCC0058

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, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 25, 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: JAN 30 2018
o12518
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PRINCE, AUBREY
Employee/Petitioner

Case# **13WC042617**

ST OF IL DEPT OF REVENUE
Employer/Respondent

18IWCC0058

On 4/25/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.95% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0139 CORNFIELD & FELDMAN LLP
JIM M VAINKOS ESQ
25 E WASHINGTON ST SUITE 1400
CHICAGO, IL 60602

5855 ASSISTANT ATTORNEY GENERAL
KATHLEEN C HAGAN
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

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

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

APR 25 2017

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

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

AUBREY PRINCE
Employee/Petitioner

v.

STATE OF ILLINOIS
DEPARTMENT OF REVENUE
Employer/Respondent

Case # 13 WC 42617

Consolidated cases: _____

18IWCC0058

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **KURT CARLSON**, Arbitrator of the Commission, in the city of **CHICAGO**, on **MARCH 14, 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 **JUNE 25, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$76,817.38**; the average weekly wage was **$1,477.26**.

On the date of accident, Petitioner was **45** 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

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of **$984.84**/week for **1 weeks**, commencing **June 25, 2013 through July 1, 2013,** as provided in Section 8(b) of the Act.

Medical benefits

Respondent shall pay reasonable and necessary medical services from the date of accident **June 25, 2013 through August 1, 2013,** as provided in Sections 8(a) and 8.2 of the Act.

Permanent Partial Disability benefits

The Arbitrator finds that Petitioner sustained permanent partial disability to the extent of **2% loss of use of person as a whole pursuant to §8(d)2, and 0% loss of use of the right knee and .5% of the left thumb pursuant to 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

04-26-17
Date

APR 25 2017

FINDINGS OF FACT

On June 25, 2013, Petitioner was employed with the Respondent as a Field Revenue Auditor 2. He had been employed 18 years with the Respondent up to that point. His job duties were to travel from business to business and verify that the taxpayer was in compliance with the Illinois tax laws. His work shift was from roughly 9:00 am to 5:00 pm. He is assigned an office in the State of Illinois Thompson Center but he testified that he seldom would go to his office for his job. Usually, he is assigned a taxpayer by his supervisor. Petitioner would pull the necessary file and information on the taxpayer and schedule an appointment to meet the taxpayer. Petitioner testified that 90% of the time the meeting would take place at the taxpayer's location.

When traveling, the Petitioner uses his own vehicle and generates a monthly field report which designates the miles traveled for the month. He receives reimbursement from the Respondent for the miles traveled. He would have in his car a computer, taxpayer files, and office supplies. In fact, Petitioner testified that if he needed more paper, pens, staplers, etc. he would email the secretary and his office would mail him the supplies to his home.

Petitioner lives near the intersection of 7600 South Cicero. On the date of the accident, June 25, 2013, he was driving to a taxpayer who was located at 700 North Cicero. Petitioner was alone in his car. Cicero Avenue is a six lane road with three lanes going North and three going South. While driving northbound at around 9:00am in the right lane, he passed a car that was in front of him by going into the middle lane. There were four males in the vehicle he passed. They apparently became upset that he passed them, so they changed lanes in order to drive directly behind the Petitioner in the middle lane. They began to tailgate him. The assailants then started passing Petitioner's car and threw liquid onto his vehicle and made obscene gestures towards him. They then drove into Petitioner's lane and in front of his car. They threw a can of liquid at his windshield and broke the windshield. Petitioner called 911 to report the assault. When both cars stopped at a stop light at Cicero and Roosevelt road, 3 males jumped out of their car and began banging on Petitioner's hood, and windows. They opened the Petitioner's driver's side door and began beating the Petitioner and actually pulled him out of the vehicle while beating him. Petitioner tried to defend himself. There was blood from his fractured nose all over

the front seat of the car. The assailants hit Petitioner's head, nose, left hand/thumb, and right knee. Petitioner called 911 again to explain the sequence of events. The assailants returned to their car and continued to drive North on Cicero. Petitioner followed their car in order to provide the police with the make, model, and license plate number. Petitioner never detoured away from Cicero Avenue.

The police were able to find two of the three assailants and arrested them. Petitioner drove himself to St. Joseph's Hospital emergency room. The medical records indicate that x-rays were taken of Petitioner's left hand/thumb, and a CT of the facial bones and head. The CT revealed a nasal bone fracture. On June 28, 2013, Petitioner returned to the emergency room at St. Joseph Hospital where he complained about his fractured nose, and added that he had right knee pain that worsened since the accident. Doctor Patel in the ER prescribed a knee immobilizer. On August 1, 2013, Petitioner was seen by his treating physician, Dr. French from Klein and Slotten medical associates. He was diagnosed with a right knee strain, closed fracture nasal bone. Dr. French released Petitioner for his physical injuries from the assault and wrote a medical note returning Petitioner to work without restrictions on July 1, 2013. The medical records show and Petitioner testified that he did return to work on July 1, 2013.

Upon his return, he noticed problems with his left shoulder while working but did not seek additional medical care until January 2014. On February 12, 2014, Dr. French wrote that Petitioner was off work from February 7, 2014 for neck and shoulder pain but "no specific new injury". Dr. French also wrote that his severe neck and arm pain are related to prior cervical spine surgery. Petitioner testified that he has been off work from February 7, 2014 to the present and receiving disability benefits from SERS. His group health insurance has been paying the medical bills. In addition, Petitioner was involved in a non-work related motor vehicle accident on July 29, 2016. Petitioner testified that his injuries were to his lower extremities. There was no treatment to Petitioner's upper body from the MVA.

Petitioner testified that as of today, he still has pain in his neck and left shoulder from the accident. He notice dizziness at times.

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 did have an accident arising out of and in the course of his employment. Petitioner's job duties required him to travel to various businesses to audit the taxpayer's business. Petitioner credibly testified that he is on the road 90% of his work days. He uses his own vehicle but is compensated for the mileage by the Respondent. His office supplies are all provided by the employer. Petitioner is a travelling employee. As long as he was acting in a reasonable and foreseeable manner, his injuries from the road rage arise out of and in the course of his employment. The unrebutted testimony of Petitioner provides a clear picture that Petitioner never detoured from his route to the taxpayer. Petitioner's decision to follow the assailants in his car seemed motivated by the desire that the perpetrators were apprehended by the law, than revenge, which is reasonable. He was not the instigator of the assault. He wisely chose to call 911 and was able to provide the details needed to capture the assailants.

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

The Arbitrator, having found in favor of Petitioner for accident, finds that the current condition of ill-being is causally connected to this injury. The medical records support and are consistent with Petitioner's history of the accident. The Petitioner drove himself to the hospital soon after the assault on the same day. The records indicate he fractured his nose, and hurt his left hand and right knee. The records of the treating physician, Dr. French, released him from care on August 1, 2013.

"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, having found in favor of Petitioner for accident and causation, also finds that Petitioner incurred medical care through August 1, 2013 related to this accident. He was diagnosed with a fractured nose, left hand sprain, and right knee sprain.

"K" (What temporary benefits are in dispute?)

The Arbitrator finds that Petitioner was off work from June 25, 2013 through July 1, 2013. Dr. French wrote a return to work slip without restrictions on August 1, 2013.

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

Permanent Partial Disability with 8.1b language (For injuries after 9/1/11)

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 **Field Revenue Auditor 2** 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 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. Because of his **advanced age**, 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 was returned to his regular job** by his treating doctor on July 1, 2013. The Arbitrator therefore gives ***no*** weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner continues to have discomfort in his neck and left shoulder and he notices dizziness at times. The Arbitrator therefore gives ***little*** 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 2% loss of use of person as a whole pursuant to §8(d)2, and 0% loss of use of the right knee and .5% of the left thumb pursuant to section 8(e) of the Act.**

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Benito Orea,

Petitioner,

vs.

NO: 14WC 15848

Metropolis Country Club,

Respondent.

18IWCC0059

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 2, 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: JAN 30 2018
SJM/sj
o-1/11/2018
44

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

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

OREA, BENITO
Employee/Petitioner

Case# **14WC015848**

METROPOLIS COUNTRY CLUB
Employer/Respondent

18IWCC0059

On 6/2/2017, 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 1.06% 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:

1413 BRAD L BAGLEY PC
26 PUBLIC SQUARE
BELLEVILLE, IL 62220

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

18IWCC0059

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)

BENITO OREA
Employee/Petitioner

v.

METROPOLIS COUNTRY CLUB
Employer/Respondent

Case # **14** WC **15848**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Collinsville**, on **November 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. ☒ 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, **October 24, 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 **$29,681.60**; the average weekly wage was **$570.80**.

On the date of accident, Petitioner was **37** years of age, ***married*** with **4** 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 **$36,367.79** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$36,367.79**.

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

ORDER

As explained in the Arbitration Decision, Petitioner's current condition of ill-being with regard to his lumbar spine is causally related to the accident at work on October 24, 2013. Petitioner has not reached maximum medical improvement.

Respondent shall pay reasonable and necessary medical services totaling $944.00, as reflected in Petitioner's Exhibits 2b, 7, and 8 that remain unpaid. Specifically, Respondent shall pay the following bills, subject to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act: Dr. Vaught/Regional Brain & Spine $218.00 for date of service January 6, 2016; and Integritas Emergency Physician $726.00 for date of service April 25, 2014. Respondent shall receive credit for amounts paid, including those paid through its group medical plan, for which credit is allowed under Section 8(j) of the Act. Respondent shall hold Petitioner harmless from any claims by any providers for which Respondent is receiving credit under Section 8(j) of the Act.

Respondent shall pay for prospective medical treatment related to Petitioner's lumbar spine, including the proposed two-level lumbar fusion, pursuant to Section 8(a) of the Act.

Respondent shall pay temporary total disability benefits of $380.53 per week for 133 5/7 weeks, for the periods of October 25, 2013, through April 17, 2016, and October 14, 2016, through November 18, 2016, that being the date of hearing, for a total of $50,882.30. Respondent shall be given credit for benefits previously paid in the amount of $36,367.79, and shall pay the remaining balance of $14,514.51.

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

May 31, 2017
Date

JUN 2 - 2017

STATE OF ILLINOIS)
) SS
COUNTY OF MADISON)

18IWCC0059

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

BENITO OREA
Employee/Petitioner

v. Case #: 14 WC 15848

METROPOLIS COUNTRY CLUB
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The parties stipulated that on October 24, 2013, Petitioner sustained an accident which arose out of and in the course of his employment with Respondent, resulting in a low back injury. The Arbitrator notes at the outset that, although Petitioner spoke English, it was broken at times and it appeared at times that he was either confused by the question or had difficulty articulating the answer he desired in English. On the date of accident he was 37 years old, married, with four dependent children. He testified he received a high school education in Mexico and attended six semesters of college. He was employed by Respondent as a groundskeeper and had been so employed for about a year. His duties included mowing grass, picking up branches and rocks, and the like. Petitioner testified that on the date of accident he was moving broken pieces of concrete when a piece weighing about 350 pounds fell from the bucket of a loader. He testified he attempted to stop or hold the chunk of concrete with a bar and in the process his low back popped. He denied any prior accidents or injuries to his low back.

Petitioner testified he sought treatment with Dr. Dixon, a local chiropractor, upon referral by his boss. Dr. Dixon recommended he see a specialist and the adjuster assigned to his claim referred him to Dr. Kevin Vaught. He remained under Dr. Vaught's care from November 25, 2013, through July 2, 2014. He underwent injections and physical therapy, which did not improve his condition. Dr. Vaught eventually recommended surgery.

Petitioner testified he attended an independent medical examination with Dr. Robert Bernardi in St. Louis on April 9, 2014. Dr. Bernardi spent about an hour with him. He also attended a second independent medical examination with Dr. Bernstein in Chicago, who spent about 15 to 20 minutes with him. Both Dr. Bernardi and Dr. Bernstein viewed surveillance video of Petitioner. Petitioner testified that in one video he attempted to rotate the tires on his car and when he tried the first tire he started to have back pain. He told his friend, also in the

video, that he could not do it because of his back pain and his friend then did it for him. He testified that in the other video he was washing his car with a hose at the car wash and then drying the car with one hand while he held onto the car with the other hand.

Petitioner testified he had not returned to work for Respondent, but had recently worked for Energy Masters from April 18, 2016, until he was laid off on October 13, 2016. Energy Masters is an insulation company, and his job was to hold and pull the hose while a co-worker sprayed the insulation. He estimated the hose weighed about 10 pounds. He worked about 50 hours a week and earned $14 per hour.

Petitioner testified he currently continues to have pain in his low back and down his legs and would like to proceed with the surgery recommended by Dr. Vaught.

On cross-examination, Petitioner testified he had weakness in his legs, primarily in his left leg, in the first few months after the accident. The weakness got better with medication, but then returned about three months later and had never completely gone away. In addition, his pain got better with medication, but increased with activity and had never completely gone away. He testified that he treated with Dr. Vaught through July 2, 2014, but had not returned because insurance would not pay. Dr. Vaught told him that "after the shots and medication", the surgery was necessary. He denied that Dr. Vaught left it up to him as to whether he wanted the surgery or not. He agreed that the only time he had seen Dr. Vaught after July 2, 2014, was in January 2016, at the request of his attorney. He testified his pain was a little better at that time. Petitioner acknowledged that he had been involved in a motor vehicle accident in October 2014, resulting in significant property damage to the other vehicle, but testified he did not get hurt in the accident and did not go to a doctor afterwards. He testified he had not worked anywhere other than Energy Masters for a short time, but acknowledged he was able to do some yardwork and housework at his home.

Continuing on cross-examination, Petitioner testified that on the date of the accident the piece of concrete that fell was in the bucket of the tractor. The tractor slipped in the mud, and the concrete fell when he was putting another piece on and holding it with a bar. The bar was long and weighed about 20 pounds and was in the mud on the ground. He testified that the bucket was lying down, the concrete fell at his legs, he pulled the bar to hold it and prevent it from hitting him, and that was when his back popped. He testified the concrete was wet and it was muddy in the area next to the pump because the pump overfilled. They were raising the pump and breaking the concrete and removing it from that area. The Arbitrator notes that Petitioner was questioned about the concrete being "wet", as in a liquid state, rather than solid. He appeared to be a bit confused, but the Arbitrator believes he was referring to it being wet on the surface from the pump water, rather than it being in a liquid state that had not solidified.

Following the accident, Petitioner presented to Dr. Dewey Dixon on October 25, 2013. He reported he had been picking up big blocks of concrete at work. He picked up a block that weighed 300-350 pounds to put in the tractor, and felt a pop in his low back. He started having pain about 10 minutes later when he took a break. He reported the pain was severe, sharp, and constant, and went around both sides and radiated down into the back of both legs. PX4.

On November 15, 2013, Petitioner underwent a lumbar MRI upon referral by Dr. Dixon. It revealed: (1) L3-4 mild disc bulge; (2) L4-5 minor disc bulge, small central disc protrusion, annular tear, and bilateral facet arthropathy; (3) L5-S1 mild to moderate disc osteophyte complex with small broad-based central and left posterolateral disc protrusion that encroaches on the left S1 nerve; and (4) bilateral chronic L5 parts defects. PX4, PX5.

On November 18, 2013, Dr. Dixon authored a letter to the insurance adjuster and attached a copy of the MRI report. He advised Petitioner had not responded to conservative treatment and he recommended a neurosurgical consultation with Dr. Tolentino of Regional Brain & Spine. PX4.

On November 25, 2013, Petitioner presented to Regional Brain & Spine and was examined by Dr. Kevin Vaught. He testified he was referred to Dr. Vaught by the worker's compensation adjuster. He reported he was lifting heavy concrete blocks at work and had sudden onset of low back pain. He complained of pain in his low back and left leg and occasional pain in his upper back. On examination, there was some weakness noted in the left lower extremity and sensation was decreased in the L5 and S1 dermatomes. Lumbar range of motion was moderately limited, there were muscle spasms, and straight leg raise resulted in low back pain complaints. Dr. Vaught recommended a lumbar CT, lumbar epidural steroid injection, and a muscle relaxant and pain medication. PX2c.

On December 27, 2013, Petitioner underwent lumbar epidural steroid injection at L5-S1. He returned to Dr. Vaughn on January 14, 2014, and reported his symptoms had worsened in intensity. He advised the injection gave some relief for about a day, but the pain returned and was more intense. On examination, he had some decreased strength and sensation in the left leg, normal lumbar range of motion, spasm and tenderness in the left lumbar spine, and positive straight leg raise on the left. PX2c. On January 15, 2014, Petitioner underwent a lumbar CT, which revealed (1) L3-4 disc bulge; (2) L4-5 central posterior disc bulge and degeneration; (3) L5-S1 degeneration and broad-based disc bulge with possible contact with the exiting nerve roots. PX2c, PX5. On February 12, 2014, Petitioner returned to Dr. Vaught with continued complaints of pain in his low back and left leg. His examination was unchanged. Dr. Vaught noted the CT findings and further noted examination findings of some weakness and sensory deficit in the left leg. Petitioner advised he wished to continue with conservative care, and Dr. Vaught recommended two additional injections, as well as a lumbar corset. He noted that if Petitioner did not get relief he would recommend a posterior lumbar fusion at L5-S1. PX2c.

On February 28, 2014, and March 18, 2014, surveillance was undertaken of Petitioner. The Arbitrator viewed the videos in their entirety. On February 28, two men, one of whom is presumed to be Petitioner, were viewed from a distance as they stood by a truck at a golf course for about 15 minutes. Petitioner is then seen walking from his truck to a house or business, and then returning. He walked with a slow and slightly antalgic gait. As he got into the truck he stood with both feet on the running board and then got into the truck in a gingerly fashion. Later that day he was observed standing next to a car with another man. He appeared to attempt to loosen or remove the right front tire, had difficulty with it, and had the other man complete it. The other man appeared to remove and rotate all four tires. Petitioner was seen bending over slightly to wipe the tires, and he was seen limping afterward. On March 18 Petitioner was

observed going into and out of a building and the Arbitrator notes he had a slightly antalgic gait while walking. He is later seen at a carwash, operating a manual power washer and then drying off his car with towels. The process took approximately 12 minutes. The Arbitrator notes that as Petitioner leaned over to wipe off his tires he used his right hand to wipe while steadying himself with his left hand on the car. RX4, RX5.

On April 9, 2014, Petitioner was evaluated by Dr. Robert Bernardi, Respondent's Section 12 examiner. He reported he was picking up a broken piece of concrete at work and felt an immediate pulling sensation in his low back. He complained of low back pain which radiated to the left pelvis, buttock, and left leg, which was made worse with sitting, standing, and walking. Dr. Bernardi reviewed medical records and performed a physical examination. He noted Petitioner appeared to be uncomfortable and moved slowly. He did not detect any Waddell's signs. On exam, there was tenderness to palpation on the left, painful range of motion on the left, and positive straight leg raise on the left. Dr. Bernardi reviewed the surveillance videos taken of Petitioner on February 28, 2014, and March 18, 2014. He noted the following: Petitioner appeared to walk gingerly at several points; he attempted to loosen a lug nut and then his companion finished the job of removing the tires; he climbed slowly into the car after his companion rotated the tires; he cleaned his car with a power washer and then bent slightly to dry it while supporting his weight with his left hand. PX2d.

Dr. Bernardi noted that in order to formalize his opinions he needed to see Petitioner's MRI and CT scans. However, he opined Petitioner's diagnoses were (1) multilevel lumbar degenerative disc disease; (2) left L4-5 lateral recess stenosis; (3) L5-S1 isthmic spondylolisthesis; (4) bilateral L5 foraminal stenosis; and (5) low back and left leg pain, probable L5-S1 radiculopathy. He opined that Petitioner's symptoms were causally related to his work accident of October 24, 2013. He found Petitioner to be a "credible historian" and noted he did not see Petitioner perform any activities in the surveillance videos that were incompatible with the symptoms he described. He further noted: (1) he did not detect any Waddell's signs; (2) Petitioner denied prior back or leg pain and he had no medical records to suggest otherwise; (3) the mechanism of injury as described could produce the symptoms; (4) the accident was reported promptly; (5) Petitioner's subjective complaints correlated with the objective findings; and (6) taken as a whole, his back problems were considered work-related. PX2d, PX3b.

Dr. Bernardi recommended three to four weeks of physical therapy, unless it caused Petitioner's symptoms to worsen. He also recommended a complete series of epidural injections and a left L5 selective nerve root injection, along with an anti-inflammatory. He noted if Petitioner's symptoms persisted despite this treatment, then surgery may be warranted. He could not comment on the specific procedure without reviewing the imaging studies, but noted "the definitive surgical procedure for a symptomatic isthmic spondylolisthesis is usually a lumbosacral decompression and fusion". He opined Petitioner should reach maximum medical improvement nine to twelve months post-op and would likely have a 50-pound permanent lifting restriction. For the time being, Dr. Bernardi recommended restrictions of no overhead work, no extension of his lumbar spine, no prolonged sitting, and no lifting over 20 to 25 pounds. PX2d.

On April 25, 2014, Petitioner underwent a second L5-S1 lumbar epidural steroid injection. PX2c. Later that evening, he presented to the emergency department of Heartland

Regional Medical Center and reported shooting pain in his back and down his left leg following the injection. He was advised to take Motrin with Tylenol for pain, was given a prescription for a muscle relaxer, and instructed to follow up with his physician. PX6. He followed up with Dr. Vaught on May 21, 2014, and reported continued pain rated at 6/10. He reported that following his recent injection he presented to the emergency room due to worsening left leg pain. He also reported continuing left inguinal pain and lower abdominal pain. Examination revealed normal strength, decreased sensation at the left L5 dermatome, normal reflexes, mildly limited range of motion, and positive left straight leg raise. Dr. Vaught recommended an updated MRI, bilateral medial branch blocks, and prescription of Neurontin. Petitioner was to remain off work. PX2c.

On June 20, 2014, Petitioner underwent a lumbar MRI, which was compared to the MRI of November 13, 2013, and the CT scan of January 15, 2014. It revealed: (1) minimal spondylosis, mild facet arthropathy, and mild degenerative disc disease, similar to November 2013; (2) no lumbar spine central canal stenosis; (3) minimal/mild multilevel foraminal narrowing; and (4) L4-5 disc extrusion, possible source of back pain. That same day Petitioner also underwent lumbar medial branch blocks of the L4-5 and L5-S1 facet joints. PX2c.

Petitioner followed up with Dr. Vaught on July 2, 2014, and reported his pain was stable. On examination, strength, sensation, and reflexes were normal. Range of motion was mildly limited, there was no spasm or tenderness to palpation, and left straight leg raise was negative. Dr. Vaught noted Petitioner had a large central disc herniation at L4-5, degenerative disc disease at L4-5 and L5-S1, and bilateral L5 pars defects. He recommended posterior lumbar interbody fusion at L4-5 and L5-S1 and opined that a fusion at only L4-5 would leave Petitioner at significant risk of deterioration of the L5-S1 segment and need for future surgery. Dr. Vaught further opined that Petitioner's symptoms and need for treatment were related to his work injury and that he was not at maximum medical improvement. PX2c.

On February 16, 2015, Dr. Bernardi issued an Addendum Report, after reviewing the MRI and CT scans and updated medical records. He opined that Petitioner's lower abdominal/upper inguinal pain was not likely a hernia, as it radiated from his back, and the L5 nerve root irritation and structural pathology at L4-5 and L5-S1 "are rather notorious for causing referred pain to this area and/or the lower abdominal wall". Dr. Bernardi agreed with Dr. Vaught that Petitioner had exhausted all reasonable non-operative treatment and opined that if his pain was sufficiently disabling, then surgery would be an option. If Petitioner chose not to undergo surgery, he would be at maximum medical improvement. PX3c.

On April 1, 2015, Dr. Bernardi authored a letter to Respondent's attorney in response to inquiries. He explained there were three potential explanations for Petitoner's back and leg symptoms. (1) He could have injured his L4-5 disc during the work accident, as there was an appropriate mechanism of injury and this segment will refer pain into the buttock and leg in a distribution similar to what Petitioner described. However, he noted Petitioner reported he began to involuntarily lean to the right shortly after the accident. This is a sciatic list and strongly suggestive of nerve root irritation. Dr. Bernardi did not believe Petitioner's symptoms were due to a disc injury at L4-5. (2) Petitioner's work accident could have aggravated his pre-existing but previously quiescent L5 foraminal stenosis. Dr. Bernardi noted the foraminal narrowing was due to L5 pars fractures, L5-S1 degenerative disc disease, and associated L5-S1

spondylolisthesis. He further noted that his experience and medical literature supported the notion that traumatic events can cause previously asymptomatic foraminal narrowing to become symptomatic. He opined this was a reasonable explanation for Petitoner's complaints. (3) Petitoner's complaints could represent left S1 radiculopathy due to the left paracentral disc protrusion seen on the MRI's at L5-S1. Dr. Bernardi noted that Petitoner's bulging was more prominent and more lateralized to the left than is typically seen with spondylolisthesis and had increased signal intensity, suggesting it may be relatively acute. It produced left lateral recess narrowing that could irritate the left S1 nerve root, and many of Petitoner's symptoms were consistent with S1 radiculopathy. Dr. Bernardi opined it was possible the work accident caused an acute paracentral disc protrusion superimposed on his chronic degenerative disease. PX3d.

Dr. Bernardi opined it was possible but unlikely that Petitioner's symptoms were related to the changes at L4-5. Rather, he believed it was much more probable that his symptoms were related to the pathology at L5-S1. However, he agreed with Dr. Vaught that it would be best to include the L4-5 level in the lumbar fusion. The degenerative changes and disc extrusion at L4-5 suggested it would be better to anchor the fusion to his relatively normal L3-4 level. PX3d.

On August 3, 2015, Petitioner was evaluated by Respondent's second Section 12 examiner, Dr. Avi Bernstein. He reported he was helping break concrete and move large chunks of concrete and was prying on a bar when he felt a pop in his low back. He complained of low back pain that radiated into the left posterior thigh down to the knee. His symptoms increased with physical activity, such as lifting his three year old child or helping with groceries. On exam, he had a non-antalgic gait, normal strength, sensation, and reflexes, and straight leg raise was negative. It was noted he forward flexed "carefully" and straightened "in a careful fashion". Dr. Bernstein noted Petitioner had no Waddell's findings. He did not have CD's of Petitioner's diagnostic studies or the surveillance undertaken, and requested them prior to completing his evaluation. Lumbar x-rays taken in the office that day showed chronic spondylolysis and spondylolisthesis. He opined these findings were chronic and preexisting and could be responsible for low back pain but could also be asymptomatic. RX3, Dep.RX2.

On August 4, 2015, Dr. Bernstein issued an Addendum after reviewing radiographic studies and surveillance videos. He opined that the surveillance strongly supported the notion that Petitioner was fully functional in February and March 2014, and that his condition was not symptomatic to the extent that it would limit his functional abilities. He opined that the radiographic studies showed degenerative disc changes with disc bulging and protrusion as well as bilateral spondylolysis. He again noted that the conditions could be completely asymptomatic or cause low back pain and radiating leg pain. As to causation, Dr. Bernstein opined that Petitioner may have suffered an aggravation of his pre-existing condition but was at maximum medical improvement, and that any current treatment recommendations were not causally related to his work accident. RX3, Dep.RX3.

On October 7, 2015, Dr. Bernardi authored a letter to Petitioner's attorney in response to inquiries. He noted he had read Dr. Bernstein's report and had previously viewed the surveillance videos referenced by Dr. Bernstein, prior to examining Petitioner on April 9, 2014. He disagreed with Dr. Bernstein's interpretation of the surveillance videos and noted his own interpretation was incorporated into his opinions in previous reports. He stated, "Specifically,

my opinion that surgery is an option for this gentleman and his need for the procedure is causally connected to his work activities on 10/24/2013." PX3e.

On December 15, 2015, Petitioner attempted to take the deposition of Dr. Vaught. Respondent's counsel objected to Dr. Vaught being shown the surveillance videos that day, as he had not previously viewed them. Rather, he had received a summary of the videos that was attached to Dr. Bernardi's report of April 9, 2014. Petitoner's counsel agreed to reset the deposition after he had an opportunity to view the videos and re-examine Petitioner. PX1.

On January 6, 2016, Petitioner returned to Dr. Vaught at the request of his attorney. It was noted he had been seen by Dr. Bernardi, who agreed with the recommended surgery, and by a physician in Chicago who did not recommend surgery. Petitioner reported he was walking daily to try and strengthen his core, but often had to be picked up by his wife due to pain. On examination, strength was normal, sensation was decreased in the L5 and S1 dermatomes, reflexes were decreased on the left, range of motion was mildly limited, lumbar spasm was present bilaterally, there was tenderness to palpation, and straight leg raise was negative. Dr. Vaught noted that Petitioner's history remained constant and that there were no Waddell's findings. He further noted Petitioner continued to have symptoms attributable to his L4-5 and L5-S1 pathology that had failed an extensive and appropriate course of conservative care. He opined that Petitoner's best opportunity for improvement was surgery, and that the surgery was causally related to his work injury. He further stated, "The surveillance video that I have reviewed does not change my opinion on causation." He opined Petitioner was not at maximum medical improvement and could not presently work. PX2c.

On January 9, 2016, Dr. Vaught authored a letter to Petitoner's attorney in response to inquiries. He described in detail the surveillance videos. He stated, "There is nothing that I observed in the surveillance video that suggests that Mr. Orea did not suffer the reported work related injury or that he has exaggerated or misrepresented his symptoms of back and leg pain." He went on to state, "I have always been of the opinion that he was injured at work as he has described. I have found him to be credible and he has never given me any reason to doubt his history or pain complaints. Certainly this video does not change my impressions in any way." Dr. Vaught also reviewed Dr. Bernardi's report of April 9, 2014, and his letter of October 7, 2015, in which he disagreed with Dr. Bernstein's interpretation of the surveillance video. He opined that his records and impressions concurred with Dr. Bernardi's opinions. Dr. Vaught also reviewed Dr. Bernstein's report of August 3, 2015, and his addendum of August 4, 2015. He stated, "I find Dr. Bernstein's opinions to be lacking clinical credibility. I cannot understand how the surveillance video remotely proves that Mr. Orea was fully functional and lacked a distinct clinical problem of the lumbar spine or that Mr. Orea lacked any significant symptoms that would limit his activities." He disagreed that there was any suggestion that Petitioner had reached maximum medical improvement. He reiterated that Petitioner remained symptomatic, was unable to work, and that surgery was his best opportunity to improve. PX2c.

Dr. Vaught testified by way of deposition on January 19, 2016. He is a Board Certified Neurosurgeon. He testified consistent with his treating records and supplemental reports. He testified he continued to recommend a two-level decompression and fusion at L4-5 and L5-S1,

and that Petitioner was not capable of working. Further, he believed the delay in performing the surgery would result in deconditioning of Petitoner's lumbar spine. PX2.

On cross-examination, Respondent attempted to elicit from Dr. Vaught that his interpretation of the diagnostic study referenced a herniated disc larger than that observed by the radiologist. The doctor disagreed. He did acknowledge that Petitoner's subjective complaints seemed to improve and respond somewhat to conservative treatment. PX2.

On re-direct examination, Dr. Vaught testified that, to an extent, any improvement in Petitioner's subjective complaints was attributable in part to his lack of physical activity and temporary relief from nerve blocks. He opined that Petitioner was credible, and that his complaints and injuries and desire to get better were legitimate. PX2.

Dr. Bernardi testified by way of deposition on February 19, 2016. He is a Board Certified Neurosurgeon. He testified consistent with his reports. He testified Petitoner's condition was causally related to his work accident either by way of direct causation or an aggravation. He opined Petitioner was capable of working with restrictions but that he had not reached maximum medical improvement. His recommendations for surgery were consistent with Dr. Vaught. His opinions were not affected by the surveillance films. He believed Petitioner's complaints were credible. PX3.

On cross-examination, Dr. Bernardi acknowledged that certain medical records following his examination would suggest that Petitioner's condition had improved. When asked about Petitioner's ratings of pain complaints from July 2014 and January 2016, he testified he would generally not perform surgery on someone with pain ratings of 2-3/10. With regard to the herniated disc on the right, which appeared post-accident, Dr. Bernardi testified it may be unrelated to Petitioner's accident or may be an extension of the original injury. PX3.

Dr. Bernstein testified by way of deposition on July 14, 2016. He is a Board Certified Orthopedic Surgeon. He testified consistent with his reports. He opined that based upon his clinical exam, Petitioner was normal neurologically. The only finding was slight guarding during range of motion testing. He testified Petitioner's conditions in his lumbar spine were chronic and pre-existing and that, at best, he suffered a temporary aggravation which had resolved and warranted no further treatment after July 2, 2014. He testified the video surveillance from February and March 2014 suggested Petitioner was fully functional. RX3.

On cross-examination, Dr. Bernstein testified that with respect to the issue of surgery, it was not a standard of care issue, but rather a choice of treatment issue. He acknowledged that he received no evidence disputing how the accident occurred and no evidence that Petitioner had suffered prior low back pain or injury. He confirmed that Petitioner's accident may have aggravated his preexisting condition, but conceded that his report did not quantify or otherwise identify the length or duration of the aggravation. Further, he conceded that his report did not mention the word "temporary" in conjunction with the aggravation. RX3.

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 (F), whether Petitoner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

A claimant has the burden of proving by a preponderance of the credible evidence all elements of the claim, including that any alleged state of ill-being was caused by a workplace accident. *Parro v. Industrial Commission*, 260 Ill.App.3d 551, 553 (1st Dist. 1994).

The Arbitrator finds Petitioner's current condition of ill-being with regard to his lumbar spine is causally related to his work accident of October 24, 2013. In so concluding, the Arbitrator finds significant that the record is consistent throughout with regard to Petitioner's complaints and objective findings, which started immediately after the accident.

Petitioner consistently reported low back pain that radiated into his left buttock and down his left leg. Objectively, he had positive findings on multiple physical examinations and in multiple diagnostic studies. Petitioner consistently denied any treatment, complaints, or problems with his low back prior to the accident, and the record is void of any evidence to the contrary. He underwent extensive and prolonged conservative treatment, yet continued to suffer from symptoms.

The Arbitrator finds significant that both Dr. Vaught and Dr. Bernardi were physicians chosen by Respondent, one as a treater and one as a Section 12 examiner. Both doctors thoroughly examined Petitioner, took a history of the accident, reviewed his records and diagnostic studies, and viewed the surveillance videos. Both doctors remained steadfast in their opinions that Petitoner's work accident caused or aggravated his symptoms and need for treatment, and that the surveillance videos did not depict anything that contradicted Petitoner's complaints and objective findings.

Rather than authorize the surgery recommended by Dr. Vaught and Dr. Bernardi, Respondent had Petitioner examined by a third physician. Dr. Bernstein disputed the relationship between the accident and the need for surgery on the basis that Petitioner suffered only a *temporary* aggravation of his pre-existing degenerative disease, which resolved three to six months after the accident. However, Dr. Bernstein's report, contrary to his testimony, indicated the accident *aggravated* the pre-existing condition. In his report he did not identify or quantify the length or duration of the aggravation, nor did he use the work "temporary". The Arbitrator finds Dr. Vaught and Dr. Bernardi to be much more persuasive than Dr. Bernstein.

The Arbitrator viewed both surveillance videos in their entirety and agrees with Dr. Vaught and Dr. Bernardi that the videos do not depict any activity that is inconsistent with Petitoner's subjective complaints and objective findings. While the videos do show Petitioner to

be walking or bending over slightly, they also clearly show him limping and getting in and out of vehicles in a guarded manner.

Respondent attempted to elicit at trial that Petitioner had not, in fact, moved a 350 pound chunk of concrete, but rather was working with liquid ("wet") concrete which had not yet solidified, thus calling into question the history he provided to every medical provider and examiner. After carefully reviewing Petitioner's testimony, the Arbitrator is not persuaded. Rather, Petitioner's testimony regarding the concrete being wet referred to the fact that water had overflowed from the pump house, causing the ground to become wet and muddy and causing the concrete chunks to become wet. This is shown by the fact that the reason the concrete fell in the first place was because the tractor slipped in the mud, causing it to move. The history of the accident was consistent throughout Petitoner's testimony and throughout every medical record, and was unrebutted by Respondent. Further, the Arbitrator found Petitioner to be credible in his testimony.

Based upon the foregoing and the record in its entirety, the Arbitrator finds Petitioner met his burden of proof on the issue of causal connection.

In support of the Arbitrator's decision relating to issue (J), whether the medical services that were provided to Petitioner were reasonable and necessary, and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

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

In light of the Arbitrator's findings with respect to issue (F), the Arbitrator finds that medical services rendered to date were reasonable and necessary in Petitoner's care and treatment relative to his accident of October 24, 2013. The parties stipulated and the Arbitrator finds that Respondent is entitled to a credit for all payments previously made to providers, including those made pursuant to Section 8(j), for which a credit is allowed. The Arbitrator finds that Respondent is liable for the following outstanding medical bills as set forth in Petitoner's Exhibits 2b, 7, and 8, subject to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act.

1. Dr. Vaught/Regional Brain & Spine, **January 6, 2016, $218.00**.
2. Integritas Emergency Physician, **April 25, 2014, $726.00**

TOTAL AMOUNT $944.00

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

Upon establishing causal connection and the reasonableness and necessity of recommended medical treatment, employers are responsible for necessary medical care required

by their employees. Specific medical procedures or treatment that have been prescribed by a medical service provider have been "incurred" within the meaning of the statute, even if they have not yet been paid for. *Plantation Mfg. Co. v. Industrial Commission*, 294 Ill.App.3d 705, 710 (2nd Dist. 1997).

In light of the Arbitrator's findings with respect to issue (F), the Arbitrator finds that Petitioner is not currently at maximum medical improvement and is in need of further care, including a two-level lumbar fusion. Further, the Arbitrator finds that the need for prospective medical care is causally related to Petitoner's work accident of October 24, 2013.

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

In order to be eligible for temporary total disability benefits, a claimant must prove not only that he did not work, but also that he was unable to work. *City of Granite City v. Industrial Comm'n*, 279 Ill.App.3d 1087, 1090 (5th Dist. 1996). The period of temporary total disability encompasses the time from which the injury incapacitates the claimant until such time as the claimant has recovered as much as the character of the injury will permit, i.e., until the condition has stabilized. *Gallantine v. Industrial Comm'n*, 201 Ill.App.3d 880, 887 (2nd Dist. 1990). The dispositive test is whether the claimant's condition has stabilized, i.e., reached MMI. *Sunny Hill of Will County v. Ill. Workers' Comp. Comm'n*, 344 Ill.App.3d 752, 760 (4th Dist. 2003).

Petitioner claimed on the Request for Hearing that he was entitled to temporary total disability for the period of October 25, 2013, through November 18, 2016, that being the date of hearing, for a total of 159 2/7 weeks. However, it was clear from his testimony that he worked for Energy Masters from April 18, 2016, through October 13, 2016, for a total of 25 4/7 weeks.

The parties agreed and stipulated that Respondent paid TTD benefits from October 25, 2013, through August 24, 2015, for a total of $36,367.79. Respondent claimed it was obligated to pay benefits only through July 2, 2014, thus creating an overpayment.

In light of the Arbitrator's findings with respect to issues (F) and (K), the Arbitrator finds that Petitioner is entitled to temporary total disability benefits from October 25, 2013, through April 17, 2016, and from October 14, 2016, through November 18, 2016, the date of hearing, for a total of 133 5/7 weeks. It is undisputed that Petitioner was taken off work completely first by Dr. Dixon and then by Dr. Vaught, and that Dr. Bernardi believed Petitioner could work only with restrictions of no overhead work, no extension of his lumbar spine, no prolonged sitting, and no lifting over 20 to 25 pounds. There was no evidence that Respondent could accommodate work within those restrictions. Petitioner's testimony established that he obtained a job on his own within those restrictions at Energy Masters, albeit short-lived. However, when he was laid off from that job he remained, at minimum, on the restrictions given by Dr. Bernardi. Again, there was no evidence that Respondent could accommodate, or even attempted to accommodate, those restrictions. As such, Petitioner is entitled to temporary total disability benefits.

The Arbitrator is mindful that Petitioner did not seek medical attention with Dr. Vaught from July 2, 2014, through January 6, 2016. He testified it was because further treatment had been denied, and the Arbitrator finds him credible on this point. Respondent took the position that Petitioner was not entitled to additional medical treatment or temporary total disability benefits based on Dr. Bernstein's opinions, despite the adamant opinions of two other doctors chosen by Respondent to treat or evaluate Petitioner. Respondent now claims Petitioner is not entitled to benefits because he did not seek medical treatment, when both Dr. Vaught and Dr. Bernardi opined that he needed further treatment and could not work (or work with restrictions) until further treatment was rendered, yet Respondent denied such treatment. The Arbitrator is not persuaded by Respondent's argument.

The parties stipulated that Petitioner's average weekly wage was $570.80, and the Arbitrator finds his temporary total disability rate is $380.53. Respondent is liable for temporary total disability benefits of $50,882.30, representing the periods of October 25, 2013, through April 17, 2016, and October 14, 2016, through November 18, 2016, the date of hearing, for a total of 133 5/7 weeks. Respondent is entitled to credit for TTD previously paid, in the amount of $36,367.79, leaving a balance of $14,514.51.

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

RAQUEL HOUSLEY,

Petitioner,

vs.

NO: 14 WC 31520

CTA,

18IWCC0062

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, temporary total disability, causal connection,medical expenses, and permanent partial disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission modifies the award of permanent partial disability from 7% to 1% of the person as a whole, having found that Petitioner was discharged from treatment and returned to full-duty work without restrictions on May 25, 2015. There is no evidence presented that Petitioner lacked the physical ability to return to the work place. Petitioner had, however been terminated as a bus operator for the CTA at the end of March 2015. There was no testimony presented by Petitioner that she sustained any permanent physical impairment. Petitioner did not describe any activities in which she was no longer able to engage following her release from treatment by Dr. Murtaza on May 25, 2015. The Commission further corrects the weekly of permanent partial disability rate from $760.80 to reflect the maximum rate of $735.37.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $845.33 per week for a period of 36 2/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

18IWCC0062

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $735.37 per week for a period of 5 weeks, as provided in §8(d)2 and 8.2 of the Act, for the reason that the injuries sustained caused the loss of use of 1% of the person as a whole

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $35,051.00 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.

DATED: JAN 30 2018
o- 12/14/2017
SM/msb
44

Stephen Mathis

David L. Gore

Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HOUSLEY, RAQUEL
Employee/Petitioner

Case# **14WC031520**

CTA
Employer/Respondent

18IWCC0062

On 12/15/2016, 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 0.64% 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:

5327 MICHAEL HIGGINS
ATTORNEY AT LAW
6204 W 63RD ST
CHICAGO, IL 60638

0515 CHICAGO TRANSIT AUTHORITY
ARGY KOUTSIKOS
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

18IWCC0062

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

Raquel Housley
Employee/Petitioner

v.

CTA
Employer/Respondent

Case # **14** WC **31520**

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 **Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **October 25, 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 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*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$65936.00**; the average weekly wage was **$1268.00**.

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.

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

Respondent shall be given a credit of $4,226.65 for TTD, **$0** for TPD, **$0** for maintenance, and $2,867.40 for other benefits, for a total credit of $7,094.05.

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

ORDER

Respondent shall pay Petitioner the outstanding bill of $23,961.95 for Illinois Orthopedic Network and $11,089.05 for the H&M bills, according to Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability at the rate of $845.33 per week, from September 13, 2014 through May 24, 2015, representing 36 2/7 weeks, totaling $30,660.12.

Respondent shall pay Petitioner permanent partial disability of $760.80 for 35 weeks as the injury sustained caused 7% loss of a person as a whole as provided in Section 8(d)2 of the Act.

Respondent shall be given a credit of $4,226.65 for total disability previously paid to Petitioner and a credit of $2,867.40, for other benefits paid.

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

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

RAQUEL HOUSLEY
14 WC 31520

The disputed issues in this matter are: 1) accident; 2) causal connection; 3) medical bills; 4) temporary total disability and 5) the nature and extent of Petitioner's injury. *See,* AX1.

Findings of Fact

Petitioner's testimony
Raquel Housley (hereinafter "Petitioner") has been a bus operator for Chicago Transit Authority, (hereinafter "Respondent") for eleven (11) years. She testified that her normal, daily routine was to check in with the CTA clerk, inspect her assigned bus, pull out the bus, drive the assigned route picking passengers up and dropping them off. She worked forty (40) hours per week.

On September 12, 2014, Petitioner was assigned the number eight (8) Halsted Street route. On this date, she was performing her normal job duties. While driving her route, she drove the bus over potholes while heading under a viaduct on Halsted Street. These potholes were near the Halsted and Milwaukee intersection and Petitioner testified that before September 12, 2014, she had driven that specified route for about a year; and had noticed the potholes on previous occasions. After driving the bus over the specified potholes, Petitioner felt a shooting, sharp pain in the right side of her lower back. The pain "shot down" into Petitioner's right calf.

Petitioner continued to perform her job duties, but did not finish her route. Petitioner drove the bus to the Broadway stop and at that point, routed her bus southbound on Halsted. As she reached the prior described viaduct, she once again drove over the potholes. After this encounter with the potholes, Petitioner noticed pain and numbness in the right side of her body. She stopped the bus just before Lake Street, parked it and called the control unit of Respondent. Petitioner spoke with one of the controllers and informed her that she needed for medical attention. The personnel at control requested an ambulance to assist Petitioner.

Petitioner was taken to the emergency room ("ER") at Northwestern Memorial Hospital via an ambulance and sought treatment with the on-call ER doctor. The September 12, 2014 medical record notes that Petitioner "states she drove over uneven pavement and felt a sharp pain to her lower back." Petitioner was released the same day. RX3.

Petitioner sought treatment with Dr. Murtaza on September 15, 2014 and those office notes reflect that "patient comes in for initial evaluation of low-back pain following a work-related injury. She states she went to the ER after experiencing sharp pain in the lower back, worse on the right side after driving over a large pothole." Dr. Murtaza took Petitioner off work, ordered a MRI and prescribed physical therapy. PX1; (September 15, 2014 office note).

The MRI was performed on September 18, 2014 and Dr. Murtaza reviewed it at a follow-up visit on October 9, 2014. The office notes reflect that Dr. Murtaza found facet dysfunction at multiple levels including L3-4 and L4-5; and a left lateral disc bulge at L4-5 that correlate with Petitioner's clinical and subjective complaints. Petitioner's pain level is 8/10. Dr. Murtaza prescribed right-sided, intra-articular facet injections at L3-4 and L4-5, as well as physical therapy. PX1; (10/9/14 office note).

Petitioner performed physical therapy at H & M Medical in Chicago, Illinois. She testified that she felt pain, numbness and tingling down her right leg during her initial treatment with Dr. Murtaza and H & M. She went to physical therapy two to three times per week. Dr. Murtaza performed three (3) facet injections on October 23, 2014, December 4, 2014 and January 22. 2015. Petitioner testified, initially, the facet injections relieved her pain and that the relief lasted a few days. When the relief expired, the numbness, pain and tingling returned in Petitioner's right side. Petitioner testified physical therapy helped relieve the pain as well.

The March 5, 2015, Dr. Murtaza office notes reflect that Petitioner's pain level decreased to five (5) out of ten (10). Dr. Murtaza opined that the petitioner needed more strengthening and prescribed work conditioning. Petitioner performed the work conditioning at H & M. Dr. Murtaza took Petitioner off work through May 24, 2015. Dr. Murtaza released Petitioner from his care and returned her back to full duty work on May 25, 2015. Petitioner testified that she continues to feel discomfort, slight pain, a little numbness and weakness in her right leg.

On October 17, 2014, Dr. Julie Wehner performed an Independent Medical Examination on behalf of Respondent. Dr. Wehner opined "based on Petitioner's subjective complaints and the emergency room reports, her back pain is causally related to the September 14, 2014 injury." Dr. Wehner diagnosed Petitioner with soft tissue injury or a sprain to the lumbar spine. RX4.

Conclusions of Law

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

The burden is on the Petitioner seeking an award to prove by a preponderance of credible evidence all the elements of his claim, including the requirement that the injury complained of arose out of and in the course of his or her employment. *Martin v. Industrial Commission*, 91 Ill.2d 288, 63 Ill.Dec. 1, 437 N.E.2d 650 (1982). The mere existence of testimony does not require its acceptance. *Smith v. Industrial Commission*, 98 Ill.2d 20, 455 N.E.2d 86 (1983). To argue to the contrary would require that an award be entered or affirmed whenever a claimant testified to an injury no matter how much his testimony might be contradicted by the evidence, or how evident it might be that his story is a fabricated afterthought. *U.S. Steel v. Industrial Commission*, 8 Ill.2d 407, 134 N.E. 2d 307 (1956).

It is not enough that the petitioner is working when an injury is realized. The petitioner must show that the injury was due to some cause connected with the employment. *Board of Trustees of the University of Illinois v. Industrial Commission*, 44 Ill.2d 207, 214, 254 N.E.2d 522 (1969); *see also*

Hansel & Gretel Day Care Center v. Industrial Commission, 215 Ill.App.3d 284, 574 N.E.2d 1244 (1991).

It is the burden of every Petitioner before the Workers' Compensation Commission to establish with evidence every disputed issue litigated at trial, including the issues establishing Respondent's liability for benefits. *Board of Trustees of the University of Illinois v. Industrial Commission*, 44 Ill.2d 207 at 214, 254 N.E.2d 522 (1969), *Edward Don v. Industrial Commission, 344* Ill.App.3d 643, 801 N.E.2d 18 (2003). For an employee's workplace injury to be compensable under workers' compensation, Petitioner must establish the injury is due to a cause connected with the employment such that it arose out of the employment. *Hansel & Gretel Day Care Center*.

In order for an injury to be deemed compensable, Petitioner must establish it arose out of and in the course of the employment. "An injury 'arises out of' employment when it originates from some risk related to the employment, thereby establishing a causal connection between the injury and the occupation." *Wise v. Industrial Commission,* 54 Ill.2d 138, 142 (1973); *Material Service Corp. v. Industrial Commission*, 53 Ill.2d 429, 292 N.E.2d 367; *Thurber v. Industrial Commission*, 49 Ill.2d 561, 276 N.E2d 316. "A compensable injury occurs 'in the course of' employment when it is sustained while claimant is at work or while he performs reasonable activities in conjunction with his employment." *Wise v. Industrial Commission,* 54 Ill.2d 138, 142 (1973); *Hydro-Line Manufacturing Co. v. Industrial Commission*, 15 Ill.2d 156, 154 N.E.2d 234; *Associated Vendors, Inc. v. Industrial Commission*, 45 Ill.2d 203, 258 N.E.2d 354.

The Arbitrator finds Petitioner suffered an accident that arose out of and in the course of her employment, on September 12, 2014. While Petitioner operated her bus on the 8 Halsted Street route she ran over potholes and immediately felt a sharp pain in her back. Petitioner's testimony, the incident report (signed on the date of the accident), the Northwestern Memorial emergency room records; and Dr. Murtaza's first office note provide the same description of the accident. Petitioner's testimony is unrebutted and her medical records support her testimony.

Respondent offered video of Petitioner's route however, the lighting was dim due the viaduct and visibility was limited due to rainy conditions. The Arbitrator finds the consistency of Petitioner's testimony is supported by the multiple recorded reports of the accident within days of the occurrence. Therefore, the Arbitrator finds Petitioner has proven, by a preponderance of the evidence, that she suffered an accident on September 12, 2014, that arose out of and in the course of her employment with Respondent.

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

The Arbitrator finds Petitioner's current lumbar condition of ill-being causally related to the September 12, 2014 accident. After the occurrence, Petitioner immediately sought treatment at the emergency room at Northwestern Memorial Hospital. In addition, within three (3) days after the accident, Petitioner was diagnosed with low-back pain by two (2) different medical providers. Three (3) days after the September 12, 2014 accident, Dr. Murtaza noted that Petitioner "came in for initial

evaluation of low-back pain following a work-related injury. She states she went to the ER after experiencing sharp pain in the lower back, worse on the right side after driving over a large pothole."

After review of the September 18, 2014 lumbar spine MRI, Dr. Murtaza found facet dysfunction at multiple levels including L3-4 and L4-5, and a left lateral disc bulge at L4-5 that correlated with Petitioner's clinical and subjective complaints. Dr. Murtaza felt the injury required right-sided intra-articular facet injections at L3-4 and L4-5 as well as physical therapy. Petitioner testified that both the injections and physical therapy provided relief from her symptoms.

Dr. Julie Wehner also opined "based on Petitioner's subjective complaints and the emergency room reports, her back pain is causally related to the September 14, 2014 injury." While Respondent did offer medical evidence that the petitioner was noted to have "chronic back pain" in 2012, it is well settled that the respondent takes its employees as it finds them; and there was no evidence to suggest Petitioner's current low-back complaints are unrelated to her September 12, 2014 work-related accident. RX6.

Considering Drs. Murtaza's and Wehner's opinions, i.e., both agreed that the condition of ill-being of Petitioner's low-back, is causally related to her September 12, 2014 injury, the Arbitrator finds Petitioner's low back injury is casually related to her September 12, 2014 accident. Petitioner's initial pain level was 8/10. After three (3) facet injections, physical therapy and work conditioning, Petitioner finally displayed relief of symptoms. The Arbitrator finds the facet injections, physical therapy and work conditioning through her release in May 2015; was necessary to resolve low back conditions, causally related to the September 12, 2014 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?

Respondent shall pay the outstanding $23,961.95 Illinois Orthopedic Network (Dr. Murtaza) bill; and H&M medical bills of $11,089.05, at the corresponding fee schedule rates. These bills are found to be reasonable, necessary and related to the September 12, 2014, work-related accident.

K. What temporary benefits are in dispute? Temporary total disability ("TTD")

Arbitrator finds Petitioner is entitled to TTD from September 13, 2014 through May 24, 2015. Dr. Murtaza took her off work during this period. Dr. Murtaza's office notes support Petitioner's complaints of numbness, tingling and pain. Petitioner testimony mirrors her complaints as noted by Dr. Murtaza. Petitioner further testified that she was afraid, due to her symptoms; that she was unable to drive a bus. She was afraid that she would put her safety and that of her passengers at issue. The Arbitrator finds Petitioner's testimony to be credible. Hence, the Arbitrator orders Respondent to pay TTD for 36 2/7 weeks, at the rate of $845.33 per week, totaling $30,660.12.

L. What is the nature and extent of the injury?

The Arbitrator awards Petitioner 7% person as a whole. The Arbitrator relies on the September 18, 2014 MRI report, in which Dr. Murtaza found facet dysfunction at multiple levels including L3-4 and L4-5; and a left lateral disc bulge at L4-5 that correlates with Petitioner's clinical and subjective complaints. Petitioner's original pain level was 8/10. Her treatment consisted of three (3) facet injections, work hardening and she currently complains of back pain.

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
14WC31520
SIGNATURE PAGE

18IWCC0062

Signature of Arbitrator

December 15, 2016
Date of Decision

DEC 15 2016

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

Braxston L. Perry,

Petitioner,

vs.

NO: 15 WC 35793

18IWCC0063

J. Squared Carpentry, 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 the nature and extent of Petitioner's disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 17, 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.

18IWCC0063

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $4,300.00. 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: JAN 30 2018
TJT:yl
o 1/23/18
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PERRY, BRAXSTON
Employee/Petitioner

Case# **15WC035793**

J SQUARED CARPENTRY INC
Employer/Respondent

18IWCC0063

On 8/17/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.11% 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:

0834 KANOSKI BRESNEY
CHARLES EDMISTON
129 S CONGRESS ST
RUSHVILLE, IL 62681

2674 BRADY CONNOLLY & MASUDA PC
GRANT CAMPBELL
211 LANDMARK DR SUITE C2
NORMAL, IL 61761

18IWCC0063

STATE OF ILLINOIS)
)SS.
COUNTY OF Sangamon)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Braxston L. Perry
Employee/Petitioner

v.

J Squared Carpentry, Inc.
Employer/Respondent

Case # 15 WC 35793

Consolidated cases: _____

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Springfield**, on **July 26, 2017**. By stipulation, the parties agree:

On the date of accident, **8/19/14**, 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 **$1,685.00**, and the average weekly wage was **$337.00**.

At the time of injury, Petitioner was **21** 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 **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$1,320.00** for other benefits, for a total credit of **$1,320.00**.

18IWCC0063

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 $**220.00**/week for a period of 25 weeks, as provided in Section **8d2** of the Act, because the injuries sustained caused 5% loss of Person As A Whole.

Respondent shall be given a credit of $1,320.00 against the awarded PPD for the statutory payment of 6 weeks of benefits previously made.

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.

D. Dglas McEarty

8/10/2017

Signature of Arbitrator

Date

AUG 17 2017

18IWCC0063

Findings of Fact

Medical Treatment

The petitioner was employed as a framer for the employer J Squared Carpentry. (T. 9) The parties stipulated that on August 19, 2014, the petitioner sustained accidental injuries arising out of and in the course of employment when he fell from the second story of a house injuring his low back. (Ax. 1; T. 9)

Immediately following the accident, the petitioner was taken to Koke Mill Medical Center for evaluation. (T. 11) The petitioner was subsequently transported by ambulance to Memorial Hospital for further evaluation. (Px. 1 and T. 11) During that evaluation the petitioner denied hitting his head or losing consciousness, but complained of mild left-sided hip pain. (Px. 1) It was noted the petitioner was capable of walking without difficulty. (Id.) The petitioner underwent a CT of his entire spine and was diagnosed with an L2 vertebral fracture and a broad based disc bulge at L4-5.(Id.)

Thereafter, on September 4, 2014 the petitioner presented to Dr. Rakerry Rahman at Springfield Clinic for further evaluation. (Px. 3) The petitioner complained of low back and paraspinal pain, moderate in severity. (Id.) Dr. Rahman diagnosed the petitioner with an acute low back strain and instructed him to take Tylenol and Aleve for pain as needed. (Id.) The petitioner was instructed to follow up in six weeks. (Id.)

On September 16, 2014, the petitioner followed up at Memorial Hospital. (Px. 1) The petitioner was instructed to continue taking cyclobenzaprine and hydrocodone and follow up in three weeks. (Id.) The petitioner was provided light duty work restrictions of no lifting over 20 pounds and no bending/lifting/stooping/climbing. (Id.)

The petitioner followed up with Dr. Rahman on October 16, 2014. (Px. 3) The petitioner reported ongoing symptoms including pain in his back with sitting up straight. (Id.) The petitioner noted again that his symptoms were moderate in severity. On examination, the petitioner had strength rated 5/5 and was otherwise unremarkable. (Id.) The petitioner was instructed to remain off work for another six weeks and follow up for re-examination in six weeks. (Id.)

The petitioner followed up with Dr. Rahman again on December 11, 2014. (Id.) At that time, Dr. Rahman noted the petitioner no longer had complaints of pain located in his back, except with overexertion causing some pain. (Id.) Dr. Rahman diagnosed the petitioner with a healed L2 fracture with normal examination and released the petitioner back to work with no restrictions. (Id.)

The petitioner returned to Dr. Rahman on August 12, 2015. (Id.) The petitioner reported not having very much pain and stated that he wanted to discuss a recent trapezial strain he sustained while playing basketball for the first time in many months. (Id.) The petitioner's examination was unremarkable and Dr. Rahman again noted the petitioner was no longer having pain in his back, except for with occasional overexertion causing some pain. (Id.) Dr. Rahman opined the petitioner had reached maximum improvement for his injury and instructed him to follow up on

an as-needed basis. (Id.) Dr. Rahman stated the petitioner did not need any formal orthopedic follow-up. (Id.)

On April 25, 2016, the petitioner presented to Dr. Mark Hansen at Memorial Hospital. (Px. 1) The petitioner's intake questionnaire indicated he wished to discuss a referral to a back specialist and recommendation for marijuana for chronic spinal pain. (Rx. 4) The petitioner stated that Dr. Rahman advised him he would have to "deal with the pain" as there is nothing further he could do. (Px. 1). The petitioner was referred for an MRI of his lumbar spine and prescribed meloxicam. (Id.)

On April 29, 2016, the petitioner underwent an MRI of his lumbar spine that revealed:

- Collective findings suggestive sequela of prior mild juvenile lumbar osteochondrosis/scheuerman's disease with minimal lower thoracic anterior wedging, straightening of normal thoracolumbar curvature and Schmorl's node formation;
- New superior endplate Schmorl's nodes at L2 and L3 since 2014 with edema along the L2 endplate suggesting either acuity or associated type 1 degenerative endplate change;
- Disc bulging facet hypertrophy with mild L4-5 and mild to moderate L5-S1 foraminal stenosis. Id.

He then followed up with Dr. Hansen on May 16, 2016. (Id.) The petitioner reported having aches and pain in his back. (Id.) Dr. Hansen noted the petitioner was prescribed meloxicam, but that the petitioner stated he never took it. (Id.) The petitioner reported that he was lifting boxes at work which increased his back pain, but that he was recently promoted and only handling approximately 10 boxes a day. (Id.) Dr. Hansen stated the petitioner was supposed to see "SIU" but the evaluation never occurred. (Id.) As such, the Dr. Hansen referred to the petitioner to Washington University for further evaluation. (Id.)

On September 19, 2016, the petitioner presented to Dr. Farid Zahedieh at SIU Health. (Px. 5) The petitioner complained of constant episodes of bilateral low back pain rated 5/10. (Id.) The petitioner alleged that his back pain started after his August 2014 work injury. (Id.) The petitioner explained that he had been released by Springfield Clinic Orthopedics, but he continued to have back pain with activity and he would like to get a second opinion at Washington University. (Id.) The petitioner also stated that he would like to attempt rehabilitation for his back and as such was referred for physical therapy. (Id.) On examination, the petitioner had no tenderness to palpation, but some tenderness with twisting and back flexion. (Id.) The petitioner was diagnosed with back pain and prescribed Naproxen. (Id.)

On November 7, 2016, the petitioner presented to Dr. Frank Bender at Orthopedic Center of Illinois. (Px. 2) The petitioner reported pain located in his back and bilateral knees rated 7/10. (Id.) The petitioner stated his pain occurred most the day and was exacerbated by nothing in particular. (Id.) The petitioner alleged that he tried Flexeril, but that this made his stomach hurt. (Id.) The petitioner confirmed he had not participated in physical therapy or undergone any injections. (Id.) On examination, the petitioner had mild discomfort at L5, but no pain to palpation of lumbar spine along the lumbar facets. (Id.) Dr. Bender reviewed the petitioner's lumbar MRI and diagnosed him with lumbar compression fracture and multilevel degenerative disc disease. (Id.) Dr. Bender stated the petitioner was relatively pain-free on examination, but that he was able to aggravate the petitioner's spine somewhat at the L5 – S1 level. (Id.) Dr.

Bender opined the petitioner's L2 fracture had healed and that he was doing well working a new job. (Id.) Dr. Bender wrote that the injury sustained at work, specifically a fall from height, where he landed on his feet, resulted in the multi-level disc degeneration on MRI a year and a half after the injury. Dr. Bender placed the petitioner maximum medical improvement stating he did not need any further therapy, medical treatment, interventional spinous procedures or surgery. (Id.)

Petitioner's Testimony

On direct examination, the petitioner testified on August 19, 2014 he injured his back while building the back wall for a home. (T. 9-10) The petitioner explained that he stepped off the roof and fell onto his feet causing his knees to buckle and fall onto his butt. (T. 10-11) The petitioner alleged he blacked out and felt immediate pain after the incident. (Id.) The petitioner testified it took approximately five to ten minutes for him to be able to stand up and he was immediately taken to Koke Mill Medical Center and then Memorial Hospital. (Id.)

Following the incident, the petitioner testified he followed up with Dr. Rahman and was prescribed medication. (T. 12) He testified this was the only treatment he was offered and he continued to have pain during his follow-up treatment. (Id.) The petitioner testified that he was released by Dr. Rahman to return to work in December, but that he actually returned to work in November. (T. 14) The petitioner started working for FedEx Ground stating that he changed jobs as he was "afraid to go back into the construction field" that it was "too much of a risk" and that he "should not have to put [his] life up at a risk while working" when he could "get a job that offered benefits" and he could "go to school and get an education." (Id.)

The petitioner testified that he spoke with FedEx regarding his back injury and that if he encountered a package that he felt like he could not lift he could call for assistance. (T. 15) The petitioner testified that he continues to work for FedEx and continues to have ongoing back pain. (T. 15-16) The petitioner testified that lifting and twisting aggravates his back pain. (T.16)

The petitioner testified that he returned to Dr. Rahman on August 2, 2015 to see if there was anything further the doctor could do for his back pain. (T. 17) The petitioner testified that he was experiencing the same type of back pain and that it had not resolved since the work incident. (Id.)

The petitioner further testified he presented to his primary care physician, Dr. Hansen, in April 2016 and underwent MRI of his low back and received a referral to Washington University for a second opinion. (T.17-18) The petitioner testified that evaluation never occurred and therefore in September 2016 he presented to Dr. Farid Zahedieh for another opinion regarding his low back. (T. 18) The petitioner testified that Dr. Zahedieh stated there was nothing else that can be done and no further medical treatment for his injuries and was he referred to Dr. Bender at Orthopedic Center of Illinois. (T. 18-19)

The petitioner testified that Dr. Bender did not provide any additional medical treatment. (T. 19) The petitioner testified that he continued following up with these physicians because he was in constant pain throughout the day. (T. 19-20)

The petitioner testified prior to the work incident he did not have any pain with his back and that he played football in high school. (T. 20-21) The petitioner testified that he spoke with some colleges about playing football at the collegiate level, but he did not pursue those opportunities as he did not have any idea of the financial aid or clearinghouse process. (T. 21) The petitioner testified he started running in 2014 but following the injury he is unable to go for a jog outside nor can he play basketball due to his condition. (T. 22-23) The petitioner testified that when he tries to run his whole spine trembles and he does not play basketball because afterward he is in pain for at least one to two weeks and is not able to move. (T. 23-24) The petitioner testified that he has pain every day and that it never goes away. (T. 25)

On cross-examination, the petitioner testified that he never had any prior back pain or treatment. (T. 27) The petitioner confirmed that following the work injury he landed on his feet and was able to walk after the incident. (Id.) He confirmed that he was placed on light duty work restrictions and received off work benefits from the insurance company. (T. 27-28)

The petitioner testified he was still on work restrictions when he obtained the job with FedEx and that it was a regular position with no accommodations. (T. 28) The petitioner testified that he did not believe he could return to construction because of the heavy lifting and claimed to have had a conversation with the employer stating that the safest option for him was not to return to construction. (T. 30) The petitioner confirmed that he was not restricted by any physician to return to work in construction. (T. 30) The petitioner testified that he has always experienced pain and that any medical records should reflect the same. (T. 31-32) The petitioner testified at the time of Dr. Rahman's evaluations he may not have been as painful as usual, but that he was never pain free. (T. 32) The petitioner testified that Dr. Rahman stated this was a permanent injury and that he would have to deal with it over time, but that he kept going back for treatment because he had ongoing pain. (T. 32-33)

The petitioner testified that he returned to Dr. Rahman in August 2015 because he was having ongoing pain. (T. 33-34) The petitioner testified that he was unsure why Dr. Rahman noted that the petitioner stated he was not having pain and that this may have been how he felt on the day of that examination. (T. 35) The petitioner explained that he has had constant pain since the time of the injury. (Id.) The petitioner further testified that he did not remember ever talking to Dr. Rahman about the trapezial strain from playing basketball. (T. 36)

The petitioner testified he returned for additional medical treatment in April 2016 and that he was given muscle relaxers which caused him to have diarrhea and headaches and that hydrocodone caused him to have withdrawals. (T. 38-39)

The petitioner confirmed that he followed up at SIU Health on September 19, 2016 for ongoing back pain. (T. 40) The petitioner confirmed he was referred to physical therapy but that he did not undergo this treatment as he never scheduled it. (T. 40-41) The petitioner testified that he could perform stretching on his own and that his schedule is not flexible enough to participate in therapy. (T. 41) The petitioner confirmed that he did not know how long therapy visits would take or if they would be flexible with his schedule. (T. 41-42)

The petitioner testified that he presented to Dr. Frank Bender for a second evaluation and he did not recommend any additional treatment. (T. 43) The petitioner confirmed that Dr. Bender

allowed him to continue working full duty and also stated that he was at maximum medical improvement and did not require any additional medical treatment. (T. 43-44)

The petitioner testified the reason he never presented for evaluation at Washington University was he was on vacation and missed the calls to schedule this evaluation. (T. 46-47) The petitioner testified that he tried to follow up and schedule the evaluation but was told he needed a referral and ultimately underwent the second evaluation with Dr. Bender. (T. 47)

The petitioner further testified that he does not take any ibuprofen or Aleve for his condition. (T. 48) The petitioner claimed that he could have played football after the work incident and that he would have been able to walk on any college program. (T. 49) The petitioner confirmed that no physician had restricted him from playing football but that after the injury he was not able to run without having severe pain in his spine. (T. 50-51)

The petitioner testified that although he was having ongoing severe pain, he may not have reported this severe pain to Dr. Rahman as he may have been feeling good at the time of that examination. (T. 52)

The petitioner testified that he was studying Business Administration at the University of Illinois at Springfield and he was planning on completing his Bachelor's degree in the winter of 2018. (T. 53) He is then planning on obtaining his Master's degree at the University of Illinois at Springfield. (Id.)

On redirect examination, the petitioner testified he disclosed his back injury to FedEx and he is able to get assistance with any heavy lifting. (T. 55-56)

On re-cross-examination, the petitioner confirmed that he is been promoted twice since working at FedEx and that he is earning $17.65 an hour working part-time, which is more than he was earning working full time for the respondent. (T. 60) The petitioner was also questioned regarding a prior medical record from May 8, 2012 documenting complaints of prior back pain. (T. 60-61) The petitioner testified that he had no recollection of this medical note or any prior back pain. (T. 61-62)

Conclusions of Law:

In determining a 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) [obtained through the most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment"]; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 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. 820 ILCS 305/8.1b(b).

i. ***Level of Impairment:*** Neither party submitted an AMA impairment rating as to the petitioner's work injury. As such, the arbitrator places no weight on this factor.

ii. ***Occupation:*** The petitioner was working as a framer building new homes at the time of the accident. The petitioner testified following the work incident, he decided construction was too much of a risk and that he would rather find a job that has benefits and go back to school. There was no job description submitted at trial and the petitioner did not testify as to his specific job duties with the employer. Obviously the job requires climbing as part of the home construction process. The Arbitrator takes judicial notice of the fact that construction work involves some lifting and bending on a regular basis. As such, the Arbitrator gives this factor moderate weight in the petitioner's favor.

iii. ***Age:*** The petitioner was 21 years old at the time of the work incident. Given the petitioner's age, the petitioner has a greater capacity for healing but will have to live longer in the work force with his disability. The arbitrator gives this factor some weight.

iv. ***Earning Capacity:*** The petitioner started working for FedEx November 2014, approximately three months following the work incident. Since this time the petitioner has received two promotions and is currently earning $17.65 per hour. The petitioner confirmed that he earns more working part-time for FedEx than he was earning working full time for the respondent.

The petitioner further testified that he is in school studying Business Administration at the University of Illinois at Springfield and is planning on completing his Bachelor's degree in the winter of 2018. Thereafter, the petitioner is planning on obtaining his Master's degree at the University of Illinois at Springfield.

The petitioner has been released to work full duty without restrictions and is currently making more part-time at FedEx than he was working for the respondent. There is no evidence to suggest that the petitioner's future earning capacity is adversely affected by the work injury. Further, the petitioner testified that FedEx was aware of the work injury when he was hired. This is further evidence that the petitioner's injury has not affected his future earning capacity. Therefore, the arbitrator places moderate weight on this factor in the respondent's favor.

v. ***Disability:*** As a result of his work accident, the petitioner sustained an L2 vertebra fracture. He also testified that he briefly lost consciousness as a result of the fall. The petitioner testified that he has never had any prior back pain or injuries and that his back pain has been severe and constant since the work incident. The petitioner claimed his back pain is so severe that it has kept him from playing basketball, jogging and even running to the mailbox. He testified that he has continued to experience daily back pain. The petitioner claimed that he continues to return for treatment due to his ongoing back pain and that he continues to be limited.

The Arbitrator notes that the petitioner followed up with his treating physician, Dr. Rahman, on December 11, 2014 and August 12, 2015 and reported that he was having very little to no back pain. The petitioner had been working with FedEx since November

2014 and, although he testified that he was having severe back pain that kept him from running and playing basketball, his medical records indicate he was essentially pain free.

Additionally, during the follow up visit with Dr. Rahman on August 12, 2015, the petitioner reported that he recently played basketball and strained his trapezius. The petitioner did not report any pain with his back associated with playing basketball, although he reported this trapezius pain. This arbitrator finds this significant based on the petitioner's testimony claiming that if he runs his "whole spine trembles" and that after trying to play basketball his "spine is in pain for at least a week or two and [he] can't move the same." (T. 22-24) If the petitioner truly returned to Dr. Rahman because he was having significant ongoing pain, including after an activity that allegedly causes him significant pain, one would imagine that he would report the same to his treating physician, especially given that the petitioner testified that he returned to Dr. Rahman because he was having ongoing pain. The arbitrator finds these records significant, calling into question the credibility of the petitioner's alleged ongoing pain complaints and current physical status.

The petitioner further testified that he did not participate in physical therapy because his schedule was not flexible enough to participate in therapy. However, it was the petitioner himself on September 19, 2016 that requested the referral to therapy. Yet he failed to ever try to schedule this treatment and during cross-examination testified that he was not interested in therapy as he could perform stretching on his own.

During the petitioner's second evaluation with Dr. Frank Bender on November 7, 2016, the petitioner reported back pain rated 7/10, yet the petitioner only had mild discomfort on examination at L5 with no pain to palpation of the lumbar spine. Dr. Bender specifically stated the petitioner was relatively pain-free on examination and that his L2 vertebra fracture had healed and the petitioner did not require any further medical treatment for this injury.

Dr. Bender causally related the petitioner's multi-level disc degeneration to his accident. He noted the findings from the MRI of April 29, 2016.

Based upon the above evidence, the Arbitrator finds the Petitioner disabled to the extent of 5 % Person As A Whole. The parties acknowledge and agree the respondent shall be given a credit against that award for the statutory payment of 6 weeks of PPD totaling $1,320.00.

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

Donette R. Martin,

Petitioner,

vs. NO: 14 WC 34119

State of Illinois-House of Representatives,

18IWCC0064

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 November 18, 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: JAN 30 2018
TJT:yl
o 1/23/18
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MARTIN, DONETTE R
Employee/Petitioner

Case# **14WC034119**

ST OF IL HOUSE OF REPRESENTATIVES
Employer/Respondent

18IWCC0064

On 11/18/2016, 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 0.62% 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:

0834 KANOSKI BRESNEY
CHARLES N EDMISTON
129 S CONGRESS
RUSHVILLE, IL 62681

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

0988 ASSISTANT ATTORNEY GENERAL
JORDAN A HOMER
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 62794-9155

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

NOV 18 2016

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

18IWCC0064

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

Donette R. Martin
Employee/Petitioner

v.

State of IL House Of Representatives
Employer/Respondent

Case # 14 WC 34119

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Springfield**, on October 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 July 18, 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 **$41,999.88** ; the average weekly wage was **$807.69** .

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

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

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

Respondent shall receive credit for payments of employer sponsored health insurance on the claimed medical bills under Section 8J.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $538.46/week for 1 5/7 weeks, commencing 10/2/14 through 10/6/14 and 11/6/14 through 11/12/14, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of $11,312.00, as provided in Sections 8(a) and 8.2 of the Act, subject to the medical fee schedules and credit to Respondent for payments by employer sponsored health insurance. Payments by Petitioner shall be reimbursed first before any 8J credits are applied.

Respondent shall pay Petitioner permanent partial disability benefits of $484.61/week for 28.5 weeks, because the injuries sustained caused the 8 % loss of the right hand and 7% loss 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.

D. Dyas McCarty

Signature of Arbitrator

11-14-2016

Date

NOV 18 2016

In considering the issues in dispute in this cause, the Arbitrator considers the following facts:

Petitioner testified that in July 2014 she was employed as a legislative secretary for the Illinois General Assembly and had been so employed for 26 years. Petitioner that she would spend 50 to 60 percent of her day keyboarding and working on a computer. Petitioner testified that at time she would help put together mass mailings which would involved folding documents by bending her wrists to fold each document in to three parts and stuffing it into an envelope. She testified that there could be hundreds or thousands of these mailings, and she could spend a morning and an afternoon at this task alone. She testified that she worked seven hours per day, five says per week, though she was busier in the period from January to May when she would work five to ten extra hours per week. She testified that sometimes she would answer phones and occasionally would be engaged in filing. Petitioner testified that while engaged in these activities she began to notice in the months leading up to July 2014 that her hands would go numb. She testified that while working if she did not wear a brace her hands would tingle and she would be unable to feel her hands, and these problems were worse when she was engaged in her work activities. She acknowledged that she is given breaks during the day and for lunch but whens she is busy she often doesn't take her breaks or eats her lunch at her desk. She testified that she tried using a brace that she bought on her own at a store upon the advice of another secretary that she worked with who had the same problem. She testified that in July 2014 she first sought medical care from Dr. Meander.

On July 18, 2014, sought care from Dr. Christopher Meander, an orthopedic surgeon with the Orthopedic Center of Illinois in Springfield. (PX 1, pp. 6-9) He noted that the Petitioner was complaining of bilateral wrist pain, worse on the right dominant side. Petitioner also reported numbness and tingling and pain at night. Petitioner reported a gradual onset with worsening pain, and noted that work activities were the aggravating factor. Petitioner reported that she had tried a brace on her right hand but it did not help. Petitioner also reported some lateral elbow pain that radiated down to her hand. Petitioner had positive Tinel's and Phalen's testing on the right at the carpal tunnel. Dr. Meander felt that Petitioner likely was suffering from carpal tunnel syndrome and recommended EMG/NCV testing. Surgical release was discussed.

EMG testing was performed by Dr. Watson at OCI on July 23, 2014, finding moderate to severe right carpal tunnel syndrome and moderate left carpal tunnel syndrome. (PX 1, pp. 26-28)

Dr. Meander's records include a written initial worker's compensation report including as the description of accident the "repetitive use of hands". (PX 1, p. 10)

Records show that after a pre-operative evaluation on September 26, 2014 (PX 2, pp. 5-7), Petitioner underwent a right carpal tunnel release on October 2, 2014 (PX 2, pp. 13-14) and, following another pre-operative evaluation on October 29, 2014 (PX 2, pp. 84-86) a left carpal tunnel release on November 6, 2014 (PX 2, pp. 93-94) The median nerve in the right wrist was noted to have turned a slight red color consistent with compression. (PX 2, p. 14) Petitioner followed up with Dr. Meander on October 14, 2014, after the first surgery (PX 1, pp. 4-5) and on November 19, 2014 (PX 1, pp. 2-3) and was released from active care at that time. At this final visit, Petitioner was sore "as expected after surgery" and her pain was "well controlled". She was instructed in scar massage and directed to increase activity as tolerated.

Petitioner offered the deposition of Dr. Meander taken on March 18, 2016. (PX 5) When asked how the Petitioner described her work activities to him, Dr. Meander testified:

> "She described them as typing a variety of difficult material requiring reading of handwritten hard copies. She composes responses to correspondence, operated typical office equipment, word processing terminals, typewriters, copy machines and personal computer on a daily basis. She transcribed dictations, types lists, labels, cards, form letter completions, and envelopes using a typewriter, word processor or computer." (PX 5, pp. 11-12)

Based upon the Petitioner's description of her work activities, Dr. Meander opined that her "work activities were an aggravating factor to her carpal tunnel and I think it did lead to her needing the surgery with her increase in symptoms." (PX 5, p. 12) Dr. Meander testified that the Petitioner was off work from October 2, 2014 through October 7, 2014 and November 6, 2014 until November 13, 2014. (PX 5, pp. 12-13) Dr. Meander reaffirmed his causation opinion in response to a hypothetical question outlining the Petitioner's work activities for Respondent. (PX 5, p. 13-14) Though on cross-examination, Dr. Meander testified that the aggravation to Petitioner's carpal tunnel syndrome by her work activities was "temporary" (PX 5, p. 15), on re-direct-examination, Dr. Meander testified that the aggravation that the Petitioner suffered to her carpal tunnel syndrome "moved up" the time at which surgery was required for those conditions. (PX 5, pp. 16-17)

Respondent offered the evidence deposition of Dr. Michael Lewis, a Section 12 examiner. (RX 2) Dr. Lewis testified that in his opinion the Petitioner's carpal tunnel syndrome was not causally related to her work activities, because those activities lacked sufficient use of force or repetition. (RX 2, p. 12) On cross-examination, Dr. Lewis disputed the Petitioner's report of increased symptoms in the course of her work activities because "I don't think that she is familiar with evidence-based medicine concerning causation". (RX 2, p. 16) When asked repeated to explain how her symptoms could have even temporarily be exacerbated by the work activities that the Petitioner pursued, Dr. Lewis essentially evaded the question. (RX 2, pp. 15-18) Dr. Lewis testified that in the past year he had performed "maybe two" carpal tunnel releases. (RX 2, p. 18) Dr. Lewis testified that 15 percent of his practice was performing independent medical evaluations, being two or three per week. (RX *, pp. 18-19

Petitioner testified that since she has been released by her doctor in November 2014 she has continued to work at the same job. She testified that if she does something consistently she will still get tingling in her hands that goes up to her elbow. She is unable to put pressure on the base of her palm where the surgery was done and she lacks the grip now to open big jars like a pickle jar.

Petitioner testified that when she saw Dr. Lewis, the Respondent's Section 12 examiner, she was in his office examining room for three hours and only saw him for about five minutes. She testified that he did not examiner her hands as thoroughly as Dr. Meander did.

Based on the foregoing facts the Arbitrator makes the following findings on the disputed issues:

1. **Accident and causation:** Petitioner's testimony regarding the repetitive nature of her work and intensive use of her hands in keyboarding and performing mass mailings is not contradicted by other evidence. Based upon the Petitioner's testimony regarding the onset and exacerbation of her symptoms while performing her work activities and the more credible opinion of Dr. Meander, the Arbitrator finds that it is more likely than note that the Petitioner's work activities were a contributing cause of her carpal tunnel syndrome. Though Dr. Meander testified on cross-

examination that the aggravation of Petitioner's condition by her work activities may be temporary, he acknowledged that this repeated aggravation at work accelerated her need for surgery. Dr. Maender testified that he understood what the Petitioner did on the job. His understanding was consistent with the Petitioner's testimony. Dr. Lewis testified that keyboarding is not an activity which could cause or aggravate carpal tunnel syndrome. He based his opinion on what he described as evidenced based medicine which he obtained from reading the AMA Guides, 6th edition. (RX 2 at 10,11) Based upon his reliance on evidenced based medicine, the Arbitrator concludes that Dr. Lewis' opinion on causation would be the same no matter how long an individual spent keyboarding at work. He was also asked why the Petitioner complained of an increase in her symptoms while she was performing her keyboarding work, and he answered that he questioned her validity in making such statements. (Id at 15) Dr. Maender's opinion was based upon what the Petitioner actually did at work. The Arbitrator finds his opinion more persuasive that that of Dr. Lewis. Petitioner has shown an accidental injury arising out of her employment which is causally related to her hand injuries.

2. **TTD:** Based upon the medical records and testimony of Dr. Meander, Petitioner was off work for her surgeries from October 2, 2014 to October 6, 2014 and November 6, 2014 to November 12, 2014 for a total of 1 5/7 weeks.
3. **Medical expenses:** Based upon the medical records submitted into evidence and the testimony of Dr. Meander and the Petitioner the Arbitrator finds that the medical bills submitted into evidence as PX 6 are reasonable and necessary and causally related to the Petitioner's work-related injury and should be paid pursuant to the fee schedules,
4. **Permanent partial disability:** In considering permanency, the Arbitrator must consider the following factors:

Reported level of impairment: Dr. Lewis performed an assessment of impairment using the aforementioned AMA Guides. It yielded an impairment rating of zero for each hand. His accompanying examination on July 30, 2015 found the Petitioner with a minimal QuickDash score concerning her symptoms and normal readings for motor strength and range of wrist motion. He also found negative Tinel's signs on each hand and wrist. The Arbitrator attaches moderate weight to this factor

Occupation of the Petitioner: Petitioner returned to the same occupation that brought on and exacerbated her condition, exposing her to further aggravation. This factor has moderate weight.

The age of the Petitioner: Petitioner is 50 years old and thus has several years before retirement to suffer the effects of the injury. This factor is given moderate weight.

The employee's future earning capacity: No evidence was offered that the Petitioner's injury has had an impact upon her future earning capacity. This factor is given limited weight.

Evidence of disability corroborated by medical records: Petitioner testified to some residual effects of the injury that are consistent with having undergone surgery for carpal tunnel syndrome. Dr. Maender last saw the Petitioner on November 19, 2014, only thirteen days after her left carpal tunnel release. At that time he removed her stiches and instructed her to massage her scar. She reported no symptoms other than tenderness at the left surgical site.

The Petitioner had only worked for four days at the time she last saw Dr. Maender. The Arbitrator feels her symptoms reported at arbitration are credible given the nature of her injury. The factor is given moderate weight.

Based upon the foregoing factors, the Arbitrator awards 8% loos of the right hand and 7% loss of use of the left hand.

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

Reona Pearson,

Petitioner,

vs. NO: 16 WC 13523

18IWCC0065

Denny's,

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, wages, medical expenses and prospective medical treatment, and being advised of the facts and law, reverses the Decision of the Arbitrator as 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 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).

Findings of Fact

Petitioner testified that she has worked for Denny's "[g]oing on six years. Almost seven", earning $4.95 an hour plus tips. (T.27-28). She indicated that the $250.00 a week in wages she is alleging is accurate. (T.29).

Petitioner testified that on April 7, 2016 she told Anna Costney, one of her co-workers, that she was going to the bathroom and that "[w]hen I walked in the stall the paper towel [sic] roll was sitting on top of the – between like the door and the ledge so when I opened it, it fell on top of my head." (T.31). She noted that it was an industrial roll that was very heavy, weighing probably ten pounds. (T.31). She pointed out that the roll hit her on the top or back of her skull. (T.31). She stated that she "... kind of stumbled back when it hit me and, you know, a little dizzy, seeing stars, kind of sat there for a second. Instantly I went out and I told – I saw Mr.

18IWCC0065

Robert, he is one of the maintenance men at Flying J. I told him, we walked into the bathroom together and I showed him the roll … I told him of the incident and he went his way and I went into the Denny's and I instantly told Anna that the paper towel [sic] roll hit me and my head was hurting and I was a little dizzy." (T.32). Petitioner indicated that she had never sustained any injuries to her head, neck or shoulders prior to the date of the alleged accident or received any treatment for same. (T.30). She also noted that she had never filed a workers' compensation claim before. (T.30). She stated that she is 5'5" and weighs 126 pounds, and agreed that she has been in good shape her entire life. (T.30).

Petitioner testified that the restroom she was in at the time of the accident is used "[v]ery frequently" and that there is a lot of traffic from Denny's and Flying J customers, including truckers. (T.35). She noted that she was not expecting the incident to happen, and that she did not see any of it before it happened. (T.36).

On cross examination, Petitioner agreed that she is an employee of Denny's and not Flying J. (T.36). She also agreed that in order to access the bathroom you have to physically leave Denny's restaurant. (T.36). In addition, she agreed that the photo admitted at RX2 was a fair depiction of "what we're talking about", and that it was fair to say that the distance between Denny's and the bathroom was approximately 20 feet. (T.37). Likewise, she agreed that anybody can use that bathroom, not just employees, and that if she wanted to she could have used the bathroom on the other side of the Flying J property. (T.37). She also agreed that on the date of the accident she was going to the restroom to use the facilities, not to clean or restock supplies. (T.37-38). She similarly agreed that the bathroom is maintained by Flying J. (T.38).

Petitioner agreed that the toilet paper roll came from above her head. (T.38). When asked whether that was where the toilet paper was typically kept, Petitioner responded: "[t]hat's one question I asked. That is one of the bathrooms that I use all the time. It's never been up there. Never. It wasn't a cart, you know, the cleaning cart out there from Flying J, from the maintenance men. Usually when I see that cart I know he's coming in to use the bathroom or, you know, he's on the other side at the men's so I have – you know, when I see a cart I knew he was going to clean it but there wasn't a cart out there or anything so I don't know if he – I don't know if the maintenance man put it up there to change it or what the situation was but it has never been up there." (T.38-39). Instead, she agreed that the toilet paper is typically kept in the toilet paper dispenser next to the toilet. (T.39). She also agreed that there are multiple stalls – approximately five or six -- in the bathroom. (T.39). She likewise agreed that there was no rule that Denny's employees had to use that stall, noting that she could use any one she wants. (T.39-40). In fact, she agreed that anyone off the street could have used that stall. (T.40).

Petitioner testified that following the accident she filled out a report. (T.33). In a "Memo for Record" form dated April 7, 2016, Petitioner noted that "I went to the restroom and as I opened the door a big roll of toilet paper fell down on top of me and hit me in the head. I kind of stumbled back and I went out the door and called Mr. Robert and showed him the toilet paper roll. I made a report to Flying J's manager stating what happened and also complained I have a headache and also pains in my neck" (PX7; RX1).

18IWCC0065

Anna Marie Costney (Blue) was called by Petitioner. Ms. Costney testified that she works at the Denny's in Allerton. (T.13). She noted that she was present on April 7, 2016 when she heard Petitioner "... talking about [the alleged accident], that she had got hit in the head with the tissue when she came back from the restroom." (T.14). She indicated that she did not witness the event and did not inspect the washroom afterwards. (T.14). Ms. Costney believed that she filled out a "Memo for Record" concerning the incident wherein she stated that Petitioner "... said that she had got – the tissue had fell [sic] off the stall and hit her in the head. But I didn't see it." (T.14-15). She noted that the Flying J restrooms have the industrial size tissue rolls, but she did not know how much they weighed. (T.15). She agreed that it is not your typical roll of toilet paper and that it almost looks like a cheese wheel. (T.15). She also agreed that this is a very heavy traffic area and that it is a busy truck stop with all kinds of activity. (T.15-16).

Ms. Costney agreed that as an employee of Denny's she is encouraged to go to the washroom when she needs to go, and that she does not get in trouble for taking a washroom break. (T.16). She also noted that it is mandatory to wash her hands before returning to work after going to the washroom. (T.16). In addition, Ms. Costney testified that the washroom in question is the closest one to where she worked, but that she does not use that washroom because "[i]t's too much traffic in there." (T.17).

On cross examination, Ms. Costney agreed that there is no bathroom inside Denny's, and that the maintenance workers on the Flying J side maintain the restroom that Petitioner used. (T.19). She indicated that Denny's does not clean or stock the bathrooms, and that the bathrooms can be used by anybody, including travelers stopping at the rest stop. (T.19). She noted that the other bathroom was probably about 50 feet away at the other end of the building by the game room. (T.20). Ms. Costney testified that the other restroom is smaller and doesn't have much traffic, and that it is the restroom that she generally uses. (T.20). She agreed that Denny's employees, as well as members of the general public, could use either bathroom. (T.20). In addition, she indicated that it is standard protocol for "... employees, manager, anyone, if they're done using the restroom, taking a break, going outside they're supposed to wash their hands before returning to work. Even if they already washed them in the washroom they're supposed to rewash again." (T.20-21). Along these lines, she noted that there are three sinks in Denny's – one up front by the counter and two in the back, one on each side. (T.21). She also stated that she heard Petitioner say that she had talked to management at Flying J to let them know about the tissue roll hitting her in the head. (T.21).

Sharan Jant was called by Petitioner and was present when Ms. Pearson testified. (T.22). Ms. Jant indicated that she is the restaurant general manager. (T.22). Ms. Jant agreed that there was nothing that Petitioner testified to that she would disagree with. (T.22-23). She noted that Petitioner told her "[t]hat she got hit in the Flying J bathroom with the tissue. She said it was on the top of the door and it fell and hit her and she only told me that after I asked her." (T.23). Ms. Jant stated that the bathroom is "... inside the Flying J and it's maintained by the Flying J and we're allowed to use their restrooms because we don't have one." (T.23). She noted that going to the bathroom is permitted while working on the job at Denny's. (T.24). She indicated that when she is on duty she asks the employees to let her know when they're going. (T.24). She also noted that she was not on duty when the accident happened. (T.24). Ms. Jant stated that Petitioner was not disciplined, punished or written up in any way for using the bathroom on the

18IWCC0065

day of the accident. (T.25). She also testified that "[i]f [Petitioner] needs to go to the bathroom she's allowed to go to the restroom." (T.25).

When asked whether she agrees with Ms. Costney's statements to the effect that this was an incredibly high traffic area with lots of truck drivers, motorists, tourists using the bathroom, Ms. Jant testified that "I don't agree with the truck drivers because they use the bathroom on the other side. The one she told you that was about 50 feet away, that's where the truck drivers usually use the restroom. Customers that's coming into the building, sometimes they come to that restroom. I don't monitor them so I can't tell you how often someone's in there." (T.25). She also indicated that she wasn't sure whether it was a high traffic area. (T.26).

On cross examination, Ms. Jant testified that her employees are allowed to use the restroom closest to the Denny's side, but that they also have the ability to go to the other restroom. (T.26). She noted that customers that come into Denny's use the bathroom closest to Denny's. (T.26). Once again, she agreed that Flying J is responsible for maintaining and cleaning the bathroom, and that at no time does Denny's stock or clean the restrooms. (T.26).

Following the incident, Petitioner visited Belleville Memorial Hospital. In an "Emergency Room Visit Report" dated April 7, 2016, it was recorded that the patient presented with complaints of "... headache and right side neck pain. Pt states she was at work tonight when a paper towel roll fell off the top of a door and hit her in the head. Pt denies LOC (loss of consciousness). Denies numbness, tingling, chest pain, SOB (shortness of breath), nausea, and emesis." (PX3). Cervical CT revealed no definite acute cervical vertebral body fracture or subluxation, while a CT of the head was unremarkable. (PX3). Petitioner was diagnosed with a head injury and cervical strain and was allowed to return to work without limitations as of Saturday April 9, 2016. (PX3).

Petitioner agreed that she started treating with chiropractor Dr. Daniel Brunkhorst a few days after her visit to Belleville Memorial Hospital. (T.41). She noted that her attorney referred her to Dr. Brunkhorst. (T.42).

In an office note dated April 11, 2016, Dr. Brunkhorst recorded that Petitioner suffered a work injury on April 7, 2016 when she was "... struck on top of the head by an economy size roll of toilet paper in the women's restroom while at her place of employment. The patient states that the roll of toilet paper was a new roll making it over 10 pounds. The patient states that someone had placed the roll on the top of the stall door and side wall. Upon opening the stall door, the roll of economy size toilet paper fell and struck the patient directly on top of her head. The force of the roll of toilet paper made her head snap down and to the right. The patient states that she did not lose consciousness, but states that 'the hit on her head made her see stars.' The patient states that she had immediate pain in her head and neck. The pain in her neck and head made her feel ill." (PX4). Upon examination, Dr. Brunkhorst's impression included concussion without loss of consciousness, sprain of the cervical and thoracic ligaments, cervical disc disorder with radiculopathy, cervicalgia, pain in thoracic spine, myalgia and contracture of muscle, unspecified. (PX4). Treatment on that date included "[m]yofascial [r]elease", electrical stimulation and "[p]ercussion therapy." (PX4).

18IWCC0065

In an "Employer's First Report of Injury" form dated May 13, 2016, it was noted that at 9:00 am on April 7, 2016 "EE was coming back from restroom when a large roll of toilet paper fell on ee resulting in strain to neck and head." (PX7).

Petitioner underwent an MRI of the cervical spine without contrast on May 13, 2016. (PX5). This study was interpreted as revealing 1) mild disc desiccation with diffuse annular disc bulge at C4-5, as well as mild central canal stenosis and mild bilateral neural foraminal exit stenosis; 2) mild disc desiccation with diffuse annular disc bulge, as well as a right foraminal disc protrusion at C5-6, as well as mild to moderate central canal stenosis without effacement of the spinal cord, disc/osteophyte complex which contributes to severe right neural foraminal exit stenosis and mild left neural foraminal exit stenosis; 3) mild reversal of normal cervical lordosis likely degenerative; and 4) cerebellar tonsillar ectopia as the inferior cerebellar tonsils extend up to 5 mm below the foramen magnum. (PX5).

In an "Initial Spine Examination" report dated May 31, 2016, Dr. Matthew Gornet noted that the patient presented with complaints of "... neck pain with headaches to the right trapezius, right shoulder, upper back and intermittent numbness in her right arm." (PX6). Dr. Gornet recorded that Petitioner "... states her current problem began on or about 4/7/16. She was working as a server for Denny's, which is a restaurant inside the Flying J rest stop. She went into a stall and opened the door and a large roll of toilet paper was placed on top of the door and it suddenly fell, striking her on the head. She developed fairly immediate pain. It was reported that day. She continues to work full duty. She began seeing Dr. Brunkhorst who has performed some physical therapy. She has felt some improvement, but continues to have significant headaches, neck pain and some mild arm symptoms, which have been problematic for her. She does not recall any previous problems of significance with her neck or shoulder. Her symptoms remain constant and worse with reaching, pulling or prolonged fixed head positions and is better with a change in position. At this point, she has right-sided symptoms. She denies left-sided symptoms." (PX6).

Following his examination and review of the MRI, Dr. Gornet noted that he believed that Petitioner's "... current symptoms and requirement for treatment is causally connected to her work related injury. She is working full duty and I would like to try a more conservative approach with chiropractic and physical therapy services three times a week for six weeks and I have referred her back to Dr. Brunkhorst... I have also referred her to Dr. Granberg for a single injection at C5-6... Again, she can work full duty. If she is not significantly improved, consideration could be given to disc replacement surgery at C4-5 and C5-6. As stated above, I do believe her current symptoms and requirement for treatment is causally connected to her injury as described." (PX6).

Petitioner has continued to treat with Dr. Brunkhorst thereafter, with her most recent visit having occurred on August 26, 2016. (PX4). At that time Dr. Brunkhorst recorded that the patient rated her pain as a 2-3 and described it as "... aching, numbness, throbbing, tightness. Mrs. Pearson states that the pain is present for approximately 20% of [her] day. The patient states that applying heat to the area, chiropractic, physical therapy and stretching help to alleviate the pain... The patient states that radiating symptoms are present. The patient states that the radiating symptoms are into the right upper arm..." (PX4).

18IWCC0065

Petitioner testified that she currently sees her chiropractor "Dr. Dan" three days a week, which she noted "... does [help] at the time." (T.34). She indicated that she has an appointment with Dr. Gornet for an injection on October 3, 2016. (T.34-35). She also indicated that she continues to work full duty in order to support her family of three kids. (T.35).

Petitioner indicated that following the incident she missed work "[o]n and off. Not more than three days. When it first happened I missed maybe two days and that was it." (T.33-34). The Commission notes that Petitioner is not requesting temporary total disability benefits as a result of her injuries. (See Request for Hearing form [Arb.Exh. #1]).

Conclusions of Law

To obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of the evidence, that she has suffered a disabling injury which arose out of and in the course of her employment. *Sisbro, Inc. v. Industrial Commission*, 207 Ill. 2d 193, 203, 797 N.E.2d 665, 278 Ill. Dec. 70 (2003).

"In the course of" employment refers to the time, place and circumstances surrounding the injury, meaning that, generally, the injury must occur within the time and space boundaries of the employment. *Sisbro*, 207 Ill. 2d at 203. However, under the personal comfort doctrine, the course of employment is not considered broken by certain acts relating to the personal comfort of the employee. *Eagle Discount Supermarket v. Industrial Commission*, 82 Ill. 2d 331, 339, 412 N.E.2d 492, 45 Ill. Dec. 141 (1980).

An injury "arises out of" employment when "the injury had its origin in some risk connected with, or incidental to, the employment and the accidental injury." *Sisbro*, 207 Ill. 2d at 203. There are three (3) categories of risk to which an employee may be exposed: (1) risks that are distinctly associated with one's employment, (2) risks that are personal to the employee, such as idiopathic falls, and (3) neutral risks that have no particular employment or personal characteristics, such as those to which the general public is commonly exposed. *Springfield Urban League v. Ill. Workers' Comp. Comm'n*, 371 Ill. Dec. 384, 990 N.E.2d 284 (4th Dist. 2013). 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 a risk to a greater degree than the general public. *Springfield Urban League v. Ill. Workers' Comp. Comm'n*, 990 N.E.2d 284, 371 Ill.Dec. 384 (4th Dist. 2013). The increased risk may be either qualitative (i.e. when some aspect of the employment contributes to the risk) or quantitative (such as when the employee is exposed to the risk more frequently than members of the general public by virtue of his employment). *Metropolitan Water Reclamation Dist. of Greater Chicago v. Ill. Workers' Comp. Comm'n*, 407 Ill.App.3d 1010, 1014, 944 N.E.2d 800, 348 Ill.Dec. 559 (2011).

In the present case, in leaving the employer's restaurant to use the restroom in the adjoining Flying J Truck Stop, Petitioner's actions clearly fell within the personal comfort doctrine, especially in light of the fact that Respondent did not provide any such facilities to its employees on its premises. The record also shows that the Respondent acquiesced in the use of the public restroom in question by its employees, based on the testimony of Petitioner, Ms. Costney and general manager Ms. Jant. In addition, there is absolutely no evidence to suggest

that Petitioner availed herself of the Flying' J facilities in an unreasonable or unforeseen manner so as to remove herself from the scope of her employment. Indeed, Petitioner did nothing more than open the door to a restroom stall only to find herself on the receiving end of the proverbial accident waiting to happen.

In terms of "arising out of", the Commission finds that the case at bar can fairly be described as involving a neutral risk – one that is neither personal in nature nor unique to the employment. As such, the question of compensability comes down to whether Petitioner was exposed to a risk of injury to a greater extent than a member of the general public, either from a quantitative or a qualitative standpoint. The Commission finds elements of both in the present situation. Indeed, Petitioner's employment increased the risk of injury qualitatively by way of Respondent's failure to provide bathroom facilities for its employees, forcing Petitioner and her fellow workers to leave their place of employ to go off site to seek personal comfort in the form of a busy public restroom. As a result, Petitioner's choices were severely limited, and any safeguards with respect to the safety and cleanliness of any such facility were effectively outsourced by Respondent. Thus, the employment and its lack of basic bathroom accommodations had a very real effect on the circumstances leading up to the injury, and as such exposed Petitioner to a greater risk of injury than members of the general public. Likewise, from a quantitative standpoint, Petitioner was exposed to a greater risk of injury due to her employment given the frequency with which she was forced to utilize these public facilities compared to members of the general public, who no doubt would have visited the facilities in question on a decidedly less frequent basis.

Therefore, based on the above, and the record taken as a whole, the Commission reverses the decision of the Arbitrator and finds that Petitioner proved by a preponderance of the credible evidence that she sustained accidental injuries that both arose out of and in the course of her employment on April 7, 2016.

The Commission further finds that Petitioner's current condition of ill-being is causally related to the accident on April 7, 2016 based on the chain of events as well as the opinion of Dr. Gornet. Along these lines, Dr. Gornet stated that he believed Petitioner's "... current symptoms and requirement for treatment is causally connected to her work related injury" as described. (PX6).

In addition, with respect to the issue of average weekly wage, the Commission notes that Petitioner testified she earned $4.95 an hour plus tips while working as a server for Respondent. (T.27-28). She also submitted into evidence a "Check/Direct Deposit" registry showing bi-monthly gross payments, including "server" and "cashier" hourly pay as well as reported tips, for the year preceding the accident (pay periods from April 2, 2015 through April 13, 2016) totaling $12,227.89. (PX7). Respondent submitted no evidence to refute the information contained in this statement. The Commission notes that a review of the check/direct deposit registry reveals that tips, not suprisingly, made up almost half of Petitioner's gross earnings as a server for Respondent. (PX7). As a result, and based upon the documented evidence submitted by Petitioner as to the amount of reported tips she received during the year preceding the injury, the Commission finds that said tips should fairly be included in the calculation of average weekly wage given that they would not be considered overtime or bonus pay that would otherwise be

18IWCC0065

excluded under §10. Furthermore, the Commission finds that PX7 shows that Petitioner worked 44 weeks and parts thereof during the period in question, given that the registry does not include direct deposit entries for the eight (8) week period extending from 9/3/15 through 10/28/15. (PX7). Therefore, based on the above, and the record taken as a whole, the Commission finds that Petitioner's average weekly wage was equal to $277.91 ($12,227.89 ÷ 44 weeks).

Furthermore, given the above findings as to accident and causation, the Commission finds that Petitioner is entitled to reasonable and necessary medical expenses as set forth in PX1, pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act.

Finally, the Commission finds that Petitioner is entitled to prospective medical care and treatment as recommended by Dr. Gornet, including a single injection at C5-6 as well as conservative treatment in the form of physical therapy and chiropractic services provided by Dr. Brunkhorst. (PX6). This finding is based on the opinion of Dr. Gornet as to the reasonableness and necessity of said treatment as well as the fact that as of the date of arbitration no medical provider has yet to find that Petitioner has reached maximum medical improvement.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated April 4, 2017 is reversed as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner reasonable and necessary medical expenses as set forth in PX1, pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for the current treatment recommendations of Dr. Gornet, including an injection and continued physical therapy and chiropractic care, pursuant to §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 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 pursuant to §8(j) of the Act; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers for which Respondent is receiving credit under this order.

18IWCC0065

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

DATED:
o:12/5/17 JAN 30 2018
TJT/pmo
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

PEARSON, REONA
Employee/Petitioner

Case# **16WC013523**

18IWCC0065

DENNY'S
Employer/Respondent

On 4/4/2017, 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 0.91% 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

2674 BRADY, CONNOLLY & MASUDA, PC
NOAH HAMANN
211 LANDMARK DRSUITE C2
NORMAL, IL 61761

18IWCC0065

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)

REONA PEARSON
Employee/Petitioner

v.

DENNY'S
Employer/Respondent

Case # **16** WC **13523**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Collinsville**, on **August 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. ☒ 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 7, 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.

In the year preceding the injury, Petitioner earned **$12,227.89**; the average weekly wage was **$250.00**.

On the date of accident, Petitioner was **27** years of age, ***single*** with **0** dependent children.

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 April 7, 2016. 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

March 30, 2017
Date

ICArbDec19(b)

APR 4 - 2017

STATE OF ILLINOIS)
) SS
COUNTY OF MADISON)

18IWCC0065

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

REONA PEARSON
Employee/Petitioner

v.

Case #: 16 WC 13523

DENNY'S
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The parties agreed that Petitioner sustained an accident and was injured on April 7, 2016. However, Respondent disputed that the accident arose out of and in the course of her employment and therefore also disputed causal connection, medical bills, and prospective medical. At trial the parties disputed Petitioner's average weekly wage, but subsequent to trial came to an agreement on $250.00 per week.

On April 7, 2016, Petitioner was 27 years old and single. The Arbitrator notes that the Request for Hearing (AX1) indicated Petitioner had no dependent children, yet she testified that she had three children and the medical records reference her taking care of her baby. As such, it is unclear from the record the actual number of her dependent children. She worked as a server for Denny's Restaurant, which was located within Flying J Travel Center in Alorton, Illinois. Flying J is a travel center/truck stop chain. Petitioner testified that prior to this accident she had never injured or sought treatment for her head, neck, or shoulders, including diagnostic x-rays or MRI or CT scan, and had never filed a worker's compensation claim.

Petitioner testified that on April 7, 2016, she went into the restroom on Flying J's premises and walked into a bathroom stall to use the toilet when an industrial size roll of toilet paper fell on her head. The roll was sitting on top of the stall, between the door and the ledge, and she did not realize it was there. As she opened the stall door, the roll fell and struck her on the top and back of her head. She estimated it weighed about ten pounds. She testified that after being hit she stumbled back, was a little dizzy and "seeing stars", and sat there for a second. Afterward, she told Mr. Robert, one of the maintenance men at Flying J, and took him to the restroom to show him the roll. She did not believe he filled out any sort of report. She then told her supervisor Anna and wrote out a report.

Following the accident, Petitioner sought treatment with her chiropractor, Dr. Dan, and she continues to see him three days a week. He referred her to Dr. Gornet, who ordered an MRI. She was scheduled to return to Dr. Gornet on October 3 for an injection. She has continued to work since the accident.

Petitioner testified that the restroom where she was injured is used "very frequently", with a lot of traffic from Denny's customers, Flying J customers, truckers, and travelers who stop to use the restroom. She did not see the toilet paper roll before it fell, and she did not expect it.

On cross-examination, Petitioner confirmed that she is an employee of Denny's and not an employee of Flying J. In order to access the bathroom in question, she had to physically leave the Denny's store. She reviewed Respondent's Exhibit 2, a photo of the inside of Flying J, and testified it is a fair depiction of the premises. She agreed that the distance between Denny's and the Flying J restroom is approximately 20 feet. She acknowledged that anyone can use the restroom, not just employees, and testified there was also another restroom on the other side of the Flying J property that anyone can use. She was free to use either of the restrooms, and was not restricted to use the one where the incident occurred.

Petitioner confirmed that when she went to the restroom that day she did so for the purpose of using the toilet and not to clean it, restock supplies, or the like. She acknowledged that the restroom was maintained by Flying J. She testified that the toilet paper is usually kept in the dispenser next to the toilet and that it has never been above the stall. There was not a cleaning cart in front of the restroom, which would signify the restroom was being cleaned or about to be cleaned. There are five or six stalls inside the restroom, and she was free to use any of them. Anyone off the street could have used the same stall she used that day. She testified she reported the incident to Mr. Robert because he was the maintenance man for Flying J.

Petitioner called Anna Marie Costney-Blue as a witness. She is also employed at the Denny's located inside Flying J, and was working on the day of Petitioner's accident. After Petitioner returned from the restroom, Ms. Blue heard her talk about getting hit in the head with toilet paper. She did not witness the accident and did not inspect the restroom afterward. A "Memo for Record" was filled out, stating what happened. She testified that the Flying J restrooms have industrial size toilet tissue rolls but she did not know how much they weighed. She further testified the restroom where Petitioner was injured is a heavily trafficked area within a busy truck stop.

Ms. Blue testified that employees of Denny's are allowed to use the restroom when they need to. They are required to wash their hands not only in the restroom but also in one of the three sinks inside Denny's. The restroom where Petitioner was injured is the closest restroom to the Denny's location, but there is also another restroom in the Flying J building.

On cross-examination, Ms. Blue reviewed Respondent's Exhibit 2 and confirmed it was an accurate scene that shows the separation and difference between the Denny's property and the Flying J property and also shows the location of the Flying J restroom where the accident occurred. The front door of Flying J is located to the left of the Cinnabon window advertisement

and is open to the general public. Ms. Blue testified that once an individual leaves the Denny's restaurant, they are in the Flying J property.

Ms. Blue testified that there is no restroom located inside Denny's. The restrooms are inside Flying J and are maintained by Flying J employees. Denny's does not maintain, clean, or stock the restrooms. Members of the general public use the same restroom that Petitioner used on the date of accident. There is another restroom located at the other end of the Flying J building, which the general public and Denny's employees can use as well.

Petitioner called Sharon Jant as a witness. She is the general manager of the Denny's located inside Flying J but was not on duty when Petitioner's accident occurred. Petitioner reported to her that she got hit in the Flying J restroom when a roll of toilet tissue fell from above the door. Ms. Jant testified that the restroom where the accident occurred is located inside the Flying J property and is maintained by Flying J. Denny's employees are allowed to use the restrooms because there are no restrooms within the Denny's property.

On cross-examination, Ms. Jant confirmed that the restroom used by Petitioner is open to the public and is a high traffic area used by travelers, as well as by Denny's customers and Flying J customers.

Following the accident, Petitioner presented to the Emergency Room at Belleville Memorial Hospital with complaint of headache and right sided neck pain. She denied numbness or tingling. The ER record notes a history that a "paper towel roll" fell off the top of a door and hit Petitioner in the head. Cervical spine and head CT scans were unremarkable. Petitioner was prescribed Hydrocodone and Ibuprofen and instructed to follow up in two to three days. PX3.

On April 11, 2016, Petitioner presented to chiropractor, Dr. Daniel Brunkhorst. She testified she was referred to Dr. Brunkhorst by her attorney. She reported a consistent history of the accident. Her complaints included head, neck, and upper back pain, severe headaches, balance issues, and dizziness. She rated her pain at 7/10. On examination, cervical range of motion was reduced and painful and caused dizziness with flexion. Muscle spasms were noted in the cervical, right thoracic, and right shoulder regions. Cervical and shoulder compression tests were positive. Petitioner treated with Dr. Brunkhorst throughout the months of April and May 2016 and was seen an average of two to three days per week. On May 2, 2016, Dr. Brunkhorst noted he was referring her to an orthopedic physician and on May 11, 2016, he noted she was scheduled for an MRI on May 13. PX4.

On May 13, 2016, Petitioner underwent a cervical MRI at MRI Partners of Chesterfield, upon referral by Dr. Brunkhorst. It revealed: (1) C4-5 mild disc desiccation with diffuse annular bulge and mild stenosis; (2) C5-6 mild disc desiccation with diffuse annular bulge, right foraminal disc protrusion, mild to moderate stenosis without effacement of the spinal cord, severe right neural foraminal exit stenosis, and mild left neural foraminal exit stenosis. PX5.

On May 31, 2016, Petitioner presented to Dr. Matthew Gornet of The Orthopedic Center of St. Louis, upon referral by Dr. Brunkhorst. She gave a consistent history of the accident and her treatment to date, and reported current complaints of neck pain with headaches and into the

right trapezius, right shoulder and upper back, and intermittent numbness in her right arm. On examination, she had mild decreased range of motion, particularly with rotation to the right. Dr. Gornet reviewed the MRI from May 13 and interpreted it to show "an obvious large right-sided herniation at C5-6" and "a central herniation/annular tear at C4-5". The Arbitrator notes these findings are slightly different than those reported by the radiologist, Dr. Dusek. Dr. Gornet recommended Petitioner continue to work full duty and referred her back to Dr. Brunkhorst for continued chiropractic and physical therapy care. He also dispensed Meloxicam and Cyclobenzaprine in the office and referred her to Dr. Granberg for an injection at C5-6 on the right. She was to return in six weeks. Dr. Gornet noted, "If she is not significantly improved, consideration could be given to disc replacement surgery at C4-5 and C5-6." He opined that Petitioner's symptoms and need for treatment were causally related to the incident of April 7, 2016. The Arbitrator notes this is the only treatment record from Dr. Gornet. PX6.

Petitioner returned to Dr. Brunkhorst on June 10, 2016, and treated with him throughout the months of June, July, and August. She was seen an average of two to three days per week. The last treatment record was August 26, 2016, three days prior to hearing. At that time she reported continued cervical pain, along with numbness, throbbing, and tightness, and radiating pain into the right arm. Symptoms were alleviated with heat, chiropractic treatments, physical therapy, and stretching. She rated her pain at 3/10. On examination, there were trigger points in the right trapezius, right cervical paraspinals, right sternocleidomastoid, and right thoracic paraspinal muscles. Cervical range of motion was decreased. Dr. Brunkhorst noted Petitioner had shown improvement as compared to the last visit and that her prognosis was good. He recommended continued treatment of two visits per week for four weeks. PX4.

CONCLUSIONS OF LAW

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

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 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); *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d 52, 57 (1989). Both elements must be present in order to justify compensation. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill.2d 478, 483 (1989).

The phrase "in the course of" refers to the time, place and circumstances under which an accident occurred. *Orsini v. Industrial Comm'n*, 117 Ill.2d 38, 44 (1987). An injury is in the course of employment when it occurs within the period of employment at a place where the employee can reasonably be expected to be in the performance of his duties and while he is

performing those duties or something incidental thereto. *Panagos v. Industrial Comm'n*, 171 Ill.App.3d 12, 15 (1st Dist. 1988). Injuries sustained by an employee while in the performance of reasonably necessary acts of personal comfort may be found to have occurred "in the course of" his employment. *Chicago Extruded Metals v. Industrial Comm'n*, 77 Ill.2d 81, 395 N.E.2d 569 (1979). Using the restroom to meet the demands of personal health or comfort certainly falls within those acts considered incidental to the employment and therefore is considered to be in the course of the employment. *Illinois Consolidated Tel. Co. v. Industrial Comm'n*, 314 Ill.App.3d 347, 350 (5th Dist. 2000).

Pursuant to the above-referenced personal comfort doctrine, the Arbitrator finds that Petitioner's accident occurred in the course of her employment. Thus, the sole issue is whether the accident and injuries arose out of her employment.

For an injury to "arise out of" 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 injury. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill.2d 193, 203 (2003). There are three categories of risk to which an employee may be exposed: (1) risks distinctly associated with the employment, (2) personal risks, and (3) neutral risks that have no particular employment or personal characteristics.

The case at bar involves the third category, that being a neutral risk. Whether an injury caused by a neutral risk arises out of employment is dependent upon whether claimant was exposed to a risk to a greater degree than the general public. *Illinois Institute of Technology Research Institute v. Industrial Comm'n*, 314 Ill.App.3d 149, 162-163 (1st Dist. 2000). Such an 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 of Greater Chicago v. Ill. Workers' Compensation Comm'n*, 407 Ill.App.3d 1010, 1014 (1st Dist. 2011).

The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that the accidental injuries she sustained on April 7, 2016, arose out of her employment, as she failed to prove she was exposed to a risk to a greater degree than the general public.

The facts of the case are not in dispute. The testimony of Petitioner, Ms. Costney-Blue, and Ms. Jant clearly established that the accident occurred on the Flying J premises. All three testified that the accident occurred in a heavily trafficked area which was open to members of the general public. There were two separate restrooms that Petitioner had access to and could have used; she was not required to use a specific restroom or a specific stall. Petitioner's risk of accidental injury while in this restroom was the same as that of the general public.

With regard to the qualitative aspect of an increased risk, the Arbitrator notes that the restroom was located on Flying J's premises. It was not owned or maintained by Respondent, and Respondent had no control over the premises. There was no aspect of Petitioner's employment which contributed to the risk of her being injured in Flying J's restroom. With regard to the quantitative aspect, the Arbitrator notes that the presence of an industrial roll of toilet paper on top of a restroom stall was not a risk that Petitioner faced with any regularity. She

testified that the toilet paper was typically kept in a dispenser next to the toilet, and not stored above the door. In fact, she testified, "It's never been up there. Never." The location of the roll, and the risk of it falling on the day in question was unusual and not a risk that Petitioner faced on a regular or ongoing basis. In fact, she had never faced such risk. As such, she had no quantitative increased risk beyond that faced by the general public

Based on the foregoing and the record in its entirety, the Arbitrator concludes that Petitioner failed to prove by a preponderance of the evidence that she sustained an accidental injury which arose out and in the course of her employment on April 7, 2016. All benefits are denied. The remaining issues are moot and the Arbitrator makes no conclusion as to those issues.

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

Jason Hart,

Petitioner,

vs.

NO: 15WC024542

18IWCC0061

Menard Correctional Center,

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, causal connection, medical expenses, prospective medical care, notice, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 14, 2017 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.

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: JAN 30 2018
SJM/sj
o-1/11/2018
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

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

HART, JASON
Employee/Petitioner

Case# **15WC024542**

MENARD CORRECTIONAL CENTER
Employer/Respondent

18IWCC0061

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:

4075 FISHER KERKHOVER & COFFEY
JASON COFFEY
1300 1/2 SWANWICK ST POB 191
CHESTER, IL 62233

0558 ASSISTANT ATTORNEY GENERAL
KENTON OWENS
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 SYSTEMS
RISK MANAGEMENT SERVICES
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

FEB 14 2017

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

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)/8(a)

JASON HART
Employee/Petitioner

v.

MENARD CORRECTIONAL CENTER
Employer/Respondent

Case # **15** WC **24542**

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 **Herrin**, on **September 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. ☒ 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 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 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 **$71,059.02**; the average weekly wage was **$1,366.52**.

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 for medical expenses previously paid under Section 8(j) of the Act.

ORDER

The Arbitrator finds that the Petitioner has failed to prove that he sustained accidental injuries which arose out of and in the course of his employment with the Respondent. The Arbitrator further finds that the Petitioner has failed to prove that his alleged upper extremity conditions are causally related to repetitive work duties while in the Respondent's employ.

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 8, 2016
Date

ICArbDec19(b)

FEB 14 2017

STATEMENT OF FACTS

The Arbitrator initially notes that prior to the hearing, the Petitioner moved to amend the alleged date of accident to 4/29/15, with no objection from Respondent, and the motion was granted. The change was indicated on Arbitrator's Exhibit 1, the Request for Hearing Form.

The Petitioner worked for the Respondent as a correctional officer for 16 years at Menard Correctional Center, and was promoted to sergeant as of January 2015. The Petitioner alleges that he suffered a work-related repetitive trauma injury with a manifestation date on or about 4/29/15. He testified to several various job duties required of correctional officers at Menard. The first such job duty is called "bar rapping." The Petitioner explained that this involved using a foot long metal bar to drag it across cell bars to ensure they were not cut or compromised. This would be done once per shift in the morning, and, depending on the cell house, would be done for 25 to 50 cells.

He would use what is called a "Folger-Adams" key in various cell door locks. He described the key as being about three to four inches long, and he would hold the base of the key in the center of his hand with the stem of the key between his fingers and turn his wrist to open a lock. He would use one or both hands to do this, depending on the lock he was working with. He testified that Menard was a very old facility and most of the cell locks were difficult to open. The cell doors themselves had to be slid open, they were not hinged. Again, the Petitioner indicated he would perform this activity this between 50 and 100 times per work shift, depending which cell house he was assigned.

The Petitioner testified he also would have to check cell doors when there would be a line movement of multiple prisoners. This would involve grasping and pulling and pushing on the doors to make sure they were secure. He testified that the doors do not move smoothly and he would sometimes have to use two hands "because one is not going to get it".

The Petitioner testified that his job also involved cuffing and uncuffing inmates. When working as a crank officer, he would use a crank handle to open all the cell doors at once. The Petitioner testified that the cranks were also old and some of them were hard to operate. The crank officer would operate the crank around 10 times per shift, and would still be responsible for opening individual doors.

The Petitioner testified during direct examination that he had filed a prior 2010 workers' compensation claim regarding pain in his upper extremities, with an Application for Adjustment of Claim alleging repetitive trauma to the bilateral hands and elbows. He testified that an EMG/NCV performed at that time was negative for carpal tunnel syndrome and/or cubital tunnel syndrome, and that he dismissed his claim with the IWCC on 3/12/13. Commission records indicate the claim was dismissed for want of prosecution after his attorney had withdrawn from representation. (see Rx11 & Rx12).

At that time, the Petitioner saw orthopedic surgeon Dr. Brown on 6/2/10 with complaints of a six month history of intermittent numbness and tingling in his hands. There was no specific trauma, but Petitioner reported being ambidextrous and that his job at Menard for the past ten years involved repeatedly unlocking, opening and closing cell doors with Folger-Adams keys, as well as bar rapping, working 40 to 50 hours per week. Dr. Brown's examination was essentially normal, but given the symptoms, an EMG/NCV was prescribed, and Petitioner was advised to use bilateral wrist and elbow splints and anti-inflammatory medication. Dr. Brown noted that, based on the Petitioner's description of his job and Brown's understanding of the job, and given no other known common risk factors, that the Petitioner's work would be a contributing and/or aggravating factor

in a possible peripheral compression neuropathy. (Rx13). Dr. Phillips performed an EMG/NCV the same day, indicating it was negative for any peripheral neuropathy. Petitioner reported he was left handed, with a six month history of gradually progressive sharp intermittent elbow pain, along with intermittent numbness impacting all his fingers bilaterally. Noting the normal EMG/NCV findings, Dr. Brown recommended that Petitioner observe his symptoms and if he failed to improve, to return in 4 to 6 months. He was discharged and released to full work duties. The Petitioner agreed that when he saw Dr. Brown in 2010 and completed paperwork, he indicated at that time that he believed his condition was work related due to turning locks for 8 hours per day and rapping bars. (Rx13). Petitioner testified that as of the hearing date his symptoms have remained the same since 2010. but have gotten worse.

Going forward to 2014/2015, the Petitioner testified that he was having numbness and tingling in his upper extremities and occasional pain in his elbows as well. The Arbitrator notes that on 9/23/14 the Petitioner reported to his primary doctor, Dr. Hays, that he had a 2 month history of tremor in his hands and twitching at times in his hands, shoulder, legs and feet. There was no pain or discomfort, nor any precipitating event he could point to. It was not progressive, but was persistent. He was diagnosed with a generalized muscle movement abnormality. Lab testing was requested. (Rx10). At a 10/27/14 follow up, Dr. Hays documented Petitioner's report of off and on bilateral wrist and shoulder pain for a year, as well as muscle twitches in his fingers and feet. Again, there was a general myalgia diagnosis, as an explanation wasn't indicated, and Dr. Hays recommended deeper lab studies for possible auto-immune disease. On 2/24/15, Dr. Hays noted Petitioner had seen a rheumatologist for his complaints, and reportedly had elevated creatine phosphokinase levels. Petitioner reported his muscle pain had resolved, but the twitching had not. The rheumatologist also did not find an explanation and recommended Petitioner see a neurologist. Dr. Hays referred him to neurologist Dr. Alam. (Px10). The Petitioner testified that he underwent a 4/29/15 EMG/NCV with Dr. Alam which revealed moderately severe bilateral ulnar neuropathy at the elbows (cubital tunnel syndrome) and mild bilateral carpal tunnel syndrome. There was no evidence of cervical or lumbar radiculopathy or motor neuron disease. (Px3).

The Petitioner testified that he did report muscle twitching in both his arms to Dr. Alam in March 2015: "Well, like when I hold - - say if I was doing - - washing my car or whatever, if you hold the nozzle at the car wash, my hand would like twitch - - felt like it, numb twitch. It would twitch, but it felt like - - I don't know. It was hard to explain, so that's why I went to get it checked out." He agreed that he reported that he also had these symptoms in his lower extremities, or the front or back of his body. Asked about Dr. Alam's report indicating he denied numbness or tingling in his hands or feet. Petitioner testified, "I might not have told him that." That is when Dr. Alam prescribed EMG/NCV testing for both the upper and lower extremities.

The Petitioner completed a TRISTAR Workers' Compensation Employee's Notice of Injury form on 5/20/15. The form indicates the Petitioner reported an injury, "numbness and tingling of hands", which he alleged was due to turning locks, checking doors and rapping bars at work. He indicated a date of injury of 4/21/15, and that he was not at work when it was diagnosed. His written statement was: "I've had pain, tingling and numbness in my wrist and hands and elbows for several years and on 4/21/15 during a visit to Dr. Alam I was diagnosed with carpal tunnel \ cubital tunnel syndrome. Symptoms were brought on by doing my job as a Correctional Officer. My job consists of repeatedly on a daily basis of turning lock wrapping (sic) bars and checking doors, with sometimes having to use both hands to turn keys or when checking doors." (Px1; Rx1). As noted above, the Petitioner amended the alleged manifestation date to 4/29/15, the date of the noted EMG/NCV.

A TRISTAR Supervisor's Report of Injury or Illness was completed by Petitioner's supervisor, Major Thomas, on 5/29/15, indicating the Petitioner was diagnosed with carpal and cubital tunnel syndrome brought on by repeatedly rapping bars, checking doors, and turning locks on a daily basis. He had been in his sergeant position for 5 months according to this document. (Px2; Rx1).

The Petitioner testified he next sought treatment with orthopedic surgeon Dr. Young on 5/28/15. Dr. Young noted Petitioner complained of numbness, tingling, and pain involving bilateral upper extremities, left greater than right (per the intake form), for several years. Dr. Young's report notes the Petitioner worked at Menard for 17 plus years and that turning locks and rapping bars tended to exacerbate Petitioner's symptoms. The form Petitioner completed indicated his statement that he performed each of these two activities plus checking doors as 75% of his job, working 40 to 50 hours per week. Petitioner reported that he performed handwriting left handed, but did most everything else right handed. He noted discomfort in the thumb, 4th and 5th fingers. A physical exam was performed, the EMG/NCV was reviewed, and Dr. Young confirmed the diagnosis of bilateral carpal tunnel and cubital tunnel syndrome Dr. Young initially recommended conservative measures and prescribed left-sided splinting. On 6/29/15, the Petitioner returned, reporting that splinting did not help, and Dr. Young recommended surgery beginning with a left carpal tunnel release and left ulnar nerve transposition, which would be performed once it was approved, and he was released to full duty pending same. (Px4). Petitioner agreed that he told Dr. Young in 2015 that he'd had symptoms for several years and had previously filed a claim.

Dr. Young authored a letter dated 8/11/16 (Px5). In it, the doctor noted that the Petitioner reported numbness and tingling involving the bilateral upper extremities for several years. He had pain in the extremities, which reached as high as 6 on a scale of 1 to 10. He noted the thumb, small finger and ring finger as being most involved. He stated: "He had worked at Menard Correctional Center for over 17 years and specifically stated that turning keys and locks, wrapping (sic) bars and checking doors exacerbated his symptoms." The report indicated that physical examination showed positive provocative signs for carpal and cubital tunnel, and that conservative treatment did not alleviate Petitioner's symptoms. Dr. Young then addressed causation as follows:

> "As for causation of the upper extremity compression neuropathy, the following factors could be contributory or causative. The patient's history of diabetes, weight of 200, and age of 47. Most often carpal tunnel is diagnosed as an idiopathic condition. However, I feel that despite this, it is likely that the work conditions that the patient has listed have aggravated and/or contributed to the underlying conditions. I am saying this within a reasonable degree of medical certainty. Additionally, it should be noted that the patient was promoted to correctional [sergeant] in January 2016. My understanding is that this is a less rigorous position in regards to physical activity. It is often argued that these symptoms should not be present if one removes a contributing or aggravating factor following the development of a cubital or carpal tunnel syndrome. However, I believe that after 17-1/2 years of performing these duties on a repetitive and additive basis that the patient has likely developed the pathology to a point that it is unlikely to resolve with any conservative care, including simple activity modification. Once again, I do believe that the work situation, as previously outlined, has contributed to or aggravated the patient's bilateral upper extremity compression neuropathies." (Px5).

The Petitioner was examined on 12/10/15 by orthopedic surgeon Dr. Sudekum at the request of the Respondent pursuant to Section 12. (Px6; Rx4). Dr. Sudekum opined that Petitioner had right cubital tunnel syndrome that could have been aggravated by his work for the Respondent, but that he did not have bilateral carpal tunnel or left cubital tunnel syndrome. This was based on his examination and the NCV he had performed in his office. Dr. Sudekum indicated that he has toured the Menard himself and had reviewed the job video and job analysis. Dr. Sudekum performed a physical exam on Petitioner and found that there was no observable or measurable objective evidence of carpal and/or cubital tunnel syndromes. Dr. Sudekum also performed an NCV study which he testified indicated a possible right ulnar neuropathy but no evidence of left cubital tunnel or carpal tunnel syndrome bilaterally. (Rx4).

The Petitioner testified to various positions he had been assigned to per the Staff Assignment History (Rx2). He agreed he became a correctional sergeant on 1/20/15, noting he performed this job previously on temporary assignment "a lot of times." He agreed this was more of a supervisory position with more paperwork, but that he still would have to check or open doors at times.

The Petitioner worked on the "adjustment committee" from December 2013 to March 2014 and from June 2014 to December 2014, noting this essentially involved arbitrating incidents regarding improper inmate behavior. He still would have to do his regular job as a corrections officer, but not during times he sat for the committee, which varied. This meant he would do less work with cell locks, and possible avoidance of bar rapping, while on committee.

Petitioner agreed he worked as a gallery officer from 6/2 to 6/13/14. When he worked in escort sanitation from 1/6/13 to 7/18/13, the Petitioner testified that job involved supervising inmate janitorial workers to make sure they were keeping the building clean.

As a school building correctional officer (11/12 to 11/30/12), he did not rap bars. While on catwalk duty (4/24 to 10/16/12), there was no opening of cells or rapping bars. As a shakedown officer (12/2/11 to 2/22/12), he would not rap bars, he would shake down inmates leaving the facility for contraband. In perimeter patrol (also 12/2/11 to 2/22/12), he would drive a vehicle to patrol the prison grounds. When on Tower duty (also 12/2/11 to 2/22/12), he would work in a tower with no bar rapping or cell door duties.

The Petitioner testified that he worked in the Menard medium security facility (MSU), a much newer facility than the maximum security unit (built sometime in the 1980's or 1990's) for 12 of his 16 years at Menard. That facility doesn't have large solid steel doors, there is no use of Folger-Adams keys, and there is no bar rapping. Officers at that facility use an electronic switch, as opposed to a crank, to open all prison doors for mass movements of inmates. The Petitioner agreed that a correctional officer's duties in medium security were a lot less physical than in maximum security with regard to upper extremity use. The Petitioner agreed that he worked at the MSU facility until January 2012, when he moved to the maximum security unit.

Following his move to maximum security, the Petitioner had a north gallery assignment from 12/4/12 to 1/3/13 and from 6/2/14 to 6/13/14. He agreed that when he was in a gallery but on adjustment committee, he would not have to work a full 7.5 hour shift in the gallery. The Arbitrator's review of the Staff Assignment History (Rx2) indicates that all other gallery or wing officer duties were performed prior to 2012, when he worked in the medium security (MSU) facility.

As of the hearing date, the Petitioner testified that he continued to have upper extremity symptoms. On cross examination, the Petitioner testified he had been diagnosed with diabetes in 2012, but that it had been treated with diet, not medication. The Petitioner's medical records indicate the diagnosis went back to 2007, but they affirm that the only indicated treatment was the Petitioner's diet, and that his sugar levels did improve. The Arbitrator notes that just prior to the initial type II diabetes diagnosis the Petitioner reported a 2 month history of symptoms that included weakness in his hands and difficulty with grip. (Rx8).

The Arbitrator reviewed the Corvel Job Analysis (Rx6) and Job Video (Rx7) with regard to the job duties of a correctional officer, and notes that it appears that both of these pieces of evidence reflect duties performed at the Menard maximum security facility.

Petitioner submitted his claimed causally related medical expenses, totaling $2,346.00, as Petitioner's Exhibit 7.

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:

The Arbitrator finds that the Petitioner has failed to prove that he sustained accidental injuries arising out of and in the course of his employment with the Respondent, and has failed to prove that said injuries are causally connected to a repetitive work accident.

The evidence reflects that the Petitioner's assignment at Menard until 2012 was at the Medium Security Unit, or MSU. In that job, the Petitioner testified that the job duties were less hand intensive than in the maximum security unit, and that the facility was built much more recently than the maximum security unit, and thus did not have the same degree of locks that were difficult to operate. He did not have to rap bars there. His testimony was unclear with regard to whether the bar rapping, unlocking/relocking of cell doors and cell door checks took place at both MSU and maximum security, or just at the maximum security unit. The job analysis and job video both depict what appears to be the maximum security unit only, so there is minimal evidence in the record with regard to his job tasks at MSU, how often they were performed and how hand and arm intensive they may have been.

The Petitioner's testimony indicated that he initially began to develop the noted symptoms in 2010. This is supported by the records of Dr. Brown and Dr. Phillips at that time. Dr. Brown's 6/2/10 report noted a six month history of intermittent numbness and tingling in the hands, which would put the onset around December 2009 / January 2010. He testified that his symptoms have remained the same since that time, though they are worse. In 2010 the Petitioner was working in MSU, and had been for years, not maximum security. He testified that there was no bar rapping in that area, nor use of Folger-Adams keys. It also appears that the doors there are different. Thus, he had already developed symptoms prior to performing the activities he claims resulted in his condition, namely operation of the locks with Folger-Adams keys, bar rapping and checking cell doors.

The Arbitrator further notes that even after 2012, the Staff Assignment report indicates that he had significantly varied job duties in maximum security, many of which appear to have involved very little intensive hand and arm usage.

Dr. Young specifically noted that, while he opined to a causal relationship, carpal tunnel was most often diagnosed as an idiopathic condition, meaning of unknown cause. Dr. Sudekum's report noted the fact that correctional officers generally are not performing the noted activities constantly throughout the day, that the noted activities are of short duration and are predominantly performed in neutral or near neutral positions, and that much of the officer's time was spent simply in observation of inmates, leaving a lot of recovery time between the noted activities.

The Arbitrator further notes that it appears that both Dr. Young and Dr. Sudekum had limited knowledge of the Petitioner's actual job duties leading up to the alleged manifestation date. All they indicated were some knowledge of bar rapping, cell lock use and the opening and closing of cells. Neither doctor has indicated any specific knowledge of what the Petitioner did in MSU, or how often they may have performed various activities while in MSU or maximum security.

Further, neither doctor appeared to be aware of the Petitioner's prior treatment in 2010, nor were they aware of the symptoms the Petitioner complained of in 2015 involving twitching-type symptoms in both the upper and lower extremities. While it is unclear what these latter symptoms involved despite a rheumatological work-up

(the Arbitrator notes records regarding this work-up were not presented into evidence), the fact that he had symptoms in his lower extremities as well leads to a possibility that something beyond carpal and/or cubital tunnel may have been occurring with Petitioner. While this in and of itself does not in any way decide the case, it is another factor which leads the Arbitrator to find a failure to prove.

In total, the record reflects uncertainty with regard to when the Petitioner actually performed the duties of bar rapping, cell door lock/unlocking and cell door checks. The record is also inconsistent with regard to exactly when the Petitioner initially developed symptoms, as there is a reference in one 2007 record of hand weakness and grip problems, which goes back almost a decade prior to the alleged manifestation date.

Based on the evidence presented, the Arbitrator does not believe that the Petitioner has shown by a preponderance of the evidence that his activities were repetitive and/or forceful to the extent required by the Act and supporting case law. Taking all of the evidence into consideration, the Arbitrator believes that the greater weight of the evidence indicates that the Petitioner has failed to prove either accident or causation in this case. As a result, benefits are denied.

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 accident and causation, 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 findings with regard to accident and causation, 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 accident and causation, this issue is moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

John Jones, Jr.,

Petitioner,

vs. NO: 13WC 23124

Bill Doran Company,

18IWCC0060

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, causal connection, permanent disability, temporary disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

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

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: JAN 30 2018
SJM/sj
o-1/11/2018
44

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JONES JR, JOHN
Employee/Petitioner

Case# **13WC023124**

BILL DORAN COMPANY
Employer/Respondent

18IWCC0060

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:

5559 CROWLEY BUNGER & SCHROEDER
EDWARD J PRILL
3012 DIVISION ST
BURLINGTON, IA 52601

0265 HEYL ROYSTER VOELKER & ALLEN
BRETT E SIEGEL
3731 WABASH AVE
SPRINGFIELD, IL 62711

18IWCC0060

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

John Jones, Jr.
Employee/Petitioner

v.

Bill Doran Company
Employer/Respondent

Case # 13 WC 23124

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Springfield** on **August 24, 2016** and in the city of **Quincy**, on **April 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. ☒ 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 **07/01/2013**, 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.

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

In the year preceding the injury, Petitioner earned $**15,582.32**; the average weekly wage was $**299.66**.

On the date of accident, Petitioner was **31** years of age, ***married*** with **4** dependent children.

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

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

Respondent shall be given a credit of $**5,607.92** for TTD, $**0** for TPD, $**0** for maintenance, and $**All medical bills paid** for other benefits, for a total credit of $**$5,607.92** .

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

Petitioner failed to prove he sustained an accident that arose out of and in the course of employment on July 1, 2013 or that his current condition of ill-being was causally connected to his alleged accident. 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 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 1, 2017
Date

JUN 6 - 2017

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

Medical records admitted into the record show that Petitioner was seen at SIU Healthcare on January 29, 2009 for pneumonia and back pain, having previously been seen at the emergency room on January 22, 2009 for pneumonia and back pain. He had been diagnosed with a sprained back (mid-back and shooting up). Petitioner reported he was now doing better but had been off for a few days due to tremendous pain. He was given stretches to help with the pain and was instructed to use Ibuprofen and follow up. (RX 3)

Petitioner was seen at Express Care on July 1, 2013 at about 1:00 p.m. stating he was getting out of his work van earlier in the day when he "twisted and had sudden low back pain." Petitioner reported constant but non-radiating pain of an "8/10." Petitioner had taken Ibuprofen earlier in the day. He denied any prior back injury or pain. On examination Petitioner was noted to have limited flexion and extension at the waist due to pain. Moderate tenderness to palpation of the surrounding lumbar paraspinal muscles was also noted. He was given a shot of Toradol without any problems being noted. Petitioner was diagnosed with back pain and told to follow up with his primary care provider within 7-10 days, if needed. He was prescribed Nabumetone and Tramadol. (PX 4; RX 1)

On July 1, 2013, an Employer's First Report of Injury form was completed. Petitioner reported being in an accident on July 1, 2013 at 8:45 a.m. while making a delivery in Chatham, Illinois. He wrote "getting out the work van." Petitioner had been seen at Express Care and claimed a back injury. (PX 2)

Petitioner presented to Dr. Choudhary at the SIU Center for Family Medicine on July 5, 2013. The doctor noted Petitioner's chief complaint was "worker's comp, back pain, twisted back on Monday 7/1/13 – felt something pop." Petitioner explained that he drove for a living and was "just bending on his back" picking something from inside his vehicle when he developed severe lower back pain located on the entire lumbar area, which worsened with bending, walking, and lying down straight. He denied any lower extremity pain or weakness. Nabumetone and Tramadol reportedly provided no relief. Petitioner reported the inability to sit or stand comfortably. Dr. Choudhary noted, "Acute back pain after seemingly minimal bending /trauma which he does every day as part of his work. Possible lumbar strain. Exam today was positive for severe lumbar spine tenderness but I was unable to localise [sic] it due to patient discomfort." Lower extremity strength was grossly intact. Petitioner was given him a script for Norco to be taken as needed. Petitioner was taken off work (retroactive to July 1) to be re-examined in one week after the initial inflammation had, hopefully, subsided. (PX 3; RX 3)

Petitioner telephoned the office of Dr. Choudhary on July 11, 2013 wishing to speak with the doctor as he needed a referral to see Dr. Warrington, a chiropractor. (PX 3; RX 3)

Petitioner signed his Application for Adjustment of Claim herein on July 11, 2013 alleging low back and "MAW" injuries when he was "existing [sic] the van & stepped down and twisted." The date of accident was given as July 1, 2013 (PX 1)

On July 15, 2013 Petitioner was advised by Dr. Choudhary's office that the doctor did not refer patients to chiropractors and he would need to handle that directly. Petitioner was also reminded that he didn't show up for his July 12th appointment. (PX 3; RX 3)

Petitioner returned to see Dr. Choudhary on July 17, 2013, accompanied by his nurse case manager. Petitioner reported injuring his lower back while taking out something from his vehicle. Petitioner was reporting ongoing sharp, constant low back pain but no hip pain or problems with numbness, weakness or loss of sensation. Medication was reportedly only helpful for 1-2 hours. He was using 5-325 Norco every six hours and Nabumetone every 12 hours. He reported one episode of right radicular symptoms while sitting but of very short duration. Petitioner appeared to be in moderate distress and looked uncomfortable while trying to get on the bed and often requested allowance to stand up. Toe and heel walk could not be performed due to patient discomfort. He kept his back straight and was unable to move it in anticipation of pain. They discussed that Petitioner still could not work and wasn't ready for therapy. They agreed to discuss work at the next visit. Petitioner was kept off work until then. (PX 3; RX 3)

Numerous phone calls took place between Petitioner and Dr. Choudhary's office on July 23, 2013 and July 24, 2013. Petitioner had received a call about therapy and didn't think it had been authorized. The doctor's office explained that he would be evaluated and then the doctor would be contacted about other avenues to explore. Petitioner advised that he didn't wish to go to therapy; rather, he wished to be referred to Dr. Richard Kube and needed a referral. He later called back with information on Dr. Kube. Dr. Choudhary noted that Petitioner was called but no one answered. The doctor further noted that "He [is] just 3 weeks into acute onset lower back pain. He is still on pain control. He has no neurologic symptoms. I do not see any reason for referral at any time. [If he] wants he can contact them directly." Petitioner later called back, voiced being upset with doctor and indicated "he would go around the doctor and do it himself." (PX 3)

Petitioner, accompanied by a nurse case manager, referred himself to Dr. Richard Kube, upon the referral of Petitioner's brother who had treated with Dr. Kube. Dr. Kube examined Petitioner on August 12, 2013. Petitioner gave a history of a work injury in early July of 2013 when he was getting out of his work van a "250 style work truck that needed to be stepped up into it" and he twisted and tweaked his back when stepping out. Petitioner denied any leg pain but had initially experienced some pain in his right calf but that had "somewhat resolved" at this point. His back pain was ongoing. On examination Dr. Kube noted some pain in the mid lumbar spine around L3-4, muscle fullness on the left side consistent with a strain sprain, and some spasm of the muscle. The doctor noted a "pretty good sized lump" the size of his thenar eminence as the area of his maximum pain. Straight leg raise testing was negative bilaterally. X-rays taken that day were negative. Dr. Kube felt Petitioner had a lumbar strain with muscle spasms and a knot. He recommended trigger point injections and some physical therapy. He was given sedentary work restrictions. He felt conservative treatment would take care of the problem. (RX 2; PX 9; PX 10)

Petitioner underwent a trigger point injection with Dr. Cummings on August 14, 2013 and followed up on August 15, 2013 reporting relief for only one day with the injection. He denied any radicular component or neural deficits. He had not yet started physical therapy. Ultram was added for additional pain control. The doctor spoke with the nurse case manager. Petitioner remained on sedentary activity. (RX 2; PX 9; PX 10)

Petitioner underwent an initial therapy evaluation on August 19, 2013 at Springfield Clinic. He was to be seen two times a week for four weeks. (RX 2)

Petitioner underwent trigger point injections on August 20, 2013. (RX 2)

Petitioner underwent a therapy evaluation on September 10, 2013. Petitioner reported little change in his pain since starting therapy. He reported doing the exercises on a consistent basis bothered him. Electrical stimulation helped the most. He had not progressed well due to lack of change in his subjective complaints and the inability to tolerate therapy. He was to follow up with his doctor. (RX 2)

Dr. Kube re-examined Petitioner on September 13, 2013. Petitioner reported ongoing muscular spasms and significant back pain. Petitioner denied any leg pain. The trigger point injections helped but the electrical stimulation at therapy helped even more. Dr. Kube noted that Petitioner's pain presentation was "not really the typical pattern." He ordered an MRI to ascertain if there was an underlying problem not yet identified. His nurse case manager was there and they spoke. Petitioner's treatment plan remained unchanged. (PX 9)

At the request of Respondent, Petitioner underwent an examination with Dr. Timothy Van Fleet on September 27, 2013. Petitioner reported being employed by Respondent and WDL Leasing Inc. as a floral deliveryman, and that on July 1, 2013, he was getting out of his car when he felt a pain across his back and a "pop." Petitioner was noted to be 6'3" tall and 356 lbs. Petitioner had been seen at Express Care and then followed up with Dr. Choudhary whose records Dr. Van Fleet did not have. Petitioner told the doctor he had been initially treated with medication and some physical therapy but was ultimately advised by his case coordinator that he should see a spine surgeon so he went to Dr. Kube who had treated his brother at the referral of Strong Law Office which was representing his brother for a work injury. Dr. Van Fleet had Dr. Kube's records. Petitioner denied any previous back injuries to Dr. Van Fleet but the doctor noted a December 9, 2009 injury in Dr. Kube's questionnaire. Petitioner's complaints included pain across his back with no radiation. He was reporting the use of a muscle relaxant. No positive exam findings were noted. Dr. Van Fleet stated that he felt Petitioner's current complaints were, in part, connected to the reported mechanism of injury; however, his morbid obesity and general deconditioning were the "overall" contributors to his current difficulties. He wrote, "Merely getting out of a motor vehicle, certainly in his condition, can be aggravating to the lumbar spine." He diagnosed Petitioner with a back strain with no objective findings. Subjectively, Petitioner reported diminished range of motion. Dr. Van Fleet felt Petitioner's treatment, to date, had been reasonable and necessary. In response to a question about whether Petitioner had a pre-existing condition Dr. Van Fleet noted that it sounded like he did but he had no records or films to review. He recommended that Petitioner continue with a home exercise program. He could return to work without limitation. While Petitioner was noted to be limiting his activities, Dr. Van Fleet noted Petitioner's job description didn't require him to do anything involving significant lifting. He did not anticipate the need for any permanent work restrictions and felt Petitioner was at maximum medical improvement. He also suggested a weight loss program. (RX 4)

Per the order of Dr. Kube, Petitioner underwent a lumbar spine MRI on October 1, 2013. It revealed: (1) generally mild spinal canal stenosis multifactorial in nature and largely related to developmentally short pedicles, degenerative disc disease, and facet arthropathy; (2) mild multi-level foraminal narrowing except on the left at L5-S1 which was described as moderate in severity; and (3) no evidence of an acute lumbar spine compression fracture. (PX 5; RX 2)

Dr. Kube restricted Petitioner to sedentary activity as of October 24, 2013. (PX 10)

Dr. Van Fleet issued another report on November 1, 2013, having had the opportunity to review the October 1, 2013 MRI. His opinions as stated in his earlier letter remained unchanged. He added that he didn't think Petitioner's back strain was related to the work accident. He was noted to have degenerative disc disease, a pre-existing condition, and unrelated morbid obesity. (RX 5)

Petitioner followed up with Dr. Kube on November 4, 2013. They reviewed the MRI with the doctor advising Petitioner that he had mild degenerative disc changes at L4-5 and L5-S1 as well as a disc protrusion and mild stenosis "at that area." Dr. Kube recommended epidural injections given the left-sided pain Petitioner noticed occasionally. He was to continue with therapy and work status. (PX 9)

Petitioner underwent an initial physical therapy evaluation at Springfield Clinic on November 5, 2013, having last been there on October 9, 2013. Petitioner reported pain in the middle of his lower back and into the left side of his low back along with numbness down the left leg in the posterior aspect, the latter of which was elicited upon direct questioning as to any leg pain. Petitioner reported that he was working for a florist which required some lifting and he had been there for two years. Prior to that he had another job that required lifting and he had been hurt at that job in the past, too. Petitioner was to be seen once that week and then they were going to skip a week due to the epidural injection but then he was to return. (PX 7)

Petitioner underwent transforaminal lumbar injections at L4-5 and L5-S1 on the left on November 7, 2013 and November 11, 2013. (PX 11)

Petitioner was seen at Springfield Clinic regarding his therapy on November 20, 2013 for continued complaints of pain. He had undergone an epidural described as "the most painful thing of his life." He had not been doing his exercises for 7 – 10 days due to the epidural but acknowledged that he would start. Petitioner was noted to continue to complain of pain with every exercise, as well as the epidural. The therapist recommended discharging Petitioner from therapy with a home exercise program. (PX 6)

Dr. Kube restricted Petitioner to sedentary activity as of November 26, 2013. (PX 10)

Dr. Kube re-examined Petitioner on December 3, 2013 at which time Petitioner denied any leg pain and reported no benefit from the injections but ongoing back pain although his leg pain was more intermittent. Dr. Kube recommended a discogram given Petitioner's more problematic back pain. (PX 9)

Dr. Van Fleet's Deposition

The deposition of Dr. Van Fleet was taken on April 2, 2014. (RX 6) Dr. Van Fleet is a board certified orthopedic surgeon specializing in spinal surgery. Dr. Van Fleet testified to performing an independent medical exam of Petitioner on behalf of Respondent. He saw Petitioner on September 27, 2013. Dr. Van Fleet testified that Petitioner provided a history of injuring his back on July 1, 2013 while working as a corporate floral deliveryman for Respondent. At that time Petitioner was getting out of his car and he felt a pain across his back which he described as a "pop." After the popping incident, Petitioner reportedly went to Memorial Express Care and was given some medications. He then followed up with his primary care doctor. Dr. Van Fleet testified that Petitioner told him he had tried some therapy and medication and was then advised by his case manager that he should see a spine surgeon so he presented to Dr. Kube who

had previously treated Petitioner's brother and had been referred there by Strong Law Office. Dr. Van Fleet testified that Petitioner did not tell him that he slipped while getting out of the vehicle, that he stepped on anything when he exited the truck, that he was reaching for anything while getting out, that he was lifting anything while getting out or that he had anything in his hands. It was Dr. Van Fleet's understanding that Petitioner was "essentially,...just getting out of the car." (RX 6, pp. 1 – 13)

Dr. Van Fleet testified that he had copies of some of Dr. Kube's records and the Memorial Express record. Dr. Van Fleet also testified that Petitioner told him about a prior back injury in December of 2009 which resulted in some non-significant back pain. He had no other details about it. (RX 6, pp. 13 – 15)

Dr. Van Fleet also testified regarding his physical examination performed on Petitioner. Petitioner was noted to be 75" tall and weighing 356 lbs. He demonstrated restricted range of motion of his lumbar spine with forward flexion and extension secondary to what he described as pain. Dr. Van Fleet could not detect any palpable spasm. There was no evidence of any dysrhythmia in the muscles on forward flexion. He had symmetric range of motion and reflexes of his hips and knees. His neurologic exam was entirely normal which meant there was no indication of any nerve root dysfunction. Dr. Van Fleet described Petitioner's examination as "pretty much unremarkable" except for the fact he didn't flex or extend very well. The doctor found Petitioner's weight and height very compelling as he was in the "significantly obese" category and anyone who is about twice their ideal body weight can have problems with their low back. (RX 6, pp. 15 – 17)

Dr. Van Fleet was asked about Petitioner's pain complaints and he explained that it was limited to his lumbar spine in the area of the "belt line." Petitioner did not voice any complaints of radicular pain going down his buttock or lower extremities. Dr. Van Fleet testified that he reached a diagnosis of a morbidly obese condition with a lumbar strain. He found the limited flexion and extension largely subjective rather than objective. His only treatment recommendation was to continue with his home exercise program and try to lose some weight. He did not feel any work restrictions were necessary and he also felt Petitioner was at maximum medical improvement. (RX 6, pp. 17 – 19, 20-21, 41)

Dr. Van Fleet testified that after the examination he was sent Petitioner's lumbar spine MRI to review. He reviewed the film and felt it showed three-level degenerative disc disease at L3-4, L3-4, and L5-S1. The most significant degeneration was at L4-5 and L5-S1. Petitioner also had evidence of stenosis in the lateral recess on the right side at L3-4 secondary to a small disc protrusion. He had no central stenosis. Petitioner also had some evidence of lateral recess stenosis at L4-5. L5-S1 showed no sign of central stenosis. His review of the MRI did not change any of his opinions regarding Petitioner's low back injury. (RX 6, pp. 19 -21)

On cross-examination Dr. Van Fleet acknowledged that in his written report Petitioner denied any history of prior back problems. He testified that he must have pulled that information from Dr. Kube's questionnaire. He also acknowledged that he didn't see any medical records pertinent to a prior back injury. When asked how he would explain his negative finding of a muscle spasm and Dr. Kube's August and September exams that noted a muscle spasm, the doctor stated that it wasn't there when he examined him. He agreed that it is possible for a patient with spasms to have good days and bad days. However, if the spasm is there, it's not going to be gone one day and present the next. He felt it highly unlikely that the spasm would fluctuate. In physically, and objectively, testing for a spasm, Dr. Van Fleet explained that one looks at the back itself and you determine if the patient is listing one way or the other or if their

pelvis is kind of forward-flexed or retroverted. The second way one can test for a spasm is to put one's hand on the patient's back and feel the paraspinal muscles. One can feel firmness with a spasm. Finally, one can go through a range of motion and the muscles will demonstrate some dysfunction in the form of dysrhythmia. He incorporated all three tests into his exam and Petitioner had no palpable spasm or evidence of dysrhythmia on his forward flexion. He did agree that back spasms can be a significant source of pain for an individual and they can be caused by a multitude of factors. (RX 6, pp. 21 – 27)

Dr. Van Fleet was asked some questions about the MRI findings. He explained that anterolisthesis refers to a forward shift of one vertebrae on top of another. Spondylolisthesis is the same thing. He explained that there are different levels of severity and Petitioner's was minor; however, he added that an MRI is not an appropriate film to assess for spondylolisthesis as one usually wants upright radiographs for it. He also agreed that degenerative conditions are more commonly seen in older patients it would not be unusual to see it in someone of Petitioner's age. He also agreed that spondylolisthesis can be caused by trauma. (RX 6, pp. 27 – 29)

On further cross-examination Dr. Van Fleet was asked about the mechanism of injury related by Petitioner. He agreed that Petitioner did not tell him what kind of van he was driving and he didn't recall seeing any mention of a 250-style truck in Dr. Kube's notes. He agreed that if the truck needed to be "stepped up into," that kind of mechanism of injury could be caused by twisting and hyperextending the spine while stepping down. He also agreed that if someone is twisting and hyperextending at the same time one can have a back injury. He disagreed that back strains could result in spondylolisthesis. (RX 6, pp. 29 – 31)

Dr. Van Fleet further testified that aging can cause loss of disc space and that desiccation is drying out of a disc. He agreed that trauma can cause disc desiccation over a long period of time and if the trauma is cumulative. He also testified that it would be possible for spondylolisthesis to cause disc dessication if there were abnormal forces on the disc and it could further degenerative the disc. One can also see loss of disc space due to a patient's body habitus or from smoking. (RX 6, pp. 31 – 36)

Dr. Van Fleet also testified that it usually takes six to eight weeks to recover from a back strain. He also explained that bulging discs don't heal; rather, you just leave them alone. Dr. Van Fleet was also asked about his opinion that the MRI performed on Petitioner was unnecessary. He testified that whether to order an MRI is largely dependent upon the individual patient, especially in the case of a patient with a back strain who has undergone physical therapy and trigger point injections to no benefit. An MRI is appropriate if there is radiculopathy or motor weakness suggestive of neurologic dysfunction, nighttime pain, weight loss, fevers and chills. However, if a significantly overweight person has back pain but no red flags or neurologic signs, an MRI is not appropriate. He further added that if there have been plain films suggesting mild degenerative changes, that, too, suggests an MRI is not appropriate. He acknowledged, however, that if someone is complaining of leg pain, such as Petitioner did with Dr. Kube, the MRI might be appropriate. However, when he examined Petitioner, Petitioner denied any leg pain. Dr. Van Fleet could not recall if Petitioner complained to Dr. Kube about leg pain. (RX 6, pp. 36 – 38)

Dr. Van Fleet agreed that, based upon Petitioner's report of the injury, his back strain was due to the accident. (RX 6, p. 38)

When asked what the purpose of epidural steroid injections was, he explained that they are given for lumbar radiculopathy. He did not think the injections were necessary in Petitioner's case. (RX 6, p. 38)

On redirect examination, Dr. Van Fleet testified that trigger point injections and therapy are prescribed to address spasms. Given that Petitioner had undergone both prior to his examination of Petitioner, one reasonable conclusion could be that there were no muscle spasms noted on examination because they had resolved. Dr. Van Fleet further testified that the degenerative disc disease and stenosis seen on Petitioner's MRI pre-dated the accident. (RX 6, pp. 39 – 40) Dr. Van Fleet also confirmed that he saw no "red flags" while examining Petitioner. (RX 6, p. 40)

Further Medical Treatment

Petitioner returned to see Dr. Kube on April 18, 2014 at which time he reported ongoing back pain but he was interested in what kind of work he might be able to do and foregoing surgery, if possible. Petitioner's VAS score reflected low back and bilateral leg pain. Dr. Kube did not think Petitioner would tolerate full activity and ordered a functional capacity evaluation. (PX 9) Dr. Kube restricted Petitioner to sedentary activity. (PX 10)

Dr. Kube's Deposition

The deposition of Dr. Richard Kube was taken on July 14, 2014. (PX 15) Dr. Kube is a board-certified spine surgeon. Dr. Kube testified that he began treating Petitioner on August 6, 2013. At the initial visit Petitioner told him he had sustained a work injury in July of 2013. He was getting out of his work van and he said he twisted and tweaked his back stepping out of the van. Dr. Kube further testified that Petitioner told him he had some initial pain in his right calf but it had resolved by the time of the appointment but the back pain had continued. Petitioner's back pain was in the "mid-back around L3-4." Petitioner had some mid paraspinal musculature and some sprain/strain spasms. On exam, he had some decreased range of motion. His lumbar spine x-rays were relatively unremarkable. Dr. Kube testified that he diagnosed Petitioner with a lumbar sprain and muscle spasm along with a specific, fairly good-sized knot in the musculature on the left side. Petitioner was given restricted activity and referred to Dr. Cummings for trigger point injections to see if that would help the muscle release and improve. (PX 15, pp. 1 - 8)

Dr. Kube testified that Petitioner returned to see him in September of 2013 at which time Petitioner reported ongoing muscular spasm and pain. According to Dr. Kube, the injections had helped as had E stim therapy. Dr. Kube recommended an MRI which showed some degenerative changes at L4-5 and L5-S1 along with a disc protrusion "in that area" and stenosis. Dr. Kube still felt Petitioner had a sprain/strain but he also thought Petitioner might have aggravated the degenerative findings noted on the MRI. Dr. Kube recommended an epidural steroid injection as Petitioner was reporting occasional left-sided leg pain. Dr. Kube testified that he next saw Petitioner in November of 2013 after the injection. Petitioner did not feel the injections had been beneficial although it helped with his radicular leg pain. Nevertheless, Dr. Kube felt Petitioner's back pain remained fairly significant. At that point the doctor recommended a discogram but he didn't know if it had ever been performed. (PX 15, pp. 8 – 12, 14)

Dr. Kube testified that he last saw Petitioner in April of 2014. Petitioner was still complaining of back pain and still having intermittent leg issues. Petitioner wished to avoid surgery and wished to see if he could try working with restrictions instead. Dr. Kube testified that he recommended an FCE; however,

workers' compensation denied it. As of the date of the deposition, Dr. Kube did not think Petitioner was at maximum medical improvement as he needed the FCE and then a follow-up visit with him to review the FCE and determine any restrictions. Dr. Kube felt Petitioner's diagnoses remained spasms due to a sprain/strain, aggravated degenerative disc disease, and protruded discs causing intermittent radiculopathy. (PX 15, pp. 14-15, 17 - 18) Dr. Kube was of the opinion Petitioner's diagnoses were caused or aggravated by the mechanism of injury Petitioner sustained in July of 2013. With regard to the aggravation of his degenerative disease Dr. Kube explained that the twisting movement Petitioner described would be consistent with an aggravating activity. (PX 15, pp. 15 – 16) He also felt Petitioner's accident in July of 2013 would have aggravated the stenosis shown on the MRI. (PX 15, pp. 16 – 17) Dr. Kube also testified that all of Petitioner's treatment, including his injections, were reasonable and necessary as a result of Petitioner's work injury. (PX 15, pp. 17-18)

Dr. Kube further testified that he placed Petitioner on sedentary activity as of August 6, 2013 and he has remained at that level. He defined sedentary activity as limited (20 to 40% of the day) lifting up to ten pounds, no overhead work or work from the waist down in terms of lifting, rare (0 to 20% of the day) bending and twisting, no prolonged (over sixty minutes with a five to ten minute change in position) sitting or standing. (PX 15, pp. 18 – 20)

On cross-examination Dr. Kube testified that he could not recall if he saw any medical records from Petitioner's primary care doctor or Memorial Medical Center Express Care. He was unaware of any allegation that Petitioner might have slipped on anything when he exited the work van. He did not believe Petitioner was lifting or carrying anything at the time of his accident. Counsel then stated, "So basically what he described to you was an activity that you normally do just getting in and out of a vehicle, correct?" and the doctor replied, "More or less." (PX 15, pp. 22 -23) Dr. Kube also testified that it was the foregoing mechanism of injury that resulted in Petitioner 's pain and it was described to him as a specific injury. (PX 15, p. 23)

Dr. Kube also acknowledged that Petitioner told him he had experienced back pain before and it occurred in 2009 but the doctor didn't have any specifics regarding that pain. It was his impression that any prior problems had resolved as Petitioner had been working full duty prior to the accident. (PX 15, pp. 23 -24)

Dr. Kube testified that he finds it "very useless" to have prior medical history on a patient. He described his practice as very "heavily into a lot of revisionary kind of work" and he is accustomed to evaluating people who walk in with "umpteen" operations and medical charts a mile thick, and it's not practical for him to go through all of that every time a patient comes in. (PX 15, pp. 25-26) Dr. Kube also acknowledged that he didn't review any x-rays or MRI films from 2009 but he didn't consider such records pertinent to Petitioner's baseline status. He acknowledged that Petitioner's x-rays when he saw him were "relatively fine." His degenerative changes are relatively mild and the disc protrusion is difficult to age. He explained that degenerative changes in and of themselves don't mean a whole lot based upon imaging. More important is whether there were significant ongoing problems when the images were taken that would reflect active treatment. In Petitioner's case, Dr. Kube was unaware of any. (PX 15, pp. 25 – 27)

On further cross-examination, Dr. Kube reiterated that Petitioner's primary complaint at their initial visit was low back pain and that the right calf pain had somewhat resolved. He also agreed that Petitioner is

morbidly obese. He further testified that obesity has not been shown to be a direct cause of back problems. (PX 15, pp. 27 – 30)

Dr. Kube also testified that he ordered the MRI because Petitioner's strain/sprain had not resolved and he was still complaining of pain. After getting the MRI, Petitioner's diagnoses changed to include aggravated degenerative disc disease and disc protrusions. The doctor agreed that pain complaints are subjective in nature. He agreed that the MRI cannot show if a finding is acute or chronic. Dr. Kube doesn't think Petitioner will make a full recovery and go back to work without restrictions. If Petitioner doesn't want back surgery, his options are to try and do as much as he can without hurting himself – hence, an FCE. In addition to the FCE, Petitioner should do home exercises and try and lose some weight because, according to the doctor, "It can't hurt." (PX 15, pp. 31 – 36)

Dr. Kube charged $1,817.48 for his deposition testimony. (PX 14)

Further Medical Treatment

Petitioner returned to the SIU Center for Family Medicine on August 14, 2014 with complaints of chronic left-sided low back pain. He had been seen on July 22, 2014[1] for symptoms of several weeks duration with no injury. Now, Petitioner was reporting a work injury on July 1, 2013 and "dealing with the insurance company." According to the note, "States nature of fall was missing step." Petitioner reported seeing Dr. Kube in Peoria and undergoing an MRI that showed a bulging disc, protrusion and spinal stenosis. He had undergone an epidural injection. A discogram was recommended but not done due to an insurance issue. Petitioner reported having note been back to "this doctor" but he had an appointment scheduled for September 11, 2014. Petitioner reported no relief with non-steroidal anti-inflammatories or Tramadol but his sister's Percocet helped. On examination, mild tenderness was noted. He was given a script for Norco due to his chronic low back pain; however, no refills would be given without the Center receiving records of Midwest Imaging and Dr. Kube. Petitioner was examined that day by N.P. Novar. (PX 3)

Petitioner underwent an FCE at Azer Clinic on March 16, 2015 per the order of Dr. Kube. (PX 13) The test took two hours and 35 minutes. Petitioner gave "good consistent effort." Petitioner's complaints included left-sided low back pain and numbness and tingling down his left lower extremity that increases with trunk flexion. After two hours of testing Petitioner requested ice for his low back and wished to get in the prone position due to pain described as "8-9/10." Petitioner reported being out of his pain medications and asking the therapist to call Dr. Kube's office to refill the prescription. The next day the therapist checked on him and he reported "9-10/10" pain and that his back had given out and he could hardly move. (PX 13, p. 1) Petitioner's target level was identified as medium level work. The therapist did not think he could perform the physical demands of his job and that he would benefit from a work conditioning program and would be best suited for positions allowing frequent positional changes with no stooping, squatting, or crouching. (PX 13, p. 4)

Dr. Kube restricted Petitioner to light activity as of April 7, 2015. (PX 10)

[1] There is no record of this visit contained within the exhibits.

PA-C Morrow[2] spoke with Petitioner on April 13, 2015 regarding Petitioner's recent increase in pain. Petitioner told him he had a substantial amount of pain in his low back and down his left leg. They were about equal in strength. Petitioner described the pain in his back as though "bones [were] rubbing against each other." The leg pain was described as shooting and he also reported numbness into the left buttock, down the posterior thigh, posterior calf and into all of his toes which Mr. Morrow noted seemed consistent with the L5 or potentially S1 dermatome. He was instructed to take 800 mg. of Ibuprofen every 8 hours for the pain along with his Tramadol. Mr. Morrow was also sending a script for Gabapentin to the pharmacy and it should help with the radicular symptoms. (PX 9)

Petitioner called Dr. Kube's office on May 6, 2015 reporting his back was in a lot of pain and he would be unable to drive to his doctor's appointment on the 7th. He also wanted to know if there was something else he could try because the Tramadol was not working for him. (PX 9)

Petitioner returned to see PA-C Morrow on June 23, 2015 for "medication management." His VAS reflected back and bilateral leg pain. He seemed to be doing "quite well" but was out of Tramadol and Gabapentin. Dr. Kube still recommended work conditioning. His work restrictions were not changed. (PX 9)

- Petitioner failed to show up for his July 30, 2015 appointment with Mr. Morrow. (PX 9)

PA-C Morrow examined Petitioner on August 18, 2015. His VAS reflected back and bilateral leg pain. Petitioner reported that his back occasionally felt like it was "going out" and they discussed why it might feel that way. The only that that reportedly helped Petitioner was being down on his knees and crawling. He denied being able to stand up which the doctor attributed to the axial loading, compressing the discs down low; however, that only takes a little while to resolve and he seemed to be doing quite well. Mr. Morrow noted that the lumbar spine MRI indicated minimal protrusions and disc heights rather well maintained but probably causing his left radiculopathy. His medications were refilled. Petitioner remained on "light" activity. (PX 9)

Petitioner called Dr. Kube's office on September 11, 2015 reporting severe pain in his back and legs. His back had gone out on him several times to the point he couldn't get out of bed and he wanted to know what to do. He was told he had an appointment scheduled for 9/22/15 but if he was in too much pain he could go to prompt care or ER. (PX 9)

Petitioner was seen at the St. John's Hospital Emergency Room on September 11, 2015 reporting back pain "of a few days' onset." Petitioner gave a history of a back injury while working two years earlier with chronic back pain ever since along with an exacerbation over the last few days. He denied any new trauma or injury only worsening pain with movement and standing. He was taking Flexeril, Gabapentin and Tramadol daily and being scheduled to see a specialist in 11 days. Petitioner, on examination, had good range of motion, the ability to stand on his tip toes, heels and each leg independently. He also bent forward and backward with no difficulty. The Illinois Drug Monitoring Program was reviewed with the doctor ascertaining that Petitioner had received 5 narcotic pain medications in the past three months from three different doctors which contradicted with the report from Petitioner, to wit, he was only receiving pain medication from Dr. Kube. Petitioner had driven himself to the emergency room but was calling a

[2] Dr. Kube's office

friend to take him home so that he could be given adequate pain relief. Petitioner was discharged to follow up with his doctor. (PX 8)

PA-C Morrow examined Petitioner on September 22, 2015 still complaining of back pain and a feeling of "locking up." His VAS reflected both back and bilateral leg pain. Mr. Morrow updated Petitioner's work status indicating they would stay the same as imposed by Dr. Kube ("light" activity). He did change Petitioner's medication by doubling the Gabapentin. (PX 9; PX 10)

PA-C Morrow again saw Petitioner on October 22, 2015. His VAS reflected both back and bilateral leg pain. Petitioner reported a recent increase in pain, both in the back and radicular. Mr. Morrow increased the Gabapentin and added Cyclobenzaprine. His Lunesta and Tramadol were also refilled. (PX 9)

Petitioner returned to see PA-C Morrow on November 19, 2015 reporting everything was still "pretty much the same." His VAS reflected back and bilateral leg pain.His meds were refilled. The possibility of a facet injection in the future was discussed. Work status remained unchanged. (PX 9; PX 10)

Petitioner again saw PA-C Morrow on December 17, 2015 reporting a recent flare-up in pain. "It seems to be just an aggravation when he was rolling around in bed, nothing that lasted for a long time." His VAS reflected both back and bilateral leg pain. His meds were refilled and labs were to be ordered on the next visit. Petitioner's work status remained unchanged. (PX 9; PX 10)

When Petitioner returned to see PA-C Morrow on January 19, 2016 he was needing medication refills and reporting some right shoulder pain that he was having evaluated. Lab work was to be done to check liver and kidney function. (PX 9) Dr. Kube restricted Petitioner to light activity as of January 19, 2016. (PX 10)

Dr. Kube's office notes contain a chart note dated January 20, 2016 – "Added new problem of displacement of lumbar intervertebral disc without myelopathy" and "removed problem of NHP – lumbar without myelopathy." (PX 9)

Petitioner's primary care doctor called Dr. Kube's office on February 5, 2016 to indicate Petitioner had been in the office the day before regarding medications that the pcp was going to start handling; however, Petitioner wishes to stay with Dr. Kube. The office was advised that Petitioner must be seen monthly for medication management. (PX 9)

Petitioner failed to show up for his February 18, 2016 appointment with Dr. Kube. (PX 9)

PA-C Morrow examined Petitioner on March 3, 2016 and Petitioner reported quite a bit of pain and left lower radiculopathy. His VAS reflected both back and bilateral leg pain. His meds were refilled and he was given a trigger point injection in his left lumbar musculature. (PX 9) Dr. Kube restricted Petitioner to light activity as of March 3, 2016 (for one month). (PX 10)

Dr. Kube's chart note of March 22, 2016 indicates Petitioner's problem was being changed from "lumbar degenerative disc to degenerative disc disease, lumbar spine." (PX 9)

When Petitioner returned to see PA-C Morrow on March 31, 2016 he reported that the trigger points seemed to helped out a last this time. His VAS reflected both back and bilateral leg pain. His flare of the

pain was back to baseline. Petitioner still complained of some left leg numbness but the severity of the pain had calmed down. (PX 9)

As of April 26, 2016, Petitioner was reporting ongoing significant left lower back muscles to Mr. Morrow. His VAS reflected back and bilateral leg pain.Some trigger points were attempted that day and he was put back on sleep medication. (PX 9) Dr. Kube restricted Petitioner to light activity as of April 26, 2016 (for one month). (PX 10)

Petitioner returned to see Mr. Morrow on May 24, 2016 and a diagnosis of chronic pain (both lumbar and left lower leg) were noted. His VAS reflected both back and bilateral leg pain. His medications were refilled. A trigger point injection was given. (PX 9) Dr. Kube restricted Petitioner to light activity as of April 26, 2016 (for one month). (PX 10)

Petitioner called Dr. Kube's office on June 7, 2016 reporting he had been in a lot of pain and went to the hospital and received an injection but was informed there wasn't much they could do as he was under doctor's care. He was complaining of pain on the left side groin from his back to his hip and some numbness. (PX 9)

Petitioner again called Dr. Kube's office on June 9, 2016 requesting a refill on his Tramadol after going to ER. He was reportedly taking Tramadol every two hours and was almost out of it. "He thinks he blew [his] back out and can't get out of bed for about 2 day, the ER told him to call is[sic] since we are the ones who is seeing him for this issue." Mr. Morrow was to be contacted for guidance. Petitioner was later told he would need to be seen. (PX 9)

As of June 14, 2016, Petitioner was telling Mr. Morrow that his pain was increasing and he had had several hospital visits in the recent past for his back pain or "locking up." His VAS reflected both back and bilateral leg pain. On examination Petitioner had pain in the axial spine, central in location in the low lumbar area. Petitioner rated his pain as "7/10." Petitioner was given an additional prescription that day for Norco only to be used when his back "locks up." The rest of his medications were refilled. (PX 9) Dr. Kube restricted Petitioner to light activity as of June 14, 2016 (for one month). (PX 10)

Petitioner did not show up for his appointment with Dr. Kube/PA-C Morrow on June 23, 2016. (PX 9)

Dr. Kube restricted Petitioner to light activity as of July 8, 2016 (for one month). (PX 10)

Petitioner returned to see Dr. Kube on July 21, 2016 with no substantive change in his condition being noted. His VAS reflected both back and bilateral leg pain. He denied any new injuries, was tolerating the medications, and only taking Norco sparingly. They were all refilled. (PX 9)

Dr. Kube re-examined Petitioner on August 12, 2016 at which time he reported that the left leg issue was starting to "ware on him." His left leg would reportedly give out and he had pain in the left leg. He also had back pain. The challenge was Petitioner's young age and his desire to avoid surgery. His VAS reflected both back and bilateral leg pain. Petitioner wished to think about everything a little bit and, in the meantime, his prescriptions were refilled. (PX 9) Dr. Kube ordered an EMG with Dr. Trudeau on August 12, 2016 and restricted Petitioner to light activity as of that date (for one month). (PX 9; PX 10)

Dr. Kube's office made a chart notation on August 16, 2016 – "Changed problem from displacement of lumbar intervertebral disc without myelopathy to lumbar disc herniation with radiculopathy." (PX 9)

The Arbitration Hearing

Petitioner's case proceeded to arbitration on August 24, 2016. At that time the disputed issues were accident, causal connection, temporary total disability benefits, maintenance benefits, medical expenses, and nature and extent. Petitioner was the sole witness testifying at the hearing.

Petitioner testified that he is 34 years of age and divorced. He acknowledged being married at the time of his alleged accident with four children. His highest level of education was ninth grade. Petitioner testified that he is currently unemployed.

Petitioner further testified that he began working for Respondent in 2012 as a delivery driver. As such, he was responsible for packing, loading, and delivering flowers and glass vases. On the morning of July 1, 2013 Petitioner clocked in and got right to work loading his van. He identified RX 7 as a copy of the type of van he drove for Respondent. He believed it was a Ford Econoline van. He further explained that there are two front doors on the van for the driver and a passenger but there is also a set of double doors on one side of the van that would open out from the van and that is where he would load the flowers and vases. He could also use the back doors for loading/unloading if necessary.

Petitioner testified that he was working alone on July 1, 2013 and it was a very busy day. When he went to work that day, he felt "perfectly fine." At his first stop he had 20 boxes of roses to deliver. He had been told by "Ms. Chris" to strap four of the boxes together for his first stop. Petitioner testified that he felt a pull in his back while picking up some boxes for his first stop but he thought nothing of it and continued to work and load his van. He then left and drove to Chatham, Illinois where he had a delivery at the County Market grocery store. When he arrived at the store he opened up the doors and as soon as he stepped down with his left leg he felt a pain shoot through his leg and up his back. He testified that he still thought "nothing of it" and went around the van, opened up the double doors, grabbed the boxes out, began to lift them and his back went out. He called "Dino" and told him what had happened and he was told to bring the van back. Petitioner did so and then went to Memorial Express Care.

Petitioner further testified that altogether there were three separate incidents that occurred on July 1, 2013. Initially he picked up a bundled box of roses and felt a stabbing pain. Then he had a problem while exiting out of the driver's side of the van and, again, felt a stabbing pain. Then, later in the morning, he picked up another set of boxes and felt a "pop" in his back.

Petitioner also testified that there are no running boards on the van to step up into the driver's seat. He further testified that when he stepped directly from the floorboard down to the ground his body would twist.

Petitioner denied having any problems with his back for the six months to a year before July 1, 2013. He identified PX 2 as a copy of the accident form he completed for Respondent.

Petitioner testified that he initially went to Memorial Express Care where he reported he was having lower back pain. He couldn't recall if he underwent any x-rays but they told him he had back spasms and

should go see his primary care doctor. He was also taken off work and he provided the off-work slip to Respondent.

Petitioner next went to his family doctor, Dr. Chaudhary, on July 5, 2013 because he was still experiencing the same back pain as he had on July 1st. Dr. Chaudhary took x-rays, gave him some medicine, and told him he needed to see a back specialist.

Petitioner testified that he was eventually referred to Dr. Richard Kube and when he saw him on August 12, 2013 he was still having the same sharp pains in his low back and numbness down his left leg. Petitioner testified that Dr. Kube would make work status recommendations which, Petitioner, in turn, would submit to Respondent. When Dr. Kube imposed work restrictions, Respondent did not offer anything to him. Petitioner also testified that there was a change in Respondent's management during this time as "Ms. Chris" was sent to the Peoria store and Bob Smith returned to Springfield. Petitioner gave his work slips to Mr. Smith. When he asked Mr. Smith when could he return to work, Mr. Smith told him that he wasn't needed right then. Petitioner has never been notified that he no longer works for Respondent.

Petitioner testified that he continued to treat with Dr. Kube and the doctor had him undergo a lumbar MRI followed by epidural steroid injections. Petitioner testified that the injections did not provide any relief. He also testified that he was examined by Dr. VanFleet at the request of Respondent. He thought the doctor spent about fifteen minutes with him.

Petitioner testified that in 2015 Dr. Kube recommended a function capacity evaluation (FCE) and that was performed at Azer Clinic in Galesburg on March 16, 2015. Dr. Kube then went over the results with Petitioner and imposed permanent work restrictions for light duty work. Petitioner testified that he has never undergone surgery.

Petitioner testified that after the FCE and meeting with Dr. Kube he looked for work within his permanent restrictions and he applied at Walmart, K-Mart, and Contech Construction. No one has offered him any employment. While looking for work he was never advised by Respondent that he had been terminated. Presently, Petitioner plans on getting his CDL and becoming a truck driver.

Petitioner testified that he doesn't have a GED. Before working for Respondent Petitioner worked at Aaron's Sales & Lease, Henry Technology, Contech Construction and Northfield Inn.

Petitioner testified that he continues to treat with Dr. Kube and last saw him on August 18, 2016 at which time the doctor recommended a nerve test and outpatient surgery to release the pressure off his back. Petitioner testified that he would like to undergo the treatment being recommended by Dr. Kube. He is scheduled to see the doctor after the arbitration hearing.

Petitioner testified that even though he has medical treatment pending he wished to go ahead and have his case heard on "all issues." He then testified that he wished to have the Arbitrator award medical treatment as recommended by Dr. Kube. At that point in the proceedings, Petitioner amended the nature of the proceeding to make it a 19(b)/8(a) proceeding and the proceeding was continued until such time as the attorneys were ready to proceed.

Additional Medical Treatment

Petitioner was examined by Dr. Trudeau on August 25, 2016. (PX 16) Petitioner told Dr. Trudeau that he had been injured on July 1, 2013 "in the course of lifting-type injury." Dr. Trudeau found evidence of a left L5 radiculopathy, mild to moderate in testing. (PX 16)

Dr. Kube re-examined Petitioner on September 8, 2016. Dr. Kube noted the nerve conduction studies showed a left L5 radiculopathy which was felt consistent with Petitioner's foraminal stenosis at L5-S1. Petitioner now wished to discuss surgery. The doctor went through matters with him explaining that he needs to get his body mass index down to 40 or lower and the surgical table has a 300 pound limit. (PX 9)

Petitioner returned to see Dr. Kube on October 4, 2016. His weight was noted to be 388 lbs., still too significant a weight to be able to consider surgery. Medications were refilled and weight loss strategies discussed. (PX 9)

Dr. Van Fleet again examined Petitioner on October 21, 2016 at Respondent's request. A written report issued. In conjunction with the exam, Dr. Van Fleet reviewed records of Dr. Kube as well as Dr. Trudeau's report. Petitioner reported he still wasn't working and he was continuing to have back pain and leg pain described as "unbearable." He rated his daily pain as "8/10"and he was taking Tramadol, Gabapentin, Hydrocodone and Ambien. On exam he ambulated slowly across the floor with limited range of motion secondary to subjective complaints of pain with forward flexion and extension. Based upon his exam, meeting with Petitioner, and review of the medical records, Dr. Van Fleet stated that his earlier opinions remained unchanged. He felt any treatment since September 27, 2013 was not reasonable or necessary as Petitioner had reached maximum medical improvement by that time and, additionally, he denied the treatment had been of any help. The doctor wrote, "There is, in my opinion, no reason why this gentleman would be three years after the fact still having such extreme difficulty after getting out of his car. He has an underlying degenerative condition and has an underlying obesity condition, but there is no medical explanation for his current predicament." Dr. Van Fleet did not feel any surgery would help Petitioner as "He has a chronic pain condition. He is malingering and he has no identifiable source for his persistent low back pain, aside from the previously mentioned condition." (RX 8)

As of October 25, 2016, Dr. Kube noted that Petitioner had lost four pounds since earlier in the month. (PX 9)

Dr. Kube restricted Petitioner to light activity as of November 17, 2016 (for one month). According to the office note, Petitioner had gained a pound since his earlier visit. (PX 9; PX 10)

Dr. Kube restricted Petitioner to light activity as of December 15, 2016 (for one month). Petitioner was seen by PA-C Jennifer Meeker. Petitioner was denying any worsening symptoms or problems with medications. He noted pain with the weather and was having trouble sleeping. They discussed a sleep aid but it was also felt he might have sleep apnea and he should probably have his primary care doctor evaluate the issue (PX 9; PX 10)

Dr. Kube met with Petitioner on January 17, 2017 and they discussed Petitioner's ongoing problems with weight loss as he was gaining, rather than losing, weight. Dr. Kube discussed daily eating patterns with Petitioner. His weight was 392 lbs. (PX 9)

Dr. Van Fleet's Supplemental Deposition

A second deposition of Dr. Van Fleet was taken on January 25, 2017. (RX 9) Dr. Van Fleet testified consistent with his October of 2016 written report. (RX 9, pp. 1 – 13)

On cross-examination Dr. Van Fleet explained that his opinion that Petitioner is malingering is based upon his two examinations and meetings with Petitioner as well as his experiences as a treating practitioner for eighteen years. He had not seen any video surveillance or other medical records suggesting Petitioner was a malingerer. (RX 9, pp. 13 – 14)

Dr. Van Fleet was unaware of any accidents involving Petitioner since the work accident in July of 2013. When asked what he meant by stating in his report that Petitioner had a "chronic pain condition," the doctor explained that Petitioner complains of chronic pain in his back. He does not consider that a diagnosis. He probably should have called it a chronic non-specific low back condition. In the doctor's opinion, Petitioner does not have a treatable condition. ((RX 9, pp. 14 – 16)

Dr. Van Fleet agreed that treating spine specialists often rely upon the veracity of their patients regarding pain complaints but if he believes a patient is malingering or not being truthful, he may not identify that in the records. He would agree Dr. Kube never discussed that in his records. (RX 9, pp. 16 – 17)

Dr. Van Fleet was also asked about his first examination of Petitioner in 2013. He agreed that he received no information regarding prior low back problems. (RX 9, p. 17)

When asked if he considered Dr. Trudeau's EMG/nerve conduction studies to be reliable, the doctor replied "On occasion." He agreed with Dr. Trudeau's finding of a left L5 radiculopathy. He also agreed that he had not seen any records from Dr. Kube generated after September 8, 2016. (RX 9, pp. 17-18)

Dr. Van Fleet further testified that the signs of malingering he saw during his exam was the way in which Petitioner "moped" about as he walked as if he was in great discomfort and limited flexion/extension all of which suggested a theatrical manner. He further explained that if someone is going to recommend surgery on a back there needs to be clear evidence of objective findings that are clearly correlated with the clinical picture. (RX 9, pp. 18 – 21) While Dr. Trudeau may have found evidence of left L5 radiculopathy, Dr. Van Fleet considers that to be a subjective test because it relies upon the patient's subjective responses. (RX 9, pp. 21-22)

Dr. Van Fleet was asked about his charges for examining Petitioner. He was paid $1500.00 and he is paid $1500.00 per hour for a deposition. He also acknowledged seeing the FCE from 2015. He agreed that the report states Petitioner was giving his best effort. (RX 9, pp. 22 – 25) Dr. Van Fleet felt Petitioner's mechanism of injury was not something he would consider as requiring restricting Petitioner from a lifetime of regular duty. "It's not my practice to suggest that somebody who complains of pain across their back go get an FCE because they say they can't do their job." (RX 9, p. 25)

The Arbitration Hearing (Closing Proofs)

Petitioner's case again proceeded to arbitration in Quincy on April 5, 2017 to close proofs. At the commencement of the proceedings Petitioner's attorney represented that the case was no longer going forward on a 19(b)/8(a) Petition but, instead, was going forward on all issues (accident, causal connection, medical bills, TTD, maintenance benefits, and the nature and extent of any injury). Petitioner's attorney also represented that Petitioner was claiming maintenance from August 25, 2016 through the date of hearing (4/5/17).

Petitioner testified that he underwent a nerve conduction study on August 25, 2016. He then went over the studies with Dr. Kube. Petitioner further testified that he has continued to see Dr. Kube, monthly, from August of 2016 up until about January of 2017. Petitioner testified that he has never undergone any back surgery. He explained that he weighed 381 pounds at one point in time and the doctor wanted him to lose some weight before undergoing any surgery. Petitioner is trying to do so and if he can get his weight down to an acceptable level, Dr. Kube will discuss surgery with him then.

Petitioner also testified that after the first hearing, Respondent had him undergo a second examination with Dr. VanFleet. He thought the doctor spent about five minutes with him and the doctor didn't speak with him; rather, he just examined him.

Petitioner testified that he has continued to look for work as he contacted UPS and filled out a form for Fed Ex. He is also trying to get his CDL. Petitioner continued to live in Springfield and he has remained off work due to his restrictions and inability to find work.

Petitioner testified that sitting for long periods of time is problematic. He also cannot lift and it is hard to bend. He cannot play basketball or football with his son. He feels very restricted around his house and can't do much of anything except try to lose weight and exercise a little. He continued to feel a sharp stabbing pain and his left leg is numb. If he sleeps and turns the wrong way, his back goes out explaining that it "feels like two bones rubbing together and I try to get up and it just forces me right back down". His mother takes care of him. He described his level of pain as "8/10" to "off the chart." He has good days and bad days. He takes Tramadol, Hydrocodone and Gabapentin as prescribed by Dr. Kube. He feels pain all day long.

Petitioner identified his medical bills as being set forth in PX 154. He did not believe anyone has paid anything on the bills. He has no personal insurance to pay them.

Petitioner testified that he is scheduled to see Dr. Kube on April 18, 2017.

On cross-examination Petitioner was asked about his Application for Adjustment of Claim and he agreed that the accident was described as "exiting the van and stepped down and twisted." He also identified PX 2 as the accident report he completed with help from "Miss Chris." He agreed that he completed the part that said he injured himself "getting out [of] the work van."

Petitioner agreed that at the initial hearing, he described three separate incidents occurring on July 1st that contributed to the injury. He agreed that he was familiar with the van he was driving that day as he had been driving it daily for about a year. Petitioner, who is 6'3" tall, testified that when he stepped out of the van, he wasn't carrying anything nor was he in a hurry. He had stopped to make his first delivery and was

getting out of the van. His left foot hit the ground first and he immediately felt pain in his low back. He denied that his foot slipped.

Petitioner testified that his parents drove him from Springfield for his hearing in Quincy. Petitioner further testified that the van was owned by Respondent and he would drive his personal vehicle to and from work. Petitioner worked for Respondent on a part-time basis, approximately thirty hours per week. The number of hours he worked per day would fluctuate. He agreed that he finished his shift on July 1st.

Petitioner denied any back injuries before July 1st. He denied having any conversations with his supervisor, Chris Strong, about prior back injuries. He denied every injuring his back in San Diego and telling Ms. Strong about that. He acknowledged a prior workers' compensation case. When asked if he was involved in an incident on December 6, 2003 that involved a back injury, he replied "No, I don't know." He could not recall. He did not recall settling a workers' compensation claim for 3% loss of a person as a whole for a back injury. He acknowledged working for Harbor Freight in 2003 but didn't recall filing a workers' compensation claim against it. He also didn't recall filing a workers' compensation claim against Manpower, Inc. in 2006 for an injury date of August 1, 2005. Petitioner also couldn't recall injuring his back in 2009 or being diagnosed with a back strain/sprain in 2009.

Petitioner testified that Dr. Kube imposed permanent restrictions in April of 2015 involving, essentially, light duty work and he has been unable to find any employment since then. He denied applying for any jobs other than the ones he testified to. He is not on social security.

Petitioner acknowledged that some doctors have told him losing weight might help lessen his back pain. He thought he weighed about 340 lbs. in 2013. It is his understanding that Dr. Kube won't recommend surgery unless he gets his weight under 300 lbs. Petitioner also acknowledged that he is a smoker and smokes three to four cigarettes a day. He has reduced his smoking habit over time. He denied that any doctors have told him that cessation of smoking might help his back pain.

On redirect examination Petitioner testified that because the van had no running board he would have to step up "even higher" to get in the van.

Petitioner also testified that Respondent is a wholesale florist company. To his knowledge, it is still in business. He also testified that Ms. Strong is no longer employed there. Petitioner was given an opportunity to look at RX 3, an office note dated 1/29/09, from SIU Healthcare. Petitioner testified that at that time he went to SIU for his primary medical care. He agreed that he was seen there at that time for back pain but it was in the middle of his back.

Petitioner's medical bills are found in PX 14.

The Arbitrator concludes:

Issue C. Did Petitioner sustain an accident on July 1, 2013 that arose out of and in the course of his employment with Respondent?

Petitioner failed to prove he sustained an accident on July 1, 2013 that arose out of and in the course of his employment with Respondent.

In order to find that Petitioner sustained an accident arising out of his employment the Arbitrator must also find Petitioner credible. She is unable to do so as Petitioner's testimony regarding what occurred on July 1, 2013 is not corroborated by any of the medical evidence or the accident report submitted into evidence. Additionally, Petitioner was not forthright regarding his prior back problems.

Petitioner testified that three events occurred at work on July 1, 2013. His accident report simply stated that he was getting out of his work van. He mentioned back pain but no leg pain. Petitioner also failed to give the same history of three incidents to any of his medical providers, especially, Dr. Kube, upon whose opinion Petitioner relies to establish causation. Petitioner testified that when he opened the door and stepped out of the driver's door he felt a pain shoot through his left leg and up his back. Petitioner never mentioned any left leg pain when exiting the door to any of his doctors. He told Express Care personnel that he was getting out of his van at work and "twisted" with sudden low back pain. Nothing was ever said about left leg pain. Furthermore, nothing was said about the other two alleged incidents occurring that morning. While Petitioner appears to have focused on the exiting of the van when initially seen by medical personnel, he didn't even mention that incident when seen by Dr. Choundhary; rather, he told her he was picking something up from inside his vehicle when he developed severe lower back pain. Dr. Choundhary was not deposed. Petitioner's Application for Adjustment of Claim alleged he exited his van, stepped down and twisted. He then told Dr. Kube that he "twisted and tweaked" his back stepping out of a 250 style work truck. Finally, he told Dr. Van Fleet that he was getting out of his car and felt a pain across his back and a "pop." None of these histories mentioned any shooting leg pain and, they are inconsistent with one another, in their description of what occurred. Also, while Petitioner told Dr. Van Fleet he felt a "pop" in his back while exiting the vehicle, he did not testify to that. Instead he testified to feeling a "pop" in his back later in the morning while picking up a set of boxes. Furthermore, the Arbitrator notes that Petitioner testified that after stepping down on his left leg to exit the van he thought "nothing of it" and proceeded to walk around the van, open the double doors, grab boxes and began lifting them when his back "went out." By this very testimony Petitioner is suggesting that the second "incident" of exiting the vehicle was not that strenuous or significant. He was, as several doctors noted, simply getting out of the van.

Petitioner bears the burden of proving that he sustained an accident at a specific, date, time and place. Petitioner is not claiming repetitive trauma herein. Rather, he testified to three separate incidents which culminated and contributed to his injury. Unfortunately, no mention of these three separate and distinct incidents was noted in his accident report or any of the medical histories provided to the doctors. There are simply too many contradictions and inconsistencies in the histories to know when and how Petitioner allegedly injured his back. Petitioner's claim for compensation is denied.

Issue F. Is Petitioner's current condition of ill-being causally connected to the injury?

Even assuming, arguendo, that Petitioner sustained an accident on July 1, 2013 arising out of and in the course of his employment with Respondent, Petitioner failed to prove that his current condition of ill-being in his low back and left lower extremity is causally connected to his July 1, 2013 accident. In so concluding the Arbitrator notes: (1) Petitioner's incomplete and inconsistent histories to his medical providers; (2) his lack of lower leg complaints post-accident; and (3) Petitioner's credibility/motivation concerns.

As noted above under Issue (C), Petitioner failed to give any of the doctors involved in this case a history of what occurred on July 1, 2013 consistent with his arbitration testimony. Most especially, he failed to give a complete and accurate history to Dr. Kube. Dr. Kube testified that Petitioner sustained a sprain/strain, aggravation of degenerative disc disease and protruded discs causing intermittent radiculopathy as a result of the accident. Dr. Kube testified that Petitioner was getting out of the work van when he "twisted and tweaked" his back. Dr. Kube didn't have any knowledge of the two other incidents Petitioner associated with his back pain, including the incident wherein Petitioner claimed he felt a pop in his back when he lifted a box out of the van. The doctor never explained how Petitioner's act of getting out of the van caused the radiculopathy he diagnosed which is especially important in this case since Petitioner did not originally associate any left leg complaints with the accident. It is also important given the relatively benign nature of the mechanism of injury compared to the multitude of problems Petitioner alleges resulted from this relatively simple act of getting out of a vehicle. While Petitioner emphasized the lack of a "step up" on the van, the Arbitrator also notes Petitioner is 6'3" tall and it is doubtful a step would be necessary for him to exit and enter the vehicle. She is also mindful of Dr. VanFleet's persuasive testimony that, given Petitioner's significant weight, he could have problems with his low back for that reason alone. Dr. Van Fleet also noted that, given his size, Petitioner was likely to aggravate his back any time he exited a vehicle.

While Dr. Kube testified that he knew Petitioner had experienced prior episodes of back pain he felt information regarding such a prior history would be "useless." The Arbitrator disagrees noting the doctor's testimony on this issue was not at all persuasive. While the doctor might not be interested in the history from a treatment perspective, such history is, of course, relevant to determining causation in a disputed case such as this one.

- With regard to Petitioner's left lower extremity complaints, the medical records fail to note any left leg complaints until November 5, 2013, approximately six months post injury and, even then, Petitioner didn't volunteer that information. As of December 3, 2013, Petitioner reported his left leg pain was intermittent with no specific leg pain complaints being noted at that time. When Petitioner returned to see Dr. Kube on April 18, 2014 the doctor's notes are silent as to any specific leg pain complaints although, subjectively, Petitioner's VAS was showing back and bilateral leg pain. Thereafter, Petitioner underwent no treatment between April 18, 2014 and August 14, 2014. Petitioner then sought treatment at SIU Center for Family Medicine on August 14, 2014 reporting chronic left-sided low back pain "for several weeks duration." He denied any injury except for his July 1, 2013 work injury but there is a note "States nature of fall was missing step." According to the history Petitioner had been seen earlier on July 22, 2014 but (as noted by the Arbitrator earlier in the decision) there is no record of such a visit included in any of the exhibits. The absence of the July 22nd visit is concerning as the history might have been most insightful. No left-sided radicular complaints were documented. At no time is there any reference in any medical notes that Petitioner's left lower extremity radiculopathy stemmed from his July 1, 2013 work accident.

While Dr. Kube's office notes reference "VAS" scores indicative of both back and bilateral leg pain, it was not until August and September of 2015 that the doctor's notes record any actual bilateral leg concerns being voiced by Petitioner. That was over two years after the accident. Due to the significant gap in time between the accident and the notation of any right leg complaints, together with Dr. Kube's failure to explain how any such right leg complaints would be related to the accident, the Arbitrator does not find Petitioner's ongoing right leg complaints to be causally related to the accident.

Finally, the Arbitrator addresses Petitioner's credibility. Quite simply, the Arbitrator has had great trouble, as did Dr. Van Fleet, finding that Petitioner's alleged mechanism of injury was significant enough to result in as serious an injury as Petitioner suggests. At the arbitration hearing, Petitioner denied any prior low back problems whatsoever. The Arbitrator has taken judicial notice of Petitioner's prior settlements for back injuries: case # 04 WC 858 and case # 06 WC 14807. Both were MAW awards and one specifically referenced a back claim. It was only after Petitioner's attorney refreshed Petitioner's recollection that he was able to recall the 2009 back claim. The Arbitrator further finds Petitioner's job search efforts to be suspicious given the lack of documentation for them and reflective of his motivation in this case given the fact he has only looked for less than a handful of jobs since his injury. Petitioner has appeared eager to direct his care in this case from the very beginning, wanting to be referred to a chiropractor very quickly, filing his claim herein within ten days of the accident, and then insisting upon being referred to a surgeon. The Arbitrator also finds it interesting that Petitioner, who claims he can do very little around his house and experiences constant pain all day long, chooses to treat with a doctor who works approximately seventy miles one way from his home. Certainly there are other orthopedic surgeons in Springfield; however, Petitioner has chosen to treat with the doctor his brother used and at the referral of his attorney.

Given Petitioner's credibility/motivational issues, together with inconsistent histories, and an unpersuasive causation opinion from Dr. Kube, the Arbitrator is unable to find Petitioner's current condition of ill-being is causally related to any work accident.

Petitioner's claim for compensation is denied and no benefits are awarded. Any remaining issues are moot.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tonya Hedges,
Petitioner,

18IWCC0066

vs.

NO: 13 WC 32044

SIU School of Medicine,
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, notice, causal connection, medical, temporary disability, permanent disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 29, 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: JAN 31 2018
o1/11/18
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

18IWCC0066

HEDGES, TONYA
Employee/Petitioner

Case# **13WC032044**

SIU SCHOOL OF MEDICINE
Employer/Respondent

On 8/29/2016, 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 0.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1824 STRONG LAW OFFICES
MICHAEL BRANDOW
3100 N KNOXVILLE AVE
PEORIA, IL 61603

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

4993 ASSISTANT ATTORNEY GENERAL
AMY OXLEY
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SPRINGFIELD, IL 62706

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 29 2016

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

Tonya Hedges
Employee/Petitioner

v.

SIU School of Medicine
Employer/Respondent

Case # 13 WC 032044

Consolidated cases: ---

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Springfield**, on **July 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 **May 2, 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.

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

In the year preceding the injury, Petitioner earned $**40,651.12**; the average weekly wage was $**781.75**.

On the date of accident, Petitioner was **41** 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 $**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 0 under Section 8(j) of the Act.

ORDER

Petitioner has failed to prove by a preponderance of the credible evidence that she sustained an injury to her left arm and left hand due to repetitive work activities that arouse of and in the course of employment with Respondent and manifested itself on May 2, 2013. Furthermore, Petitioner has failed to prove by the preponderance of the credible evidence that her current condition as it relates to her left arm and left hand is causally related to the alleged accident. 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.

D. Dyan McCarty

Signature of Arbitrator

8/23/2016

Date

AUG 29 2016

Finding of Facts

Petitioner Tonya Hedges filed an Application for Adjustment of Claim on September 27, 2013, alleging that she sustained repetitive trauma injuries to her left arm and left hand in the course of her employment with the Respondent, Southern Illinois University School of Medicine, which manifested itself on May 2, 2013. (Arb. Ex. 2, P. Ex. 1).

Petitioner testified that she is a right-handed registered nurse who worked for the Respondent for approximately 7 years and 2 months, where she served as either a clinic nurse or a charge nurse at various departments within the SIU School of Medicine. (TX pp. 8, 43). Petitioner testified she worked as a clinic nurse in the pediatrics department for ten (10) months from March 2009 through January 2010. (TX p. 8). Petitioner testified that as a clinic nurse in the pediatrics department, her schedule was split in two-week, alternating increments where she would "work the floor" for two weeks and then work triage for two weeks. (TX p. 9). While working the floor, Petitioner testified that she would keyboard for approximately 7.5 hours a day. Petitioner testified that working triage involved speaking with patients via telephone and documenting their conversations in narrative form. (TX p. 11). Petitioner testified that while working triage she typed approximately 7.5 hours a day. (TX p.11). Petitioner testified that her regular office hours were from Monday through Friday, 8:00 to 4:30, though at times she worked longer hours. (TX pp. 40, 14).

Petitioner testified that she transferred to the Respondent's bariatric surgery department around January 2010. There she worked as both a charge nurse and a clinic nurse. (TX p. 12). As a charge nurse, she was tasked with supervising 15 other nurses in the department. (TX p. 13). In this position, she testified, her clinic nursing duties included accompanying patients to and from their rooms, taking and documenting vital signs, and discussing patient's problems with them over the phone. (TX pp. 14-15). Petitioner testified these duties were augmented by also needing to document any disciplinary actions against those nurses whom she supervised. (TX p. 13). These tasks, Petitioner testified, required her to type 7.5 hours each working day. (TX p. 14). Petitioner testified that she generally typed on a desktop computer and would be either sitting on a chair or standing to perform the necessary typing. (TX p. 16).

Petitioner testified she was a charge nurse for only 14 months, as she elected to take off-site classes. (TX p. 19). At that time, continuing through the alleged manifestation date of Petitioner's alleged injury, Petitioner was working as a clinic nurse. (TX p. 42).

On cross-examination, Petitioner testified that as a clinic nurse, her typing was interrupted when she performed nursing tasks, such as speaking on the phone with patients, taking their vitals, walking them to the treating room, et. cetera. (TX p.48).

Petitioner testified that Respondent's Exhibit 3, a position description for a clinic nurse, dated May 10, 2013, was an accurate, if generalized, description of her job duties. (TX p. 27). This document describes an 80% time commitment to: (A) providing clinic nursing care and delegation of clinical duties to LPNs and MAs while in clinic, including but not limited to obtaining patient histories, assisting with portions of physical examinations, administering medications, providing wound care, performing other nursing procedures and documenting nursing functions appropriately; (B) performing clinic laboratory testing and procedural testing according to clinic protocols and reporting findings to physician and records on patient medical record; (C) assisting with procedures; (D) developing and implementing patient plan of care; (E) coordinating delivery of patient plan of care; (F) organizing clinic patient flow; (G) scheduling follow up patient activities including radiologic studies, surgical procedures and other testing as ordered; (H) obtaining patient history from referring physician, pertinent radiologic studies, laboratory results, and operative reports as necessary; (I) communicating with the call center; and, among others (J) triaging patient care priorities for patent phone calls and needs, etc.. (R. Ex. 3). Petitioner testified on cross-examination, that she typed to record every task she performed. (TX p. 49). As such, her

typing was not continuous, but interrupted to perform various tasks enumerated in Respondent's Exhibit 3 and as described in Petitioner's testimony.

Petitioner testified that she began experiencing pain in her left arm, from the elbow radiating to her forearm in May 2013. (TX p. 17). Prior to May 2, 2013, Petitioner had not sought treatment for a condition relating to her left hand or arm.

Petitioner testified that she saw Patricia Lacy, a nurse practitioner for orthopedic surgeon Dr. El-Amin, on May 2, 2013. (PX 5). She complained of symptoms in her left arm and hand, including a burning pain in the elbow as well as numbness and tingling in her left hand and forearm. Petitioner was referred to St. John's Hospital for an MRI of her left arm. The MRI, performed on May 17, 2013, indicated joint effusion. Petitioner was also referred to Dr. Trudeau for an EMG nerve conduction study on May 2, 2013. Petitioner was diagnosed with carpal tunnel syndrome at the left wrist, moderately severe, and mild to moderately severe posterior interosseous neuropathy ("PINS/radial tunnel syndrome") in the left dorsal proximal forearm. (PX 4). Patricia Lacy then saw Petitioner on June 7, 2013, and diagnosed her with carpal tunnel syndrome in the left wrist, lateral epicondylitis in the left elbow and PIN entrapment in the left forearm. (PX 5).

Petitioner testified that she discussed her job duties with Dr. El-Amin, but he did not state affirmatively or negatively whether her job duties caused her injuries. (TX p. 28). On June 25, 2013, Dr. El-Amin performed a left elbow lateral epicondylectomy and extensor tendon repair, a left elbow cubital tunnel ulnar transposition, and left elbow carpal tunnel release. (PX 7).

Petitioner testified she was off work due to this surgery from June 25, 2013, through August 11, 2013. (TX pp. 22-23). On August 12, 2013, Petitioner returned to work with restrictions of working 2 to 3 days a week, with a break after 45 minutes of typing. (TX p. 23). Respondent returned to full duty on April 1, 2014. (TX p. 26). While Petitioner was off work, she utilized her benefit time, including sick time and vacation time. (TX p. 32). She also utilized FMLA time. (PX 11).

On November 13, 2013, Petitioner sought a second opinion regarding her left arm from Dr. Greatting. (PX 6). Petitioner complained of pain in her left forearm and noted that the numbness and tingling in her left hand improved. Dr. Greatting referred Petitioner to Dr. Trudeau for a second EMG study. The EMG study was performed on December 9, 2013, and revealed PINS/radial tunnel syndrome and left radial sensory neuropathy (Wartenberg syndrome). (PX 4). Following the December 2013 diagnostic study, Dr. Greatting recommended surgical treatment to release Petitioner's left posterior interosseous nerve. This surgery took place on May 26, 2016. (PX 6).

Petitioner testified that she was off work from May 26, 2015 though July 7, 2015, following Dr. Greatting's surgery. (TX p. 32). Petitioner was released from Dr. Greatting's care on September 24, 2015. (PX 6). Petitioner returned to work with Respondent without restrictions. While Petitioner was off work, she utilized her benefit time, including sick time, vacation time. (TX p. 32). She also utilized FMLA time. (PX 11).

Petitioner testified that she currently has the following symptoms in her left extremities: occasional, intermittent aching at her left elbow, occasional discomfort in her left wrist, and, she testified, she "occasionally get[s] a little bit of numbness" in her left third, fourth, and fifth fingertips when she gets cold. (TX pp. 36-37)

The deposition of Dr. Greatting was taken on August July 23, 2014, and was entered into evidence at trial. Dr. Greatting is a board certified orthopedic and hand surgeon. (PX 8, p. 5). Dr. Greatting testified regarding his treatment of Petitioner. Dr. Greatting gave the opinion that Petitioner's work duties aggravated her radial tunnel condition and posterior interosseous neuropathy. (PX 8, pp. 14-15). Dr. Greatting testified that his opinion is based on Petitioner's informing him that she would experience symptoms while typing. He also responded

based upon a hypothetical asking him to assume the individual used a keyboard 7.5 to 9 hours per day. (PX 8, p. 14). Dr. Greatting testified he did not have an opinion as to whether Petitioner's left carpal and left cubital tunnel syndromes were the result of her work activities because he did not treat her for those conditions. (PX 8, p. 16). He further testified that he did not have reason to disagree with findings contained within Dr. El-Amin's medical records. (Id).

On cross-examination, Dr. Greatting testified that Petitioner did not personally discuss her job duties with him. (PX 8, pp. 20-21). He did not know any of Petitioner's specific, regular job duties, but knew generally of the requirements of a clinic nurse. (PX 8, p. 22). He did not know of the administrative duties Petitioner performed nor the amount of time she spent typing each day. (PX 8, pp. 22-23). He did not know of the ergonomics of Petitioner's office or of the place where she entered information. (PX 8, p. 24).

The deposition of Dr. Lewis was taken on June 30, 2014, and was entered into evidence at trial. Dr. Lewis is a board certified orthopedic surgeon. (RX 2, p. 4). Dr. Lewis' performed a Section 12 examination of Petitioner on February 26, 2014. (RX 1). During his testimony, Dr. Lewis reiterated that Petitioner's job duties did not cause or aggravate her lateral epicondylitis, cubital tunnel syndrome, or carpal tunnel syndrome. (RX 2, pp. 10-11). Dr. Lewis testified that he had a good understanding of her job duties. (RX 2, p. 9). Dr. Lewis testified that Petitioner's job duties did not involve the "tremendous amount of force and repetition" necessary to cause carpal tunnel syndrome. (RX 2, p. 10). He also testified that "there is no evidence that repetitive motion in and of itself causes" lateral epicondylitis and cubital tunnel syndrome. (RX 2, p. 9).

Petitioner testified she notified Respondent of her injuries on March 24, 2013. (TX p. 39). She further testified that the date on the Workers' Compensation Employee's Notice of Injury, Respondent's Exhibit 4, was erroneously entered as March 24, 2014. (TX p. 39).

Petitioner's medical bills were produced in Petitioner's Exhibit 11. (PX 11

Conclusions of Law

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

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

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

The Arbitrator concludes that Petitioner's left hand and arm repetitive trauma injuries did not arise out of and in the course with Respondent.

In support of this conclusion the Arbitrator notes the following:

At the time of her alleged injury, Petitioner had worked as a clinic nurse for approximately 26 months from March of 2011 through May 2013. Petitioner testified that as a clinic nurse she typed 7.5 hours per day. She also testified that she worked from 8:00 A.M. to 4:30 P.M., a period of 8.5 hours. She said she was lucky if she was able to take a lunch. Petitioner claimed that her typing consisted of inputing the results of various medical tests she conducted, doing narrative reports of various medical services rendered, and documentation of disciplinary actions taken against those nurses whom she supervised. While Petitioner's testimony made her position seem very heavy with data entry, it is apparent by the job descriptions contained in Respondent's Exhibit 3 and Petitioner's testimony that Petitioner's positions involved a number of other job duties which were not hand intensive. As a clinical nurse, the job she performed from approximately March of 2011 until she became symptomatic in March of 2013, she did a number of other tasks besides data entry. She escorted patients to their

examining rooms and took their vital signs. She dispensed medications, providing wound care, as well as various other nursing tasks. She then did some keyboarding to enter the results into the computer before moving on to the next patient. There is simply no way that the Petitioner could have engaged in keyboarding 7.5 to 9 hours per shift while performing those duties.

In regard to the evaluation of the medical evidence, Petitioner's treating surgeon, Dr. Greatting, did not have much knowledge of Petitioner's work duties. He testified that he was familiar with Petitioner's job duties primarily because he was familiar with the general duties of a clinic nurse vis-à-vis his own experience as a physician. He did not know how long Petitioner typed or the ergonomics or the areas where she typed. His causation opinion was based upon a hypothetical asking him to assume that the individual keyboarded at least 7.5 hours a day. As noted above, the evidence did not support those time estimates. Dr. Greatting's testimony indicates that he would consider any activity Petitioner performed which caused her to report having symptoms as aggravating to her condition. Furthermore, Dr. Greatting refused to comment on the cause of Petitioner's left cubital tunnel, left lateral epicondylitis and left carpal tunnel syndromes, as he did not treat Petitioner for those conditions. The only physician opinion in the record connecting the Petitioner's elbow and wrist conditions to work was contained in the conclusory remarks of Dr. Trudeau in his second report. The Arbitrator further notes that in his first report, Dr. Trudeau makes no reference to the Petitioner's work or her duties.

Respondent's Section 12 physician, Dr. Lewis, testified that Petitioner's conditions of lateral epicondylitis, cubital tunnel syndrome, and carpal tunnel syndrome were not caused by her work activities. Though Dr. Lewis did not have a job description for Petitioner's position, Petitioner did describe her job duties to him as well as the amount of time she spent typing.

Based upon the above evidence, the Arbitrator finds that the Petitioner has failed to meet her burden of proof on the issues of accident and causation. As such, the claim is denied. All other issues become moot.

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

Leonard Kellow,
Petitioner,

18IWCC0067

vs.

NO: 13 WC 15112

SOI-Pontiac Correctional Center,
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, temporary disability, permanent disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 25, 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: JAN 31 2018
o1/11/18
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

18IWCC0067

KELLOW, LEONARD
Employee/Petitioner

Case# **13WC015112**

SOI-PONTIAC CORRECTIONAL CENTER
Employer/Respondent

On 8/25/2016, 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 o.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0252 HARVEY & STUCKEL CHTD
DAVID W STUCKEL
101 S W ADAMS ST SUITE 600
PEORIA, IL 61602

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

5002 ASSISTANT ATTORNEY GENERAL
JOSEPH E BLEWITT
500 S SECOND ST
SPRINGFIELD, IL 62706

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

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

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

AUG 25 2016

Ronald A. Peria
RONALD A. PERIA, Acting Secretary
Illinois Workers' Compensation Commission

18IWCC0067

STATE OF ILLINOIS)
)SS.
COUNTY OF MCLEAN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

LEONARD KELLOW
Employee/Petitioner

v.

STATE OF ILLINOIS-PONTIAC CORRECTIONAL CENTER,
Employer/Respondent

Case # **13** WC **15112**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Bloomington**, on **7/26/16**. 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. ☒ 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 **4/25/13**, 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 not* sustain an accident that arose out of and in the course of employment.

In the year preceding the alleged injury of 4/25/13, Petitioner earned $**112,320.00**; the average weekly wage was $**2,160.00**.

On the alleged date of accident, Petitioner was **50** 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 $**00.00** for TTD, $**00.00** for TPD, $**00.00** for maintenance, and $**00.00** for other benefits, for a total credit of $**00.00**.

Respondent is entitled to a credit of $**00.00** under Section 8(j) of the Act.

ORDER

Petitioner has failed to prove by a preponderance of the credible evidence that he sustained an accidental injury to his bilateral hands due to repetitive work activities that arose out of and in the course of his employment by respondent, and manifested itself on 4/25/13. 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

8/22/16
Date

AUG 25 2016

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 50 year old correctional food service supervisor, alleges he sustained an accidental injury to his bilateral hands due to repetitive work activities that arose out of and in the course of his employment by respondent and manifested itself on 4/25/13. Petitioner worked at Pontiac Correctional Center for 22 years before transferring to Graham Correctional Center a year and a half ago.

Petitioner identified his duties as being an Administrator of Food for the entire institution. He stated that he breaks food out and the inmates cook it. He instructs the inmates on how to do the work. Petitioner worked either the 4:30am-12:30 pm shift, or the 10am-6pm shift, plus overtime at times. Petitioner testified that food was served to 1600 inmates, 3 times a day. Food was also made for the officer's kitchen, 3 meals a day, at extended times. In the officer's kitchen the inmates served the food, and he only instructed the inmates on how to prepare it. Petitioner testified that he was on the line infrequently, and spent most of his time in the inmate kitchen.

To prepare meals the inmates would come in and they would get the food out. He would unlock the door for them. He would help with taking food out, as well as the getting cleaning equipment out. Petitioner used a Folger Adams key to get in the room where the styrofoam trays were. He testified that this key required a higher degree of force to operate. While preparing and serving meals, petitioner had to open and close 10 doors, and half of them required the use of a Folger Adams key. Petitioner then testified that he opened and closed doors on average 45-50 times a day.

In the kitchen food was taken out of the freezer manually and then put on 18x24 inch pans that weighed 50-60 pounds when full. Petitioner would lift the trays by putting his fingers underneath and his thumb on top. He handled 25-30% of the 200-300 pans that held chicken. If it was meat in the pans that were 10x18 inches and 4 inches deep, they would weigh 25-30 pounds full, and he could handle 100-200 pans the same way. Petitioner also handed mashed potatoes. The tools petitioner used in the kitchen included paddles and manual can openers. The cans they opened held 5 pounds of food, and 120 cans were opened for one meal. Sometimes petitioner would lift cartons and boxes out of the store room and place them on a cart. Petitioner would also handle cases of milk that held 52 - 8 oz cartons. Forty cases were used per meal. He would sometimes lift and place these cases on a cart.

After the food was prepared in the kitchen it was put on carts and rolled to the line. Petitioner testified that the inmates did this, but he would open and lock the doors. Petitioner would help serve the inmates using the serving utensils. He did this with both hands. Petitioner testified that he served about 400 inmates during the one hour food service. He did not serve continuously. He had a 15 minute break.

Petitioner testified that he worked the service line at Pontiac Correctional Center to show inmates that the job in the kitchen was worth having. He testified that by doing the job himself on a routine basis he got more inmate participation.

On cross examination petitioner testified that his primary job was monitoring and supervising inmates. During 2012-2013 petitioner worked the midnight shift. He would show the inmates only once how to do things. He would make sure they did the job correctly. During this period, petitioner did not work the service line. On a typical day he might open 10-20 cans and lift pans, and 20-25 crates of milk. He would also lock and unlock doors about 15 times each. Overnight he used the Folger Adams key 10 times.

Petitioner testified that he started noticing symptoms in his hands in 2008, or early 2009. He stated that at that time he did not know what it was and kept working. Petitioner testified that he continued doing the same job between 2008 and 2013. Petitioner testified that in 2009 he had trouble holding on to things, his hands would fall asleep, he had trouble driving, and had pain with both hands when doing work duties.

Petitioner testified that he presented to Dr. Mulch in 2010. On 9/9/10 petitioner underwent EMG/NCV studies in the Hillsboro Neurology Clinic on the referral of Dr. Mulch. Petitioner complained of bilateral hand numbness and pain induced by manual activity waking him at night, and induced by driving. The impression was bilateral median neuropathies at the wrist, moderate in degree, with neuropraxia seen bilaterally and early sensory axon loss seen on the right.

On 9/30/10 petitioner completed a Workers' Compensation Employee's Notice of Injury for a date of injury on 1/15/10. He indicated that while turning keys for locks and doors he felt pain in his wrist and arm. He stated that both arms and hands were affected.

On 10/4/10 petitioner presented to Dr. Greatting for evaluation of his bilateral hand complaints with numbness and tingling. Petitioner noted that he had diabetes, heart disease, and hypertension. Petitioner reported that he is a correctional officer and had complaints of bilateral hand pain, numbness and tingling. He also reported some pain up his arms, and pain, numbness and tingling at night. Petitioner identified activities such as using a computer mouse and keyboarding, as well as driving, as things that bother him. He reported that at work he has to write a lot and his symptoms increase with this activity. He also reported that he drops things at work and has to turn a lot of keys to open and close door locks. He also reported that he uses some smaller keys and larger keys up to 100 times a day. He reported increased symptoms while doing work activities that include serving food. He stated that he fills food trays and hands out trays. He denied any acute trauma or injury.

Following an examination and review of the EMG/NCV results Dr. Greatting assessed bilateral carpal tunnel syndrome. Dr. Greatting was of the opinion that based on petitioner's history that his work activities caused, contributed to, or aggravated his symptoms related to his carpal tunnel syndrome. Bilateral carpal tunnel releases were recommended. Petitioner stated that he was going to schedule the right carpal tunnel release followed by the left carpal tunnel release 4 weeks later.

Petitioner testified that in 2010 Dr. Mulch told him that if he did not want surgery he should take B12. Petitioner testified that he took B12 soft gels for 3 years. At first he felt better, but then after about a year his symptoms came back and were worse. He stated that his symptoms were worse when he was turning the Folger Adams key, and using the can opener.

Petitioner testified that from 2008 to 2013 his hobbies included quilting by machine. He also used a razor knife when quilting.

Petitioner testified that after 2011/2013 he stopped doing supervisory work. However, by then his hand conditions were bad at times, even though he had stopped a lot of his kitchen/serving activities. Petitioner testified that from 2010-2013 he did a lot of handwriting with his hand. He stated that at one time he signed 130 signatures. He signed when tools were taken out and returned. He wrote the name of the tool, time out and back, and name of the inmate. Petitioner filed out forms for tools and mop closet items.

Petitioner's next followed up with Dr. Greatting on 4/9/13. He complained of ongoing pain to his bilateral forearms and wanted to discuss surgery again. He reported that his symptoms were getting significantly worse. He stated that his hands frequently fell asleep, his grip was weaker and the pain and numbness were travelling up to his elbows at times. Dr. Greatting examined petitioner and his assessment remained unchanged from 2010. He ordered a repeat EMG/NCV. Petitioner's sugars were noted as being a little high.

On 4/25/13 petitioner underwent a repeat EMG/NCV of his bilateral upper extremities. The findings were consistent with bilateral medial neuropathies at the wrists, moderately severe in degree, with some interval progression from the earlier study in 2010 on the right.

Petitioner testified that after this second EMG he told his supervisor Richard Runyon about his problems and that he needed surgery.

On 5/6/13 petitioner returned to Dr. Greatting. He reported that he had worked 20 years and 4 months for respondent in the food service area. He reported that he instructs and watches inmates doing food preparation and meal preparation. He also helps and assists with the food prep and making and serving meals. He also reported that he does a lot of writing activities with his right hand and will sign his name 100 or more times a

day. He reported that he opens and closes a lot of locks with his hand and does a lot of lifting activity. He complained of numbness and tingling in both hands, right greater than left, for 3-4 years, that had slowly gotten worse. He reported that his hands bother him at night and during the day, and while driving. He reported increased symptoms when writing, and with work activities including the food preparation and serving activities. Following an examination Dr Greatting's assessment remained chronic bilateral carpal tunnel syndrome. He again recommended bilateral carpal tunnel releases and petitioner again indicated he wanted to undergo the recommended surgery.

On 5/8/13 petitioner's Application for Adjustment of Claim was filed. The date of accident was identified as 4/25/13. Petitioner alleged injuries to both upper extremities due to repetitive use. Petitioner indicated that notice was provided orally.

On 8/26/13 petitioner presented to Dr. Mulch for a 6 month visit with respect to his diabetes. Dr. Mulch noted that petitioner's sugar levels had been running at 160, and were uncontrolled.

On 10/7/13 petitioner returned to Dr. Greatting. He reported that he felt that his symptoms were getting worse and he wanted to proceed with surgery.

On 11/18/13 petitioner underwent a right carpal tunnel release. This procedure was performed by Dr. Greatting. Petitioner followed-up post-operatively with Dr. Greatting.

On 12/16/13 petitioner underwent a left carpal tunnel release, also performed by Dr. Greatting. Petitioner followed-up post-operatively with Dr. Greatting.

On 1/2/14 petitioner followed up with Dr. Greatting. Theraputty was provided with instructions for 5 minutes 4 times a day. Petitioner reported that his numbness in both hands had significantly improved. Dr. Greatting released petitioner to full duty work in 1/16/14 without restrictions. He released him on an as needed basis.

On 8/24/15 the evidence deposition of Dr. Greatting was taken on behalf of the petitioner. Dr. Greatting opined that on 10/4/10 he was of the opinion that petitioner's wok activities caused, contributed to, or aggravated the symptoms of his bilateral carpal tunnel syndrome, and he recommended surgery. He testified that when he saw petitioner on 5/6/13 petitioner had similar complaints to what he had in 2010. Dr. Greatting understood that petitioner worked the same duties in 2010 as he did in 2013. Dr. Greatting testified that when he treated petitioner that his diabetes was under control.

On cross-examination Dr. Greatting stated that the left median distal motor latency went from 6.2 mm to 5.7 mm from the 9/9/10 EMG to the 4/25/13 EMG, and that was an improvement on the left side. He stated that the right side had worsened a bit. Dr. Greatting stated that petitioner writes with his right hand, and believed meal preparation, serving, and lifting would likely require both hands. He also agreed that petitioner lifted crates of milk and juice, served two meals daily, and did computer work. Dr. Greatting was of the opinion that even if petitioner was varying his duties he believed these duties require similar activities with the wrists and hands. So even if they are different or varied they are still similar as far as the effect they would be having on the wrists. Dr. Greatting was of the opinion that all petitioner's activities are to some degree or some nature repetitive and that some of them have more force involved than others. Dr. Greatting believed the lifting and food and meal preparation were more forceful than petitioner's other duties. However, he did not know how long on any given day petitioner was doing any of his specific duties. Dr. Greatting did not know what types of lock or keys petitioner used, or the weight of the keys, or the force needed to open the locks. Dr. Greatting opined that people considered obese, actively smoke, are diabetic and have hypertensions have a higher incidence of carpal tunnel syndrome. Dr. Greatting opined that given petitioner's comorbidities, petitioner would still have a decent chance of having carpal tunnel symptoms, even if he did not perform the duties of the food supervisor.

On 10/29/15 petitioner underwent a Section 12 examination performed by Dr. Lawrence Li, at the request of the respondent. Petitioner stated that he works for Graham Correctional Center, but worked at Pontiac Correctional Center for 21 years. He stated that on 1/15/10 he was working in food service. He stated that his job was to procure the food products, such as gallons of juice and milk and put them in the appropriate places, serve food, and wipe tables. He stated that occasionally he would help prepare the food, but most of the time the food was prepared by the inmates. He stated that he first noticed symptoms in 2009. He complained of bilateral hand pain at that time, that had not resolved. Petitioner's Quick Dash Score on both hands was zero. Petitioner had no current complaints.

Petitioner described his job duties as instructing and watching inmates do food preparation and meal preparation, assist with the food prep and making the meals, and helping with serving the meals. He also reported that he did a lot of writing and opening and closing locks and lifting the products.

Following a record review and examination, Dr. Li noted that petitioner has significant factors for carpal tunnel that include diabetes and obesity. He also noted that petitioner was a former smoker, and smoking is also associated with the development of carpal tunnel syndrome. The date of injury Dr. Li was given was 1/15/10. Dr. Li opined that there is no causal connection between petitioner's work duties and his bilateral carpal tunnel

syndrome. The reason for this opinion was that petitioner does not work with any vibratory tools. He opined that the transfer of crates of milk and juice do not constitute an activity that would cause or aggravate carpal tunnel syndrome. He further opined that writing and turning locks would not cause carpal tunnel syndrome. Dr. Li opined that petitioner mainly watches the food prep and helps serve, and that this job, as well as the job of wiping down the counters, did not seem that strenuous or an activity that would cause carpal tunnel syndrome. Dr. Li opined that the treatment for carpal tunnel syndrome was reasonable and necessary. He further opined that petitioner can do full duty and has no limitations. He was of the opinion that petitioner had reached maximum medical improvement. Based on the AMA Guides to Evaluation of Permanent Impairment, Sixth Edition, Dr. Li opined that petitioner had a 2% loss of the upper extremity, or 1% loss of use of the person as a whole.

On 1/28/16 the evidence deposition of Dr. Li was taken on behalf of the respondent. Dr. Li opined that none of the activities petitioner reported to him seemed to be stressful at all to the wrist and certainly did not seem repetitive, and he did not use any vibratory tools. Dr. Li opined that just because something is done repetitively does not mean it would cause carpal tunnel syndrome. Dr. Li opined that if diabetes is uncontrolled it is worse as it relates to carpal tunnel. Dr. Li testified that petitioner never told him he serves 1000 meals an hour, or that he used any special or older type keys in doing his job.

On cross examination Dr. Li did not believe diabetes or obesity is a sole cause of the development of petitioner's carpal tunnel syndrome. He believed they are associative factors. He believed most carpal tunnels are idiopathic. Dr. Li opined that the use of skeleton keys that require an extreme amount of force suggest a condition that could be a factor in the development of carpal tunnel if they were turning the key 6 times a minute for 8 hours a day. He did not believe turning these keys 100 times a day or 12 times an hour would be considered repetitive. Dr. Li did not believe that gripping a tray, regardless of the amount of weight, would be an issue where you would cause carpal tunnel. He was of the opinion that there was nothing to suggest that petitioner had to position his wrists in any non-ergonomic way, so the weight would not matter. Dr. Li opined that none of petitioner's physical activities played any part whatsoever in the development of his carpal tunnel. Dr. Li opined that idiopathic carpal tunnel syndrome can progress if not treated.

Currently, petitioner testified that his pain is not as bad. He reported some loss of strength and stated that his grip is not as good. He also reported tingling once in a while. Petitioner testified that he does not use the Folger Adams key at Graham Correctional Center. He further testified that the inmates are more involved in the food service at Graham Correctional Center, and he is in more of a supervisory role.

In 2010 petitioner earned $67,000 a year. In the year preceding the alleged injury on 4/25/13 petitioner earned $112,320.00, due to a lot of overtime. Petitioner chose to transfer to Graham, and had a reduction in duties in 2012-2013. He testified that at the time his duties were reduced the condition of his hands still included tingling, pain, and his hands falling asleep.

Petitioner testified that in 2010 he knew his bilateral hand symptoms were related to his work activities.

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

Petitioner is alleging injuries to his bilateral hands due to repetitive work activities that arose out of and in the course of her employment by respondent and manifested itself on 4/25/13.

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

Since petitioner is claiming injuries to his bilateral hands and right arm, in Illinois, recovery under the Workers' Compensation Act is allowed, even though the injury is not traceable to a specific traumatic event, where the performance of the employee's work involves constant or repetitive activity that *gradually* causes deterioration of or injury to a body part, assuming it can be medically established that the origin of the injury was the repetitive stressful activity. In any particular case, there could be more than one date on which the injury "manifested itself". These dates could be based on one or more of the following, depending on the facts of the case:

1. The date the petitioner first seeks medical attention for the condition;
2. The date the petitioner is first informed by a physician that the condition is work related;
3. The date the petitioner is first unable to work as a result of the condition;
4. The date when the symptoms became more acute at work;
5. The date that the petitioner first noticed the symptoms of the condition.

Petitioner has been employed by respondent for 22 years, and until a year and a half ago, worked in the Pontiac Correctional Center. Petitioner testified that while at Pontiac Correctional Center he was Administrator of Food for the entire institution. Petitioner gave various duties and frequencies of duties depending on what records one reviews, and his testimony at trial.

At trial, on direct examination, petitioner testified that he breaks food out, instructs the inmates on how to prepare the food, and was on the line infrequently. He also testified that he and the inmates would get food out of storage and he would unlock the door for them. He testified that he helped the inmates get the cleaning equipment out. Petitioner gave Dr. Greatting a history of instructing and watching inmates do food preparation and meal preparation. He also reported that he helped and assisted with food prep, as well as making and serving meals.

Petitioner reported to Dr. Li on 10/29/15 that on 1/15/10 he was working food service and his job was to procure the food products, such as gallons of juice and milk and put them in the appropriate places, serve food and wipe tables. He also stated that he occasionally would help prepare the food, but most of the time the food was prepared by the inmates. He reported that he first started noticing symptoms in 2009. He described his job duties as instructing and watching inmates do food preparation and meal preparation, assist with food prep and make the meals, and help serve the meals.

Petitioner offered varying testimony on the use of regular keys and Folger Adams keys. He testified that the Folger Adams key required greater force to operate than regular keys. While preparing and serving meals he testified that he had to open and close 10 doors, and half of them required use of the Folger Adams key. He then testified that he opened and closed doors 45-50 times a day. On cross examination, petitioner testified that he would lock and unlock doors about 15 times each, and used the Folger Adams key about 10 times a night. Petitioner reported to Dr. Greatting on 10/4/10 that he had to turn a lot of keys to open and close doors. He also reported that he used some smaller keys and larger keys up to 100 times a day. Petitioner told Dr. Li that he did a lot of opening and closing locks and lifting products.

Petitioner testified that after the food was prepared in the kitchen the inmates, put on carts, and rolled the food to the line, he would open and lock the doors for them as they brought the food to the line. Petitioner testified that he would help serve about 400 inmates during the one hour food service. He would use serving utensils for this and used both hands. He denied that he served inmates continuously during this hour.

Petitioner testified that after the frozen food (chicken) was placed on 18 x 24 inch pans that weighed about 50-60 pounds each, he would help lift the trays by putting his fingers underneath and his thumb on top. He

testified that he handled about 50-100 of these trays. He also handled 10 x 18 inch pans 4 inches deep that contained meat and weighed 25-30 pounds full. He stated that he could handle up to 100-200 pans of meat the same way as the chicken pans. Petitioner testified that he also mashed potatoes and opened 120 cans weighing 5 pounds each with a manual can opener for each meal. Petitioner also testified to handling 40 cases of milk that held 52-8ounce cartons for each meal. He testified that he sometimes would take these out of the store room and place them on a cart.

On cross examination, petitioner testified that in 2012 an 2013 his primary job was working the midnight shift and his primary job was monitoring and supervising the inmates. He testified that he only showed inmates once how to do things. During this period petitioner did not work the service line. He stated that during this period on a typical day he might open 10-20 cans, and lift pans. He stated that he lifted 20-25 crates of milk. He testified that he locked and unlocked doors about 15 times each, and used the Folger Adams key about 10 times a night.

Other duties petitioner did on a regular basis included using a computer mouse and keyboard; a lot handwriting activities; and completing forms when inmates took tools out. He stated that he signed his signature 130 times and wrote down the name of the tool, the time out, the time in, and the name of the inmate.

Based on this testimony and the histories he gave Dr. Greatting and Dr. Li regarding his work activities, the arbitrator finds the petitioner performed many varying activities throughout the day, and the actual number of repetitions he performed each activity each day is unclear based on the varying testimony he gave, as well as the varying work activities he described to Dr. Greatting and Dr. Li. Therefore, the arbitrator finds the petitioner has failed to place into evidence specific and detailed information concerning his work activities, including the frequency, duration, manner of performing, etc.

The arbitrator notes that it is also equally important that the medical experts have a detailed and accurate understanding of the petitioner's work activities. On cross examination Dr. Greatting testified that he knew petitioner wrote with his right hand; believed he used both hands for meal preparation, serving, and lifting; lifted crates of milk and juice; served two meals a day; and did computer work. Although Dr. Greatting believed that petitioner's job duties were varied and required similar activities with his wrists and hands, and that all of petitioner's activities were repetitive to some degree, and some required more force, Dr. Greatting testified that he did not know how long on any given day petitioner performed any of his specific duties. He also did not know what types of locks or keys petitioner used , or the weight of the keys, or the force needed to open the locks. Dr. Li opined that the transfer of crates of milk and juice, writing, and turning locks, watching food prep, helping serve, and wiping down counters were repetitive. However, his records do not include any evidence

that he had a detailed and accurate understanding of the petitioner's work activities especially as it related to the frequency, duration, manner of performing, etc.

Based on the above, the arbitrator finds the medical experts did not have a detailed and accurate understanding of the petitioner's work activities.

Notwithstanding the fact that the arbitrator finds the petitioner has failed to place into evidence specific and detailed information concerning his work activities, including the frequency, duration, manner of performing, etc., and the medical experts did not have a detailed and accurate understanding of the petitioner's work activities, the arbitrator also finds a manifestation date of 4/25/13 is not the date on which the injury and its causal link to work became plainly apparent to a reasonable employee. The arbitrator finds the date on which a reasonable person or the petitioner would have plainly recognized the injury and its relation to work was on 1/15/10.

Petitioner testified that he started noticing symptoms in his hands in 2008 and 2009. He testified that at that time he had trouble holding on to things, his hands would fall asleep, had trouble driving, and had pain in his hands while doing work duties. Petitioner presented to Dr. Mulch in 2010 and on 9/9/10 petitioner underwent an EMG/NCV that showed bilateral median neuropathies at the wrist, moderate in degree, with neuropraxia seen bilaterally and early sensory axon loss seen on the right.

After this exam petitioner reported the injury to respondent and completed a Workers' Compensation Employee's Notice of Injury for a date of injury on 1/15/10. He indicated that while turning keys for locks and doors he felt pain in his wrist and arm. He stated that both arms and hands were affected.

Shortly thereafter, on 10/4/10, he presented to Dr. Greatting for evaluation of his bilateral hand complaints with numbness and tingling. Petitioner noted that he had diabetes, heart disease, and hypertension. Petitioner reported that he is a correctional officer and had complaints of bilateral hand pain, numbness and tingling. He also reported some pain up his arms, and pain, numbness and tingling at night. Petitioner identified activities such as using a computer mouse and keyboarding, as well as driving as things that bother him. He reported that at work he has to write a lot and his symptoms increase with this activity. He also reported that he drops things at work and has to turn a lot of keys to open and close door locks. He reported that he uses some smaller keys and larger keys up to 100 times a day. He reported increased symptoms while doing work activities that include serving food. He stated that he filled food trays and handed out trays. He denied any acute trauma or injury.

Following an examination and review of the EMG/NCV results, Dr. Greatting assessed bilateral carpal tunnel syndrome. Dr. Greatting was of the opinion that based on petitioner's history that his work activities

caused, contributed to, or aggravated his symptoms related to his carpal tunnel syndrome. Bilateral carpal tunnel releases were recommended. Petitioner stated that he was going to schedule the right carpal tunnel release followed by the left carpal tunnel release 4 weeks later. However, petitioner never did this and continued to work. His salary at this time was $67,000a year. Petitioner testified at trial that in 2010 he knew his bilateral hand symptoms were related to his work.

Petitioner stated that his symptoms continued to worsen, especially with respect to turning the Folger Adams key and using the can opener. Petitioner also did quilting using a quilting machine. He used a razor knife when quilting.

Petitioner did not seek any further treatment until 4/9/13. At that time he returned to Dr. Greatting. Although petitioner testified that his symptoms were worse, Dr. Greatting's assessment remained unchanged from 2010. He again assessed bilateral carpal tunnel syndrome and again recommended bilateral carpal tunnel releases. Just like in 2010, petitioner again stated that he wanted to undergo the recommended surgeries. Dr. Greatting also noted that petitioner's sugars were uncontrolled at that time.

On 5/8/13 petitioner's completed Application for Adjustment of Claim was filed. Petitioner identified the date of accident as 4/25/13. This was the date that petitioner underwent a repeat EMG/NCV of his bilateral hands that again showed bilateral median neuropathies at the wrists, moderately severe, with some interval progression on the right when compared to the earlier study in 2010. In the year proceeding this alleged accident date, petitioner earned $112,320.00, due to a lot of overtime he worked. He also admitted that he had a reduction in duties in 2012-2013. The arbitrator also notes that around this time petitioner's sugar levels were elevated indicating that petitioner's diabetes was not under control.

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 to his bilateral hands due to repetitive work activities, that arose out of and in the course of his employment by respondent, and manifested itself on 4/25/13.

Nothwithstanding this finding, the arbitrator further finds that even if the petitioner had proven by a preponderance of the credible evidence that he sustained an accidental injury to his bilateral hands due to repetitive work activities, that arose out of and in the course of his employment by respondent, the proper manifestation date would have been 1/15/10, the date petitioner alleged an injury to his bilateral hands on the Workers' Compensation Employee's Notice of Injury he completed on 9/30/10. The arbitrator finds that at this time petitioner was performing the same work duties he testified to performing prior to his alleged 4/25/13; that

at that time Dr. Greatting assessed bilateral carpal tunnel and opined that it was causally related to petitioner's work duties for respondent; that at that time Dr. Greatting recommended petitioner undergo bilateral carpal tunnel releases; and that at trial petitioner admitted that in 2010 he knew his bilateral hand symptoms were related to his work activities.

Given the fact that Dr. Greatting assessed bilateral carpal tunnel and opined that it was causally related to petitioner's work duties for respondent on 10/4/10; that in 2010 Dr. Greatting recommended petitioner undergo bilateral carpal tunnel releases; that when petitioner completed the Workers' Compensation Employee's Notice of Injury on 9/30/10 he alleged an injury to his bilateral hands on 1/15/10; that when petitioner presented to Dr. Li he gave an injury date of 1/15/10; that at trial petitioner admitted that in 2010 he knew his bilateral hand symptoms were related to his work activities; and that Section 6(d) of the Act requires that a claim for compensation be filed with the Workers' Compensation Commission within two years from the last payment of compensation or three years from the date of injury, whichever is later, the arbitrator finds that with an alleged injury and manifestation date of 1/15/10, petitioner's claim for compensation needed to be filed with the Workers' Compensation Commission by 1/15/13. Since petitioner did not file any claim for an injury date of 1/15/10, the arbitrator finds the petitioner's claim for compensation was not timely filed.

E. WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO RESPONDENT?
F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?
J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?
K. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?
L. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

Having found the petitioner has failed to prove by a preponderance of the credible evidence that he sustained an accidental injury to his bilateral hands due to repetitive work activities that arose out of and in the course of his employment by respondent, and manifested itself on 4/25/13, and that petitioner did not timely file his claim with the Workers' Compensation Commission for an alleged repetitive injury on 1/15/10, the arbitrator finds these remaining issues 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

Joanne Szoke,
Petitioner,

18IWCC0068

vs.

NO: 11 WC 20588

Chasers, 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 causal connection, medical, 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 13, 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 $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.

JAN 31 2018

DATED:
o1/11/18
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0068

SZOKE, JOANNE
Employee/Petitioner

Case# **11WC020588**

CHASERS INC
Employer/Respondent

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:

0810 BECKER HOERNER ET AL
AARON J CHAPPELL
5111 W MAIN ST
BELLEVILLE, IL 62226

2091 HEYL ROYSTER VOELKER & ALLEN
TONEY TOMASO
PO BOX 47
EDWARDSVILLE, IL 62025

18IWCC0068

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

Joanne Szoke
Employee/Petitioner

v.

Chasers, Inc.
Employer/Respondent

Case # **11**WC **20588**

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 **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. ☐ 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 4, 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 these dates, 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 condition of ill-being *is not* causally related to the accident.

In the year preceding the injury, per the stipulation of the parties, Petitioner earned **$3,495.00** and the average weekly wage was that of **$112.36.**

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

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

Respondent shall be given a credit of **$1,925.85** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for non-occupational disability benefits, for a total credit of **$1,925.85.**

ORDER

Respondent shall pay **for treatment rendered during the timeframe of February 4, 2011 through June 29, 2011** for medical services as provided in Sections 8(a) and 8.2 of the Act. Respondent is to hold Petitioner harmless for any claims for reimbursement from any health insurance provider and shall provide payment information to Petitioner relative to any credit due. Respondent is to pay unpaid balances with regard to said medical expenses **for treatment rendered during the timeframe of February 4, 2011 through June 29, 2011** directly to the provider. Respondent shall pay any unpaid, related medical expenses **for treatment rendered during the timeframe of February 4, 2011 through June 29, 2011** according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner. Respondent shall be given a credit for all medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner the sum of **$112.36/week** for a further period of **25 weeks**, as provided in Section 8(d)2 of the Act, because the injuries sustained caused **5% loss of use of the person-as-a-whole,** as well as a further sum of **$112.36/week** for a further period of **0 weeks,** as provided in Section 8(e) of the Act, because the injuries sustained caused **0% loss of use of the right thumb.**

Respondent shall be given a credit of **$1,925.85** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for non-occupational disability benefits, for a total credit of **$1,925.85.**

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 Gillivan

Signature of Arbitrator

9/9/16

Date

SEP 13 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Joanne Szoke
Employee/Petitioner

Case # 11 WC 20588

v.

Consolidated cases: N/A

Chasers, Inc.
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that she lives in Belleville and is currently 54 years of age. She testified that she has a paralegal certificate as well as a cosmetology certificate. She testified that she currently owns a property management company. She testified that she was previously employed by Respondent Chasers, a bar located in Belleville. She testified that she worked for Respondent from 2009 through 2011 as a bartender, and that she stopped working there on February 4, 2011, when she had a slip and fall.

Petitioner testified that on February 4, 2011 she arrived at work before the bar opened at 11:00 a.m., and that she picked up trash and beer bottles in the parking lot and on the deck. She testified that she went to throw some items into the dumpster, and that she slipped on ice and fell, landing crooked. She testified that she landed on her right hand and that she felt a weird twinge in her back. She testified that she walked back inside and that as she was walking back in, one of the owners by the name of Brad was arriving, saw snow on her coat and asked what her happened. She testified that she told him that she fell and that he asked her if she was hurt. She testified that he then called Jean, who requested that she go to the hospital so she went to Memorial Hospital.

Petitioner testified that they did not do much for her at the emergency room, and that they did x-rays, gave her some pain medication and told her to follow-up with her primary care physician and Dr. Mirly. She testified that she saw Dr. Mirly for her right hand, and that she told him that she had fallen on it in either October or November of 2010 and that when she fell again, it made it hurt again. She testified that she sought no treatment for her hand after the fall in November of 2010. She testified that when she saw Dr. Mirly, he did x-rays and gave her a splint. She testified that he offered to do an injection for pain, but she declined. She testified that when she followed up with him again, he advised that she wear the splint.

Petitioner testified that she also saw Dr. Brown for her right thumb as well. She testified that Dr. Brown recommended physical therapy and that she use squeeze balls, but she denied undergoing any therapy. She testified that she sought treatment for her low back with a chiropractor, Dr. Williams. She testified that she had previously treated with him for issues with her neck while she had a painting company. She testified that the chiropractic treatment did not help, so Dr. Williams sent her for an MRI and then to a specialist, Dr. Raskas.

Petitioner testified that Dr. Raskas recommended pain management and that he really wanted to do surgery, but he could not say if it would "cure" her. She testified that he also recommended physical therapy, which she did at Memorial Hospital. She testified that she then underwent pain management

with Dr. Feinberg, who performed injections. She testified that when she first saw him, the pain was constant and that she could not do a lot nor could she bend or twist. She testified that the injections and physical therapy helped, and that she reported this to her to physicians.

Petitioner testified that she was sent to Dr. Cantrell by her employer, and that she answered all of the questions that he asked. She testified that the evaluation lasted maybe two minutes. She testified that she was cooperative with the examination. She testified that after she saw Dr. Cantrell, her benefits were stopped so she retained an attorney because she worried about the medical bills being paid. She testified that she eventually went back to Dr. Raskas, and that he recommended pain management. She denied having any health insurance at the time. She testified that she did not realize that her medical bills were not being paid for a little while, and that when she was advised the bills were not being paid, she quit going. She testified that she went back to Dr. Feinberg on the recommendation of Dr. Raskas, and that he did injections and gave her pain medications. She testified that she did not like taking the pain medications but did on occasion, and that the injections seemed to help and that her pain seemed to improve.

Petitioner testified that she followed up again with Dr. Feinberg in December of 2012, but was not sure if that was the last time she saw him. She testified that she underwent an injection on that date because she was going to see her daughter in New York City and needed it for the trip. She testified that she was in a lot of pain before the injection and that after the injection, it would immediately alleviate the pain but it would eventually come back.

Petitioner testified that she currently has pain in her central low back region. She testified that she has difficulty unloading the dishwasher, that when she goes to the restroom she has to wipe with her left hand now and that she can no longer ride a motorcycle anymore. She testified that she used to paint and rehabilitate houses, but that she stopped doing it after the accident.

Petitioner testified that since treating with Dr. Raskas and Dr. Feinberg, her symptoms have improved over time but now she is going to have to live with it. She testified that she still takes pain medications as needed, and that she exercises with various equipment including a recumbent bike. She testified that she currently takes muscle relaxers, anti-inflammatories and Percocet that she gets from her primary care physician, Dr. LeBeau. She testified that she now has insurance to pay for the medications.

Petitioner testified that she used to ride motorcycles but now no longer rides. She testified that she rode a few times after the accident, but every time she rode it hurt the next day. She testified that she has not ridden a motorcycle in several years. She denied having any low back complaints before the accident, and she further denied having sustained any injuries to her low back since the accident.

On cross examination, Petitioner agreed that she was riding a motorcycle on June 4, 2011, approximately 4 months after the accident. She admitted that she was riding a Harley Davidson motorcycle that day. She testified that she got rid of the motorcycle in approximately February of 2012. She agreed that in June of 2011, she was still experiencing low back pain associated with the accident.

On cross examination, Petitioner agreed that at no time between the accident date and the date of arbitration did she undergo surgery to her low back. She testified that on June 7, 2011 she returned to the workplace and worked for Kelly Services picking up temporary office positions. She agreed that she worked as a paralegal through Kelly Services.

On cross examination, Petitioner testified that she has had to adjust a lot of her duties as a result of her work injuries, and that unloading the dishwasher was just one of them. She agreed that after each injection she received from Dr. Feinberg, her condition improved for a little while and then went back to baseline. She testified that overall the injections had a lasting effect that improved her quality of life at

the time. She agreed that the last time she treated with either Dr. Raskas or Dr. Feinberg would have been in December of 2012. She agreed that she had opportunity to return to their offices since December of 2012, but did not go.

On redirect examination, Petitioner agreed that she worked as paralegal through Kelly Services. She testified that she had some difficulties performing the job duties of a paralegal, and that she was not able to sit for long periods of time, stand for long periods of time or walk for long stretches. She testified that she could not recall whether Dr. Raskas took her off work when she returned to him in October of 2011, but believed that he said she could work with limits and that she could not return to bartending because of her lifting restrictions.

On redirect examination, Petitioner testified that she rode motorcycles for approximately 30 years of her life and that she considered it a nice hobby. She testified that she also used it as a means of transportation and that she would sometimes ride to the bank or the post office. She testified that she also owned a car, and that after the accident riding in both the car and on the bike caused discomfort.

The medical records of Memorial Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. Petitioner was seen on February 4, 2011 after a fall at 11:00 a.m. on the ice in the parking lot at work. It was noted that Petitioner was complaining of neck, low back, right shoulder and right thumb pain. The interpretive report for x-rays of the right thumb performed on February 4, 2011 referenced being unremarkable. The interpretive report for x-rays of the lumbar spine performed on the same date referenced degenerative disc disease and levoscoliosis. The interpretive report for x-rays of the cervical spine performed on the same date referenced loss of cervical lordosis and degenerative disc disease. The clinical impression was that of contusion and lumbar strain secondary to fall. (PX1).

The records of Memorial Hospital reflect that Petitioner underwent a back evaluation on May 2, 2011 for a treatment diagnosis of lumbar extension/rotation syndrome. The progress note directed to Dr. Raskas dated May 16, 2011 noted that Petitioner had attended 7 of 7 scheduled physical therapy appointments including her initial evaluation, and that overall Petitioner felt that her back was better than it was when she began therapy but she was still having quite a bit of pain on most days in her lower back. The progress note to Dr. Raskas dated May 27, 2011 noted that Petitioner had attended 12 of 12 scheduled physical therapy appointments including her initial evaluation, and that Petitioner reported that overall she felt she was continuing to do better since beginning therapy. The Physical Therapy Outpatient Discharge Note dated September 12, 2011 noted that the reason for discharged was that the physician orders had expired, and that Petitioner had undergone 13 therapy sessions during the timeframe of May 2, 2011 to June 3, 2011. It was also noted that the goals had been achieved. (PX1).

The medical records of Dr. Harvey Mirly were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. Petitioner was seen for evaluation of a right thumb injury on February 10, 2011. It was noted that Petitioner was injured by an onset of pain actually back in November, that she had fallen about a week before that after tripping on a long coat and fell on some stairs. It was noted that she had a second injury on February 4, 2011 with a fall in a parking lot. It was noted that Petitioner had x-rays taken both November 3, 2010 and February 4, 2011 which showed CMC arthritis and no bony injuries were appreciated at the IP joint. It was noted that Petitioner lacked the ability to hyperextend the IP joint of her thumb consistent with a soft tissue mallet finger, and that she also had osteoarthritis at the CMC joint of the thumb. Petitioner was fitted with a 3-point thumb spica splint for support of the CMC joint in a stack splint for the thumb IP joint which she was recommended to wear for 6 weeks. A work slip was issued on that date, allowing her to return to work with no restrictions but it was noted that she must wear her splint while working. (PX2).

The records of Dr. Mirly reflect that Petitioner was seen on March 24, 2011, at which time it was noted that the splint was removed, that there was no extensor lag and that Petitioner was able to achieve a

little flexion and regain full extension. It was noted that Petitioner could start weaning from the splint and have light motion and avoid forceful flexion. A work slip was issued on that date, allowing Petitioner to return to work with no restrictions. (PX2).

The medical records of Dr. David Brown were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. Petitioner was seen on May 4, 2011 for evaluation and treatment for an injury that occurred to her right thumb. It was noted that Petitioner explained that on February 4, 2011 while at work she slipped and fell on ice in the parking lot, having injured her thumb. It was noted that Petitioner thought her thumb was bent backwards, and that Petitioner pointed towards the metacarpal of the thumb. Petitioner stated that she had pain from the base of the thumb to around the MP joint, but denied any numbness or tingling. It was noted that she had worn a splint for 6 weeks, that the pain was better and that her main complaint was stiffness. The impression was that of resolving contusion right thumb. Dr. Brown recommended that she undergo a 4 week course of a supervised therapy program to improve range of motion. Petitioner was allowed to return to work full duty without restrictions. (PX3).

The medical records of Dr. David Raskas were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. Petitioner was seen on April 25, 2011, at which time it was noted that Petitioner was injured at work, working as a bartender, when she was taking some things out and slipped and fell on the ice on February 4, 2011. It was noted that Petitioner had had pretty severe mid upper lumbar pain since, and that she had had some chiropractic treatments which made things better to a point but things were not anywhere back to where they were prior to her injury. It was noted that Petitioner's pain had worsened during and after exercise, and with prolonged sitting, standing, walking or twisting. It was noted that Petitioner had not had any formal physical therapy nor any injections. It was noted that Petitioner could drive, walk, climb stairs, do housework, sit, stand and get dressed, but that her pain was aggravated by bending forwards and bending backwards more than forwards. It was noted that Petitioner could not do yard work or work at a job. It was noted that Petitioner's pain was primarily in her back in the mid to upper lumbar areas and occasionally would radiated into her left buttock but not predominately. It was noted that Petitioner's pain escalated anywhere throughout the day between a 3 and a 9 on a 0-10 pain scale. It was also noted that Petitioner denied any history of any significant back problems in the past or seeing doctors for back pain, and that she stated that she did have one prior neck problem in the past which was treated with chiropractic treatment successfully. The diagnostic impression was that of aggravation of a degenerative condition in Petitioner's back which included degenerative disc disease at L2-L3 with scoliosis and that she likely had facet syndrome. Dr. Raskas recommended L2-L3 epidural injection and L2-L3 facet blocks, as well as physical therapy. (PX4).

The records of Dr. Raskas reflect that Petitioner was seen on May 16, 2011 after obtaining bilateral facet injections at the level of L2-L3. It was noted that Petitioner stated that after the injections her overall pain level had decreased, and that she still had some residual pain in her lower back about the level of the pelvis. It was noted that Petitioner had been attending physical therapy which had helped with her strength and mobility. It was also noted that on that date Petitioner's back pain score was a little bit lower than it had been in previous visits. The assessment was that of degenerative scoliosis and facet arthropathy. Petitioner was recommended to obtain bilateral facet injections at the level of L4-L5 since she was describing pain that was lower than previous visits. It was noted that Petitioner would be kept off work until her next office visit. (PX4).

The records of Dr. Raskas reflect that Petitioner was seen on May 27, 2011, at which time it was noted that Petitioner was having back pain and that the day before she had a pretty bad day but felt like the injections and therapy were improving things. It was noted that Petitioner's overall pain score was decreased down to a 4 from an 8 when she first started treating. It was noted that Petitioner was still fairly limited in terms of standing, that she felt pretty good when she got up in the morning and that as soon as she started to stand things started to bother her quite a bit more. It was noted that Petitioner was to continue physical therapy and she was given a light duty work release. (PX4).

The records of Dr. Raskas reflect that Petitioner was seen on June 22, 2011, at which time it was noted that Petitioner continued to have back pain that interfered with activities of daily living on a significant basis. Petitioner stated that if she goes grocery shopping, bends, lifts or twists frequently she will have to lie down throughout the day to recover from that type of activity. It was noted that Petitioner's back bothered her much more than her leg, and that she had some periodic symptoms in her buttocks and things of that nature. It was noted that Dr. Raskas asked her about her recreational activities, and that they talked about the fact that she rides a motorcycle every once in a while. It was noted that Petitioner could ride for 20-30 miles at most and then had to stop and get off and rest. Petitioner stated that it did not bother her any more than bouncing in a car, and that it was a large motorcycle. The assessment was that of scoliosis. It was noted that Petitioner continue with the same work restrictions, and that she was working as a paralegal and functioning within her restrictions while at work. (PX4).

The records of Dr. Raskas reflect that Petitioner was seen on October 3, 2011, at which time it was noted that Petitioner continued to suffer with significant persistent back pain. It was noted that it was disabling to the point where Petitioner tried working as a paralegal and could not tolerate the prolonged sitting. It was noted that it gave Petitioner a difficult time getting out of bed, and that it interfered with all activities of daily living, sleeping, standing and walking. It was noted that Petitioner had a fall, had degenerative scoliosis and that it had aggravated the condition causing it to become persistently symptomatic. It was noted that Dr. Raskas was not optimistic that a surgical procedure was likely to improve her overall condition, and that he suggested long-term pain management with Dr. Feinberg. It was noted that Dr. Raskas did not think that Petitioner was capable of working right now, and that he thought work status could be addressed periodically by Dr. Feinberg. (PX4).

The medical records of Dr. Barry Feinberg were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. Petitioner was seen on April 25, 2011 for a transforaminal epidurogram for a pre- and post-operative diagnosis of lumbar radiculopathy. It was noted that Petitioner's pain level on that date was 7/10, and that she complained of mid to low back pain radiating down into the left buttock. It was noted that Petitioner sat to the left side compensating her right-sided dysfunction. (PX5).

The records of Dr. Feinberg reflect that Petitioner underwent a paravertebral facet joint injection, lumbar, on April 28, 2011, and the pre- and post-operative diagnosis was that of (1) lumbosacral spondylosis; (2) lumbago. It was noted that Petitioner had a pain level of 6-7/10 on that date. Petitioner stated that now when she rests and when she wakes up in the morning, her pain level is better and that Petitioner stated she was pain free. It was noted that Petitioner stated as the day went on and she was more active, the pain increased in the low back and left side down to the left buttock. It was noted that Dr. Feinberg would consider recommending possible physical therapy depending on the results, and that Petitioner may require radiofrequency ablation bilateral at the L2-3 level. (PX5).

The records of Dr. Feinberg reflect that Petitioner underwent a paravertebral facet joint injection, lumbar, on May 16, 2011, and the pre- and post-operative diagnosis was that of (1) lumbosacral spondylosis; (2) lumbago. It was noted that Petitioner had a pain level of 7/10 on that date, and that less pain was noted for a few days. It was noted that Petitioner had low back pain, left hip pain and down the left leg. It was noted that Petitioner had been blocked at left L2-L3 level on April 28, 2011. (PX5).

The records of Dr. Feinberg reflect that Petitioner was seen on April 5, 2012 for a transforaminal epidural injection for a pre- and post-operative diagnosis of lumbar radiculopathy. It was noted that Petitioner's pain level on that date was 5-6/10 and that she was complaining of mid back pain and low back pain down to the bilateral hips. It was noted that Petitioner had left greater than right low back pain into the hips. (PX5).

The records of Dr. Feinberg reflect that Petitioner was seen on April 19, 2012 for a transforaminal epidural injection for a pre- and post-operative diagnosis of lumbar radiculopathy. It was noted that

Petitioner was last treated back on May 5, 2011 and that Petitioner stated she had the same pain location and that it was constant now. Petitioner was seen on May 2, 2012 for a transforaminal epidural injection for a pre- and post-operative diagnosis of lumbar radiculopathy. It was noted that Petitioner had low back pain down the right leg, and that 75% pain relief was noted since the last injection. Petitioner was seen on June 4, 2012 for a paravertebral facet joint injection, lumbar, for a pre- and post-operative diagnosis of (1) lumbosacral spondylosis; (2) lumbago. It was noted that Petitioner report pain in the low back and mid back, and that she had bilateral leg pain. It was noted that Petitioner was doing painting and had been standing and a lot of extension of the lumbar spine. Petitioner was seen on July 9, 2012 for a paravertebral facet joint injection, lumbar, for a pre- and post-operative diagnosis of (1) lumbar spondylosis; (2) lumbago. It was noted that Petitioner reported 70% improvement and that the pain was slowly getting better. It was noted that Petitioner had just moved into a new location, that she was on disability and that she had to move into a double-wide. It was noted that Petitioner stated that increased activity worsened her pain. (PX5).

The records of Dr. Feinberg reflect that Petitioner was seen on August 13, 2012 for a sacroiliac joint injection for a pre- and post-operative diagnosis of (1) sacroiliitis; (2) lumbar spondylosis; (3) low back pain. It was noted that Petitioner stated that she was 90% improved with the pain that was treated in the upper portion of the lumbar spine as a result of the disc herniation at L2-L3. It was noted that Petitioner reported pain across the sacroiliac region, which was the worse pain as bilateral left greater than right side. Petitioner was seen on December 6, 2012 for a paravertebral facet injection, lumbar, for a pre- and post-operative diagnosis of (1) lumbosacral spondylosis; (2) low back pain. It was noted that Petitioner had less pain in the low back, 75-90% improved, but had mid back pain. It was noted that medical clearance was given to Petitioner and returned back to the use of the gym at work. It was noted that Dr. Feinberg believed that Petitioner had come close to reaching maximum medical improvement. It was noted that Petitioner would need medical treatment, including physical therapy and injection therapies, when she had exacerbation of pain and continued medication management including medical check-ups. Petitioner was discharged at that time. (PX5).

The medical records of Dr. Jeffrey Williams were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. Petitioner underwent chiropractic treatment for the timeframe of February 11, 2011 through April 15, 2011. According to the letter dated February 14, 2011, Dr. Williams' diagnoses included: lumbar sprain/strain with associated lumbar radiculitis into her right buttock area; cervical spine sprain/strain with associated radiculitis into her right shoulder/right arm and right hand; decreased range of motion in her lumbar spine, cervical spine and right shoulder areas; and right shoulder pain. (PX6).

The transcript of the deposition of Dr. David Raskas was entered into evidence at the time of arbitration as Petitioner's Exhibit 7. Dr. Raskas testified that he is an orthopedic spine surgeon. He testified that he first saw Petitioner on April 25, 2011, at which time she reported that she was working as a bartender and was taking some things outside, and that she slipped and fell on the ice. He testified that Petitioner reported that she had been having some severe mid upper lumbar pain since, and that she had had some chiropractic treatments which made things better to a point but not near where they were prior to her injury. He testified that the physical examination performed on that date was pretty much a normal examination except for some paravertebral spasm. He testified that he diagnosed an aggravation of her degenerative condition in her back, which included degenerative disc disease at L2-3, scoliosis, and likely a facet joint syndrome. He testified that he recommended injections and physical therapy. He testified that he referred Petitioner to Dr. Barry Feinberg for the injections, and that they were performed on April 28th and May 16th, 2011. (PX7).

Dr. Raskas testified that he next saw Petitioner on May 16, 2011, at which time she reported some improvement after the injections. He testified that Petitioner had been attending some physical therapy, which she felt was helping a little bit. He testified that Petitioner still had some paravertebral spasm, and he recommended that she obtain some facet injections at a lower level. He testified that Petitioner

returned on May 27, 2011, at which time he recommended that she continue the physical therapy and he gave her a light duty work release. He testified that Petitioner next returned on June 22, 2011, at which time she was still having a lot of back pain that was interfering with normal life on a daily basis. He testified that he noted that they talked about her recreational activities, which included motorcycle riding. He testified that Petitioner stated that she could not ride like she used to. He testified that riding a motorcycle at that point and in the fashion she described was not contrary to his restrictions. He testified that riding a motorcycle like she described did not cause any additional aggravation or exacerbation of her back condition on any permanent basis. (PX7).

Dr. Raskas testified that Petitioner returned on October 3, 2011, at which time she continued to suffer with significant back pain. He testified that Petitioner could not tolerate prolonged sitting, that she had tried doing some paralegal work, and that she had a difficult time getting out of bed as well as trouble with sleeping, standing and walking. He testified that he thought Petitioner had a degenerative scoliosis which had been persistently symptomatic. He testified that he suggested long-term pain management and referred Petitioner to Dr. Feinberg for that. He testified that the need for pain management was causally related to the work accident. He testified that he has not seen Petitioner since that date, and that he did not feel that Petitioner was capable of working at all at that point. (PX7).

Dr. Raskas testified that he believed that the treatment that had been performed as well as the treatment that he was recommending was reasonable and necessary in light of the work accident. He testified that even though he had not seen her since October 3rd, it was still his opinion that Petitioner needed ongoing pain management with Dr. Feinberg. He testified that if Petitioner's pain progressed to the point where she absolutely could not stand living this way anymore at all and the pain management techniques were not effective, surgery would be an option. He testified that the pain management treatments were of some benefit to Petitioner because when they were stopped, her pain escalated. (PX7).

On cross examination, Dr. Raskas confirmed that he did not provide any treatment for either Petitioner's right hand or thumb as a result of the accident and that he had no opinion about the nature of the right hand and thumb. He agreed that there was no causal relation between Petitioner's cervical spine condition and the reported work accident. He testified that his diagnosis was that Petitioner was suffering from aggravation of degenerative changes throughout the lumbar spine. He testified that the radiographic findings pre-existed the actual work accident, but he did not believe it reached the point of being a condition where she was symptomatic from it. He agreed that the trauma from the incident Petitioner reported aggravated radiologic findings that were there before the event. (PX7).

On cross examination, Dr. Raskas confirmed that when he initially evaluated Petitioner on April 25, 2011, her physical examination was pretty normal with the exception of some paravertebral spasm. He agreed that his recommendation for treatment was driven by Petitioner's pain complaints. He agreed that pain was a subjective finding that he had to rely upon the veracity of the patient in making that determination. He agreed that for the most part Petitioner's physical examination remained for the most part normal with exception of the paravertebral spasm at the subsequent visits on May 16th, May 27th and June 22nd. He agreed that from April 25th through June 22nd, it appeared that Petitioner had had some improvement. He agreed that May 27th was the first time that he thought Petitioner would return to work with restrictions. He agreed that as of June 22nd, he saw no problems with Petitioner working as a paralegal and that he saw no problem with her working in a sedentary job. (PX7).

On cross examination, Dr. Raskas testified that as of the last visit on October 3, 2011, he did not feel that Petitioner could even work at a sedentary job as she indicated she could not tolerate the sitting. He testified that Petitioner's physical examination was a little worse on that date, and that she had range of motion loss at that point that she had not had earlier, that she had spasms, that she was not walking as well and that her subjective complaints of pain were worse. He agreed that Petitioner's strength, sensation and reflexes were all within normal limits on October 3rd. He agreed that Petitioner's range of

motion was to some extent within her control, and that the slow antalgic gait was also to some extent within her control but that he saw how she walked when she did not know that he was necessarily observing her. (PX7).

On cross examination, Dr. Raskas agreed that Respondent's Exhibit A was the photograph that was mentioned in his office note of June 22, 2011. He testified that the case manager gave him photographs, and that was what prompted the discussion about Petitioner riding a motorcycle. He testified that he never recommended anyone to ride a motorcycle. He testified that it was unlikely that riding a motorcycle could aggravate a person's low back provided they were not riding in off-road situations, and that he did not think it was any different than riding in a car. He agreed that the position of riding a motorcycle was different than a person standing. (PX7).

On cross examination, Dr. Raskas agreed that he disagreed with Dr. Cantrell regarding his opinion that no further treatment was necessary for Petitioner as of June 29, 2011. He agreed that he disagreed with Dr. Cantrell's opinion that no further restrictions on Petitioner's activities would be necessary as of June 29, 2011. He testified that he did not think that Petitioner's riding a motorcycle could have aggravated her low back condition beyond a temporary basis and that it did not do so on a long-term basis. He testified that he did not think that possible aggravation from the motorcycle would permanently alter Petitioner's complaints. He agreed that as of October 3, 2011, he did not feel that Petitioner was a surgical candidate. (PX7).

On redirect examination, Dr. Raskas agreed that Petitioner had attempted to go back to doing paralegal work in the summer between when he last saw her in June and when she returned to see him, and that she had gone through that period of June 22nd to October 3rd with no treatment. He agreed that when Petitioner returned on October 3rd, her condition had worsened to the point that he took her off work completely. He denied that Petitioner was present when the nurse case manager gave him the photographs. He testified that he was familiar with the nurse case manager prior to her involvement in Petitioner's case, and that she had sent him patients before. (PX7).

The transcript of the deposition of Dr. Barry Feinberg was entered into evidence at the time of arbitration as Petitioner's Exhibit 8. Dr. Feinberg testified that he is board-certified in anesthesiology, with additional certification in pain management. He testified that he first saw Petitioner on April 25, 2011 at the referral of Dr. Raskas. He testified that Petitioner told him that she had suffered an injury on or about February 4, 2011 when she fell on the ice and injured her back. He testified that Petitioner reported that she was on medication management and had had an MRI scan of her lumbar spine, and that she had seen Dr. Raskas for an evaluation. He testified that on examination, Petitioner had an antalgic gait on the left side, which meant she was unable to fully place weight onto the left when she was walking. He testified that Petitioner had a positive femoral stretch test, and a positive L2-L3 and L3-L4 Spurling's maneuver, which was positive provocative testing of the facet joints and that she also had an antalgic position in sitting as well as weakness in her gluteal muscles. He testified that he reviewed an MRI scan that was done on March 8, 2011. (PX8).

Dr. Feinberg testified that his diagnoses included a lumbar radiculopathy and a spondylosis involving the facet joint, as well as musculoskeletal components of her back pain. He testified that according to Petitioner's history that she was not symptomatic prior to the fall in February of 2011, so he opined that the fall aggravated a pre-existing degenerative process and caused it to become symptomatic. He testified that the plan was to identify the pain generator of the number of degenerated disks that she had and to treat the pain generator by injection. He testified that a right L2-L3 transforaminal block was performed on that date. (PX8).

Dr. Feinberg testified that he next saw Petitioner on April 28, 2011, at which time she stated that she was better and had some relief of her pain down to the buttock area. He testified that on April 28th

Petitioner had a facet joint injection done at L2-L3 on the left, and that based on the follow-up note on May 16th she had done better, so it had a positive effect. He testified that Petitioner reported that she had had less pain for a number of days, but that she still had pain in the low back into the left hip and into the left leg. He testified that he re-injected the facet joint on that date, and that Petitioner was to follow up in one month. (PX8).

Dr. Feinberg testified that Petitioner was not seen again until April of 2012, at which time she was still complaining of pain and there was no change in her medical history. He testified that it was the same problem, and that there was no interval change in her history or any other injuries. He testified that Petitioner was re-injected again at L2-L3 with an epidural injection on the left. He testified that to his knowledge, at that time Dr. Raskas was continuing to recommend long-term pain management. He testified that Petitioner followed up on April 19th, at which time she stated that she had a day's worth of relief after the injection and that the pain was constant. He testified that Petitioner stated she was working full-time, and that she had pain in her back and into her leg. He testified that Petitioner was re-injected at L2-L3 again. (PX8).

Dr. Feinberg testified that Petitioner was seen on May 2, 2012, at which time Petitioner had pain into the right leg and not as much into the left, and that the pain was less frequent. He testified that Petitioner stated about 75% pain relief was noted since the last injection, and that she was injected at the L2-L3 level again. He testified that Petitioner returned on June 4, 2012, at which time she stated she had bilateral leg pain and had been released by Dr. Raskas. He testified that Petitioner was re-injected on that date at the level of the facet joint. He testified that Petitioner returned on July 9, 2012, at which time Petitioner stated she felt she was slowly getting better. He testified that it was noted that Petitioner was increasing her activities and had just moved. He testified that Petitioner's pain was more of a shooting sensation in the back and more of an ache into the left leg. He testified that Petitioner was injected at the facet level at L2-L3 on the left again. He denied knowing the reason that Petitioner was on disability. (PX8).

Dr. Feinberg testified that Petitioner returned on August 13, 2012, at which time she was 90% improved and the pain was mostly down low into the buttock area. He testified that it was noted that the pain was across the sacroiliac joint so it was low at the base of the spine, and that Petitioner was injected in the sacroiliac joint on that date. He testified that Petitioner was to follow-up as needed. He testified that Petitioner returned one more time on December 6, 2012, at which time she reported that she was 75-90% improved. He testified that Petitioner's pain level was low, and the pain was a little bit higher up on the back but lower in intensity. He testified that Petitioner's medications were refilled, and that she had asked for medical clearance to return to using the gym that they had at work. He testified that Petitioner had the facet joint injected, and that she was instructed to return as needed and was placed at maximum medical improvement. He denied that Petitioner ever returned after that date. (PX8).

Dr. Feinberg testified that his care and treatment was causally related to the work accident that Petitioner reported to him. He testified that he believed that the treatment he provided to Petitioner was reasonable and necessary to relieve her of the effects of her work-related condition. He testified that he believed that his care and treatment was beneficial given that Petitioner was 75-90% better, performing a higher level of activities and did not have to return. (PX8).

On cross examination, Dr. Feinberg agreed that he was aware of the process of utilization review. He agreed that it was a national standard process that was used to determine whether treatments requested for an injured worker was medically necessary. He agreed that was familiar with the Official Disability Guidelines standard. He testified that it should be a peer that has similar credentials to the treating doctor when a utilization review is performed. He agreed that he was aware that there were utilization reviews that were performed for the 2012 treatment that he gave, but testified that the date of the deposition was

the first time that he was aware of that. He testified that he reviewed the utilization review records while waiting for the deposition to start. (PX8).

On cross examination, Dr. Feinberg agreed that Dr. Blum, who purported to be board-certified by the American Board of Anesthesiology with a sub-certification in pain management, had the same credentials that he had as it pertains to board certifications. He testified that he did not have anything in his records showing that he received the non-certification recommendations by Corvel for the treatment performed during the timeframe of April 5, 2012 through December 6, 2012. He testified that he has never received a utilization review that said any of his treatment was non-certified that he had ever seen. He testified that he assumed that there was a deadline for the treatment provider to appeal a decision of non-certification, but that he had never been notified of one. (PX8).

On cross examination, Dr. Feinberg agreed that the April 5, 2012 visit was the first time that he had seen Petitioner after about an 11-month break in treatment. He agreed that the last time that he saw Petitioner before April 5, 2012 was May 16, 2011. When asked to show where in the records it showed that there was radicular pain at the visit in 2012, Dr. Feinberg responded that the pain was in the back and into both hips. He testified that he performed a positive femoral stretch test that showed a deficit. He denied having any record of Petitioner receiving any sort of medical treatment or having undergone any MRIs in between the visits of May 16, 2011 and April 5, 2012. (PX8).

On cross examination, Dr. Feinberg agreed that when he saw Petitioner on April 19, 2012, her response from the last injection was about one day of relief. When asked to show the documentation of radicular complaints on the April 19, 2012 note, Dr. Feinberg responded that Petitioner was having back pain and into the leg, and it was left side greater than right side down to the hip. He testified that Petitioner on May 16, 2011 stated that she had pain in the low back, left hip and down the left leg. He denied that there was any new imaging during the time period of April 5th and April 19th, nor was there any other conservative treatment rendered beyond medical management. (PX8).

On cross examination, Dr. Feinberg agreed that the next visit was on May 2, 2012, at which time he noted lumbar radiculopathy. He agreed that Petitioner had already had two epidural steroid injections in the past month, and that he followed up with her again on June 4, 2012. He testified that Petitioner's complaints on that date were low back, mid back pain and bilateral leg pain. He testified that Petitioner was injected at the facet at L2-3, but that the diagnosis was lumbosacral spondylolysis and that the ICD-9 code covered it. He agreed that there was one date where Petitioner was injected in the sacroiliac, which was August 13th. He testified that this was the first mention of any sacroiliac pain that he noted in his records. When asked what sort of objective testing was done to show that the pain was in that area, Dr. Feinberg responded that Petitioner had positive compression testing of the sacroiliac joint. (PX8).

On redirect examination, Dr. Feinberg agreed that he was never sent the utilization review by the insurance company or Corvel. He agreed that he performed injections on Petitioner each day he saw her in 2012, and that his notes indicated her pain and relief, if any, by the injections and her functional response to the injections. He agreed that he would not have performed the injections unless he believed that they were absolutely necessary. He testified that he believed that the treatment was customary within the local medical community. (PX8).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 9.

The transcript of the deposition of Dr. Steven Blum was entered into evidence at the time of arbitration as Respondent's Exhibit 1. Dr. Blum testified that he specializes in anesthesia, and that he has a subspecialty of pain medicine. He testified that he is currently in private practice with NorthShore

University HealthSystems and sees approximately 40 patients per week, 80-90% of which he is seeing for complaints of spinal symptoms. (RX1).

Dr. Blum testified that he is an independent contractor for Claims Eval and that he performs utilization review. He testified that he has performed many thousands of utilization reviews over the past 4 years, including retrospective utilization review. He testified that the vast majority of the utilization reviews that he has performed have dealt with treatment of spinal issues. He testified that as part of the utilization review process with Claims Eval, the medical treatment is first reviewed by a nurse and if the nurse determines that the treatment is reasonable and necessary, he reviews the treatment as well. He testified that he was the final stage for determining the reasonableness and necessity of the medical treatment. (RX1).

Dr. Blum testified that he had the chance to perform utilization reviews with respect to Petitioner, and that he drafted utilization review reports following his review of her treatment. He testified that he used the Official Disability Guidelines in reaching his conclusions as contained in the various reports, and that the ODGs are nationally recognized peer review guidelines. He testified that the ODGs were uniform across the country, and that they were nationally recognized treatment guidelines. He testified that an indication that the treatment was certified meant the treatment was appropriate under the Guidelines, and also that the treatment was reasonable and necessary. He testified that non-certified meant that the treatment was not reasonable and not necessary. (RX1).

Dr. Blum testified that as to the report regarding treatment that occurred on April 5, 2012, he reviewed various medical records and that he briefly summarized what he noted in the treatment records. He testified that based on his review of the medical records and pursuant to the ODGs, he did not find the transforaminal epidural steroid injection on the left at L2-L3 level performed on April 5, 2012 to be reasonable and necessary. He testified that in this case, there was no documentation of radicular pain on the left lower extremity in the distribution of L2-3, nor was there any evidence of sensory deficit in the L2-3 dermatomes, weakness of the quadriceps, diminished lower extremity reflexes and/or positive straight leg raise. He testified that Petitioner's MRI showed no evidence of significant neural foraminal narrowing at the L2-3 level of the lumbar spine causing impingement of the exiting nerve roots, and that the medical necessity of the transforaminal epidural steroid injection on the left at L2-3 on April 5th was not established and that non-certification was recommended. (RX1).

Dr. Blum testified that the utilization review report regarding a transforaminal epidural steroid injection on the left at L2-3 that was performed on April 19, 2012 reflected that the only additional record that he reviewed was the operative note of April 19, 2012 by Dr. Feinberg and that all the other records were the same that he had previously referenced in his prior review. He testified that he did not find the transforaminal epidural injection performed on April 19, 2012 to be reasonable and necessary. He testified that the rationale for the determination was that Petitioner had a previous transforaminal epidural injection less than 6 weeks prior, but that there was no documentation noting the clinical and functional response to the injection and that there was no reported relief following the procedure. He testified that there was no mention of recurrence of low back pain with radicular symptoms, and that the medical necessity of the transforaminal epidural injection on April 19, 2012 was not supported by clinical documentation and the treatment guidelines. (RX1).

Dr. Blum testified that with respect to the utilization review report regarding a transforaminal epidural injection on the left L2-L3 performed on May 2, 2012, the additional record that he reviewed was that of the operative report dated May 2, 2012 by Dr. Feinberg. He testified that he did not find the injection performed on May 2, 2012 to be reasonable and necessary because there was no documentation of objective clinical gains and functional benefits from the completed injections and that there was no documentation of recurrence of radicular pain. He testified that the medical necessity for transforaminal

epidural injection on the left L2-3 on May 2, 2012 was not supported by clinical documentation and the treatment guideline, and that non-certification was recommended. (RX1).

Dr. Blum testified that the utilization review report regarding a paravertebral facet joint injection of the lumbar spine on June 4, 2012 referenced an additional record of the operative report on June 4, 2012 by Dr. Feinberg. He testified that he did not find the paravertebral facet joint injection to be reasonable and necessary, given the limited objective findings on physical examination suggestive of a facet joint pathology and that there was no evidence of positive facet loading maneuver or facet tenderness to palpation. He testified that Petitioner had also already had a prior facet block, and that per the treatment guidelines, no more than one therapeutic intraarticular block was supported. (RX1).

Dr. Blum testified that the utilization review report pertaining to the paravertebral facet joint injection of the lumbar spine on July 9, 2012 referenced his review of an additional record consisting of the operative report by Dr. Feinberg dated July 9, 2012. He testified that he did not find the lumbar paravertebral facet joint injection performed on July 9, 2012 to be reasonable and necessary given that there were limited objective findings on physical examination suggestive of a facet joint pathology, and that although Petitioner had a favorable response to the previous injection, a repeat facet injection was not supported by the treatment guideline. He testified that non-certification was recommended. (RX1).

Dr. Blum testified that the utilization review report regarding a sacroiliac joint injection performed on August 13, 2012 referenced his additional review of an additional record consisting of the operative report by Dr. Feinberg dated August 13, 2012. He testified that he did not find the sacroiliac joint injection performed on August 13, 2012 to be reasonable and necessary given that there was no evidence that Petitioner received conservative treatment specific to the sacroiliac joint and that without evidence of failed trials in conservative care, the medical necessity of the sacroiliac joint injection on August 13th was not established. (RX1).

Dr. Blum testified that with respect to the utilization review report regarding a paravertebral facet joint injection of the lumbar spine performed on December 6, 2012, he reviewed the additional record of the operative report submitted by Dr. Feinberg dated December 6, 2012. He testified that he did not find the lumbar paravertebral facet joint injection performed on December 6, 2012 to be reasonable and necessary given that the treatment guideline clearly indicated that facet joint injections were under study and multiple series of facet joint injections were not supported. He testified that non-certification of the injection was recommended. (RX1).

On cross examination, Dr. Blum testified that he has an office that he works out of in Skokie, Illinois. He testified that he estimated that he performed 20-30 utilization reviews per week, which he does in addition to his active practice. He testified that he is paid by report by Claims Eval. He denied having any contact with an insurance adjustor or anyone aside from Claims Eval. He denied having URAC certification. He denied having any other sort of certification that allowed him to perform utilization reviews in Illinois Workers' Compensation cases. (RX1).

On cross examination, Dr. Blum agreed that he never met or examined Petitioner. He testified that he was not familiar with Dr. Feinberg. He agreed that he referenced the ODG Guidelines in his report, and that those were what he used to form his opinions in the case. He testified that Claims Eval used the ODG Guidelines. (RX1).

On cross examination, Dr. Blum agreed that he did not have an independent recollection whether he actually reviewed the medical records in person for the treatment rendered February 4, 2011 through April 5, 2012. He denied that he summarized the medical records on the report regarding the treatment provided to Petitioner on April 5, 2012, and testified that the records were summarized by a nurse that was not with his office but was with Claims Eval. He testified that the rationale for determination in the

report was not authored by him, and that he did not know who that portion of the report was authored by. He testified that his signature appeared by the conflict of interest attestation. He testified that his name did not appear on the utilization management services non-certification recommendations page, and that he did not know the registered nurse named Christe Wolford. He agreed that the same scenario was true for the other reports. (RX1).

On cross examination when asked how it is that he came to generate a report that was not authored by him, Dr. Blum responded that the report came to him, and that he reviewed the report and determinations and then decided which medical records he wanted to review, if appropriate, and then either agreed or disagreed with the certification or non-certification. He testified that he advised Claims Eval of his agreement or disagreement through a website. He agreed that the report was issued and authored by Claims Eval, and then he either agreed or disagreed with it. (RX1).

On cross examination, Dr. Blum agreed that a treating physician was usually in the best position to determine care and treatment that was of benefit to a patient as compared to any other individual that was not treating them, and that competent physicians can disagree on a course of treatment for a patient. He agreed that he reviewed all of the reports on the same day, but that they were not sent out by an individual from his office. (RX1).

On redirect examination, Dr. Blum testified that it did not matter to him nor did it affect the results of his utilization reviews as far as who asked him to perform the utilization review. He testified that his opinions and conclusions were based on the Official Disability Guidelines. He testified that he was not aware of any requirement in the Workers' Compensation Act that a utilization review provider have some sort of certification. (RX1).

On redirect examination, Dr. Blum agreed that the report was initially prepared by a nurse, and that after the nurse prepares the report, he reviews it. He testified that he adopted the opinions in the utilization review reports as his own after reviewing the reports prepared by the nurse. He testified that it was his understanding that the treatment was first reviewed by a nurse and then a doctor reviewed it to determine the reasonableness and necessity of the treatment. He testified that when he receives the reports from the nurse on the website, he has the ability to make changes or amendments to the reports based on his review of the records. (RX1).

On further cross examination, Dr. Blum testified that he did not have any independent recollection of whether he made changes to the reports in this case. He testified that he was not aware that the IWCC had not adopted the ODG guidelines. He testified that he was not aware that under Section 8.7 of the Act, no person may conduct a utilization review program for workers' compensation services in Illinois unless once every two years that person registers the utilization review program with the Department of Insurance and achieves URAC accreditation. (RX1).

The transcript of the deposition of Dr. Russell Cantrell was entered into evidence at the time of arbitration as Respondent's Exhibit 2. Dr. Cantrell testified that he specializes in physical medicine and rehabilitation, and that he is board-certified in same. He testified that he performed an examination of Petitioner on June 29, 2011. He testified that Petitioner reported that she was working at the time of her injury on February 4, 2011 as a bartender at a friend's bar but was by training a paralegal and was between jobs. He testified that Petitioner reported that while working as a bartender she had gone out into the parking lot to pick up discarded beer bottles and in doing so turned and was walking back into the bar when she slipped and fell on ice falling backwards resulting in acute low back pain and bilateral buttock and thigh pain, left greater than right. He testified that he reviewed the medical records outlined in his report, and that he also reviewed the MRI scan of the lumbar spine of March 8, 2011. He testified that he felt that Petitioner had subjective back pain complaints in the absence of any abnormal objective abnormalities on her examination. (RX2).

Dr. Cantrell testified that he opined that Petitioner did not require any further medical treatment in relation to her alleged injury, and he believed that no restrictions needed to be placed upon Petitioner's activities. He testified that he understood a paralegal position to be primarily a sedentary-type occupation, and that he did not see any problems with Petitioner working as a paralegal as of the time that he saw her. He testified that he thought Petitioner was at that time again working as a paralegal. When asked to assume that Petitioner did need additional treatment for her low back condition and whether it would be reasonable for her to be riding a motorcycle, Dr. Cantrell responded that if the treatment goal was to improve a person's symptoms and they were telling you that riding a motorcycle for a period of time was serving to exacerbate the symptoms, you might reasonably suggest curtailing the activity at least on a temporary basis. He testified that he reviewed various photographs which were attached to the deposition transcript as Exhibit 3. (RX2).

On cross examination, Dr. Cantrell agreed that in his review of the MRI there were radiographic degenerative abnormalities. He agreed that the findings on the MRI were objective. He testified that Petitioner's history was that the injections provided her some relief, but with the passage of time her symptoms had returned. He testified that the notes of Dr. Feinberg were somewhat contradictory, but that Petitioner had not experienced any lasting improvement from the injections before on April 28th because her pain level for May 16th was still 7/10. He agreed that Petitioner reported that she underwent another injection in late May, and that the photographs he was asked to look at where she was riding a motorcycle were from May 29th. (RX2).

On cross examination, Dr. Cantrell testified that he did not ask Petitioner whether she could pull up the motorcycle to an upright position should it have fallen, but he assumed it weighed well over 20 pounds. He testified that he had no knowledge that Petitioner's riding the motorcycle caused any additional injury to her back. He agreed that he thought the treatment Petitioner had received up until the time that he saw her was reasonable. He testified that he would not anticipate further injections giving Petitioner benefit given that her pain level was back to square one when he saw her a month or so after she received her last injection and that the procedure notes documented continuing pain levels that were minimally, if any, improved after the procedures. (RX2).

On cross examination, Dr. Cantrell testified that he quite commonly referred patients for pain management, and he had referred patients to Dr. Feinberg before. He testified that when he refers a patient for an injection, he typically does so with a very specific intent in mind and does not hand the care of the patient over to the pain management physician. (RX2).

The CD from PhotoFax Surveillance containing surveillance video taken June 4, 2011 was entered into evidence at the time of arbitration as Respondent's Exhibit 3. The Report and Photos from PhotoFax Surveillance were entered into evidence at the time of arbitration as Respondent's Exhibit 4. Surveillance was performed on June 4, 2011, showing Petitioner riding a motorcycle for various lengths of time, resting on a curb and standing next to motorcycles with other unidentified individuals. (RX3).

The Facsimile and Confirmation Page dated June 23, 2014 was entered into evidence at the time of arbitration as Respondent's Exhibit 5A. The Facsimile and Confirmation Page dated June 23, 2014 at 11:25 a.m. to Dr. Barry Feinberg was entered into evidence at the time of arbitration as Respondent's Exhibit 5A. The Facsimile and Confirmation Page dated June 23, 2014 at 11:38 a.m. to Dr. Barry Feinberg was entered into evidence at the time of arbitration as Respondent's Exhibit 5B. The Facsimile and Confirmation Page dated June 23, 2014 at 12:00 p.m. to Dr. Barry Feinberg was entered into evidence at the time of arbitration as Respondent's Exhibit 5C. The Facsimile and Confirmation Page dated June 23, 2014 at 12:29 p.m. to Dr. Barry Feinberg was entered into evidence at the time of arbitration as Respondent's Exhibit 5D. The Facsimile and Confirmation Page dated June 23, 2014 at 12:48 p.m. to Dr. Barry Feinberg was entered into evidence at the time of arbitration as Respondent's Exhibit 5E. The Facsimile and Confirmation Page dated June 23, 2014 at 13:27 p.m. to Dr. Barry

Feinberg was entered into evidence at the time of arbitration as Respondent's Exhibit 5F. The Facsimile and Confirmation Page dated June 23, 2014 at 14:18 p.m. to Dr. Barry Feinberg was entered into evidence at the time of arbitration as Respondent's Exhibit 5G.

CONCLUSIONS OF LAW

The parties stipulated at the time of arbitration Petitioner sustained an accident on February 4, 2011 that arose out of and in the course of her employment with Respondent, and that no further temporary total disability and/or maintenance benefits beyond those already paid were in dispute at the time of arbitration. (AX1).

With respect to disputed issue (F) pertaining to causation, the Arbitrator finds that Petitioner has failed to prove that her current condition of ill-being is causally related to the accident of February 4, 2011.

The Arbitrator finds the opinions of Dr. Cantrell to be persuasive in this case, particularly in light of a 6-month gap in treatment between October of 2011 and April of 2012 as documented in the medical records and the migrating nature of Petitioner's subjective complaints regarding her low back condition, particularly during her treatment with Dr. Feinberg in 2012. The Arbitrator notes that on cross examination, Dr. Raskas confirmed that when he initially evaluated Petitioner on April 25, 2011, her physical examination was pretty normal with the exception of some paravertebral spasm, and he agreed that his recommendation for treatment was driven by Petitioner's pain complaints. Dr. Raskas agreed that for the most part Petitioner's physical examination remained for the most part normal with exception of the paravertebral spasm at the subsequent visits on May 16th, May 27th and June 22nd as well. (PX7). This particular testimony of Dr. Raskas, when coupled with Dr. Cantrell's opinion that Petitioner had subjective back pain complaints in the absence of any abnormal objective abnormalities on her examination, causes the Arbitrator to find that Petitioner has failed to prove that her current condition of ill-being is causally related to the accident of February 4, 2011.

With respect to disputed issue (J) pertaining to reasonable medical services, the Arbitrator finds that Respondent shall pay for the treatment rendered during the timeframe of February 4, 2011 through June 29, 2011, and that the treatment rendered subsequent to June 29, 2011 is not reasonable or necessary as it relates to the underlying accident in accordance with the opinions of Dr. Cantrell.

The Arbitrator notes that both Dr. Raskas and Dr. Feinberg testified that the care and treatment provided to Petitioner was reasonable and necessary to relieve her of the effects of her work injury. (PX7; PX8). Respondent's IME physician, Dr. Cantrell, even agreed that the treatment provided to Petitioner up to the time that he evaluated her was reasonable and necessary. (RX2). Having failed to meet the requirements of Section 8.7 of the Act, however, the Arbitrator gives no weight to the opinions of Dr. Blum. The Arbitrator notes that Dr. Blum testified that he was not compliant with the Workers' Compensation Utilization Management standards, had no credentials recognized by the Act and was not accredited by URAC. (RX1). Furthermore, no evidence was proffered on behalf of Respondent that any entity affiliated with Dr. Blum met the accreditation standards required by Section 8.7 of the Act. As a result thereof, the Arbitrator places no reliance upon the opinions of Dr. Blum in this matter.

The Arbitrator places greater reliance upon the opinion of Dr. Cantrell in this case as the basis for finding Respondent liable for treatment rendered during the timeframe of February 4, 2011 through June 29, 2011 only, and notes that Dr. Cantrell opined that Petitioner had subjective back pain complaints in the absence of any abnormal objective abnormalities on her examination. Dr. Cantrell testified that he would not anticipate further injections giving Petitioner benefit given that her pain level was back to

"square one" when he saw her a month or so after she received her last injection and that the procedure notes documented continuing pain levels that were minimally, if any, improved after the procedures. (RX2). The Arbitrator further notes that Dr. Feinberg's medical records in this case seemed to document that Petitioner's diagnosis at the time that each injection was performed during the timeframe of April of 2011 through the very last visit in December of 2012 was a bit of a moving target, which seemed to correspond with Petitioner's arguably migrating symptomatology at the time of her visits. The migrating subjective complaints, when coupled with a 6-month gap in treatment during the timeframe of October 3, 2011 to April 5, 2012 during which Petitioner underwent no documented treatment whatsoever, causes the Arbitrator to place greater reliance upon Dr. Cantrell's opinions that Petitioner did not require any further medical treatment in relation to her alleged injury after the examination was performed on June 29, 2011.

As a result thereof, the Arbitrator finds that the treatment rendered subsequent to the time of the IME with Dr. Cantrell on June 29, 2011 is neither reasonable nor necessary as a result of the accident of February 4, 2011. Accordingly, the Arbitrator finds that Respondent shall pay for the treatment rendered during the timeframe of February 4, 2011 through June 29, 2011 as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit for all medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injuries, the Arbitrator notes that Petitioner's injuries occurred on February 4, 2011 and, as such, the Arbitrator will not specifically be addressing the five factors under Section 8.1b of the Act in the determination of permanent partial disability.

The Arbitrator finds that the medical records in this case demonstrate that Petitioner sustained a hyperextended, ligamentous and contusion injury to the right thumb for which conservative treatment in the form of splinting was rendered. Additionally, the Arbitrator finds that the medical records in this case demonstrate that Petitioner suffered a lumbar sprain/strain and exacerbation of an underlying degenerative condition in the lumbar spine for which she underwent conservative treatment. Having reviewed the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of 5% loss of use of the person-as-a-whole under Section 8(d)2 of the Act and 0% loss of use the right thumb under Section 8(e) of the Act.

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

Jimmy Dean,
Petitioner,

18IWCC0069

vs.

NO: 15 WC 17216

State of Illinois/Menard Correctional Center,
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, notice and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

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

DATED: JAN 31 2018
o12/7/17
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0069

DEAN, JIMMY
Employee/Petitioner

Case# **15WC017216**

ST OF IL/MENARD CORRECTIONAL CENTER
Employer/Respondent

On 7/28/2016, 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 0.42% 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:

0969 THOMAS C RICH PC
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 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 SYSTEMS
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

JUL 28 2016

RINALDI A.RASBIA, Acting Secretary
Illinois Workers' Compensation Commission

18IWCC0069

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)

Jimmy Dean
Employee/Petitioner

v.

State of Illinois/Menard Correctional Center
Employer/Respondent

Case # **15** WC **17216**

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 **Herrin**, on **May 11, 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 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 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.

Per the stipulation of the parties, in the year preceding the injury, Petitioner earned **$69,972.17**; the average weekly wage was **$1,345.61**.

On the date of accident, Petitioner was **52** years of age, *married* with **1** dependent child.

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, **$0** in non-occupational indemnity disability benefits 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. Grace Gillman
Signature of Arbitrator

7/26/16
Date

ICArbDec19(b)

JUL 28 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

Jimmy Dean
Employee/Petitioner

Case # **15** WC **17216**

v.

Consolidated cases: **N/A**

State of Illinois/Menard Correctional Center
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that that he is currently employed by Respondent, and that he started with the Department of Corrections on December 9, 1991. He testified that before working for Respondent, he worked as a receiving manager at Penn Aluminum International and Montgomery Ward in Carbondale.

Petitioner testified that beginning in 1991 he was employed at Menard Correctional Center at the maximum security facility, where he has spent his entire career. He testified that he started as a Correctional Officer and worked in that capacity until November 9, 2015, which was just under 24 years. He testified that of his time spent as a Correctional Officer, he worked approximately 90% of the time on the gallery or wing.

Petitioner testified that he prepared Petitioner's Exhibit 15, which was the overtime log. He agreed that it was an accumulative time sheet from 2008 through 2015, which demonstrated approximately 2,200 hours of overtime.

Petitioner testified that he had the opportunity to look at the Menard correctional officer Job Site Analysis dated February 8, 2011, the Menard correctional officer video, the Menard correctional officer Post Description and the Demands of the Job form for a Menard correctional officer. He testified that he also prepared a job description, which was marked as Petitioner's Exhibit 8. He testified that in preparing the written job description, he tried to recollect all the job descriptions and assignments that he had and went through them from the time that he started to current. He testified that during the almost 24 years he worked for Respondent, he worked the 7 a.m. to 3 p.m. shift approximately 85% of the time.

Petitioner testified that he was familiar with the cell doors and that they were made of very hard steel. He testified that most of them were opened with a slide or a crank and that it was not easy to open them because they were old, outdated and heavy. He testified that at Menard the cell doors had bars, and that "bar rapping" was when you take a bar (which is made of steel and approximately 12-18 inches in length), walk up to the door, take the bar with either hand and strike all of the bars on the doors. He testified that that there were 54-55 cells to a gallery, but you had to do this at least twice a shift. He testified that his job was to make sure that it did not make a "clunk" sound because if it did, then the bars were cut. He testified that bar rapping caused a vibration or stinging sensation. He further testified that this was something that he did on most days while working as a correctional officer.

Petitioner testified that the doors were keyed open at Menard with a large Folger Adams key, which was approximately 6 inches long, very heavy and hard to handle. He testified that some doors, especially the chuckholes, were sometimes used with a Folger Adams key. He testified that when he was twisting the Folger Adams keys he was moving his arm, wrist and elbow. He testified that when you turned the key it opened the door, but if it did not open then sometimes you would have to use your other hand to put another key in the other lock and try to "jiggle" it because the doors were old and some did not work properly. He testified that this happened quite often.

Petitioner testified that a chuckhole was a little door that was inside the regular cell door that you used to serve trays in people who were on "deadlock." He testified that some of them were easy to open but some of them were not because they were also very old and they were not maintained very well. He testified that it should take one hand to open a chuckhole, but sometimes it took two because they were hard to open.

Petitioner testified that in 24 years, he has opened over 100,000 cell doors. He testified that in 24 years, he has probably turned a couple hundred thousand Folger Adams keys between cell doors, doors to the cell houses and the double gate. He testified that he has probably rapped 30,000 bars. He testified that there were approximately 36 bars to a door on each cell and that there were 54-55 cells on each wing. He then testified that it was "possibly" a lot more than 30,000 bars.

Petitioner testified that a shakedown involved going through possessions and shaking them down to make sure they had no contraband. He testified that they typically found weapons, "hooch", tattoo guns, gang materials, and letters referencing death threats towards staff, their families and others. He testified that when performing shakedowns, you were generally using your arms, legs, feet, hands, fingers and eyes. He testified that when opening cell doors, you were using your hands, wrists and arms. He testified that you also used them when opening locks, turning keys and cuffing the inmates before you let them out of their cells.

Petitioner testified that he spent time in segregation, and that he did two years as a gallery officer/shower officer. He testified that segregation was the place where you were constantly cuffing and uncuffing inmates all night long or all day long, that you were not allowed to let them out of their cells without any cuffs and that you had to cuff one person to let the other person out. He testified that he used his hands to cuff and uncuff inmates, and that some of the inmates resisted which required you use your arms, hands and wrists. When asked over the course of 24 years how many inmates he had cuffed and uncuffed, Petitioner initially responded hundreds and, when asked "Really, that's it?" by his attorney, he responded that it might be even thousands.

Petitioner testified that lockdown of an inmate was when they were restrained and confined to their cell, and they were not allowed to come out of their cell for any reason whatsoever unless they were cuffed. He testified that lockdown of the facility was when the whole facility was locked down and nobody was allowed out of their cells unless they were re cuffed. He testified that the duty of a correctional officer during a lockdown changed somewhat in that on lockdown, they were required to carry heavy trays back and forth to the inmates in order for them to eat their lunch, and that they carried out trash and heavy loads of laundry up and down large flights of stairs. He testified that it increased the duties with regard to the arms and the hands.

Petitioner testified that he believed that the DVD was pretty accurate in showing the duties of a correctional officer but that it did not show the number of times that they had to do something, it did not show the strength or intensity that you had to use to do some of the jobs and that it did not reflect the speed that they were working at when they were locking a line down. He testified that you were constantly walking down a gallery at a good clip with three or four officers behind you or in front of you,

and while you were shutting doors, some would bounce back or you would get your arm caught which would put a strain on your elbows. He testified that he believed that the Corvel Job Site Analysis was fairly accurate.

Petitioner testified that during the course of performing his job duties, he began to develop symptoms in his arms and hands. He testified that he was developing numbness in his hands, wrists and arms, that he was developing pain and fatigue and that he was dropping things more often. He testified that he could not hold onto a cell phone, a wrench or a pool stick. He denied having diabetes, gout, rheumatoid arthritis or hypertension. He testified that he went to Dr. Molnar, his family doctor, who referred him to Dr. Goldring for testing. He testified that after the testing was performed, he received the results from Dr. Molnar. He testified that March 23, 2015 was the date he learned he had problems with his hands and elbows and that was the first date that he was aware he had a work-related condition.

Petitioner testified that when he when he received confirmation from Dr. Molnar's patient coordinator, the next day he went to work and went into the health care unit and let Linda Foutch, a nurse in the health care unit, know that he had a positive result. He testified that Ms. Foutch had him fill out papers, which he then took directly to Cindy Cowell, the worker's compensation coordinator. He testified that Ms. Cowell sent him to the shift commander's office to have the paperwork signed.

Petitioner testified that Dr. Molnar made a referral to a hand specialist, Dr. Mirly, whom he has seen on one occasion. He testified that Dr. Mirly recommended treatment including hand splints and wrist splints, and that he told him that he would probably need surgery. He testified that he is still experiencing pain in his arms and wrists, and that sometimes he gets numbness in his fingers. He testified that he has fatigue, is unable to sleep at night and that it makes driving and everyday life very difficult. He testified that he is now the laundry manager at Menard, and that he is a working manager. He testified that he uses his arms and hands to handle all the laundry that comes in, that he pulls the bags and takes the laundry out of the bags, throws them in and out of the washers and also throws them out of the washers and into the dryers. He testified that he started that job on April 16, 2016, approximately one month prior to arbitration. He testified that before his current position, he was a supply supervisor and worked in the commissary and general stores. He testified that he handled all the commissary and general store items with his hands and arms, and that he had that job for four months.

Petitioner testified that he attended an examination at Respondent's request with Dr. Sudekum and that he made some notes concerning that visit. He testified that Dr. Sudekum conducted part of the exam and that his nurse did the rest. He testified that he underwent testing in his office that was performed by his nurse. He testified that Dr. Sudekum offered to perform surgery on him. He testified that he has read Dr. Sudekum's deposition, and that there were a couple things that he disagreed with concerning his job duties. He testified that at the time he had the exam he was working in a tower, and that in the towers he had to carry the ammunition and weapons to the tower and back. He testified that they were carried in large canvas bags, which put a strain on his wrists. He testified that he also told him that on various shifts that he worked overtime, and that he was working galleries for the most part and also working on doors.

Petitioner testified that he continues to work at Menard Correctional Center. He denied having any hobbies or family activities that involved repetitive use of his arms or hands. He denied hunting or fishing, and further denied operating a jackhammer. He also denied riding a motorcycle. He testified that he wants to have the surgery.

On cross examination, Petitioner agreed that on direct examination he was asked whether he has diabetes and that he denied having diabetes. He denied ever having been told that he had prediabetes. He agreed that he read the medical records in his case. He agreed that he had been at the Chester Clinic, and

that he was seen by Dr. Molnar at the Chester Clinic on March 20, 2015. He testified that it would surprise him if in those records the doctor indicated he had prediabetes. He agreed that he testified that he does not suffer from hypertension and further stated that he did not even know what hypertension was. He agreed that he has high blood pressure and testified that he takes medication to control it, but did not know for how long he has had the condition but agreed that it had been awhile.

On cross examination, Petitioner agreed that the job description was in his handwriting and that he had been at Menard since 1991. He agreed he has been assigned to the health care unit but did not recall for how long he was assigned there and did not have any idea when it was. He agreed that he was assigned to the barber shop in the past, but could not recall when. He testified that the school building was the educational building that held the school classes and that he had been assigned to that several times but could not remember when he was assigned there for the first time. He testified that he was assigned to the chapel occasionally in his 24 years but did not recall exactly when. He testified that he was assigned in the library for two years from 2007-2009, and that his job duties were to escort and watch inmates and to keep staff safe. He testified that he had three steel doors that he had to unlock and lock all the time with a Folger Adams key while assigned at the library. When asked how often during one day would he lock and unlock those three doors in the library, Petitioner responded that it depended on how many classes or library lines they had but usually 10-20 times a day each.

On cross examination, Petitioner testified that he was assigned to the visiting room on occasion and did not remember exactly when, but believed it might have been once every three months. He testified that the health care unit, the barber shop, the school building, and the library were not considered to be in a gallery. He testified that the guard hall back door was a door that was on the back of the Administration Building that was condemned and closed at least ten years ago. He testified that he was assigned to the double gate back when the guard hall was still open. He testified that the R&C unit was where people were brought into the institution, classified and placed in other cell houses. He testified that it would be considered a gallery consisting of 16 cells, but that it was torn down. He testified that he did not, however, remember when it was torn down.

On cross examination, Petitioner testified that the "MSU" was a multi security unit and was "the top of the hill." He testified that it was a division of maximum security but was not a maximum security prison. He testified that he was assigned to the MSU for five year from October 12, 2009 to October 1, 2014. He testified that he has been at the maximum security prison since 2014 but agreed that he left it in 2009. Petitioner testified that since 2014 he has worked mostly towers, but on every other shift he was mostly galleries.

On cross examination, Petitioner agreed that he testified that from 2009-2014 he was working at the medium security facility. He agreed that Petitioner's Exhibit No. 15 contained his overtime from 2008 to 2015. Although Petitioner denied that all of the overtime hours were at the medium security facility, he could not testify as to how many were at the maximum security facility. He agreed that when the Menard maximum security prison was on lockdown, inmates from the minimum security prison came down and did some tasks. He agreed that during that timeframe, there were no lines of movement for the maximum security prisoners.

On cross examination, Petitioner agreed that he indicated on his job description that he was on the road crew and further testified that it was for one day but he could not recall when that was. When asked why the description referenced driving a van pulling a trailer full of lawn equipment, his having supervised a crew of inmates while they mowed grass and his having supervised them while they shoveled snow, Petitioner then testified that he guessed it was twice because one road crew was out doing grass at the farms, and he also had a road crew inside the grounds when they had a snowstorm. He

testified that the farm still existed, that it was located on the river a little past the maximum institution and that the farm was supplied by an officer from the MSU.

On cross examination, Petitioner agreed that he had been asked about his job description where he testified that he worked at the health care unit, the barber shop, the chapel, the school building, the library, the visiting room, the guard hall back door, the galleries, the R&C unit, the road crew and the MSU, and that it was still his testimony that during his 24 years at Menard he spent approximately 90% of his time on the galleries.

On cross examination, Petitioner agreed that during his overtime he also worked at the maximum security prison. When asked how much overtime he worked there, Petitioner responded that the overtime hours were done both at the MSU and the maximum correctional center since they could go back and forth. He testified that he did over 2,200 hours of overtime in six years, and that it was divided between those two locations. He testified that he did not remember how long he worked in the tower but that he worked in all of them. He testified that he was not actually assigned to any tower, but he was available. He agreed that he would carry weapons to the tower and testified that when he worked in the catwalks he carried a mini 14 and a 12 gauge shotgun in a bag to the tower and also carried it back if he worked overtime. He testified that he did not have any idea how much the mini 14 weighed, but agreed that it was less than 15 pounds. He also agreed that the 12 gauge shotgun also weighed less than 15 pounds. He testified that he would carry 40 rounds for the one weapon and that he would carry 25 rounds for the other.

On cross examination, Petitioner agreed that he was working as the laundry manager and had been doing so since April 16th, and that before that for four months he was the supply supervisor. He testified that before he was the supply supervisor, he was a correctional officer. He denied using a Folger Adams key as a laundry manager or as a supply supervisor. He testified that some towers had Folger Adams keys to enter the actual tower itself. When asked how many times a day when he was assigned to a tower would he actually use a Folger Adams key, Petitioner responded that it depended on which tower he was in but that the most he would use it in any given tower in one day was 4 or 5 times.

On cross examination when asked when he first started noticing the numbness and tingling in his hands, Petitioner responded that he had been noticing it for quite a while but did not really think much of it. He testified that he started dropping things maybe 9 months before he was tested and started becoming more concerned. He testified that he waited until his 6-month follow-up with his doctor in March of 2015, and while he was there he asked him about it and he suggested he have the testing done. He agreed that his doctor told him that he was having increasing blood sugars. He agreed that he discussed that he had gained weight and that his doctor discussed with him the weight and its association with diabetes.

On cross examination, Petitioner agreed that he testified that he would conduct bar rapping when he was assigned to the gallery. When asked if there was any place at the MSU where he conducted bar rapping, Petitioner responded that it was the grill doors. When asked when he was assigned for five years to the minimum security prison how many times did he bar rapp at that location, Petitioner responded none. He testified that at the maximum security prison, bar rapping was usually done in the mornings or at the beginning of the shift. He agreed that it was done once per shift. He testified that normally one officer was assigned to each gallery per shift unless they were short. He testified that even if there were two officers, all of the officers were supposed to do bar rapping if they had a gallery.

David Childers was called as a witness by Petitioner at the time of arbitration. Mr. Childers denied having difficulty hearing Petitioner testify. When asked about Petitioner's description of the jobs that he did and whether anything he said made him think it was not correct, he responded that there was a lot of truth to what Petitioner said but he thought he misspoke on a lot of things. He testified that he

never worked with Petitioner in his years of service, and agreed that Petitioner had worked a lot of overtime. He testified that he normally worked the 7 a.m. to 3 p.m. shift, yet he never worked with Petitioner. He testified that the majority -- if not all -- of Petitioner's overtime was in the tower.

The Application for Adjustment of Claim was entered into evidence at the time of arbitration as Arbitrator's Exhibit 2. The Application alleged a date of accident of March 23, 2015 for a repetitive trauma claim involving the bilateral hands and arms. (AX2).

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. Joe Molnar/Chester Clinic were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. Petitioner was seen on March 17, 2015, at which time it was noted that he could not grasp things well, had noticed numbness in his arms and had progressive weakness and numbness in his hands and arms for the last nine months. Petitioner's weight-related issues were also discussed at that time. Petitioner was instructed to do portion control, repeat labs were ordered and he was instructed to return in six months. (PX3).

The medical records of Dr. James Goldring were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. Petitioner underwent an EMG/nerve conduction studies on March 23, 2015, which were interpreted as revealing evidence of bilateral carpal tunnel syndrome. (PX4).

The medical records of Dr. Harvey Mirly were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. Petitioner was seen on May 29, 2015, at which time it was noted that he was right hand dominant and was being seen for an evaluation of bilateral elbow pain, numbness and tingling. It was noted that Petitioner indicated that he tested positive for carpal tunnel syndrome in both wrists and elbows and had been experiencing pain, numbness and extreme tiredness or heaviness in both his elbows and wrists. It was noted that Petitioner had handwritten a lengthy statement regarding his activities, and that he reported working for Menard Correctional Center for 23.5 years. It was noted that Petitioner's symptoms were consistent with carpal tunnel syndrome and that he had nocturnal paresthesias and numbness in the median nerve distribution but had no thenar atrophy or weakness. Petitioner was fitted with bilateral large wrist cock-up splints for nighttime wear, and was fit with a prefabricated wrist hand orthosis without joints bilaterally. It was noted that Petitioner had questioned the work relatedness of his condition, and that Dr. Mirly had indicated that he believed that his activities would be of a nature that would contribute to the development of carpal tunnel syndrome but were not solely causative and that his outside activities contributed as well. (PX5).

The transcript of the evidence deposition of Dr. Harvey Mirly was entered into evidence at the time of arbitration as Petitioner's Exhibit 6. Dr. Mirly testified that he is an orthopedic hand surgeon and is board-certified in orthopedic surgery with a certificate of added qualification in surgery of the hand. He testified that some of the occupational risk factors that have a higher incidence or rate of development of carpal tunnel syndrome include things like the meat cutter holding a knife, people exposed to vibration, those in foundries using grinders and the impact of holding a hammer or striking it, and that you typically looked for activities with force, repetition and exposure to vibration. (PX6).

Dr. Mirly testified that he saw Petitioner on May 29, 2015 at the referral of Dr. Joe Molnar. He testified that he reviewed not only his own records but also other various documents in preparation for the deposition, including the nerve conduction study and a handwritten document prepared by Petitioner that was seven pages in length. He testified that he also reviewed a letter by Dr. Sudekum and a job description from the facility prepared by Corvel. (PX6).

Dr. Mirly testified that Petitioner indicated that he had tested positive for carpal tunnel syndrome in both wrist and elbow and was experiencing pain, numbness, extreme tiredness or heaviness in both his elbows and wrists. He testified that the impression by Dr. Goldring of the nerve conduction study was that of bilateral carpal tunnel syndrome. He testified that the physical examination revealed that Petitioner did not have severe atrophy or weakness of the thumb, which was typically a very severe finding. With respect to the job description provided by Petitioner, Dr. Mirly testified that Petitioner talked about the different units he was assigned to at different times and what the different jobs and duties were. He testified that based on the history, the physical examination and the diagnostic studies that he reviewed, the diagnosis that he was made was that of bilateral carpal tunnel syndrome. He testified that Petitioner was fitted with wrist cock-up splints which he recommended for nighttime wear, intra-tunnel injections and operative release. He testified that he has not seen Petitioner since that time. (PX6).

Dr. Mirly testified that he was of the opinion that Petitioner's job activities would be of a nature that would contribute to the development of carpal tunnel syndrome but would not be solely causative. He testified that he has been to Respondent's facility and had toured it, which he described as old and dated. He testified that that he did not turn any of the keys himself nor did he rap any bars while he was there, and he was unable to describe the doors and keys beyond saying that the doors were big and that they had big key rings. He testified that he had been at the facility 14-15 years ago but did not know the exact year. (PX6).

Dr. Mirly testified that he would need to see Petitioner again and ask him about the effectiveness of the non-operative treatment prior to making any further treatment recommendations. He testified that if Petitioner's symptoms were relieved, then he would not recommend surgery. He testified that if Petitioner had persistent symptoms, he would still have two options including a trial of an injection and carpal tunnel surgery if the frequency and severity of the symptoms warranted surgical treatment. He testified that when he saw Petitioner in May, he would not consider him to have been at maximum medical improvement. (PX6).

On cross examination, Dr. Mirly denied having reviewed any medical records other than his own and the nerve conduction study, and he further denied having reviewed any medical records of Petitioner's family physician. He agreed that in the handwritten job description prepared by Petitioner, there were a number of different job assignments that Petitioner had listed as doing over the 23 years and that some of those job duties did not have any repetitive forceful gripping or grasping. With respect to the jobs which he believed could cause or aggravate carpal tunnel syndrome, Dr. Mirly testified that Petitioner did not include the timeframe that he performed such jobs. When asked if Petitioner at the time that he was seen was performing any of the jobs that he found could be repetitive, Dr. Mirly responded that Petitioner indicated that he had been back in the general division since October which was not any of the more vigorous things with the rapping of bars. (PX6).

On cross examination, Dr. Mirly could neither confirm nor deny that Petitioner was or had been at the Medium Security Unit ("MSU") at Menard. He testified that he was aware of the MSU but had never been there. When asked if he was aware that the cell doors were steel doors and could be electronically opened through a control pod by a control pod officer, Dr. Mirly responded that there was some comment in his dictation about there being some kind of controlled doors but he could not tell which facility had what. He testified that if Petitioner had been in MSU for at least a few years prior to seeing him and whether that could change his opinion with regard to causation, Dr. Mirly responded that he did not think it would as Petitioner had been symptomatic for some time and he thought of it as a cumulative process over a period of time. (PX6).

On cross examination, Dr. Mirly testified that he based his causation opinion on their verbal discussion while they were in the office, not simply the handwritten description. He testified that he did

not have an independent recollection of an appointment, but he dictated his note on the same day that he saw Petitioner. He denied being able to recall what Petitioner told him and agreed that it was not in his notes. He further denied knowing how long Petitioner's symptoms had been present. (PX6).

On cross examination, Dr. Mirly testified that he thought it was cumulative over a process of a work history, and that it was not what one was doing when they became symptomatic but what one had done in the preceding work history. He testified that Petitioner filled out paperwork when he saw him, and that he had asked how long Petitioner's symptoms had been present in the paperwork. He testified that Petitioner reported date of injury or onset of March 21, 2015, and that he had been experiencing pain, numbness and extreme tiredness or heaviness in both of his elbows and wrists but did not indicate for how long he had been experiencing that. (PX6).

On cross examination, Dr. Mirly testified that he believed it was cumulative over a process of a work history and life, and that it was not what one was doing when it became symptomatic. He testified that it was hard to apportion causation percentages, and that he did not believe that Petitioner's work was solely causative but was of a contributing nature. He testified that Petitioner when asked to complete paperwork at the time of the initial visit indicated that the date of injury or onset was that of March 21, 2015, and that he had also indicated that he had been experiencing pain, numbness and extreme tiredness or heaviness in both of his elbows and wrists but did not indicate for how long he had been experiencing that. (PX6).

On cross examination, Dr. Mirly testified that an increased body mass index was a positive predictive risk factor for the development of carpal tunnel syndrome, but that not every obese individual developed carpal tunnel syndrome nor did everyone at their ideal body mass index not develop carpal tunnel syndrome. He agreed that being in the sixth decade of life was also a risk factor for the development of carpal tunnel or cubital tunnel syndrome. (PX6).

On cross examination, Dr. Mirly testified that Petitioner had complaints of heaviness in his arms but his symptoms were that of carpal tunnel syndrome so he did not delineate an examination of Petitioner's elbow, and that Petitioner did not have numbness in the ulnar digits. He testified that he felt that Petitioner's symptoms were attributed to carpal tunnel and not cubital tunnel, so his working diagnosis was not that of cubital tunnel but only carpal tunnel. When asked based on the nerve conduction study if he could tell the severity of the bilateral carpal tunnel syndrome, Dr. Mirly responded that he did not believe that anyone could tell the severity based on the numbers of a nerve conduction study. (PX6).

On cross examination, Dr. Mirly agreed that he noted that he believed that the opening of grill doors 300 times per day when assigned to the school building was causative, but admitted that he did not know what type of key was being used at that area at Menard. He agreed that he believed that opening and closing 300-400 times per shift the gate to the second floor was causative, but admitted that he did not know what type of key was being used. He agreed that he believed that the unlocking and locking of the crank box was causative, but admitted that he did not know the frequency with which Petitioner performed this activity. He further admitted that he did not know when or how often Petitioner was assigned on the gallery where he would be bar-rapping. He agreed that it would be beneficial to know a number or percentage in order to give an opinion to a reasonable degree of medical certainty, but stated that he thought he had a fair understanding in addition to his having treated a number of other people in "this condition." He admitted that most of the cases he had seen had not had as many assignments as Petitioner had, but stated that he did not know how long Petitioner was in each of his assignments. (PX6).

On cross examination, Dr. Mirly agreed that he was not at the Menard MSU. He admitted that he did not use the Folger Adams keys to open cell doors, and he further admitted that he never bar-rapped there. He admitted that he did not know the force required to turn a Folger Adams key in a cell door, and that he did not know the vibration with respect to bar-rapping the bars at Menard. He agreed that attorneys refer their clients to him, including Mr. Rich's office in the past. He testified that he has seen an increased number of prison employees over the last six years. (PX6).

On cross examination, Dr. Mirly admitted that he did not know what shift Petitioner worked, and testified that he assumed that on different shifts there were different responsibilities but admitted that he did not know the specifics of each shift. He admitted that he did not know the days of the week that Petitioner worked, but testified that he assumed that it varied. He admitted that he did not know if Folger Adams keys were used at Menard MSU and testified that he was mostly aware of the main facility. He testified that Petitioner commented on using handcuffs, but admitted that he did not know the number of inmates Petitioner would have to cuff. He further testified that Petitioner mentioned lockdown and that he would have to do things during lockdown including keying, but admitted that he did not know how often Menard had been on lockdown. (PX6).

On cross examination, Dr. Mirly agreed that when he saw Petitioner on May 29, 2015, he released him to return to work without restrictions. He testified that the likely prognosis for Petitioner's condition was that of progressive symptoms with time. He admitted that he did not know if Petitioner ever treated for this condition in the past because he had no outside records. He admitted that he did not know if there had been any previous nerve conduction studies. (PX6).

On cross examination, Dr. Mirly agreed that the development of carpal tunnel syndrome can be idiopathic, but further testified that more commonly it was cumulative and was hard to state a direct temporal onset to a certain activity. He testified that diabetes was a positive predictive risk factor as is obesity, and further testified that there was an increased incidence of the development of carpal tunnel syndrome in diabetics as well as those with untreated hypothyroidism. (PX6).

On redirect examination, Dr. Mirly testified that latency referred to the delay between the onset of symptoms and the aggravating activity, and that this was something that he saw in individuals who have or develop carpal tunnel syndrome. When asked to assume that Petitioner would testify that he performed a significant amount of overtime in the range of 200-300 hours of overtime per year and whether that would impact his opinion in the case, Dr. Mirly responded that overtime had increased exposure to the activity as well as decreased recovery time. He testified that occasional overtime was one thing, but the higher amount of overtime would increase contribution from his work activities. (PX6).

The Workers' Compensation Documentation Log was entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The Documentation log noted that the Notice of Injury was received on April 2, 2015 and that the Supervisor's Report of Injury or Illness was received on March 31, 2015. The Illinois Form 45 dated March 31, 2015 noted that Petitioner reported an accident date of March 23, 2015 and that he stated that his repetitive motion and work duties were the cause of his carpal tunnel syndrome. The Workers' Compensation Employee's Notice of Injury or Illness dated March 31, 2015 noted that Petitioner reported a date of injury or illness of March 23, 2015 and that it was not reported on the date of incident as Petitioner received his results on March 30, 2015. The injury was noted to have occurred through repetitive use of the hands and arms. It was noted that Petitioner had submitted a previous claim for injury/illness several years ago but was not sure of the date. The Supervisor's Report of Injury or Illness dated March 31, 2015 noted that Petitioner reported a date of accident of March 23, 2015 and that notice was received on March 31, 2015. It was noted that Petitioner stated that he was seen by his doctor for carpal tunnel syndrome and that he had pain, numbness and tingling in both hands, wrists and elbows. The Adult and Juvenile Divisions Incident Report dated March 31, 2015 noted that on

March 23, 2015 Petitioner had a nerve conduction study performed by Dr. Goldring and that he was complaining of pain, numbness and tingling in his hands, wrists and elbow, and that the test results were positive for carpal tunnel syndrome. (PX7).

Petitioner's Job Description was entered into evidence at the time of arbitration as Petitioner's Exhibit 8. In the Detailed Job Description document, Petitioner reported that his job required lifting, pushing and pulling, bending or stooping, reaching above shoulder level, the use of his hands for gross manipulation, the use of his hands for fine manipulation and loading and unloading. In the handwritten document entitled "Description (Jobs @ Menard)" Petitioner described the various job assignments that he held while working for Respondent. Petitioner noted that "[e]verything at Menard revolve around keys and locks!" (PX8).

Petitioner's Work History Timeline was entered into evidence at the time of arbitration as Petitioner's Exhibit 9. Petitioner noted a date of hire of December 9, 1991, and that his job title was that of correctional officer. Petitioner noted that he has performed various tasks, including manning gun houses and catwalks; opening doors and gates repetitively; counting inmates; counting tools; escorting inmates and construction crews, lawn mowing crews, and flood crews; shaking down cells, areas and inmates; and supervising the gym, among others. (PX9).

The Menard Correctional Officer Job Site Analysis dated February 8, 2011 was entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The job site analysis noted that the facility was toured on January 13, 2011. (PX10).

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. (PX10).

The Menard Correctional Officer Video was entered into evidence at the time of arbitration as Petitioner's Exhibit 11. 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." (PX12).

The Menard Correctional Officer deposition transcript of Dr. Sudekum dated June 13, 2011 was entered into evidence at the time of arbitration as Petitioner's Exhibit 13. 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. (PX13).

The Menard Correctional Officer Post Description was entered into evidence at the time of arbitration as Petitioner's Exhibit 14.

Petitioner's Overtime Logs were entered into evidence at the time of arbitration as Petitioner's Exhibit 15. According to the handwritten calculations, Petitioner worked a total of overtime hours in the last 8 years of 2,030.75 as of September 10, 2015. (PX15).

Petitioner's Comments on Menard Correctional Officer DVD were entered into evidence at the time of arbitration as Petitioner's Exhibit 16. The handwritten document indicated that the video was very "chincy" and did not show every door that was opened or closed or how often this was done during a shift. The document noted that Petitioner did not believe the video was accurate and it was poorly created, and that it was an embarrassment to all that work at Menard. The document further noted that "[e]verything revolves around locks and keys" and that a lot of them fail to operate smoothly. (PX16).

Petitioner's Comments regarding Post Descriptions were entered into evidence at the time of arbitration as Petitioner's Exhibit 17. The document noted that the Post Description tried to outline what their responsibilities should be, but it did not state how. (PX17).

The Illinois Form 45: Employer's First Report of Injury was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The document was duplicative of that as contained in Petitioner's Exhibit 7. (RX1).

The Workers' Compensation Employee's Notice of Injury was entered into evidence at the time of arbitration as Respondent's Exhibit 2. The document was duplicative of that as contained in Petitioner's Exhibit 7. (RX2).

The Supervisor's Report of Injury or Illness was entered into evidence at the time of arbitration as Respondent's Exhibit 3. The document was duplicative of that as contained in Petitioner's Exhibit 7. (RX3).

The Incident Report dated March 31, 2015 was entered into evidence at the time of arbitration as Respondent's Exhibit 4. The document was duplicative of that as contained in Petitioner's Exhibit 7. (RX4).

The Position Description for Correctional Officer at Menard Correctional Center was entered into evidence at the time of arbitration as Respondent's Exhibit 5. The description noted that the essential functions include, under direct supervision of the Correctional Lieutenant, performs security and custodial duties; supervises and maintains control of inmate movement and activities on an assigned shift; gives direction and makes decisions; refers non-routine decisions to the superior officer; enforces and maintains disciplinary, safety, sanitary, security and custodial measures. (RX5).

The Job Site Analysis for Correctional Officer at Menard Correctional Center was entered into evidence at the time of arbitration as Respondent's Exhibit 6. The exhibit was duplicative of that as contained in Petitioner's Exhibit 10. (RX6).

The Job Site Analysis DVD for Correctional Officer at Menard Correctional Center was entered into evidence at the time of arbitration as Respondent's Exhibit 7. The exhibit was duplicative of that as contained in Petitioner's Exhibit 11. (RX7).

The IME report of Dr. Anthony Sudekum was entered into evidence at the time of arbitration as Respondent's Exhibit 8, and the transcript of the evidence deposition of Dr. Sudekum was entered into evidence at the time of arbitration as Respondent's Exhibit 9.

The IME report of Dr. Sudekum dated September 1, 2015 noted that Petitioner was seen for evaluation of possible injuries and/or conditions affecting his bilateral upper extremities. It was noted

that Petitioner stated that he had 1-2 year history of pain and/or numbness of the bilateral volar wrists forearms, right greater than left, with occasional radiation of pain to the bilateral medial elbows. Petitioner stated that his symptoms occurred primarily at night but also intermittently throughout the day, and that the symptoms had worsened significantly over the past several months. It was noted that Petitioner complained of weakness and decreased grip strength to both hands and arms, that he dropped things and that the numbness involved the bilateral thumbs, index and middle fingers primarily at night but also intermittently during the day. It was further noted that Petitioner denied any numbness or tingling in the ring and little fingers. (RX8).

The report noted 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 and perform many of the manual tasks performed by the Correctional Officers at both Menard facilities. Dr. Sudekum noted that he felt that he was able to form an accurate impression of the job tasks, duties, and manual physical requirements of the Correctional Officers there in general, but it was his impression that there were many different job postings for correctional officers at Menard some of which may entail significantly different job duties. (RX8).

The report noted that Dr. Sudekum believed that Petitioner had multiple non-work related risk factors and comorbid conditions which could predispose him to the development of carpal tunnel syndrome and/or upper extremity peripheral neuropathies including his age over 53 years, obesity, hypertension requiring antihypertensive medication, fluid retention requiring a diuretic, hypercholesterolemia requiring medication and elevated blood sugars/pre-diabetes. Dr. Sudekum indicated that his diagnosis was that of obesity with recent significant weight gain, fluid retention, hypertension, hypercholesterolemia, elevated blood sugar, prediabetes and mild bilateral carpal tunnel syndrome. (RX8).

The report noted that Dr. Sudekum was of the opinion that the primary cause and etiology of Petitioner's mild bilateral carpal tunnel syndrome were the comorbid conditions and non-work related risk factors, and that Petitioner's recent employment activities including his job duties as a tower guard at Menard have not contributed to the causation and/or aggravation of his bilateral carpal tunnel syndrome. Dr. Sudekum indicated that he did not feel that Petitioner's use of Folger Adams keys, padlock keys or other keys used during his employment as a tower guard or cell house guard contributed to the development of his carpal tunnel syndrome. Dr. Sudekum indicated that he had not reviewed any documentation indicating that Petitioner developed or complained of carpal tunnel symptoms during a time when he was employed as a cell house guard in the general population galleries, nor had he received any specific information that Petitioner complained of any carpal tunnel symptoms during that time when his job included regular and consistent bar rapping and/or regular consistent opening and closing of heavy steel sliding cell doors in the general housing units at Menard. (RX8).

The report noted that Dr. Sudekum was of the position that if Petitioner's carpal tunnel symptoms developed and/or were present during a time when his job duties included regular and consistent (daily) bar rapping and/or regular consistent (many times daily) opening and closing of heavy steel sliding cell doors on the general housing units (galleries) at Menard, then it would be his opinion with a reasonable degree of medical certainty that his job duties at Menard may have served as a minor contributing factor to the development of his bilateral carpal tunnel symptoms, whereas the primary causal factors would be his other comorbid conditions and non-work related risk factors. (RX8).

The transcript of the evidence deposition of Dr. Sudekum was entered into evidence at the time of arbitration as Respondent's Exhibit 9. Dr. Sudekum testified that he is board-certified in plastic and reconstructive surgery and also in surgery of the upper extremity. (RX9).

Dr. Sudekum testified that Petitioner indicated to him that he had had many different postings and positions as a correctional officer at Menard, and that for the past seven months (as of the time that Petitioner was seen) he had worked as a tower officer. He testified that Petitioner indicated that during this time his symptoms had worsened significantly while he was working as a tower officer, but that he had worked in various other posts including the health care unit, the library, the barber shop, the galleries and supervisor of various work crews. (RX9).

Dr. Sudekum testified that on examination Petitioner's weight was consistent with moderately severe obesity, and that on examination of the upper extremities there was no notable abnormality or muscle atrophy. He testified that Petitioner had normal range of motion of the bilateral elbows, forearms, wrists, thumbs and fingers. He testified that Petitioner's wrist Tinel's and Phalen's signs were negative bilaterally, which was a "bit unusual" for someone who has carpal tunnel syndrome. He further testified that Petitioner's elbow Tinel's were negative and elbow Phalen's were positive for bilateral tingling in the fifth fingers, and that the grip and pinch strength were normal in both upper extremities. He also testified that while Petitioner was at his office he also had nerve conduction studies conducted, which revealed electrodiagnostic evidence consistent with mild bilateral carpal tunnel syndrome. He further testified that he spent approximately 40-60 minutes with Petitioner at the time of the independent medical examination. (RX9).

Dr. Sudekum testified that Petitioner had multiple diagnoses, including obesity, hypertension, hypercholesterolemia, fluid retention and mild bilateral carpal tunnel syndrome. He testified that Petitioner's comorbid factors for carpal tunnel included his age, obesity, hypertension requiring antihypertensive medication, fluid retention requiring a diuretic, hypercholesterolemia requiring medication, elevated blood sugars and prediabetes. He testified that Petitioner's job as a tower guard did not cause or aggravate his bilateral carpal tunnel syndrome, based upon his knowledge regarding the type of job activities performed by tower guards having visited the towers at Mendard and towers in other facilities, as well as the written job descriptions he reviewed including that provided by Petitioner in both written form and by the history at the time of the examination. (RX9).

Dr. Sudekum agreed that in the past he had given opinions that certain job duties at Menard Correctional Center may cause or contribute to carpal tunnel syndrome. He distinguished his opinion on the issue, however, by stating that the job duties performed by the gallery officers, including bar rapping and the opening and closing of steel doors on a regular basis, could potentially be strenuous enough to aggravate a condition like carpal tunnel syndrome, but he did not feel the job duties performed by a tower officer would rise to the level where they would serve to cause or aggravate carpal tunnel syndrome because the duties were different. (RX9).

On cross examination, Dr. Sudekum testified that neither Dr. Molnar nor Dr. Goldring ordered x-rays of Petitioner's hands. He denied having any records from Dr. Mirly, nor did he have a copy of Dr. Mirly's deposition. He testified that the NeuroMetrix test measured many of the same parameters that a nerve conduction study of any kind measured. He denied that a NeuroMetrix could not measure conduction velocities across elbows, and he further denied having testified in the past that he typically defers to a neurologist conduction test to interpret the results of the studies. (RX9).

On cross examination, Dr. Sudekum denied being an advocate for the State. He agreed that he has referred patients to neurologists for testing non-peripheral neuropathies in the past, and agreed that he still refers patients to Dr. Phillips occasionally. He testified that he did not refer patients to Dr. Goldring as he did not know him. He denied having an explanation as to why he did not have Dr. Mirly's records. He did not agree that Petitioner has cubital tunnel syndrome. (RX9).

On cross examination, Dr. Sudekum testified that he did not have Petitioner's overtime logs until the day of the deposition. He testified that he received Petitioner's verbal job description when he

examined Petitioner. He testified that he received Petitioner's handwritten job description on the day of the deposition. He denied having been asked to write an addendum or supplemental report for the deposition. (RX9).

On cross examination, Dr. Sudekum agreed that Petitioner told him what he did at Menard as a gallery officer. He testified that it was his opinion that the job duties of a general population gallery officer at Menard could potentially aggravate carpal tunnel syndrome in some individuals. He testified that Petitioner indicated that he started working at Menard in 1991, and that he worked there for some 23½ years. He admitted that he did not know how much of the 23½ years was spent on the wing or gallery. (RX9).

On cross examination, Dr. Sudekum testified that his nurse's name is Jamie, and that he and Jamie both conducted the nerve conduction NeuroMetrix test. He testified that he obtained written consent from Petitioner prior to taking the x-rays and conducting the tests. He agreed that Petitioner has numbness in his thumb, index and middle fingers. He did not, however, recommend surgery. He testified that he would make himself available for any kind of treatment of Petitioner, but noted that he recommended that Petitioner first address his medical conditions that he felt were contributing to the problem. (RX9).

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 March 23, 2015, 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. Mirly. 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 and perform many of the manual tasks performed by the Correctional Officers at both Menard facilities, while Dr. Mirly testified that, while he toured the facility, he did not turn any of the keys himself nor did he rap any bars while he was there, and was unable to describe the doors and keys beyond saying that the doors were big and that they had big key rings. (RX8; PX6). The Arbitrator notes that Dr. Mirly on cross examination testified that an increased body mass index was a positive predictive risk factor for the development of carpal tunnel syndrome and further agreed that being in the sixth decade of life was also a risk factor for the development of carpal tunnel or cubital tunnel syndrome, which 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 and/or upper extremity peripheral neuropathies including his age over 53 years, obesity, hypertension requiring antihypertensive medication, fluid retention requiring a diuretic, hypercholesterolemia requiring medication and elevated blood sugars/pre-diabetes. (PX6; RX8). 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.

Furthermore, the Arbitrator notes that Petitioner himself provided in written form and via testimony a litany of different job assignments that he had performed over the 23 years he has worked for

Respondent, and yet when asked on cross examination about the specific timeframes during which he worked at the various assignments, Petitioner was simply unable to recall many details which causes the Arbitrator to question the credibility of Petitioner's testimony in this case.

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 March 23, 2015, 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 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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LUTHER WOODS,

Petitioner,

vs.

NO: 17 WC 012419

CITY OF EAST ST. LOUIS,

18IWCC0070

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 nature and extent of Petitioner's 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 finds that Petitioner's fracture of the third metacarpal anatomically represents an injury to his left hand rather than his left third middle finger as was the basis for the arbitration award. Petitioner has no restrictions from any medical providers. He returned to full duty on April 3, 2017. Petitioner does not take any medication. The injury has not affected Petitioner either workwise or recreationally. As such the Commission amends the award to a loss of use of 2% of the Petitioner's left hand.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $775.18 per week for a period of 4.1weeks, as provided in §Section 8 (e) of the Act, for the reason that the injuries sustained caused the loss of use of 2% of the left hand.

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

18IWCC0070

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 case 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:
o: 1/11/18
SM/msb
44

JAN 31 2018

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WOODS, LUTHER
Employee/Petitioner

Case# **17WC012419**

CITY OF EAST ST LOUIS POLICE DEPT
Employer/Respondent

18IWCC0070

On 7/11/2017, 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 1.12% 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

5196 CLAYBORNE SABO & WAGNER
JENNIFER L BARBIERI
525 W MAIN ST SUITE 105
BELLEVILLE, IL 62222

18IWCC0070

STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Luther Woods
Employee/Petitioner

v.

City of East St. Louis Police Department
Employer/Respondent

Case # 17 WC 12419

Consolidated cases: N/A

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Collinsville**, on **June 23, 2017.** By stipulation, the parties agree:

On the date of accident, **February 17, 2017**, 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's earnings were **$130,000.00,** and the average weekly wage was **$2,500.00.**

At the time of injury, Petitioner was **53** years of age, ***married,*** with 0 dependent children.

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

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 bills paid under its group medical plan for which credit may be allowed under Section 8(j) of the Act.

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 **3.8** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **10% loss of use of the left middle finger.**

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

7/5/17
Date

ICArbDecN&E p.2

JUL 11 2017

18IWCC0070

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Luther Woods
Employee/Petitioner

Case # 17 WC 12419

v.

Consolidated cases: N/A

City of East St. Louis Police Department
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The Parties stipulated that Petitioner sustained accidental injuries arising out of his employment on February 17, 2017, when he was reaching in his vehicle to apprehend a suspect and struck the metal door frame with his left hand between his third and ring fingers. (AX1).

Petitioner testified that despite the improvement from immobilization and therapy, he continues to experience stiffness, cramping, locking and soreness over the injury site and that he rubs it to alleviate his symptoms.

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 Touchette Regional Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on February 17, 2017, at which time it was noted that he accidentally hit his left hand on a car door while attempting to apprehend a criminal. It was noted that Petitioner had pain and swelling to the top of the left hand and that he had decreased movement due to pain. The records reflect that Petitioner underwent x-rays of the left hand on February 17, 2017, which were interpreted as revealing (1) acute intraarticular third metacarpal fracture; (2) dorsal hand soft tissue swelling; (3) mild osteoarthritis. The clinical impression was noted to be that of a fracture of the left third metacarpal. It was noted that Petitioner was to call Dr. Schwarze for a follow-up appointment. (PX3).

The records of Touchette Regional Hospital reflect that Petitioner underwent x-rays of the left hand on February 23, 2017, which were interpreted as revealing a stable non-displaced intraarticular fracture of the third metacarpal head; no new or progressive injury. The records reflect that Petitioner underwent x-rays of the left hand on March 13, 2017, which were interpreted as revealing interval healing changes of comminuted third distal metacarpal fracture with stable interval alignment. The records further reflect that Petitioner underwent x-rays of the left hand on March 27, 2017, which were interpreted as revealing comminuted fracture distal third metacarpal with slight increased healing response since prior exam. (PX3).

The records of Touchette Regional Hospital reflect that Petitioner underwent physical therapy for the timeframe of April 3, 2017 through May 12, 2017. At the time of the May 12, 2017 visit, it was noted that Petitioner had a pain/discomfort level of 0. Petitioner was discharged to a home exercise program at

that time. At the time of the May 5, 2017 visit, it was noted that Petitioner's pain/discomfort level was a 0 and that his only complaint was his inability to make a tight fist with the left hand. It was noted that Petitioner had minimal swelling noted. At the time of the May 3, 2017 visit, it was noted that Petitioner stated that he felt more stiffness on that date due to the weather. Petitioner was a no-show to the April 28, 2017 visit. Petitioner cancelled the April 26, 2017 visit due to a work conflict. At the time of the April 21, 2017 visit, it was noted that Petitioner reported that he was able to begin his exercise routine and that he did push-ups with no pain reported. At the time of the April 19, 2017 visit, it was noted that Petitioner had no pain at the present and that he denied pain the day before when having to apprehend someone at work. At the time of the April 17, 2017 visit, it was noted that Petitioner had no pain but reported that he still could not extend his fingers all the way. At the time of the April 14, 2017 visit, it was noted that Petitioner reported an improved ability to grasp objects. At the time of the April 10, 2017 visit, it was noted that Petitioner denied any complaints of pain and that he reported stiffness in his wrist and left third finger. Petitioner was a no-show for the April 5, 2017 visit; it was noted that Petitioner cancelled his appointment for April 7th due to a wedding. At the time of the initial evaluation on April 3, 2017, it was noted that Petitioner felt that his strength and mobility were better but that he was concerned with his inability to fully extend his left middle finger. (PX3).

The medical records of Archview Medical Specialists were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen on February 23, 2017, at which time it was noted that he sustained a right [*sic*] hand injury. It was noted that the duration was one week, that the timing was acute, that the context was that of a work injury and that Petitioner struck an object, that aggravating factors included gripping and that x-rays revealed a non-displaced head of the third metacarpal fracture. The assessment was noted to be that of a closed fracture of shaft of metacarpal bone, left, and left hand pain. Petitioner was ordered to undergo x-rays. It was also noted that Petitioner was unable to use his left hand until his fracture healed. At the time of the March 13, 2017 visit, it was noted that Petitioner fractured his right [*sic*] hand on February 17th while apprehending a suspect. It was noted that x-rays revealed healing and that callous formation was noted. At the time of the March 27, 2017 visit, it was noted that Petitioner was allowed to return to work on April 3, 2017 and that he was to attend physical therapy for hand therapy for four weeks. (PX4).

The Form 45: Employer's First Report of Injury was entered into evidence at the time of arbitration as Petitioner's Exhibit 5.

The First Report of Injury was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The documentation was duplicative of that as contained in Petitioner's Exhibit 5. (RX1; PX5).

The Police Report was entered into evidence at the time of arbitration as Respondent's Exhibit 2.

The medical records of Touchette Regional Hospital were entered into evidence at the time of arbitration as Respondent's Exhibit 3. The records were duplicative of those as contained in Petitioner's Exhibit 3. (RX3; PX3).

CONCLUSIONS OF LAW

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injury, and consistent with 820 ILCS 305/8.1b, permanent partial disability shall be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of Section 8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. No single enumerated factor shall be the sole determinant of disability. *Id.*

With respect to Subsection (i) of Section 8.1b(b), the Arbitrator notes that no AMA rating was offered by either party. The Arbitrator places no weight on this factor when making the permanency determination.

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that the record reveals that Petitioner was employed as a police officer at the time of the accident and that he returned to his position upon the completion of treatment. The Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 53 years old on his date of accident. Given the age of Petitioner and the fact that the medical records lack any reference to his having been placed under any restrictions, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (iv) of Section 8.1b(b), the Arbitrator notes that, following his work injury, Petitioner returned to his position as a police officer for Respondent. As there was no direct evidence of reduced earning capacity contained in the record, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (v) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that despite the improvement from immobilization and therapy, he continues to experience stiffness, cramping, locking and soreness over the injury site and that he rubs it to alleviate his symptoms. At the time of the March 27, 2017 visit at Archview Medical Specialists, it was noted that Petitioner was allowed to return to work on April 3, 2017 and that he was to attend physical therapy for hand therapy for four weeks. (PX4). Furthermore, at the time of the May 12, 2017 physical therapy visit, it was noted that Petitioner had a pain/discomfort level of 0. (PX3). The Arbitrator concludes that Petitioner's evidence of disability at the time of arbitration, namely his continued complaints and limitations, were only somewhat corroborated by his treating records entered into evidence at the time of arbitration. The Arbitrator accordingly places greater weight on this factor in determining permanency.

The Arbitrator notes that the determination of permanent partial disability benefits is not simply a calculation, but an evaluation of all of the factors as stated in the Act in which consideration is not given to any single factor as the sole determinant. Based on the above factors and the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of **10% loss of use of the left middle finger** as provided in 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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARTHA MARTINEZ,

Petitioner,

vs.

NO: 13 WC 26401

LUTHERAN HOME,

18IWCC0071

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

The Commission finds that the lumbar MRI as recommended by Dr. Mina Foroohar is not reasonable or necessary as required under Section 8(a) of the Act.

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).

The Commission finds that Petitioner failed to establish that the lumbar MRI ordered by Dr. Foroohar was reasonable and necessary. Dr. Foroohar had examined Ms. Martinez and noted that she had some additional pain upon her return to work. PX.3. pg. 9. Dr. Foroohar explained her reasoning for ordering the MRI: "[P]atients sometimes have to just accept it and move on. You know, they think that sometimes when you do surgery they should have no pain. Well, it's not that simple. You know, there is going to be some pain with some activities, some positions, although it may not be strenuous, can give you some pain, you know." PX.3. pg.15. Dr. Foroohar testified that "sometimes when you do the imaging, the patient then is also mentally satisfied that everything looks good. You know, they're reassured…" PX.3. pg.10. Dr. Foroohar further explained that it is more common for her to order MRIs for surgical patients after they returned to work in worker compensation patients stating that "ordering an MR is not a huge deal. The MR doesn't cost—I mean it's really a minimal cost." PX.3. pg.17. The Commission finds that while Dr. Foroohar's testimony explains the reason she ordered the MRI, none of her statements demonstrate the reasonableness or necessity for the MRI. "Mentally satisfying" a patient does not establish reasonableness or necessity.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 21, 2017, is hereby modified as stated above and otherwise affirmed and adopted.

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

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

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

No Bond is required for removal of this cause to the Circuit Court by Respondent. 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: JAN 31 2018

Michael J. Brennan

MJB/tdm
O: 1/8/18
052

Kevin W. Lamborn

DISSENT

I respectfully dissent from the opinion of the majority and would affirm and adopt the Arbitrator's decision. In the original 19(b) Decision issued July 10, 2014, the Arbitrator found that Petitioner's then-current state of ill-being was causally related to the January 6, 2011 work accident. (PX 1). In relevant part, the Arbitrator awarded prospective medical benefits to Petitioner in the form of the lumbar fusion surgery recommended by Dr. Foroohar. Petitioner underwent the awarded fusion surgery at the L4-L5 level on October 20, 2014.

After the surgery, Petitioner continued treatment with Dr. Foroohar and eventually returned to work with light duty restrictions pursuant to an October 19, 2015 FCE. On April 5, 2016, Petitioner returned to Dr. Foroohar with complaints of worsening pain following her return to work. The doctor testified that there is no basis to question Petitioner's history of increasing pain. (PX 3, pg. 18). Dr. Foroohar examined Petitioner and recommended a new lumbar MRI in addition to lumbar x-rays. Dr. Foroohar testified that the lumbar MRI was reasonable and necessary because Petitioner presented with new or worsening complaints of radicular pain following her return to work with restrictions. The doctor also testified that she would not want to release Petitioner from her care without examining a lumbar MRI and verifying that there are no new problems with the surrounding discs.

Based on the evidence, I believe Petitioner met her burden of proving by a preponderance of evidence that the recommended lumbar MRI is reasonable and necessary. After all, Respondent's own Section 12 examiner, Dr. Deutsch, testified that a new MRI would be reasonable and necessary if a patient complained of new pain. (RX 1, pp.14-15) When asked how he differentiates new pain, Dr. Deutsch used the example of a patient who comes in and says that something specific happened and since that event the pain has worsened to the point that the patient begins taking more pain medications. *Id.* at 22-23. Here, Petitioner is complaining of increasing pain as a direct result of her return to work with restrictions. As there is no evidence that calls into question the history of Petitioner's current complaints, there is no reasonable basis for the majority to overturn the Arbitrator's decision.

For the forgoing reasons, I would affirm the Arbitrator's well-reasoned decision.

Thomas J. Tyrrell

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

MARTINEZ, MARTHA
Employee/Petitioner

Case# **13WC026401**

LUTHERAN HOME
Employer/Respondent

18IWCC0071

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:

4128 RUBENS AND KRESS
FRANK D KRESS
134 N LASALLE ST SUITE 444
CHICAGO, IL 60602

1120 BRADY CONNOLLY & MASUDA PC
IVAN NIEVES
10 S LASALLE ST SUITE 900
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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)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Martha Martinez
Employee/Petitioner

v.

Lutheran Home
Employer/Respondent

Case # 13 WC 26401

Consolidated cases: _____

18IWCC0071

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 **January 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. ☒ 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, 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*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$23,166.00**; the average weekly wage was **$445.50**.

On the date of accident, Petitioner was **54** 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 **$0.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$0.00**.

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

ORDER

Prospective Medical benefits

Respondent is ordered to authorize and pay for the MRI as recommended by Dr. Foroohar. Respondent is also ordered to authorize a follow-up visit with Dr. Foroohar following the MRI.

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 17, 2017
Date

ICArbDec19(b)

FEB 21 2017

Martha Martinez v. Lutheran Home
13 WC 26401

MEMORANDUM OF DECISION OF THE ARBITRATOR

Findings of Fact

The Petitioner in this matter works as a certified nursing assistant for the Respondent. The Decision of Arbitrator Jessica Hegarty was submitted as Petitioner's Exhibit 1 to this matter. The Decision of Arbitrator Hegarty found that the Petitioner's current state of ill-being was causally related to a work accident of January 6, 2011. As a result, Arbitrator Hegarty awarded the Petitioner prospective medical benefits in the form of a lumbar fusion at the L4-L5 level. Dr. Mina Foroohar performed the fusion with the assistance of Dr. Richard Mannion on October 22, 2014 (Pet. Ex. 4). Following the surgery, the Petitioner returned to see Dr. Foroohar for several post-operative consultations (Pet. Ex. 1). On September 29, 2015, Dr. Foroohar recommended a functional capacity evaluation to determine the Petitioner's work restrictions and limitations (Pet. Ex. 1, P. 15). On October 19, 2015, the Petitioner underwent a functional capacity evaluation at ATI Physical Therapy (Pet. Ex. 5). The FCE revealed that the Petitioner could work in a light-duty capacity, lifting at most twenty-eight pounds (Pet. Ex. 5).

On April 5, 2016, the Petitioner saw Dr. Foroohar with continued complaints of pain (Pet. Ex. 1, P. 20). In her deposition given in connection with this matter, Dr. Foroohar testified that "it seemed like there was a big gap" in the Petitioner's treatment due to "her work comp" because "they weren't authorizing her to come back" (Pet. Ex. 3, P. 9). Dr. Foroohar explained that at the April 5, 2016 visit, the Petitioner had additional pain due to being forced to perform tasks at work that were not light duty (Pet. Ex. 3, P. 9). Based upon these ongoing complaints, Dr. Foroohar recommended a new lumbar MRI and x-rays "prior to making final recommendations" (Pet. Ex. 1, P. 20).

On April 1, 2016, Dr. Harel Deutsch examined the Petitioner on the behalf of the Respondent pursuant to Section 12 of the Illinois Workers' Compensation Act. Dr. Deutsch opined that the Petitioner had reached maximum medical improvement and was not in need of the MRI that Dr. Foroohar recommended.

Due to the conflicting opinions of the medical experts in this matter, this litigation ensued regarding whether the MRI as recommended by Dr. Foroohar constitutes reasonable and necessary medical care pursuant to Section 8(a) of the Act.

Conclusions of Law

(F)

The Respondent has disputed whether the Petitioner's current state of ill-being is causally related to her work accident of January 6, 2011. Based upon the initial Decision of Arbitrator Hegarty and the subsequent medical records, it is abundantly clear that the Petitioner's current state of ill-being remains causally related to the work accident.

(K)

In support of her medical opinion that the Petitioner is in need of a lumbar MRI, Dr. Foroohar provided the aforementioned deposition testimony in this matter. Dr. Foroohar testified that it was not necessarily typical of her patients to have a repeat MRI following a surgery, but that there's no harm in doing it (Pet. Ex. 3, P. 9). She explained that post-operatively she follows her patients x-rays and usually does flexion-extension [x-rays] to make sure there's no new movement above or below the fusion and then an MRI to rule out there is no new disc herniation (Pet. Ex. 3, P. 9). She added that sometimes when you do the imaging, the patient then is also mentally satisfied that everything looks good (Pet. Ex. 3, P. 10). She explained that because patients like [the Petitioner], where it took several years to get to [the end of treatment] and they need more reassurance (Pet. Ex. 3, P. 10). Accordingly, Dr. Foroohar explained that she didn't see any issue with doing an MRI, especially if the patient has a new complaint (Pet. Ex. 3, P. 10). With all of this in mind, Dr. Foroohar testified that the MRI being recommended was reasonable and necessary medical care and that it was "not a big deal" as it was "just imaging" (Pet. Ex. 3, P. 10).

Dr. Deutsch also gave deposition testimony in this matter. Dr. Deutsch testified that by the time he examined the Petitioner, she was at maximal medical improvement and that any further diagnostic testing, including MRIs and further films, would not be related to the alleged work accident and surgery for which she already attained a solid fusion, and, if she did have any further testing, it would be related to a new problem, not the work injury (Resp. Ex. 1, P. 14). Dr. Deutsch explained that if the Petitioner was having severe pain such as new pain down the leg or some new symptom, you may want to get a new MRI if you're considering doing surgery or other treatment (Resp. Ex. 1, P. 15). However, in Dr. Deutsch's opinion, if the Petitioner was continuing to complain of some lower back pain which she's had for a long time, there is no reason to get an MRI just to do it or just for surveillance purposes (Resp. Ex. 1, P. 15). Dr. Deutsch testified that unless she has some new finding or new symptom, there would be no reason to get a new MRI (Resp. Ex. 1, P. 15).

Upon cross examination, Dr. Deutsch testified that as the result of a fusion, an x-ray would tell you some things, but that mainly you can see the bones on X-ray (Resp. Ex. 1, P. 20). For that reason, an x-ray would be insufficient to provide any indication if there are any further discogenic problems that might have occurred as a result of a fusion (Pet. Ex. 1, P. 20). Dr. Deutsch testified that once the fusion is done, it's fused, but other

levels can have problems too and can be aggravated indirectly by a fusion at an abutting level (Resp. Ex. 1, P. 20). Specifically, Dr. Deutsch explained that as we get older, all of our discs kind of degenerate over time, and other discs can have problems and there is this idea that if you do a fusion, it may put more stress at the other levels (Resp. Ex. 1, P. 20). Dr. Deutch conceded that discogenic issues at abutting levels were a possibility, but then testified, "you know, you could have problems no matter what happens (indicating that discogenic problems at other levels maybe inevitable regardless of an abutting fusion)" (Resp. Ex. 1, P. 20). When directly asked if a problem might develop at the L3-L4 level as a result of an L5-S1 fusion, Dr. Deutsch equivocated before conceding that possibility (Resp. Ex. 1, P. 21).

When asked whether an MRI would be a reasonable and necessary recommendation given that it was possible that a fusion at L4-L5 could affect the disc at L3-L4 and the disc at L5-S1 causing complaints of back pain, and thusly providing a basis for the possibility that there is a discogenic generator of the pain, Dr. Duetsch seemed to agree with the caveat that the risk of discogenic pain at an abutting level was "very, very small" (Resp. Ex. 1, P. 22). Notwithstanding this "very, very small" chance that a patient would have discogenic pain at a different level subsequent to a fusion, Dr. Deutsch admitted that in his own practice he had recommended an MRI for a patient that came back to him following a fusion (Pet. Ex. 1, P. 23). He clarified that this was done when a patient came to him with "new pain" (Pet. Ex. 1, P. 23).

Based upon a review of the records, a consideration of the Petitioner's testimony and a review of the deposition testimony, it is clear to the Arbitrator that it is not unreasonable for the Respondent to provide authorization for a lumbar MRI in this matter. The Petitioner testified with regard to the pain that she continued to feel in her lumbar spine. Dr. Foroohar was quite clear that given the Petitioner's ongoing pain complaints, she cannot place her at maximum medical improvement without first reviewing an MRI to ensure that the Petitioner's increased pain with her return to work was not discogenic in nature. The Arbitrator adopts the opinion of Dr. Foroohar and rejects that of Dr. Deutsch. The Respondent is ordered to approve and pay for the MRI and a follow up visit with Dr. Foroohar to review the MRI and determine whether the Petitioner has reached maximum medical improvement.

Deborah L. Simpson

Signature of Arbitrator

February 17, 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 down	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DEBORAH FOGARTY,

Petitioner,

vs.

NO: 06 WC 28166

DAVIS STAFFING AND FINANCIAL APPLICATIONS CORPORATION INC.,

18IWCC0072

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission modifies the Decision of the Arbitrator and finds that Petitioner, Deborah Fogarty, failed to prove that her Fibromyalgia is causally related to her June 1, 2006 work-related accident. The Commission finds that Petitioner reached maximum medical improvement (MMI) relative to her right thumb and wrist injury on November 11, 2010. Petitioner further failed to prove that she is permanently and totally disabled (PTD) as a result of her injury of June 1, 2006.

The Commission, therefore, affirms the Arbitrator's award of temporary total disability benefits (TTD) through November 11, 2010 and the denial of penalties, but vacates the award of maintenance benefits and the finding that Petitioner is permanently and totally disabled. The Commission awards Petitioner 45% loss of use of the right thumb. The Commission further awards 10% loss of use of the right hand. The award of 10% loss of use of the right hand is in addition to any prior settlement for the right hand.

At this time, the Commission feels compelled to comment upon the contentious nature of the proceedings before the Arbitrator. The behavior of counsel, as exhibited by the record, leads one to conclude that a more measured approach would have been more appropriate. It appears that this contentious behavior led to at least some of the delay in the presentation of the case at trial.

18IWCC0072

Candidly, no advantage was gained by such antics.

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.

Per the Application for Adjustment of Claim filed June 28, 2006, Deborah Fogarty was a 46-year old, married female with 2 dependents under the age of 18. Petitioner alleged an injury to her right hand when she tripped on a computer cord on June 1, 2006.

Deborah Fogarty has a Bachelor of Arts degree from Lewis University and a degree in accounting from the University of Illinois. She was a certified public accountant. She had a hysterectomy in September 2008 and allegedly has not driven since October 2010 as she cannot drive due to her medication and because of her hands, legs, and her pain. T.43.

Fogarty was previously an accounting manager for CBS. She was charged with converting 2 million dollars from CBS, for which she pled guilty to felony theft by deception and money laundering in 2003. She was incarcerated from July 2003 through January 2006 and her husband was incarcerated from July 2003 through February 2005. T.76.

On June 1, 2006, Fogarty tripped over a cord and had to suddenly grab onto the desk with her right hand. T.47. Her thumb started to swell and bruise. She worked the next couple of days and reported the accident to Nan Foster on June 14, 2006. She then worked light duty and last worked for Davis Staffing on June 30, 2006. T.52. Fogarty stated that she was terminated as there was no more light duty work available.

Fogarty presented to Midwest Physician Centers on June 14, 2006 following her June 1, 2006 injury. She complained of a constant throbbing pain in her hand. She followed-up on June 26, 2006 with continued pain in her right hand. RX.1.

Petitioner was seen by Dr. James Davis of Midwest Physicians on June 30, 2006 for right wrist pain. It was noted that conservative care was appropriate as no surgical intervention was necessary. She was advised to use her wrist normally and was released to work without restriction. PX.3.

Petitioner was seen by Dr. Terry Light of Loyola University on October 2, 2006. It was noted that she fell onto her extended right wrist and suffered a sprain in June 2006. While the swelling and pain lessened, she had continued pain on wrist movement and hand paresthesia at night. The study was consistent with right median nerve compression at the right. PX.3.

Fogarty then began working for Waldo Corporation in October 2006 performing light accounting work and keyboarding. T.56. She worked until June 30, 2008 when Waldo Corporation closed. T.57. She stated that Waldo accommodated her right thumb issues by providing her with an ergonomic keyboard. T.156. She worked there for a year and a half. *Id.*

Respondent obtained a Section 12 examination from Dr. Paul Papierski of Hand Surgery & Specialty Orthopaedic Centers on October 10, 2006. She complained of continuous, moderate to severe pain of the right thumb and hand. There was evidence of a triquetral avulsion fracture to her right wrist. Her prognosis for recovery was excellent. Her symptoms were likely related to her June 1, 2006 accident. She could work in an unrestricted fashion. PX.20.

On August 20, 2007, Fogarty fell from an escalator in a Metra station. Per the fire department report, Fogarty had 4 lacerations on the right arm, right shoulder, right side of the face, and cheek. She slid down the escalator face first on her right side. She had razor like cuts to the right side of her arm, shoulder, and face. She was transported to Northwestern Memorial Hospital where it was noted she had abrasions to the right side of the face, forehead, forearm, and hand. RX.2.

Fogarty testified that she does not remember hurting her right hand in the Metra fall. T.37.

Fogarty worked for an accounting firm in Crestwood, Illinois for 6 weeks in 2008 and quit in August 2008 as she underwent an emergency hysterectomy on August 20, 2008. PX.2.

Petitioner was seen by Dr. John Fernandez of Rush University Medical Center on October 2, 2008 for right hand symptoms. She reported her June 1, 2006 accident. He recommended right thumb basilar joint arthroplasty and right wrist carpal tunnel. She was returned to work with a 5-pound lifting restrictions and minimal repetitive use of tools. PX.3.

Petitioner underwent a right thumb surgery and right carpal tunnel release on November 14, 2008. T.58.

Petitioner had filed a claim for bilateral carpal tunnel syndrome against Waldo Corporation. The date of that accident was June 30, 2008. Petitioner settled her claim against Waldo Corporation on April 14, 2011 for $39,114.00.

Per the Athletico physical therapy record dated February 13, 2009, Fogarty reported jamming her thumb into a desk causing pain. RX.7.

Due to continued pain, Dr. Fernandez performed a right thumb MP joint fusion on August 14, 2009. During her September 29, 2009 visit, Fogarty reported that her pain had decreased and she was pleased. She had some stiffness along the IP joint of the thumb and some stiffness of the wrist. Her pain was 7 out of 10. The diagnosis was right thumb MP joint stiffness with pain, right wrist stiffness, and left wrist carpal tunnel. She could work in a one-handed capacity. PX.3.

Per the Athletico Physical Therapy report dated January 5, 2010, Fogarty reported jamming her thumb and the tip of the thumb had been painful all day. PX.3.

Due to continued pain, Dr. Fernandez performed right thumb hardware removal and flexor tenolysis on March 12, 2010. PX.3.

Petitioner was seen by Dr. Fernandez on July 20, 2010 for left hand pain. Dr. Fernandez

noted that Fogarty indicated that therapy was not helpful to the right hand. She could work in a light duty capacity with less than 10 pounds of force involving her right and left upper extremity. She was limited to minimal repetitive use and no use of tools. PX.7

Petitioner testified that her pain following the surgery was between 6 and 8. T.74. Her TTD and medical benefits were suspended on May 22, 2010. T.76. She stated that no doctor placed her at MMI at that time. T.78. She last underwent physical therapy in June 2010 as Gallagher Bassett denied therapy. T.92.

Petitioner underwent left carpal tunnel release on August 27, 2010. PX.3. Petitioner's claim for left carpal tunnel syndrome was against Waldo Corporation, not this Respondent.

Fogarty was seen by Dr. Fernandez on September 28, 2010. She was using a wheelchair most of the time and had difficulty getting around. She had difficulty with some tasks including dressing herself, feeding herself, and typing on a computer. Dr. Fernandez noted that further treatment for her carpal tunnel would not be beneficial. She was at MMI for her carpal tunnel releases. She could engage in light activities up to 10 pounds of use with frequent breaks particularly with more significant repetitive type of use through the wrist and hands. He was still treating her for the thumb. PX.3.

Petitioner was seen by Dr. Fernandez on November 11, 2010 following her bilateral carpal tunnel complaints. She had residual pain at the basilar joint site with associated stiffness of the thumb relating to the fusion and stiffness of the IPJ. She did not have any more improvements. She was having difficulty with light activities such as getting dressed, feeding herself, and writing and keyboarding. This was secondary to loss of motion, loss of strength, and associated pain. She was at MMI. She was restricted to only very light use on the right side with less than five pounds of use with minimal repetition or use of tools. She was to have minimal exposure to typing, writing, or use of calculators and other manual activities requiring the right hand. Dr. Fernandez expected similar restrictions on the left, but those restrictions were not workers' compensation related. PX.7.

Petitioner testified that she never received a position of employment from respondent after her MMI date of November 11, 2010, and has not receive any benefits. T.97.

Fogarty was seen by psychiatrist, Yolanda Solecki on March 2, 2011 for depression. Petitioner reported that her symptoms have been present for a year or longer. She stated that it was related to her deteriorating health condition and fall at work. She had two deaths in the family. She was being sued by her sisters over her mother's estate. She gained weight with the birth of her child and has been unable to lose the weight. She was diagnosed with major depressive disorder, severe without psychotic features. PX.7.

On August 26, 2011, Dr. Evaldas Readzevicius authored a letter to "Whom It May Concern" noting that Fogarty's psychiatric symptoms seem to be related to her work accident of June 1, 2006. She has had symptoms since and they were worse after her March 2010 surgery. Per Dr. Readzevicius, there was not a history of psychiatric conditions, depression or anxiety, and no history of psychiatric medications prior to the June 1, 2006 injury. Her GAF score was 50. She was severely impaired due to all her health conditions. Her major depression and anxiety were

caused by her June 1, 2006 injury and related surgeries. She was unable to function in any work setting for the foreseeable future. PX.7.

Dr. Serushan authored a report to Dr. William Luebbe on September 14, 2011. He noted Fogarty had diffuse pain all over her body including her hands, knuckles, wrists, shoulders, hips, knees, and neck, and complained of fatigue. He noted Fogarty had a history of depression beginning after the multiple surgeries and pain in the right hand. He diagnosed petitioner with chronic Fibromyalgia and possible depression. She was started on Lyrica. PX.6.

Dr. Serushan authored a letter on October 12, 2011 at the request of petitioner's attorney. Dr. Serushan indicated Fogarty reported she was 190 pounds prior to the June 2006 injury and now weighed 250 pounds. She attributed this to inactivity and changes in lifestyles. She began to develop progressive aches and pains. He noted that petitioner's Fibromyalgia evolved after her traumatic fall, multiple surgeries, and major depression. This could be a permanent issue which she would have to deal with for her life. She had osteoarthritis of the hands secondary to trauma or repetitive work, chronic depression and chronic pain that was relentless and had not improved with medication. Her weight gain was partially due to her Fibromyalgia. He opined that she would not be able to hold any gainful employment with the disability in her hands along with all her aches and pains all over her body. PX.6.

Jeff Lucas of Effective Rehabilitation authored a report on November 18, 2011. He noted that Fogarty's disability, pain, psychological issues and mental status would impact her ability to complete a full day of employment. He noted that Fogarty could not do an entry level job as this takes good use of both hands. It was his opinion that she would be unable to find any employer to accommodate her current disability. Her current restrictions do not lend to any gainful employment. PX.7.

Dr. Lucas testified that he is a board certified vocational expert and has owned Effective Rehabilitation Management since 1985. He stated that there is no work place for Petitioner's condition in the labor market. She just would not be hired. T.48. He noted that Dr. Vendor opined Fogarty could return to work without restriction. Dr. Lucas stated that Dr. Vendor did not account for any of the medication Petitioner was taking. T.54. He met Petitioner on two occasions only. T.61. She could only work in a sheltered work shop or something that required an incredible special circumstance or accommodation. There were no jobs that he was aware of that she would have been able to perform under the restrictions set forth by Dr. Fernandez. T.70. He noted that there are many jobs that would hire felons. T.75. He noted that Fogarty's criminal background would limit her ability to find employment. T.80.

On cross-examination, Dr. Lucas testified that Fogarty's psychological problems and medications would be issues that would impede her ability to work. T.101.

Respondent obtained surveillance of Petitioner. On January 23, 2012, Fogarty was seen walking with the assistance of a cane. She walked with an altered gait. She and her husband went to the train station where her husband put her in a wheelchair and pushed her to the train. She was pushed in a wheel chair to and from her doctor's appointment.

Respondent obtained a neuropsychological evaluation on February 1, 2012 from Ronald Ganellen, Ph.D. He noted that Fogarty performed all tasks with her left hand. He noted that Petitioner managed the demands of her job until her emergency hysterectomy even though she experienced pain in her right hand and reported limitations with her right hand. She reported being depressed after her surgeries. He noted that Fogarty performed better on the more difficult tests than the easier tests. She had an intact ability to learn new information but decreased retention of the material over time. The findings could not be explained by the effects of the June 2006 injury to her right hand. The MMPI-2 test showed that petitioner deliberately exaggerated her reports of problems in adjustment and limitations in functioning. He noted this should not be taken to mean that none of the symptoms existed. The findings did, however, indicate that she deliberately and consciously overstated the problems she currently experienced to convince others she was disabled. While she has major depression, its link to the accident was questionable, at best. There was strong objective evidence that Fogarty was not providing an accurate, reliable history. The extent of other factors that occurred between 2006 and 2010 including Fibromyalgia, Osteoarthritis, Rheumatoid arthritis, the death of her mother, and conflicts with her sister all contributed to the onset and persistence of a negative mood. It was difficult to determine the extent of her condition as Petitioner's account of her condition could not be accepted at face value. She would have returned to work as an accountant had she not had the emergency hysterectomy. No psychological problems were identified until after the hysterectomy. RX.11.

Respondent obtained surveillance of Fogarty on February 1, 2012. Petitioner is seen walking slowly with a cane in her left hand and with a limp. She is also being pushed in a wheelchair. RX.3.

Respondent obtained a Section 12 examination from Dr. Michael Vender of Hand Surgery Associates on March 14, 2012. He found that Fogarty's presentation related to her right upper extremity would be considered non-physiologic in nature and not based on a true objective pathology within the upper extremity. They were consistent with behavioral abnormality consistent with her significant psychiatric history. Her Fibromyalgia was unrelated to her thumb injury as it was a systemic condition. The results of her thumb surgery were very good and it was expected that there would be very limited residual complaints and disability. She did not need work restrictions or any more medical treatment. Her inability to work was not based on any injury to the right upper extremity. RX.3.

Fogarty was awarded Social Security benefits on March 14, 2012. Her attorney contacted Dr. Serushan and Jeff Lucas to write reports supporting her claim for SSDI. Fogarty was found to be disabled for social security purposes since August 14, 2009 and received retroactive benefits to August 2009. She also received TTD from Respondent from August 2009 through May 2010. T.82.

Ms. Sharon Babat is an employment consultant for S&H Management Services and prepared a report on February 7, 2013. She noted that Fogarty had a positive work history and transferrable skills. She could work. Petitioner's barriers to employment were her felony conviction for embezzlement and imprisonment. T.27.

Ms. Babat performed a labor market survey factoring Dr. Fernandez's restrictions of 5-

pound maximum lifting with her right upper extremity and minimal use of tools. Petitioner could secure employment paying between $8.25 per hour and $25.00 per hour with expectations of higher pay given her past work experience. T.34.

On cross-examination, Ms. Babat testified that she performed a blind evaluation which is a review of the records and provision of an opinion and recommendation based on a review of the records only. T.57. She did not have Dr. Serushan's medical records or opinions. Despite this, her opinion would not change. T.84. She noted that one doctor provided 5 to 10 pound restrictions, one doctor provided a 10-pound restriction, and one doctor provided no restriction at all. T.85.

Fogarty testified that she has pain all over her body, significant fatigue, and sleep apnea. She cannot bear weight on her right hand and holds her cane with her left. T.130. She can basically do nothing at all. She has not been able to handle her household. She does not have a normal life. T.113. She cries a lot and is depressed. She is currently on social security as she is disabled. She does not recall if she had anxiety and depression dating back to 2001. She did not have Fibromyalgia prior to June 1, 2006. T.146.

Dr. Serushan, a board-certified rheumatologist, was deposed August 16, 2012. He diagnosed Fogarty with Fibromyalgia. It was so severe that she needed narcotics. He prescribed her Fentanyl to control her hand pain, neck pain and other diffuse aches and pains. Her Fibromyalgia was involved after her traumatic fall injury, multiple surgeries and major depression. He opined that Fogarty's trauma, several surgeries, and inability to work was one of the causes initiating or instigating her Fibromyalgia. PX.16. pg.55. He stated that the Osteopenia is not relevant to her Fibromyalgia. Given her medication, she cannot drive. He stated that Fogarty is totally disabled. PX.16. pg.67.

On cross-examination, Dr. Serushan indicated that he was unaware of any other falls she may have had. PX.16. pg.78. He stated that Fibromyalgia and depression often overlap. *Id.* Depression can cause Fibromyalgia and vice versa. PX.16. pg.79. Her emergency hysterectomy would not be a factor in the development of her Fibromyalgia. PX.16. pg.94.

Dr. Serushan noted that Fogarty was able to work from October 17, 2006 through June 30, 2008, but he does not know why she stopped working. PX.16. pg.95. He noted that Fogarty lied to him about her weight. The records reveal she was 250 pounds in June 2006 and not 190 at the time of the accident. Therefore, she did not put additional weight on after the accident, at bar. PX.16. pg.100. He did not know about Fogarty's fall in August 2007 at the Metra station or her February 2009 incident where she jammed her thumb into a desk. PX.16. pg.128.

Dr. Vender is a board certified orthopedic surgeon and was deposed December 7, 2012. Dr. Vender specializes in treatment of the hands. He performed a Section 12 examination on March 12, 2014. Fogarty indicated to him that her right hand was dead. He diagnosed Fogarty with status post resection arthroplasty of the right thumb CMC joint and status post right thumb MP fusion. PX.13. pg.20.

There were no objective findings to support that her right hand was dead. RX.13. pg.21. Her complaints were not related to her June 2006 accident. *Id.* He stated that there was no basis

for ascribing her then alleged condition to her fall. RX.13. pg.22. Her osteopenia was not related to her work injury. Her right hand arthritis might be related to the accident. RX.13. pg.25. Her Fibromyalgia was not related to her thumb injury. *Id.* She could work as an accountant and there was no need for restrictions as she had a good recovery from her surgery. RX.13. pg.27. Her current inability to work was not related to her thumb. RX.13. pg.27.

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).

The Commission finds Ms. Fogarty not credible. The picture painted by Ms. Fogarty is at best Wilderesque. It is as if she is opening a Fortune Cookie and looking inside for a prize. The facts at hand belie a permanent and total disability finding. Her thumb injury has been repaired and now she claims total body failure as a result. Her claim is as without merit as she is without credibility.

This record is replete with evidence supporting the finding that Ms. Fogarty is not credible. Ms. Fogarty's history includes a felony conviction for theft and money laundering to which she pled guilty. Despite her willful plea, she asks the Commission to believe that she was just a scapegoat caught up in some vast conspiracy. The Commission declines to do so.

The report from Dr. Ganellen noted that the MMPI-2 test revealed that Fogarty deliberately exaggerated her reports of problems in adjustment and limitations. His findings indicated that she deliberately and consciously overstated the problems she was currently experiencing to convince others she was disabled. Furthermore, Dr. Vender found no evidence to support Fogarty's claim that her hand was "dead."

Additionally, Ms. Fogarty was seen using a wheelchair and cane. The record contains no reference to a cane or wheelchair ever having been prescribed by a doctor or that either were necessary. On oral argument, Fogarty's counsel admitted that no physician ever prescribed any such implement. Lastly, Fogarty lied to Dr. Serushan and claimed that she was 190 pounds prior to her June 1, 2006 accident and now, because of her accident, she weighs 260 pounds. Despite her claim, the records reveal that she weighed 250 pounds at the time of her accident. Her claims of disability are nothing more than a chimerical dream.

Petitioner's lack of credibility when coupled with the medical evidence, lends the Commission to find that Fogarty failed to prove that her Fibromyalgia is related to her June 1, 2006 work accident and that her right thumb and wrist condition reached MMI as of November 11, 2010.

Regarding the right thumb, Dr. Fernandez placed Fogarty at MMI as of November 11,

2010, and provided her with restrictions of only very light use of the right side. Thereafter, respondent obtained a Section 12 examination and opinion from Dr. Vender on March 14, 2012. Dr. Vender found no true objective pathology in the right hand to support her claim that her right hand was "dead." Dr. Vender also found no basis for ascribing her current condition to the work injury of June 1, 2006 and found no need for work restrictions relative to her right thumb.

It was Dr. Vender's opinion that Fogarty could work as an accountant. The Commission finds Dr. Vender's opinions persuasive relative to her credibility and the ability to use the right hand. Accordingly, the Commission finds that Fogarty's right thumb condition reached MMI as of November 11, 2010.

The Commission further finds that Petitioner failed to prove that her Fibromyalgia is causally related to her work accident. The Commission is not persuaded by Dr. Serushan's opinion that Petitioner's Fibromyalgia is related to her work accident. Fogarty's actions following the accident belie any notion that her Fibromyalgia is somehow related to the June 1, 2006 accident. Fogarty continued to work following her accident and subsequently held multiple positions with different companies thereafter, had several non-work-related accidents, and experienced stressful personal situations.

While working for Waldo Corporation, Ms. Fogarty allegedly developed bilateral carpal tunnel syndrome and underwent a bilateral carpal tunnel release for which she received a workers' compensation settlement. She also underwent an emergency hysterectomy that required her to quit another job. She had a significant fall on an escalator. She had two incidents where she jammed her thumb. Her mother died, and she was sued by her sisters. She used a cane and a wheelchair that no physician prescribed.

Fogarty now claims that her Fibromyalgia is somehow related to her work accident of June 1, 2006. Despite her histrionics, the Commission considers her claim to be nothing more than a ruse which is intended to effectuate an award of PTD. The Commission will not countenance such an apparent farce.

In support of its opinion, the Commission finds the opinions of Dr. Ganellen persuasive. Dr. Ganellen noted that Fogarty could manage the demands of her job until her emergency hysterectomy. He also noted that no psychological issues were identified until after the hysterectomy. Not surprising to the Commission, Dr. Ganellen found strong evidence that Fogarty was not providing an accurate, reliable history. Dr. Ganellen also spoke to Petitioner's depression noting that, while she had depression, its link to the accident was questionable. This is confirmed by the evidence which establishes that Fogarty's depression pre-existed the accident. As Dr. Serushan noted, depression can cause Fibromyalgia. The evidence supports that Fogarty had numerous, significant issues present in her life absent the June 1, 2006 injury. Linking her Fibromyalgia to this accident is nothing more than speculation, if not farcical.

An employee need not be reduced to complete physical incapacity to be entitled to PTD benefits. *Ceco Corp. v. Industrial Comm'n*, 95 Ill. 2d 278, 286, 447 N.E.2d 842, 845, 69 Ill. Dec. 407 (1983). Instead, a PTD award is proper when the employee can make no contribution to industry sufficient to earn a wage. *Westin Hotel v. Industrial Comm'n*, 372 Ill. App. 3d 527, 544,

865 N.E.2d 342, 357, 310 Ill. Dec. 18 (2007). "The focus of the Commission's analysis must be upon the degree to which the claimant's medical disability impairs his employability." *Alano v. Industrial Comm'n*, 282 Ill. App. 3d 531, 534, 668 N.E.2d 21, 24, 217 Ill. Dec. 836 (1996). A person is not entitled to PTD benefits if he is qualified for and capable of obtaining gainful employment without seriously endangering his health or life. *Interlake, Inc. v. Industrial Comm'n*, 86 Ill. 2d 168, 176, 427 N.E.2d 103, 107, 56 Ill. Dec. 23 (1981).

The odd-lot category for purposes of a PTD award arises when a "claimant's disability is limited in nature so that he is not obviously unemployable, or if there is no medical evidence to support a claim of total disability." *Valley Mould & Iron Co. v. Industrial Commission*, 84 Ill. 2d 538, 546-47, 419 N.E.2d 1159, 1163, 50 Ill. Dec. 710 (1981). In these situations, the claimant can establish that he is entitled to PTD benefits under the "odd-lot" category by proving the unavailability of employment to persons in his circumstances. *Ameritech Services, Inc. v. Illinois Workers' Compensation Comm'n*, 389 Ill. App. 3d 191, 204, 904 N.E.2d 1122, 1133, 328 Ill. Dec. 612 (2009).

The claimant ordinarily satisfies his burden of proving that he falls into the odd-lot category in one of two ways: (1) by showing diligent but unsuccessful attempts to find work, or (2) by showing that because of his age, skills, training, and work history, he will not be regularly employed in a well-known branch of the labor market." *Westin Hotel*, 372 Ill. App. 3d at 544, 865 N.E.2d at 357. If the claimant establishes that he fits into the odd-lot category, the burden shifts to the employer to prove that the claimant is employable in a stable labor market and that such a market exists. *Id.*

Even if the Commission found that Fogarty's condition of Fibromyalgia was causally related to the June 1, 2006 accident, Ms. Fogarty failed to prove that she is permanently and totally disabled because of her accident.

Following her accident, Fogarty was able to find and secure employment with several companies. Fogarty worked for Waldo Corporation for a year and a half after her June 1, 2006 injury and only left their employ when the company ceased operation. Ms. Fogarty then alleged that her work duties with Waldo Corporation caused her bilateral carpal tunnel syndrome. She filed and settled a workers' compensation claim against Waldo Corporation. Now, Fogarty alleges that Waldo Corporation was accommodating her right thumb injury by providing her with an ergonomic keyboard. There is no evidence that work restrictions were ever necessary. Rather, Dr. Davis released Fogarty to work on June 30, 2006 without restrictions.

Subsequent to her employment with Waldo Corporation, Fogarty found employment with another company. She worked for that company until she voluntarily resigned due to an emergency hysterectomy. The Commission finds no evidence that her injury has impaired her employability.

Further, the Commission does not find that Fogarty established a permanent disability under the "odd-lot" theory. There is no evidence that Fogarty performed a diligent, but unsuccessful job search. The Commission is not persuaded by the contrived opinions of Petitioner's vocational experts. The Petitioner's experts summarily provided the opinion which they were hired to provide *i.e.*, that Fogarty is permanently and totally disabled. Such opinions are

18IWCC0072

illogical and not supported by the credible evidence. The Commission therefore finds that Ms. Fogarty failed to prove that she is permanently and totally disabled.

Based on the above, the Commission finds Fogarty is entitled to TTD benefits from November 14, 2008 through November 11, 2010. The Arbitrator's award of maintenance benefits is vacated, as is the Arbitrator's finding that Ms. Fogarty is permanently and totally disabled. The Commission affirms the denial of penalties in this matter.

Petitioner sustained a right thumb fracture and a right wrist fracture. She ultimately underwent an MP joint fusion, with the subsequent removal of the hardware. The Commission finds that Ms. Fogarty sustained 45% loss of use of the right thumb and an additional 10% loss of use of the right hand for the triquetral avulsion fraction.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 5, 2016, is hereby modified as stated above and otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $453.33 per week for a period of 104 weeks, November 14, 2008 through November 11, 2010, 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 $408.00 per week for a period of 54.7 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused 45% loss of use of the right thumb, and 10% loss of use of the right hand.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $24,500.00. 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: JAN 31 2018

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

MJB/tdm
O: 1/8/18
052

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
SECOND CORRECTED

FOGARTY, DEBORAH
Employee/Petitioner

Case# **06WC028166**

DAVIS STAFFING AND FINANCIAL APPLICATIONS CORPORATION INC
Employer/Respondent

18IWCC0072

On 12/5/2016, 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:

0207 STUART H GALESBURG
4548 W PRATT AVE
LINCOLNWOOD, IL 60712

2965 KEEFE CAMPBELL BIERY & ASSOC
MATTHEW IGNOFFO
118 N CLINTON ST SUITE 300
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)
☐ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
SECOND CORRECTED ARBITRATION DECISION

Deborah Fogarty
Employee/Petitioner

Case # 06 WC 28166

v.

Davis Staffing and Financial Applications Corporation, Inc.
Employer/Respondent

18IWCC0072

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 **Chicago**, on **June 13, 2013, June 20, 2013, August 19, 2013, November 5, 2013, November 13, 2013, August 12, 2014,** and **November 12, 2014,** in the city of **Geneva** on **January 12, 2015** and **April 8, 2015,** in the city of **Wheaton** on **March 31, 2015** and **June 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. ☒ 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 **June 1, 2006**, 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 of **$680.00**.

On the date of accident, Petitioner was **46** 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.

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of **$453.33**/week for **104** weeks, commencing **November 14, 2008** through **November 11, 2010**, in accordance with Section 8(b) of the Act.

Respondent shall be given a credit of **$35,814.64** for temporary total disability benefits that have been paid.

Maintenance

Respondent shall pay Petitioner maintenance benefits of **$453.33**/week for **241** weeks, commencing **November 12, 2010** through **June 25, 2015**, pursuant to Section 8(a) of the Act.

Permanent Total Disability

Respondent shall pay Petitioner permanent total disability benefits of **$453.33**/week, from **June 26, 2015** through **the duration of her disability**, because the injuries sustained in the accident of June 1, 2006 caused permanent and total disability, pursuant to Section 8(f) of the Act.

Respondent shall be given a credit of **$9,302.40** for a **30%** loss of use of the right thumb advance.

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

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

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

Signature of Arbitrator

December 2, 2016
Date

ICArbDec p. 2

DEC 5 - 2016

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION
SECOND CORRECTED ARBITRATION DECISION

Deborah Fogarty
Employee/Petitioner

18IWCC0072

v.

Case # 06 WC 28166

Davis Staffing
and Financial Applications Corporation, Inc.
Employer/Respondent

FINDINGS OF FACT

Respondent, Davis Staffing, hired Petitioner, Deborah Fogarty, in May 2006. Shortly after hiring Petitioner, Davis Staffing sent her to work for Joe Letke and Associates who in turn sent her to work as an emergency accountant for Financial Applications Corporation, Inc. (Tr., November 13, 2013, at 44, 46; Tr., August 12, 2014, at 22) On June 1, 2006, at Financial Applications Corporation, Inc., Petitioner lost her balance and tripped on a computer cord. (Tr., November 13, 2013, at 47) In the process, she smacked her right hand in the thumb area on the desk, almost fell to the floor, but caught herself. (Id. at 47-48) She testified that her right hand was swollen and became black and blue that night. Her husband iced her hand that night. Petitioner continued working after the incident for at least a week. (Id. at 48-49)

Four days after Petitioner tripped on a computer cord, on June 5, 2006, she presented for medical treatment with complaints of pain in her right knee, frequent joint pain, and degenerative joint disease. (Tr., August 12, 2014, at 27-30; RX #1)

On June 12, 2006, Petitioner went to her physician, Dr. Levine, who took x-rays and told her she needed to follow up with an orthopedic specialist. (Tr., November 13, 2013, at 49)

On June 14, 2006, Petitioner met with Nan Foster of Davis Staffing and reported the injury. Nan Foster sent her to Midwest Physician Center where they recorded, in pertinent part, the following: "pt. c/o (R) hand pain since tripping & pt. caught herself by grabbing onto a desk. PE mild swelling over distal 3rd & 4th metacarpals (dorsum). Pt. expressing tenderness to palp. over thenar eminence ..." The diagnosis was hand contusion/strain. Petitioner's weight was noted to be 244 pounds in this record. (Tr., November 13, 2013, at 49; PX #1 at 38, 39)

On June 19, 2006, the medical professional at Midwest Physician's Center wrote that Petitioner's current complaint was (Rt) hand pain. (PX #1, p. 28)

On June 26, 2006, the medical professional at Midwest Physician's Center wrote: "F/up on hand contusion + sprain on (R) side. pt. is still in pain." (PX #1, p. 28)

At that time, Petitioner returned to full time work for Davis Staffing performing light-duty work.

On June 30, 2006, Nan Foster called Petitioner and told her that her light-duty work was terminated. (Tr., November 13, 2013, at 51-53)

On June 26, 2006, Petitioner followed up with Dr. Payne with complaints of persistent pain over the dorsal right hand. X-rays were read as suggestive an old triquetral avulsion fracture, but were otherwise unremarkable. (PX #1 at 40)

On July 22, 2006, Petitioner presented to Dr. Terry Light at Loyola University Medical Center on a referral from a lawyer. She complained of an injured right hand and that it was always swollen with severe pain. History confirms a right knee replacement in 2000. (PX #2 at 1-2)

On July 24, 2006, Dr. Light recorded that Petitioner struck her hand while falling and had pain in right radial wrist. (PX #2 at 3)

On July 27, 2006, a right wrist MRI revealed distention of the radiocarpal dorsal recess; negative ganglion; TFC tear; findings consistent with ulnar abutment; and osteoarthritis first carpometacarpal articulation. (PX #2 at 13)

On July 31, 2006, Petitioner followed up with Dr. Light who reviewed the MRI and opined that it showed changes consistent with thumb carpometacarpal osteoarthritis as well as a tear of the TFCC and an abnormal signal in the adjacent lunate. He noted no tenderness over the TFCC or the lunate. Dr. Light also noted very minor symptoms with thumb CMC stress. He added the symptoms were suggestive of carpal tunnel syndrome. (PX #2 at 10-11)

On September 19, 2006, Dr. Light indicated Petitioner's symptoms were probably related to both thumb carpometacarpal synovitis and to carpal tunnel syndrome. (PX #2 at 10)

On October 2, 2006, Petitioner presented to LUMC/Foster G. McGaw Hospital complaining of wrist pain. Electromyography findings were consistent with right median nerve compression/entrapment at the wrist (CTS) which was mild in severity neurophysiologically and focal/demyelinative in type. (PX #2 at 160)

Petitioner testified that in October 2006, she started working for Waldo Corporation where she did accounting work, keyboarded, and wrote. (Tr., November 13, 2013, at 56) She worked for Waldo through June 30, 2008 when its business closed. (Tr., November 13, 2013, at 56-57) Following the closure of Waldo Corporation, in July or August 2008, Petitioner started working for an accounting firm in Crestwood, Illinois. This lasted for approximately six weeks because she had to quit due to the emergency hysterectomy that she underwent in September 2008. (Tr., November 13, 2013, at 59, Tr., August 12, 2014, at 90-92)

On October 16, 2006, Dr. Light noted Petitioner's electrical studies demonstrated mild carpal tunnel syndrome and he provided a steroid injection to Petitioner's right thumb carpometacarpal joint. (PX #2 at 9)

On August 13, 2007, Petitioner followed up with Dr. Light. X-rays were taken and revealed 75% subluxation of the thumb metacarpal on the trapezium with total loss of joint space between the trapezium and the metacarpal. According to Dr. Light, this represented advanced osteoarthritis. Dr. Light recommended a right trapezium resection arthroplasty. (PX #2 at 8)

On August 20, 2007, Petitioner fell down half of the escalator stairs at One Financial Place. She was not employed by either Respondent listed on the current Application when this event occurred. She was taken to

Northwestern Hospital by ambulance. Medical records from this visit indicate injury to Petitioner's face, right hand, right forearm, left leg, left shoulder, and neck. She hired attorneys to represent her for this incident and received a settlement. (Tr., August 12, 2014, at 36-40; RX #2)

Petitioner also testified regarding a 1999 personal injury case for her daughter, Shannon, when she fell at Kindercare Learning Center. A settlement was received for this incident as well. (Tr., August 12, 2014, at 40)

Evidence in the record indicates Petitioner's husband, Timothy Fogarty, has had eight separate workers' compensation claims filed with the IWCC since 1990. The settlements total approximately $50,000.00. (Tr., August 12, 2014, at 70-73; See RX #32 which contains certified IWCC printouts regarding Timothy Fogarty's Illinois workers' compensation claims.)

On October 2, 2008, Petitioner presented to Dr. Fernandez for treatment. Dr. Fernandez's treating records indicate that Petitioner reported she sustained an injury on June 1, 2006, while working. She specifically reported that she "tripped on a computer cord and hit her right hand on the corner of a desk." She then experienced a significant amount of pain involving her thumb. Additionally, Petitioner noted significant swelling involving the hand and wrist. She reported to Dr. Fernandez that the hand turned "black and blue" after her injury, and reported that it was "huge." Furthermore, she noted an onset of numbness and tingling primarily affecting the thumb and index finger post-injury. After examining Petitioner and reviewing x-rays, Dr. Fernandez diagnosed right hand carpal tunnel syndrome, active, and right thumb basilar joint arthritis, active. (PX #3 at 19-20)

On November 14, 2008, Petitioner underwent right thumb basilar joint arthroplasty and right wrist carpal tunnel release surgery at Rush Oak Park Hospital. Dr. Fernandez performed the surgeries. (RX #31) A note reflecting a November 11, 2008 telephone conversation indicates that Petitioner insisted on have both surgeries performed at the same time, or not at all. (RX #3, p. 80) Both surgeries were billed together and the combined bill was paid by Blue Cross/Blue Shield. Petitioner had this insurance through her husband. (Tr., June 20, 2013, at 37; Tr., August 12, 2014, at 53-57, 195, 208; RX #28, which is correspondence from BCBS to Gallagher Bassett with a Consolidated Statement of Benefits attached; PX #3 at 16, which memorializes a discussion between Dr. Fernandez's office and Petitioner.)

Petitioner subsequently requested the charges for the November 14, 2008 surgery be split. Rush Oak Park sent her a letter dated November 1, 2010 indicating the line item payment request could not be calculated. (Tr., August 12, 2014, at 58-59; RX #27)

Petitioner testified she developed bilateral carpal tunnel syndrome from her work at Waldo Accounting Systems, Inc. (Tr., November 13, 2013, at 60, 62) She filed an Application for Adjustment of Claim, 08 WC 51204, alleging a June 30, 2008 injury date. (Tr., August 12, 2014, at 43; RX #5) A Settlement Contract Lump Sum Petition and Order was approved on April 14, 2011 in the amount of $39,114.00 for disputed claims for medical, TTD and PPD benefits. The contract language indicates Petitioner had responsibility for all medical bills, paid or unpaid, and Blue Cross/Blue Shield liens. Petitioner testified that approximately $5,000.00 was paid back to Blue Cross/Blue Shield regarding its lien. (Tr., August 12, 2014, at 67-69, 210, 217; RX #6)

Petitioner testified that following her November 14, 2008 surgery, her right thumb did not get better, but her right carpal tunnel was fine. (Tr., November 13, 2013, at 64)

On February 13, 2009, Petitioner presented for treatment at Athletico and stated she jammed her right thumb into a desk again, causing pain. (RX #7) Petitioner testified she was probably at home and jammed her right thumb into her own desk. (Tr., August 12, 2014, at 84-86)

On March 3, 2009, which was approximately three weeks after she fell and jammed her thumb into her desk at home, Petitioner reported the following to Dr. John Fernandez: "I'm in a lot of pain." The injury was noted to be bilateral wrist pain, post fall at work, June 2006. His diagnosis was left hand numbness and tingling and right wrist stiffness. Therapy was to continue. He anticipated a return to full-duty work in approximately eight weeks. (PX #3 at 25)

On April 28, 2009, Petitioner followed up with Dr. Fernandez to review her March 20, 2009 EMG. It revealed mild left median motor and sensory focal demyelination across the wrist without acute axonal loss. The diagnosis was right thumb MP joint stiffness with pain, active; right wrist stiffness, improving; and left wrist carpal tunnel syndrome, EMG positive, mild. (PX #3 at 27)

On June 11, 2009, Petitioner presented to Dr. Fernandez. He noted generalized pain to the right thumb along the basilar joint region and at the IPJ. She also complained of numbness and tingling in the left hand. He discussed the possibility of a right thumb MP fusion surgery, which Petitioner wanted to have. (PX #3 at 29)

On August 14, 2009, Petitioner underwent the MP joint fusion. (RX #31) Petitioner testified that her recovery from this surgery was not coming along and that "it was a nightmare." She "couldn't do anything, basically, but sit there with [her] hand elevated." (Tr., November 13, 2013, at 68-69) Petitioner testified that she started having problems with her left thumb beginning after the August 2009 surgery. (Tr., November 13, 2013, at 95)

On September 29, 2009, she presented to Dr. Fernandez and indicated that her pain had decreased. X-rays revealed a fused MP joint with the hardware in good position without migration or failure. Physical therapy was recommended and one-handed work restrictions. (PX #3 at 33)

On October 5, 2009, Petitioner presented to Athletico for an initial therapy evaluation. She stated she had no pain at that time. (PX #4) Athletico notes of October 20, 2009 indicate Petitioner had not had any sharp, shooting pain in her thumb for the past week. She could hold a pin between her thumb and index finger. The therapist noted a very significant increase in active range of motion in all planes. (PX #4)

On December 3, 2009, Dr. Fernandez wrote that he has recommended and reinforced the importance of being compliant with the formal therapy program. He wanted the therapist to focus on range of motion and strengthening with putty, grippers, and weights. He wanted Petitioner to be supplied with flexion straps. (PX #3 at 37-38)

On January 5, 2010, Petitioner presented to Athletico. The "Subjective" notes indicate: "jammed my thumb yesterday and it was painful all day (7/10). It just hit the tip of it." (RX #8, Tr., August 12, 2014, at 88-89)

Dr. Fernandez removed the hardware from the MP joint on March 12, 2010. (RX #31) Petitioner testified that this third surgery did not improve her condition. She stated: "I basically have lost a lot of my grip strength in my hand." (Tr., November 13, 2013, at 73)

On March 16, 2010, Dr. Fernandez recommended physical therapy four to five times a week. He wanted the therapist to be aggressive regarding range of motion. (PX #3 at 92) It was noted Petitioner needed to "start therapy ASAP!" (PX #3 at 92)

The Athletico notes, dated May 4, 2010, indicate subjective pain with functional activities. However, such notes also state: "patient performs gripping exercise using 10# spring/25 reps without external signs of difficulty." (PX #4)

On May 11, 2010, Petitioner presented to Dr. Fernandez who found the range of motion in her right hand had improved, but appeared to be reaching a plateau. Petitioner continued to have generalized pain along the basilar joint and at the IPJ. Petitioner also complained of pain in her left hand. The active diagnoses were left CTS and left thumb basilar joint pain. He recommended an MRI of the left hand. (RX #31; PX #3 at 45)

The Athletico notes, dated May 14, 2010, indicate Petitioner was tolerating the current exercise program well. There were no signs of difficulty or complaints of pain during performance of clinical exercises. She performed the hand gripper 10-pound exercise 50 times. (PX #4)

MR images of Petitioner's left hand were taken on May 21, 2010. The impression was unremarkable non-contrast MRI examination of the left hand and specifically, no abnormalities are identified within the thumb at the level of the skin marker. (RX #31; PX #3 at 18)

The Athletico notes, dated May 27, 2010, indicate an ability to complete functional tasks and no complaints of pain with performance of upgraded gripping activity. The gripping exercise was upgraded to 15 pounds and she performed it 50 times. (PX #4)

The Athletico notes, dated June 3, 2010, indicate Petitioner's effort was questionable with grip testing secondary to her ability to complete resistive activities in clinic that required gripping and pinching that ranged from 4 to 15 pounds. (PX #4)

The Athletico notes, dated June 17, 2010, indicate Petitioner demonstrated improved grip strength when tested using a dynamometer however, "objective strength measurements remain inconsistent with observed performance of clinical exercises." (PX #3 at 67)

On July 20, 2010, Dr. Fernandez opined that the May 21, 2010, MRI of the left hand and wrist revealed "normal findings." Dr. Fernandez also wrote: "EMG, March 20, 2009: 'Mild left median neuropathy with motor and sensory focal demyelination across the wrist without axonal loss.'" He recommended less than ten pounds of force with minimal repetitive use and no use of tools. (PX #3 at 47-48)

Petitioner testified with regard to a July 27, 2010 correspondence between the respective attorneys regarding Respondent Davis Staffing having work available within her restrictions and the fact that Petitioner was undergoing left hand CTS treatment at the time. (Tr., November 13, 2013, at 89-90)

On August 27, 2010, Dr. Fernandez performed a carpal tunnel release of the left hand/wrist. (Tr., November 13, 2013, at 95; RX #31)

On September 9, 2010, Dr. Fernandez noted symptoms of early cubital tunnel syndrome on the left. (PX #3 at 49)

On October 5, 2010, which was more than four years after the June 1, 2006, accident, Petitioner presented to rheumatologist Majid Serushan, M.D., due to the existence of pain of unknown onset all over her body. Petitioner testified she could not move at times; she had sleep apnea; she had pain all over; she was drowsy, listless, and agitated. (Tr., November 13, 2013, at 100-101; PX #5) She presented with pain over her body including the hands, knuckles, wrists, shoulders, hips, knees, and neck. (PX #5)

Nineteen separate HCFA formatted bills for Dr. Serushan's treatment are included in PX #5 and indicate Petitioner's condition is not related to her employment, not related to an auto accident, and not related to any other accidents. (PX #5)

On November 11, 2010, Petitioner followed up with Dr. Fernandez noting she was feeling about the same. She reported difficulty with office tasks. There were residual complaints of numbness and tingling in both hands despite the bilateral CTS releases. She had been diagnosed with fibromyalgia in "the whole body." The right MPJ was solidly fused on stress testing. Pinch strength was five pounds. The active diagnoses were left thumb basilar joint synovitis and bilateral hand numbness and tingling. Maximum medical improvement had been reached. Five pound restrictions were recommended with minimal repetition or use of tools. The left hand restrictions were similar. She required no further treatment or follow up. Surgery on the left may be needed if the condition significantly worsened or degenerated. (RX #31)

On August 13, 2011, Petitioner had left hand and wrist x-rays. Degenerative changes were noted and the impression was negative. (PX #5)

In a "To Whom It May Concern" report dated August 26, 2011, Evaldas Radzevicius, M.D., offered his findings and conclusions with regard to Petitioner's condition. Dr. Radzevicius initially evaluated Petitioner on March 2, 2011, and treated her on April 4, 2011, April 29, 2011, May 4, 2011, June 2, 2011, July 7, 2011 and August 18, 2011. Dr. Radzevicius stated that it took a long time and multiple trials of medications to achieve the current level of improvement. He noted that Petitioner is on multiple psychoactive medications for her pain and for her psychiatric symptoms, including Hydrocodone, Fentanyl patch, Lidocaine patch, Voltaren gel, Lyrica, Lunesta, Viibryd and Arthrotec. This psychiatrist concluded that Petitioner developed symptoms of major depression and anxiety, which was caused by her injury of June 1, 2006 and related surgeries thereafter, that got worse with time as her health and overall medical condition deteriorated. He found that she is somewhat better with treatment, but is still severely impaired even with current treatment including medications and psychotherapy. In Dr. Radzevicius' opinion, Petitioner is totally disabled and will be unable to function in any work setting in the foreseeable future. He found that continuing psychiatric and psychological treatment are indicated for her conditions. (PX #18)

At the initial evaluation on March 2, 2011, Dr. Radzevicius noted that Petitioner's past psychiatric history is entirely negative. There have been no psychiatric hospitalizations, no prior psychiatric treatment, and no history of assaultive or suicidal behavior. There is no history of depressions, anxiety attacks, or other common psychiatric symptoms. No psychotropic medications have ever been taken. There is no history of non-compliance with medication or treatment. (PX #6)

Dr. Radzevicius referred Petitioner to Yolanda Solecki, L.C.P.C., for counselling. Ms. Solecki saw Petitioner for 9 sessions between March 2011 and July 2011. As of July 29, 2011, Ms. Solecki gave the following working diagnoses:

Axis I: Major Depressive Disorder, Recurrent, Severe w/o psychotic features;
Adjustment Disorder with Depressed Mood;
Generalized Anxiety Disorder;
Axis II: Deferred Diagnosis;
Axis III: Fibromyalgia, OA, HTN, multiple hand surgeries, cholecystectomy, hysterectomy, knee replacement
Axis IV: Social Environment
Primary Support Group
Axis V: 50 (PX #6)

On February 2, 2012, Petitioner presented to Ronald J. Ganellen, Ph.D., a clinical psychologist, at Respondent's request. (RX #11) He performed a neuropsychological evaluation. (RX #11 at 1) She reported limitations in physical activity, chronic pain, depression, and anxiety since she fell and injured her right hand on June 1, 2006. (RX #11 at 1) She related to Dr. Ganellen that she was afraid to sleep at night and she was scared of the dark. (RX #11 at 5) She presented with pain in every part of her body and marked limitations in physical capabilities. (RX #11 at 9)

At Dr. Ganellen's office, Petitioner used her left hand to sign a form and to perform all motor skill testing. (RX #11 at 8) She told him she could not write using her dominant hand. (RX #11 at 8) Petitioner's verbal and intellectual functioning was unexpected as she performed better on a more difficult part of the testing. (RX #11 at 8-9, 10) Petitioner's emotional and personality functioning was noted to be invalid. (RX #11 at 9) Dr. Ganellen opined that the validity scale pattern could be produced if Petitioner were exaggerating her account of her current problems. (RX #11 at 9) Test results revealed that Petitioner deliberately exaggerated current symptoms, problems, and limitations in functioning. (RX #11 at 9, 10)

Dr. Ganellen opined that the results further indicated that Petitioner deliberately and consciously overstated the problems she experienced at that time in an attempt to convince others that she was disabled as a result of the effects of the June 1, 2006 incident. (RX #11 at 10, 11)

Dr. Ganellen noted that Petitioner was attributing the cause of a number of her problems to the effects of the June 1, 2006 injury even when there was no apparent relationship. For instance, she attributed limitations in being able to walk to the June 1, 2006 incident. (RX #11 at 10) Petitioner stated that she needed a bilateral knee replacement surgery due to osteoarthritis, and attributed her osteoarthritis to the effects of the 6/06 injury to her hand. She also told Dr. Ganellen that she was told that her left-hand pain was due to overuse syndrome. Dr. Ganellen noted the findings were consistent with malingering. Dr. Ganellen opined Petitioner's performance on memory functioning regarding decreased retention cannot be explained by the effects of the June 1, 2006 right hand event. (RX #11 at 10)

Dr. Ganellen indicated Petitioner's diagnosis of Major Depression was reasonable, but linking the depression entirely to the effects to the June 1, 2006 incident was questionable. (RX #11 at 10) He noted there were no psychological problems identified that would have prevented Petitioner from returning to work as an accountant after the hysterectomy. (RX #11 at 10) The Arbitrator notes that she underwent the 1st surgery to her right hand approximately 2 months after she underwent an emergency hysterectomy.

Dr. Ganellen wrote: "As the mental health professionals who evaluated and treated her did not administer any objective measures of cognitive, memory, or psychological functioning, they did not have information as to whether the information she provided then was honest and accurate." (RX #11, last page)

Dr. Serushan's October 12, 2011 narrative report summarizes his rheumatological evaluation. This record indicates Petitioner weighed 190 pounds prior to the injury. She was diagnosed with fibromyalgia, osteoarthritis in the hands, secondary to trauma or repetitive work, chronic depression and pain, weight gain due to fibromyalgia, right knee osteoarthritis and right knee total replacement. Medications and mild exercises were prescribed. (PX #5)

On March 14, 2012, at the request of Respondent and pursuant to Section 12 of the Act, Petitioner presented to Michael I. Vender, M.D., for an examination. Following the exam, Dr. Vender authored a report of his findings and conclusions. (RX #13, Dep. Ex. 2)

On September 28, 2012, Petitioner had a bone density test, which revealed osteopenia. The doctor noted that her lifetime risk for sustaining a hip fracture had increased. (PX #5)

On August 16, 2012 and November 28, 2012, rheumatologist and treating physician Majid Serushan, M.D., testified on behalf of Petitioner. Dr. Serushan testified that his curriculum vitae indicates that he is board-certified in internal medicine and board-certified in rheumatology. (PX #16, p. 5)

Dr. Serushan first saw Petitioner on October 5, 2010, on a referral by Dr. Luebbe, who was one of Petitioner's internists. (PX #16, p. 8) He was dealing with someone with generalized pain, not only in her hands, but in her neck and shoulders and probably her knee. He had a patient who was in miserable pain and was on many, many pain medications. She was having severe pain in her hand, was unable to function and do the things she was supposed to do. (PX #16, Pp. 15-16)

Dr. Serushan wrote a narrative report that is dated October 12, 2011. (PX #16, p. 16) In his report, he wrote that prior to the accident, Petitioner weighed 190 and now she weighs 250. (PX #16, p. 25) He also wrote that Petitioner came to see him, per Dr. Luebbe, due to diffuse aches and pains all over her body, not because she fell. (PX #16, p. 25)

Dr. Serushan prescribed medicines to relieve her pain and her arthritis, a muscle relaxant, anti-depressant and sleeping pills. (PX #16, p. 26)

Dr. Serushan's impression was that had fibromyalgia, typical and severe case. (PX #16, p. 27)

The opinion of Dr. Serushan was that because of her general conditions and pain in her hands and history of the surgeries, Petitioner is not going to be able to have gainful employment. (PX #16, p. 30)

On direct examination, Petitioner's Counsel asked Dr. Serushan a series of questions based on a reasonable degree of medical and rheumatological certainty. (PX #16, p. 52) Dr. Serushan testified to the following:

Q: All right. Now, based upon her initial injury of 6/1/06, the fall on the right hand breaking it, breaking her fall, with three right-hand surgeries to the thumb joint, and a fusion of the right thumb with hardware and tenolysis to the right thumb - -

MR. IGNOFFO: So how many summaries (sic)?

MR. GALESBURG: Three.

MR. IGNOFFO: Right.

MR. GALESBURG: November 14th, '08, 8/14/09, and 3/12 of '10.

BY MR. GALESBURG:

Q: And then your X-ray which shows of the left hand showing - -

A: - - osteoarthritis.

Q: - - osteoarthritis in the distal radius lead to bone leading into the left thumb at the metacarpal phalangeal joint it also shows what? The MC joint.

A: The MC joint.

Q: Shows osteoarthritis?

A: MP joint - -

Q: MP.

A: - - osteoarthritis.

Q: Okay. Thank you. And do you believe that - - that her present condition of fibromyalgia, since she was healthy before 6/1/06, progressed with - - after three surgeries or during the three surgeries, progressed to the point where she last worked June 30th of '08, and limited keyboarding based on Dr. Fernandez's notes on that - -

MR. IGNOFFO: What's the question?

BY MR. GALESBURG:

Q: That her condition - - her condition, as you diagnosed, may or could be related beginning with her fall on June 1st of '06.

A: Yes. I - - I believe the trauma on that particular time, plus several surgeries following that, inability to work usually is one of the cause (sic) of initiating or instigating fibromyalgia on the basis of the fibromyalgia and history of trauma, I connected both of them together. (PX #16, pp. 53-55)

Dr. Serushan further testified that the trauma of falling, the stress of the trauma, and the stress of going through three unsuccessful surgeries that did not relieve Petitioner's pain will bring on fibromyalgia as well as depression. (PX #16, pp. 56-57)

Dr. Serushan testified that he believed in Petitioner's complaints and that he saw nothing in the surveillance video that is inconsistent with her sitting here today in a wheelchair with her husband other than walking with a cane. He testified that if she doesn't use a wheelchair, she has to use a walker, which will make her hand pain worse. (PX #16, p. 58)

Dr. Serushan testified that he disagreed with Dr. Vender's opinions that Petitioner can return to full-duty work without restrictions. Dr. Serushan wrote: "The only way to make that type of statement is to know the patients (sic) for several months and multiple visits." Dr. Serushan thought that the insurance company should refer her to another rheumatologist. (PX #16, Pp. 58-59)

Dr. Serushan agreed with the Mayo Clinic that trauma is the number one cause of fibromyalgia. (PX #16, p. 60)

Dr. Serushan recommended that Petitioner not do any driving not just because of the narcotic pain medication that she takes, but because of her right hand and right knee problems. Dr. Serushan testified that Petitioner is totally disabled. (PX #16, p. 67)

On cross-examination, Dr. Serushan explained that osteoarthritis is degeneration of the cartilage and the rubbing of the bones together causes pain. Fibromyalgia, on the other hand, comes as a result of a chemical imbalance in the body and causes diffuse pain and aches. Dr. Serushan further explained that a majority of 50% of people with fibromyalgia have depression. He noted that fibromyalgia causes depression and depression causes fibromyalgia. (PX #16, pp. 77-79) Dr. Serushan testified that overusing the left side is not a diagnosis, but it is a problem. (PX #16, p. 85) Dr. Serushan testified that Dr. Fernandez did not make an active diagnosis of overuse syndrome because he is intelligent and that would not be an intelligent diagnosis. (PX #16, pp. 85-86) Dr. Serushan testified that it is his opinion that the June 2006 fall caused a chain reaction - - a chain of pain - - and that fibromyalgia is a chronic disease. (PX#16, pp. 88-89) Dr. Serushan testified that he was asked to write a letter because Petitioner is unable to work and is applying for disability. (PX #16, pp. 89-91) He further testified that he did not know that his report was part of a workers' compensation case. (PX #16, p. 91) Dr. Serushan testified that there was a false positive test in the blood work that indicated rheumatoid arthritis. (PX #16, pp. 91-92) In his report, Dr. Serushan agreed, he made no mention of right or left wrist injury/pain but pain all over the body because he is not the doctor who performed the hand surgery. (PX #16, p. 93) Dr. Serushan was aware that Petitioner underwent an emergency hysterectomy in September 2008, but found that it was not relevant and that it would not be considered trauma to her body. (PX #16, p. 94) Dr. Serushan agreed with Respondent's Counsel that Petitioner told him that she weighed 190 pounds prior to the injury. The doctor testified that weight gain causes more health problems and that if a patient is suffering from pain, that weight gain is going to make the problem worse. (PX #16, p. 95) Dr. Serushan agreed with Respondent's Counsel that a February 20, 2006 medical record for Petitioner lists her weight at 245 and a June 14, 2006 medical record for Petitioner lists her weight at 244 and a June 19, 2006 medical record for Petitioner lists her weight at 249. (PX #16, p. 96) When confronted with the fact that Petitioner had told him that she weighed 190 before the accident when she actually weighed closer to 245, Dr. Serushan found that this factor was not significant even though his impression had been that she gained weight due to fibromyalgia and lack of exercise. (PX #16, p. 101) Dr. Serushan noted that the medications Petitioner was taking as of June 19, 2006 indicate that she was taking arthritis medicine, stomach medicine, blood pressure medications and anti-anxiety medication. (PX #16, p. 97) Dr. Serushan testified that fibromyalgia comes on slowly and the fact that Petitioner did not recall when her body aches and pains began is not unusual. (PX #16, p. 103) Dr. Serushan did not think Petitioner was taking any pain medication at the time he saw her. In his October 12, 2011 report, Dr. Serushan agreed, he mentioned aches and pains in Petitioner's neck, trapezius, scapula, chest wall, hips and knees, but he did not mention her hands. (PX #16, p. 105) Dr. Serushan testified that the number one approach to treatment for fibromyalgia patients is to have them walk and do more exercises. If a patient gains weight and is in a wheelchair, the prognosis is really poor. (PX #16, p. 107) Dr. Serushan conceded that Petitioner did not gain any weight between June 2010 and October 2010. (PX #17, pp. 118-119) He testified that weight is not the real medical or disability issue, and that her disability issue is her pain and her hand problem. (PX #17, p. 120)

Dr. Serushan testified that osteoarthritis is degenerative, but osteoarthritis can be caused by trauma. (Id.) Dr. Serushan testified that he agreed with the opinion he made in his October 12, 2011 record: "I do not believe with a disability in her hands, along with aches and all over her body, that she's able to hold any gainful employment in the future." (PX #17, pp. 120-121) Dr. Serushan explained that he is qualified to make such a statement based on 30 years of experience in rheumatology, and seeing thousands of patients with similar or some type of osteoarthritis, and knowing and following those patients and knowing - - what happened to them." (PX #17, p. 121) His opinion that she is not able to be fully employed is based on her pain, and pain is subjective. (Id.) Dr. Serushan agreed that Petitioner is complaining about pain. (PX #17, p. 122) Dr. Serushan testified that he authored a letter to Dr. Luebbe in which he stated that Petitioner has a history of depression beginning after multiple surgeries and pain in the right hand. (Id.) Dr. Serushan could not identify when Petitioner's depression began, but stated that she had become depressed in the last couple of years. (Id.) The doctor also testified that to him, it's not that important to identify when the depression began because she was suffering from pain and depression, and that is a way of life with those people. (PX #17, pp. 122-123) Patients who suffer from pain are not happy. (PX #17, p. 123) Dr. Serushan did not know if, prior to 2006, Petitioner had pain complaints or depression, but if the medical records establish that Petitioner had a history of anxiety and depression as early as 2001, it's obvious that she may have had depression prior to 2006. (Id.) Dr. Serushan testified that if Petitioner did not mention osteoarthritis in her hands when she saw him on September 14, 2011, that did not mean she did not have it. (PX #17, p. 125) Dr. Serushan denied that he changed his impression of Petitioner's disability in response to Petitioner's Counsel's letter. (PX #17, p. 126) He wanted to provide more detail and gave specific answers to questions asked of him. (PX #17, p. 127) Dr. Serushan did not know about a fall Petitioner may have had at a Metra station in August of 2007. (Id.) Dr. Serushan did not know about an injury Petitioner sustained in February 2009 when she jammed her right thumb into a desk and felt pain. (Id.)

Dr. Serushan testified that osteoarthritis is a degeneration and wearing out of the cartilage structure. (PX #17, p. 129) He further testified that women are more likely to develop osteoarthritis in the knees and the hands. (Id.) Then he testified that women are only more likely to have osteoarthritis in the knees. (PX #17, p. 130) Dr. Serushan testified that Petitioner has secondary osteoarthritis, which he opined, is related to trauma. (Id.) Being overweight causes more stress on the knees and impacts osteoarthritis of the knees. (Id.) Petitioner has osteoarthritis of the knees. (Id.) Dr. Serushan testified that a sedentary lifestyle causes obesity and obesity causes osteoarthritis of the knees. (PX #17, p. 131)

Dr. Serushan testified that he did not know this was going to be a court case, and that Petitioner came to see him because she had pain and her doctor thought she needed a rheumatologist. (PX #17, p. 131-132) When she came to see him, it was no consequence to him that she may have fallen and had a work injury. (PX #17, p. 132) The details of the trauma were initially irrelevant to him. (Id.) He had heard that Petitioner is claiming permanent and total disability due to the June 1, 2006 incident and some of the treatment she had from that incident. (Id.) Dr. Serushan opined that Petitioner is totally disabled, whether half of the disability is due to her hands and the other half from depression and osteoarthritis. He believed that Petitioner is unable to work. (PX #17, p. 133) Dr. Serushan testified that he is not talking about the work injury, but about the hand arthritis, and the subsequent surgery, and the lack of responsiveness to the surgery, lack of improvement and the constant pain in her thumb and hand, especially with the job she had. (Id.) He believed that Petitioner did some type of accounting or typing work. (Id.)

On redirect examination, Dr. Serushan testified that "pain" is the basis of his opinion that Petitioner is unable to perform gainful employment. (PX #17, p. 135) Dr. Serushan noted that Petitioner has a loss of function of the thumb that is fused and development of osteoarthritis in the base of the hand. (Id.) He thought that he found osteoarthritis also in the base of her joint of her left thumb. (Id.) Dr. Serushan has reviewed Dr. Fernandez's notes. (Id.) Dr. Serushan testified that he believed Petitioner was permanently and totally disabled

based upon the problems to both of her hands, and that the medication that she takes for pain management - - such as a Fentanyl patch - - contributes to this disability. (PX #17, p. 136) The medication Petitioner requires, per his prescription, is for pain in her hands. (Id.) Such medication has side effects and can cause lack of alertness; taking such meds may affect one's judgment, although not necessarily in the work she has performed. (Id.) One should not drive a vehicle when taking such medication. (Id.)

Dr. Serushan has reviewed Dr. Fernandez's records and agrees with Petitioner's Counsel that on May 11, 2010, Dr. Fernandez did not return Petitioner to any type of gainful employment. (PX #17, pp. 139-140) Dr. Serushan recited the restrictions Dr. Fernandez imposed on Petitioner's use of her right and left hands: very light use on the right side with less than 5 pounds of use with minimal repetition or use of tools, minimal exposure to typing, writing, or use of calculators and other manual activities requiring the use of the right hand, and that she will have similar restrictions on the left side. (PX #17, pp. 141-142)

Dr. Serushan testified that Petitioner worked through the pain that she experienced to her right hand and thumb, that she was interested in keeping her job and that her condition got worse and worse until she was unable to work. (PX#17, p. 151) Dr. Serushan would consider the first trauma to Petitioner would be her fall on June 1, 2006 and another trauma to be the surgical intervention into the joint of her hand, plus the other surgeries plus continuation of her work with the conditions she had. (PX #17, p. 152) He opined that the left hand was traumatized, but that is different because it was arthritic as shown on the x-rays. (PX #17, p. 153) Dr. Serushan testified that all of this is causally related to the initial insult, i.e., the June 1, 2006 accident, that started a chain reaction. (PX #17, p. 153)

On recross examination, Dr. Serushan testified that he is not an orthopedic surgeon, but a rheumatologist. He testified that although he does not operate, he treats orthopedic problems. He specializes in arthritis of the hands. He testified that rheumatologists are more highly qualified than orthopedic doctors. Dr. Serushan testified that has is qualified to make a diagnosis of the so-called "overuse syndrome," because he deals with repetitive motion syndrome, soft tissue conditions as well as arthritis. (PX #17, pp. 153-155)

On redirect examination, Dr. Serushan testified that osteoarthritis is the number one disease he sees in their practice, and that the majority of the osteoarthritis patients have this condition in their hands. First thumb and first CMC joint are the most common sites for arthritis. If someone has arthritis that is diffuse throughout the body, this could be more genetic. But if someone has arthritis in only one joint, and it starts suddenly, and if there is a different history of trauma, then, obviously, trauma is the cause of arthritis. (PX #17, p. 156) Obese patients get arthritis of the knees due to the heavy weight placed on the knee joints. (PX #17, p. 157) Dr. Serushan testified that he is professor of rheumatology in the medical school. (Id.) Dr. Serushan testified that fibromyalgia is diffuse pain and aches that are all over the body. (PX #17, p. 158) He testified that Petitioner has fibromyalgia, osteoarthritis of the hands, repetitive motion in the past, as well as osteoarthritis of the knees. (Id.) So, she has 3 or 4 sites in her body that hurt. (Id.) He noted that Petitioner has problems with opening of a door, opening of a car door, probably driving and turning of the key. (PX #17, p. 158-159) Chronic pain in her hands would aggravate existing fibromyalgia if she had fibromyalgia before. People who fall and people who have 3 or 4 surgeries can develop fibromyalgia. (PX #17, p. 159) Dr. Serushan testified that Dr. Luebbe's record of September 14, 2010, wherein Petitioner complained of pain in several joints and stiffness in the morning, but stated she had not been previously worked up by a physician, could be the initial manifestation of this condition. (PX #17, p. 162)

On recross examination, Dr. Serushan testified that Petitioner has fibromyalgia, which is a disease of the whole body. In response to being asked how surgery to the hand can cause fibromyalgia throughout the whole body, Dr. Serushan testified that fibromyalgia is the simulation (sic) of the body's pain receptions. So, one

single, localized area of trauma would instigate and initiate fibromyalgia. That trauma could be physical, but could also come as a result of emotional trauma following several surgeries. In her case, he thought that the fall, the three surgeries and lack of response to those surgeries, her relationship to her employer, getting fired from her job all contributed to her fibromyalgia. Also, mental problems contribute to fibromyalgia. (PX #17, p. 163) Dr. Serushan testified that the thumb is the most common part of one's body to get osteoarthritis as a result of trauma. (PX #17, p. 164) Dr. Serushan did not know if, absent trauma, Petitioner had the type of job in which she used her thumb more frequently. (Id.) Dr. Serushan testified that these activities that Petitioner cannot do, such as opening car doors, would be due to osteoarthritis. (PX #17, p. 165)

On December 7, 2012, orthopedic surgeon and examining physician, Michael I. Vender, M.D., testified on behalf of Respondent. Dr. Vender testified that he is board-certified in orthopedics and has added qualifications in surgery of the hand. He treats any condition of the hand and upper extremity. (RX #13, p. 9) Dr. Vender testified that on March 14, 2012, he performed an independent medical examination on Petitioner, Ms. Deborah Fogarty, and following the exam, drafted a report of his findings and conclusions. (RX #13, pp. 10-11, Dep. Ex. 2) When he met with Petitioner, he had no trouble communicating with her, and took a history. At that time, she stated she was 52 years old and sustained an injury to her right upper extremity on June 1, 2006 when she tripped over a cord and injured her thumb. The initial diagnosis was a thumb disorder and tear of the triangular fibrocartilage complex. In November 2008, she underwent a resection arthroplasty of her thumb. In August 2009, she underwent a thumb metacarpophalangeal joint fusion. (RX #13, p. 13) In March 2010, she underwent a tenolysis for what was described as a lack of motion in her thumb. A tenolysis is a removal or release of scar of a tendon. (RX #13, pp. 13-14) At the time of the independent medical examination, Petitioner noted multiple complaints in both upper extremities, right greater than left, and described various systemic complaints. For her upper extremities, she complained of bilateral thumb pain radiating into the forearm. With regard to her right side, she stated she has no strength in the hand, cannot feel the hand, and cannot use the hand at all. With regard to the left side, she stated that she had thumb pain. (RX #13, p. 14) She also told Dr. Vender that she is unable to sleep and does not know why. Petitioner presented to Dr. Vender that day in a wheelchair, and explained that she used it secondary to problems with her hips, knees and legs and somehow stated that it was all secondary to not ambulating properly. She further explained that her inability to ambulate properly was due to weight gain that was all related to disorders in her arms. Dr. Vender conducted a physical examination and noted that she exhibited a very flat affect. (RX #13, p. 15) Petitioner used her left hand to shake hands with Dr. Vender and explained that she cannot use her right hand because it is "dead." Dr. Vender found that Petitioner's right wrist extension was essentially the same at 70° as compared to the left side. Flexion of the right wrist was somewhat decreased as compared to the opposite side (50° versus 85°). Upon palpation, the doctor noted that there was diffuse tenderness over the areas of the first extensor department, volar radially and even proximally into the volar radial forearm. (RX #13, p. 16) The multiple palpations revealed multiple reports of tenderness even into the forearm where there is really nothing to be tender. Ranges of motion of the fingers were found to be normal. (RX #13, p. 17) There was no thumb CMC crepitation on either side. (RX #13, pp. 17-18) Motor strength testing was variable; at times she would not move a muscle and said she was paralyzed. At times she would exhibit giveaway weakness. Either one of these is nonphysiologic. (RX #13, p. 18) Dr. Vender noted that Petitioner had no indication of a nerve injury. Yet, when she was given the two-point discrimination test, when the doctor touched her with one point, she said there were two, and when he touched her with two points, she said there was one. (RX #13, pp. 18-19) X-rays of the right thumb demonstrated results consistent with the surgeries she had undergone, and x-rays of the left side displayed a degenerative change of the thumb, CMC joint, and degenerative change at the STT joint. (RX #13, p. 19) Dr. Vender's diagnosis and impression was status post resection arthroplasty of the right thumb CMC joint and status post right thumb MP fusion. His understanding of the June 1, 2006 accidental injury was that she tripped over something and fell. He noted that she had pre-existing arthritis of the right thumb and that the trip and fall would have exacerbated the pre-existing arthritis. (RX #13, p. 20) Everything was geared toward this thumb. (RX #13, pp. 20-21)

According to Dr. Fernandez's records, Dr. Vender felt that Petitioner had reached MMI in approximately May 2010. Petitioner told Dr. Vender that her hand was "dead," which implies that she has no use of the upper extremity, or at least the hand. However, there were no objective findings to support these complaints or description of the hand as being dead. Dr. Vender opined that none of Petitioner's present complaints would be related to the June 2006 injury and subsequent surgeries. (RX #13, p. 21) In certain respects, Dr. Vender opined, she has total body failure. She describes an inability to walk, her weight gain and her need for a wheelchair. It was his impression that she is trying to ascribe her current condition back to the fall, and there is no basis for that. Only her impairment or problems related to the thumb would be reasonably related back to that trip and fall. Dr. Vender did not know how any possible weight gain would relate to an injury to her thumb. (RX #13, p. 22) With regard to her left upper extremity, Dr. Vender testified that she does have existing disease in the left thumb and wrist that is similar to what she had on her right side prior to the fall. She is one of many middle-aged females who has arthritis in her thumbs, and it appears that she has some arthritis in her left thumb. Dr. Vender opined that there was no overuse of the left hand as she was using her hands to perform routine activities of daily living that were not stressful to the hands and would not represent any unusual stresses to her left side. Dr. Vender would describe her overall presentation as nonphysiologic, that is, not based on real, physical disease. Her presentation is consistent with some form of psychological or psychiatric disorder. (RX #13, pp. 23-24) Dr. Vender noted that she has a significant psychiatric history and is on multiple medications, some of which were prescribed by her psychiatrist. Dr. Vender described osteopenia as a condition in which one loses bone substance. If Petitioner has osteopenia, it could be caused by various things. He opined that Petitioner's arthritis on her left side does not have anything to do with the accidental injury. The doctor further opined that fibromyalgia is a systemic condition, and if present, would not be related her thumb injury. (RX #13, p. 25) Dr. Vender testified that the thumb surgery that Petitioner underwent is a very good surgery and rates at the end of the spectrum of predictably successful surgeries with good outcomes. (RX #13, pp. 25-26) Typically, for someone like Petitioner, he would not expect there to be complaints of pain, impairment or disability following this type of surgery because she is not a manual laborer or someone who is interested in sports and is very hard on her hands. Dr. Vender opined that Petitioner would be able to return to her job as an accountant following this type of treatment to her thumb. (RX #13, p. 26) Dr. Vender felt that Dr. Fernandez's five-pound weight restriction was extreme given the fact that Dr. Fernandez did not indicate that there were any problems with the surgeries or that the surgeries were failures. Dr. Vender thought the fusion healed properly and that the resection arthroplasty looked good. Dr. Vender opined that there was no reason to suspect that Petitioner needed any restrictions. He thought that Petitioner did not need any further care for her right thumb, and that Petitioner's claim of an inability to work had anything to do with her right thumb and the surgeries. (RX #13, p. 27) Dr. Vender testified that all of his opinions during his deposition were given within a reasonable degree of medical and surgical certainty. (RX #13, pp. 27-28)

On cross-examination, Dr. Vender conceded that Dr. Fernandez did not declare Petitioner to be at MMI or state that her condition had plateaued on May 11, 2010. (RX #13, pp. 28-32) However, the actual line from the history section of the May 11, 2010 chart note is as follows: "Overall her range of motion has improved, but appears to be reaching a plateau." (RX #13, Dep. Ex. 4) Dr. Fernandez stated in such note that Petitioner is restricted from normal work activities with the right hand and right arm. (RX #13, p. 32) Dr. Vender recited Dr. Fernandez's conclusions in his November 11, 2010 chart note. On November 11, 2010, Dr. Fernandez found Petitioner to be at MMI. (RX #13, pp. 33-34) Dr. Vender testified that putting more pressure one's left thumb to get up and move around does not cause osteoarthritis. However, it can cause a transient change in symptoms. (RX #13, p. 36) Dr. Vender defined fibromyalgia as follows: "It's a nebulous condition of significant controversy as to whether it actually represents a physiologic abnormality. And for some people it just represents multiple complaints of pain with little to no objective findings." (RX #13, p. 37) Dr. Vender agreed with Petitioner's Counsel that Petitioner is taking a lot of medications, and much of it appears to be narcotic pain medication. (RX #13, pp. 38-39) He thought that that was "pretty pitiful." He further testified that he has

had patients who have been diagnosed with fibromyalgia, but typically someone else like a rheumatologist or family doctor makes the diagnosis. (RX #13, p. 39) Dr. Vender testified that the Mayo Clinic article that Petitioner's Counsel showed him is not a reference for physicians. He opined that articles such as this one are not peer reviewed and are written by someone who has very personal and potentially anecdotal [evidence]. (Bracketed word added) (RX #13, p. 40) He was asked to read parts of the article into the record. (RX #13, pp. 40-41) Dr. Vender testified that he would consider the 3 surgeries Petitioner underwent to her right hand/right thumb area, including the fusion surgery, as well as the actual June 1, 2006 accident to be 4 individual traumas to the right hand. (RX #13, pp. 41-42) With regard to further medical treatment, Dr. Vender found Dr. Fernandez's November 11, 2010 chart note to be contradictory: Dr. Fernandez found Petitioner to be at MMI, but recommended continued conservative treatment. (RX #13, pp. 42-43) Dr. Fernandez is then asked to read Petitioner's "Chief Complaint" on September 14, 2010 to Dr. William Luebbe, which indicates left ear pain, as well as multiple areas of arthralgias including bilateral ankles, knees, wrists with morning stiffness that have never been worked up by her previous physician. She also has a history of hypertension, sleep difficulty and menopausal symptoms. (RX #13, p. 43) Dr. Vender testified that he has done an IME or deposition with Respondent's Counsel, but he did not know how many in the past year - - it could be one. Dr. Vender testified that he conducts IMEs at all points of treatment. They do not have to be disputed cases. (RX #13, p. 45) Dr. Vender testified that at the request of Respondent, he examined Petitioner on March 14, 2012. (RX #13, p. 46) Dr. Vender did not remember anything about vocational rehabilitation. When he examined Petitioner, he found that her ranges of motion of her fingers were fine, but that she had limitations of motion at the right thumb metacarpophalangeal joint because the joint is fused. (RX #13, pp. 49-50) However, he found that Petitioner still has motion related to the arthroplasty, and still has motion at the IP joint. Dr. Vender did not know where the diagnosis of osteopenia, to which he referred in his report, came from. (RX #13, pp. 50-51) He noted that Dr. Fernandez cut away the arthritis in Petitioner's right thumb, but that she still has some degree of arthritis on the left side. (RX #13, p. 51) Dr. Vender stated that the August 13, 2011, x-ray of the left hand and left wrist was negative for osteoarthritis, but the x-ray did not address the thumb. However, another part of the x-ray report indicates a degenerative change involving the distal end of the left radius and the base of the first metacarpal bone. (RX #13, p. 52) Dr. Vender testified to having performed IMEs for the past 1-2 years for Gallagher Bassett, Sedgwick James, and Liberty Mutual. He knows the name Jeanne Maggio, and it would not surprise him that she is the claims adjuster on this file. (RX #13, p. 53) Dr. Vender testified that he does not know which insurance companies he does IMEs for anymore because they do not come directly from the companies anymore. (RX #13, p. 54) Dr. Vender testified that he is the president and managing partner of Hand Surgery Associates, and he does not have anything to do with their website. He is not personally responsible for the website. (RX #13, pp. 54-55)

On redirect examination, Dr. Vender elaborated on the reason he thought Petitioner's list of medications was pitiful. He cited the Mayo Clinic blurb that indicated very benign treatment such as stress reduction and exercise. Dr. Vender opined that nowhere would they [Mayo Clinic] ever put treating fibromyalgia with narcotic medication, which can be habit-forming. (RX #13, pp. 55-57)

On November 12, 2014, Jeff Lucas, Ph.D, C.R.C, a board-certified vocational expert, testified on behalf of Petitioner at the arbitration hearing. In addition to being a Certified Rehabilitation Counselor, Dr. Lucas testified, he is a certified case manager, a certified disability management specialist, a certified ergonomic associate, a certified crisis counselor, a certified vocational expert and diplomate with the American Board of Disability Analysts, and a senior disability analyst and diplomate with the American Board of Disability Analysts. (Tr. of November 12, 2014, 5-7) Although he is now located in Florida, Dr. Lucas testified that he has been providing vocational rehabilitation services in Illinois since 1982, and that he has worked for both defense firms and plaintiff's lawyers. (Tr. 16-18) Dr. Lucas testified that, a while back, he testified for Petitioner's Counsel in another case. (Tr. 18) Dr. Lucas testified that he reviewed the February 7, 2013 vocational

assessment and March 1, 2013 labor market survey by Ms. Babat of S & H Medical Management. (Tr. 18-19) Dr. Lucas read the first paragraph of the vocational assessment and opined that a blind evaluation should take into account the claimant's abilities, their permanent restrictions and should use the most restrictive permanent medical restrictions to provide a baseline for jobs. (Tr. 25-26) Dr. Lucas had also reviewed the May 2010 report and the November 2010 report of Petitioner's treating orthopedic surgeon, Dr. Fernandez. (Tr. 26) Dr. Lucas testified that in his November 10th report, Dr. Fernandez found Petitioner to have reached MMI and gave her permanent restrictions of very light use of the right side with less than 5 pounds, minimum repetition or use of tools, and with similar restrictions on the left side. So, Dr. Fernandez gave Petitioner a less than 5-pound lifting restriction for both of her hands. (Tr. 29-30) Dr. Lucas also noted that Dr. Fernandez wrote at that time that he was hoping Petitioner would be able to avoid surgery on the left side. (Tr. 30) Dr. Lucas testified that the problem he has with Ms. Babat's February 7, 2013 vocational report is that according to the C.R.C rules under forensic rehabilitation, an individual should be able to verify the information. Dr. Lucas did not know why this individual, Ms. Babat, did not meet with Mrs. Fogarty, the Petitioner. (Tr. 31) Dr. Lucas further testified that if this individual had met with Mrs. Fogarty, she would have known that the jobs they were looking for exceeded her restrictions as put forth by the physicians. (Tr. 30-31) Dr. Lucas testified that many of the restrictions Petitioner had were left out of her report. Her report did not mention anything about the left hand and did not talk about the medications she is on. (Tr. 31) Furthermore, Lucas testified, if she would have met with Petitioner, she would have seen the GAF score of 50, which is very severe. (Tr. 32) Her February 7, 2013 assessment indicates Petitioner is taking Morphine, Vicodin, Lyrica and Arthrotec patches. Dr. Lucas testified that these medications are going to cause a person not to be able to concentrate and perform at the level necessary for the jobs that were given. Plus, Ms. Babat did not address the psychological aspect here. (Tr. 33) It was Dr. Lucas' understanding that Respondent's attorney supplied the material to Ms. Babat that she used in her report. There was no indication that Petitioner or Petitioner's attorney provided the information. (Tr. 34) Dr. Lucas testified that according to the C.R.C. code of ethics, we have a duty to confirm information where circumstances reasonable permit. (Tr. 36)

Dr. Lucas testified that the entire industry of vocational rehabilitation came about from the benefits of early intervention. (Tr. 39) By not intervening early, it decreases a claimant's ability to return to work. (Tr. 39) In the case at bar, a case manager from GENEX was involved for a one-time visit early on and then dropped it. (Tr. 39)

Dr. Lucas considered Ms. Babat's report to be just a perusal of medical reports and then a labor market survey that did not include the information that was contained within the medical reports chronicled in the pages of the February 7, 2013 report. (Tr. 47) Ms. Babat's report is not a vocational report, Lucas testified. (Tr. 47)

Dr. Lucas testified that when he met with Petitioner, she had a GAF of 50, the diagnosed overuse syndrome, the diagnosis of fibromyalgia, depression, anxiety disorder, sleep problems, crying spells, panic attacks. He further testified that the release by the doctors was not anything he could actually use to put Petitioner back to work. (Tr. 48) Dr. Lucas further testified that there is no place for her condition and her medical situation in the labor market. She just would not be hired because there are no jobs that would fulfill the requirements set forth by the medical doctors and there is no way she would be able to perform the necessary tasks involved in the jobs she has done in the past or jobs that he has looked for her for the future. (Tr. 48-49)

Dr. Lucas testified that Dr. Goebel, the examining psychologist for Social Security, gave Petitioner a GAF of 50 and agreed with the treating psychiatrist, Dr. Radzevicius. (Tr. 50)

Dr. Lucas testified that he met with Petitioner once with Petitioner's attorney and once with Petitioner herself. Petitioner's husband was present both times. Dr. Lucas was aware that Petitioner has two children. Dr. Lucas authored a vocational report dated November 18, 2011. (Tr. 61-62)

GAF is an acronym for global assessment of functioning. A GAF of 50, Dr. Lucas testified, is a serious impairment in social or occupational functioning. Dr. Lucas relied on the doctor to give him the GAF score. (Tr. 66)

In his report, Dr. Lucas testified, he recommended that Petitioner follow up with her physicians because there is nothing he can do for her, vocationally. Petitioner was not ready for vocational placement when Dr. Lucas saw her. (Tr. 68) Dr. Lucas testified that, excluding fibromyalgia, there are no jobs of which he is aware that Petitioner would be able to perform under those set forth by Dr. Fernandez in November 2010. Any position that would have been possible for Petitioner would have been through a sheltered workshop or something that required an incredibly special circumstance or accommodation. (Tr. 69-70) It would have been difficult to find work for her in a sheltered workshop as well. (Tr. 71) With a sub-sedentary position and a GAF of 50, Lucas testified, there is just no way he could place Petitioner. (Tr. 71) Without including the GAF of 50, but just using the restrictions that Dr. Fernandez imposed in November of 2010 - - based on less than five pounds and minimal repetition - - he still would not have been able to place her. Because the job of an accountant requires constant handling and reaching, Petitioner could not have done that job. (Tr. 71-72)

Dr. Lucas testified that Petitioner's work record shows that she did work as a felon. He further testified that just because you are a felon does not mean that there is no possibility of a return to work. There are many companies that work with individuals who are felons. (Tr. 75) However, Petitioner may be limited in some respects due to her criminal background. (Tr. 80)

Dr. Lucas disagreed with Ms. Babat's opinion that Petitioner could return to the workplace given that she has experience primarily in sedentary positions in the past. Her opinion does not take into account what Dr. Fernandez has to say, it does not include the medications she is on, it does not include a reference to repetitive use because the jobs listed have repetitive use and it does not include the left hand restrictions. Evidently, Ms. Babat followed the opinions of Dr. Vender. Dr. Lucas further testified that, to begin with, none of the jobs Ms. Babat lists are in line with what the parameters were for the labor market survey. That is, none of the jobs are in line with Dr. Fernandez's final assessment in November 2010. (Tr. 77-79)

Dr. Lucas did not understand why there was no medical case management on such a case with so many surgeries and so many different problems. (Tr. 84) He opined that once Petitioner reached MMI, a vocational counselor should have been assigned to make an assessment. (Tr. 86) Dr. Lucas then opined that it appears that Respondent fulfilled their obligations under the law and rules of the Commission by not providing a vocational assessment of Petitioner in a timely manner. (Tr. 87)

On cross-examination, Dr. Lucas testified that a medical case manager was needed in this case due to all of Petitioner's problems: restrictions on her hands that are keeping her out of the labor market, a GAF of 50, which is going to keep her out of the labor market, the diagnosed overuse syndrome that will keep her out of the labor market, double hand splinting, fibromyalgia, ambulation problems (not able to walk), sleeping problems, crying spells and panic attacks. (Tr. 95-96) With regard to Ms. Babat's February 7, 2013 report, she does state that whether using Dr. Vender's opinion of no restrictions or Dr. Fernandez's most recent restrictions of five pounds on the right with minimal repetitive use or use of tools, she still felt that Petitioner could return to the workforce. (Tr. 100) Dr. Lucas agreed with Respondent's Counsel that Dr. Fernandez released Petitioner in November 2010 and Lucas was not retained until November 2011. (Tr. 101) The medications would impede

Petitioner's ability to return to work and the psych issues would restrict her from certain occupations. (Tr. 101-102) Dr. Lucas did not know if Petitioner typed out the list of prescription medication that he requested of her. (Tr. 108) Dr. Lucas testified that he is not a medical doctor and is not qualified to comment on medical or legal causation. (Tr. 113-114) He testified that he is not qualified to make any medical diagnoses. (Tr. 114) Dr. Lucas agreed that Petitioner' attorney asked him to write this report and to provide services to Petitioner. (Tr. 114) Dr. Lucas testified that Petitioner's attorney told him that he had an individual who he believed needed vocational rehabilitation and asked Lucas to meet with the individual. (Tr. 115) Dr. Lucas testified that he did meet with the individual but it did not lead to any placement possibilities. (Tr. 115) Dr. Lucas agreed that he wrote that as of November 18, 2011, further vocational evaluation of the work-related injury is of no benefit to Petitioner. (Tr. 116) Dr. Lucas agreed that he wrote that Dr. Papierski, upon re-examination, found that the carpal tunnel syndrome was not related to the June 2016 injury, but the TFC tear and the advanced osteoarthritis at the first metacarpal and ulnar abatement were a result of the June 1, 2006 injury. (Tr. 117) Dr. Lucas agreed that what Dr. Papierski wrote in his report - - the right thumb carpometacarpal joint degenerative joint disease may or may not have been a pre-existing condition -- is different from what Dr. Lucas wrote in his report. (Tr. 118-119) Dr. Lucas then read into the record that Dr. Papierski wrote that the MRI findings of the right thumb ... may be related to the reported accident of June 1, 2006. (Tr. 120) Dr. Lucas also testified that Dr. Papierski wrote: "I believe this will be a result of the reported fall." (Tr. 121) Dr. Papierski used the word "may" with regard to the relationship between the June 1, 2006 incident and the degenerative joint disease and Dr. Lucas used the word. "were." Dr. Lucas wrote that because he found most IME doctors use the word "may." (Tr. 122-123)

Dr. Lucas agreed that in his report, he mentioned Dr. Fernandez's record of 11/11/10 and noted that Petitioner was diagnosed with left hand overuse syndrome. Dr. Lucas read over Dr. Fernandez's November 11, 2010 treatment record and testified that the overuse syndrome was not diagnosed by Dr. Fernandez. He believed Petitioner was diagnosed with this condition by another physician and stated that it was his error, and will take it back. (Tr. 132)

Dr. Lucas testified that he wrote that Petitioner uses a wheelchair and electric cart due to complaints of pain throughout her entire body. (Tr. 132) Dr. Lucas also testified that he wrote that Petitioner has gained 60 pounds, but was not sure if that is true. (Tr. 132-133) Dr. Lucas admitted that given Respondent's medical records that reflect Petitioner's weight, it does not appear that she gained 60 pounds. (Tr. 133) Dr. Lucas testified that he wrote that the rheumatologist, Dr. Serushan, diagnosed overuse syndrome, but he could not point to such a diagnosis in Dr. Serushan's records. (Tr. 134-135)

Dr. Lucas testified that he is not sure why he emboldened certain words in his report, but thinks that he did so because those are concerns, those are things he had questions about. (Tr. 138) Dr. Lucas is not sure of what he meant by the word "independently" when he wrote: "Independently, Miss Fogarty also suffers from generalized osteoarthritis in many joints of her body, including the left hand." (Tr. 138-139)

Dr. Lucas agreed that Petitioner has advanced certification in food service and sanitation. (Tr. 139) He also wrote about her position at CBS Channel 2 news in which she was responsible for payroll, accounting, hiring and firing and budgeting. Dr. Lucas identified positions of payroll supervisor and accountant. (Tr. 139-140) Both are sedentary positions. (Tr. 140)

Dr. Lucas agreed that he wrote that due to disability, pain, psychological issues, doctor's iteration of mental status, that she has problems with concentration, memory and focus, all of these combined further affect her persistence and pace and ability to complete a full day of employment. (Tr. 141) Dr. Lucas testified that what he meant when he wrote that she believes that she is "overusing" her body is that she believed she was walking on her knee too much and needs revision surgery on her knee because the hardware is loose. (Tr. 142)

Dr. Lucas agreed that in his report, he wrote that Petitioner claims she could not hold a pencil. Dr. Lucas agreed that no doctor has indicated she cannot hold a pencil. (Tr. 142-143) He agreed that he wrote that Petitioner enjoyed the challenge of being a career woman, that she was a hard worker and worked until the job was done, that she had a stable work history, and that she was fiscally responsible. (Tr. 143-144) Dr. Lucas was aware that Petitioner was arrested on charges that she misappropriated $2,000,000.00 in station money, and the charges included felony theft by deception and money laundering. (Tr. 144) He agreed that his voc report states that Petitioner was "set up." (Tr. 145) Dr. Lucas was aware that Petitioner was initially sentenced to 4 years and 6 months in prison. Dr. Lucas still believed that Petitioner had a stable work history and that she is fiscally responsible. (Tr. 145) Dr. Lucas testified that it is more challenging, but not impossible to place a convicted felon in a job. (Tr. 146) Dr. Lucas noted that Petitioner could possibly use speech recognition software. (Tr. 146) Dr. Lucas testified that although Petitioner passed the CPA exam and has been working in various accounting jobs since 1985, and although she has an advanced degree in food service and restaurant experience, he still does not have any vocational possibilities to offer her. (Tr. 146) Dr. Lucas testified that he wrote a report for Petitioner, did initial vocational evaluation and some testing and recommended that she needed further medical in order to qualify for vocational rehabilitation. (Tr. 147) Dr. Lucas testified that the last time he testified at the Illinois Workers' Compensation Commission was 1 – 1-1/2 years ago. Dr. Lucas agreed that Petitioner is a college graduate and that potential test scores for college graduates on the Wonderlic Basic Skills Test are 28 or higher. (Tr. 149-150) He agreed that when Petitioner graduated college, she probably would have scored 28 or higher. (Tr. 150)

On redirect examination, Dr. Lucas agreed that Dr. Fernandez's report indicates that he is hopeful Petitioner will be able to avoid surgery on her left hand, but if her condition significantly worsens or degenerates, she may require it. (Tr. 151) Dr. Lucas testified that in formulating his opinions, he took all the medical and psychological evidence into account. (Tr. 151) Dr. Lucas testified that none of what he heard or the questions he was asked have changed his opinion in any way with regard to Petitioner's ability to enter the workforce. (Tr. 152) He further testified that at the time of his assessment, there was no way Petitioner could have returned to work, and based on the labor market survey he sees here, there is no way she can return to any of those jobs. (Tr. 152) With the restrictions imposed by Dr. Fernandez in November 2010, there is no way that he would have been able to place Petitioner, except in an odd-lot situation. (Tr. 152) Dr. Lucas testified that he would not place Petitioner in any job that would require 10, 20, or 30 pounds of lifting. (Tr. 155)

On January 12, 2015, on behalf of Respondent, Sharon Babat, C.R.C, testified at the arbitration hearing. Ms. Babat testified that she works at S & H Medical Management Services, and is an employment and vocational consultant. She does complete evaluations on work comp individuals and provides job placement services. She became a certified rehabilitation counselor in 1987, and such certification requires ongoing continuing education. (Tr. of January 12, 2015, 6-7) She identified her c.v. as Respondent's Exhibit 25 and the initial vocational assessment report as Respondent's Exhibit 23. (Tr. 7-8) The initial vocational assessment report, dated February 7, 2013, contains findings and conclusions and the basis for her conclusions. (Tr. 8) Ms. Babat reviewed Petitioner medical records and provided a medical background with regard to the surgeries on her right thumb in her report. (Tr. 9-10) She reviewed Dr. Serushan's September 2011 records. Such records indicated that Petitioner was suffering from osteoarthritis, fibromyalgia and weight gain. (Tr. 10) Ms. Babat reviewed records dated March 9, 2012 that indicated Petitioner weighed 245 pounds. (Tr. 10) Petitioner's past medical history includes status post knee replacement surgery in 2000, status post hysterectomy done emergently, fracture of the right radius and a C-Section in 1996. (Tr. 10) Ms. Babat reviewed the IME report of Dr. Vender, in which he concluded that Petitioner would not need any work restrictions, and did not believe that she needed any more treatment for her right thumb. (Tr. 11) She also reviewed the records of Dr. John Fernandez that indicates a 5-pound maximum lift with regard to the right upper extremity and minimal repetitive use of tools. She also reviewed a neuropsychological report regarding Petitioner that indicated,

among other things, that for the 1-1/2 years prior to the evaluation, she was unable to do household chores. (Tr. 11-12) Ms. Babat made assumptions about Petitioner's work history and education that included an ability to use a computer at a basic level: email, Google, Facebook. (Tr. 12) She is married with 2 children, aged 16 and 21 at the time of Babat's evaluation. Her husband works outside the home at a public works department. (Tr. 12) She was aware that Petitioner was charged with embezzlement and was sentenced to 36 months in prison and that her husband was sentenced to 18 months. (Tr. 13) Her educational history indicates that she earned a college degree and passed the CPA exam and that she has an advanced vocational degree in food service and sanitation licenses. (Tr. 14) She served as a general accountant at 2 employers, and was assistant comptroller, accountant, and supervisor of payroll at CBS Channel 2 News for 14 years. (Tr. 14-15) Her responsibilities involved hiring, firing, and budget tasks. She dealt with HR, payroll and day-to-day accounting. She then worked for a temp agency, Davis Staffing, and then Waldo Accounting Services as a general accountant. (Tr. 15) The records Ms. Babat reviewed did not reflect that Petitioner participated in a self-directed job search. (Tr. 15) Ms. Babat reviewed a report of Effective Rehabilitation Management dated November 18, 2011, in which no vocational options for Petitioner were offered by the author of such report, which he based on a review of the medical history. (Tr. 15-16) Ms. Babat testified that Petitioner was placed in Level 8, on a scale of 1-9, of the aptitude profile, which indicates a minimum of 4 years and up to 8 years of training for the type of positions she held. (Tr. 17) Ms. Babat rated Petitioner's reasoning development at Level 5, mathematical development at Level 5, general educational developmental scale at Level 5 (on a scale of 1-6), and language at Level 5. (Tr. 18-19) With regard to writing, Petitioner was placed at a level in which she could write critically, perform journaling or editorial work. (Tr. 20)

Ms. Babat did an analysis of Petitioner's transferable skills using the OASYS system. Occupations identified by OASYS included: accountant, budget accountant, bookkeeper, secretary, receptionist, payroll or payroll supervisor, telephone order clerk, desk clerk and order clerk. Ms. Babat's report included entry level, median level and experienced level hourly wages for these occupations. (Tr. 19-21) Ms. Babat then identified various hourly wages for these occupations. (Tr. 23-26) Ms. Babat opined that Petitioner would be able to enter employment at the median or experienced wage level, and noted that Petitioner has a college degree and a CPA license. Barriers to attaining employment included, potentially, a conviction for embezzlement and imprisonment. Ms. Babat's overall conclusion was that she anticipated that work could be located for Petitioner within some of the categories listed, whether working within Dr. Fernandez's restrictions or following Dr. Vender's opinions, but that she should be able to obtain gainful employment. (Tr. 26-27) Ms. Babat then identified as Respondent's Exhibit 24 the labor market survey dated March 1, 2013. (Tr. 29) Ms. Babat used Dr. Fernandez's restrictions of 5-pound max lifting with the right UE, minimal repetitive use of tools, and also used Dr. Vender's return to work without restrictions. (Tr. 30) In drafting the survey, Ms. Babat used, *inter alia*, the Dictionary of Occupational Titles, IDES, Internet, area newspapers, job listings, and a telephonic survey of potential employers. She found that the positions she identified were within the restrictions identified by either physician and also within her transferable skills and known past work history. (Tr. 30-31) Background checks by potential employers could negatively impact Petitioners chances. (Tr. 31) Ms. Babat contacted 5 potential employers for desk clerk position and identified that salary range. (Tr. 31-32) Ms. Babat testified that she then contacted employers with open positions in accounting and payroll, and then in the other job categories. Ms. Babat testified that she and her colleagues identified 16 open positions where Petitioner could possibly find employment. (Tr. 32-33) Ms. Babat's overall conclusion with regard to Petitioner's ability to secure employment in her geographical area is that she would likely secure such employment in a pay range of $8.25 and $25.00 per hour, and that her past work experience and transferable skills may allow her to access positions at a higher level of pay. (Tr. 34)

On cross-examination, Ms. Babat testified that she let her LCPC license expired on March 31, 2005. (Tr. 38) Ms. Babat testified that Respondent's attorney prepared a trial outline for her. (Tr. 49) She received a

comprehensive medical summary, as well as reports from Dr. Fernandez, Dr. Vender, Dr. Ganellen, and the other rehab company. (Tr. 51-52) All Ms. Babat knew was that Dr. Serushan treated Petitioner for osteoarthritis, fibromyalgia, and weight gain as the issues. (Tr. 53) Ms. Babat did not receive any of Petitioner's treating psychiatric records from McGrath Clinic and did not view surveillance video of Petitioner. (Tr. 54) Ms. Babat testified that before January 12, 2015, the date of the arbitration hearing, she never saw Petitioner. She has never spoken to Petitioner on the phone. She did not contact Petitioner because her assignment was to only review the records and conduct a transferable skills assessment and labor market survey based on a review of records provided to her by Respondent's attorney. (Tr. 55) Ms. Babat testified that a blind evaluation involves reviewing the records and providing her opinions and recommendations based on her review of the records alone. (Tr. 57) Ms. Babat testified that she has been doing blind assessments as well as in-person assessments for over 20 years. (Tr. 61) She further testified that with any assessment, she does not know if she is getting the complete records and relies on the attorney for that. (Tr. 63) She testified that her labor market survey is up to date for the most part. She conducted the initial vocational assessment on February 7, 2013 and the labor market survey on March 1, 2013. (Tr. 64) Ms. Babat obtained a list of Petitioner's medications from the psych report dated February 1, 2012, which lists medications of Morphine, Vicodin, Lyrica and Arthrotec patch. Ms. Babat had nothing that explained the reason Petitioner was on these medications. (Tr. 65-66) Ms. Babat has had cases in which the injured workers are on psychotropic drugs and antidepressants. She believed that a person who is on morphine and other drugs could pass a drug screening for an employer for a position. (Tr. 68) Ms. Babat testified that she did take into consideration whether or not Petitioner who is on Morphine on a regular daily basis could do these jobs Babat says she can do. (Tr. 69-70) She further testified that if a doctor felt that Petitioner cannot work because she is on medication, that that would be provided to her. The medical records that she reviewed did not say anything about driving or her ability to work. Dr. Vender released her to return to work. Dr. Fernandez released her to return to work. (Tr. 74) Ms. Babat testified that Dr. Lucas, in his report, lists psychotropics – yes - 10 other medications. (Tr. 75) She further testified that she reviewed Dr. Lucas' vocational assessment dated November 18, 2011, but that she did not receive Dr. Serushan's records. (Tr. 78-79) Ms. Babat reviewed Dr. Serushan's October 12, 2011 report, and testified as to his impression, which included fibromyalgia, osteoarthritis in the hands, chronic depression and chronic pain, weight gain and right knee osteoarthritis and right total knee replacement. (Tr. 82) Ms. Babat testified that she did not know that the following medical opinion existed by a certified doctor: "I do not believe that the disability in her hands along with aches and pains all over her body that I do not believe she's able to have gainful employment in the future." (Tr. 83) She testified that her evaluation would remain the same because 2 other physicians gave her releases and restrictions. (Tr. 83-84) Ms. Babat testified that she did her report identifying jobs that fit into the restrictions imposed by Dr. Fernandez, and the no restrictions opinion of Dr. Vender. (Tr. 84-85) She only had the neuropsych report from Dr. Ganellen, and the medications, but not the rheumatology report from Dr. Serushan. (Tr. 85) The only report that Ms. Babat has from Dr. Fernandez is his November 11, 2010 report. (Tr. 86) She just needs to know the restrictions of the physicians. (Tr. 86) Ms. Babat testified that carpal tunnel of the left hand was mentioned in her report, and issues we talked about with Dr. Serushan, the right thumb. (Tr. 88) She further testified that it says in her February 7, 2013 report, that it is not known the amount that Ms. Fogarty receives in TTD presently. (Tr. 99-100) Ms. Babat did not know how she got information as to how much or what Petitioner presently receives in TTD benefits. (Tr. 101) Respondent's attorney did not tell her whether or not Petitioner was receiving benefits. (Tr. 102) Ms. Babat put in her report Petitioner's GAF level because it was stated in the records. (Tr. 103) She may have read in the neuropsych report that that Petitioner has a GAF of 50. A GAF of 50 confirms the presence of a major depressive disorder. (Tr. 104) Ms. Babat testified that in her report she does not make any mention of the effects of drugs on her, but does mention her splints. (Tr. 106) Ms. Babat assumed that Petitioner has a valid driver's license, but did not know for sure because she did not do a search and did not do a criminal background check on her. Ms. Babat did not research the exact public transportation. (Tr. 107-108) Ms. Babat based her opinion of Petitioner's ability to return to gainful employment on Dr. Vender's March 21, 2012 IME report and Dr. Fernandez's November 11, 2010

report that indicates a 5-pound max lift with minimal repetitive use of tools. (Tr. 109-110) Ms. Babat testified that in Dr. Fernandez's November 11th report, there is no restriction on the left hand. (Tr. 111) She reads into the record the WORK CAPACITY section from Dr. Fernandez's November 11, 2010 report. (Tr. 113) In her report, Ms. Babat testified, she did not mention that Petitioner has left side restrictions from Dr. Fernandez, that Petitioner is to have conservative treatment of neoprene thumb spika splints, or that he is hopeful she will be able to avoid left hand surgery but may require it if her condition significantly worsens or degenerates. (Tr. 113-114) She testified that her evaluation was to be done based on a right hand injuries that were sustained on June 1, 2006. (Tr. 117) Respondent's attorney did not tell her that Dr. Serushan testified that "Left was due to overuse of the right hand inability of three surgeries of the right thumb." (Tr. 117) Ms. Babat testified that in November 2008, Petitioner had a carpal tunnel surgery and thumb surgery, MP joint fusion, hardware removed. (Tr. 120) She testified that it varies as to when her office does a vocational assessment after a person reaches MMI based on when the case is referred to them. (Tr. 124) Ms. Babat did not know if a medical case manager had been assigned to Petitioner's case. (Tr. 1125-126) Ms. Babat read Dr. Vender's report, but not his deposition because the deposition was not sent to her. (Tr. 127-128) Ms. Babat testified: "How would I know that, that she attended court in a wheelchair?" (Tr. 135) She further testified that the positions that she identified for Petitioner are sedentary positions. (Tr. 136) Ms. Babat testified that she is basing her recommendations on the medical she received and that if a physician said she has chronic pain and shouldn't go back to work, that probably would have been part of her recommendation. (Tr. 137-138) Medications are mentioned in the record, and one of the reports referred to Dr. Serushan's report regarding osteoarthritis, fibromyalgia and weight gain. (Tr. 139) The purpose of having Petitioner vocationally assessed is to determine their potential for a return to work, and she could not say when it is best to do a vocational assessment. (Tr. 141-142) Ms. Babat testified that a vocational assessment, based on a reasonable degree of vocational counseling, is to have a complete set of records from all the treating doctors. (Tr. 142)

On redirect examination, Ms. Babat read the following impression on the August 13, 2011 left hand and wrist x-ray: "Negative left hand and wrist." (Tr. 143) She testified that in her February 7, 2013 report, she referred to a September 2011 note from Dr. Serushan. (Tr. 143) She further testified that all of her opinions to which she testified today were made within a reasonable degree of certified vocational expertise. (Tr. 144) After answering the questions posed to her on cross-examination, Ms. Babat testified, she has not changed any of her opinions. (Tr. 144)

As of November 13, 2013, the first date Petitioner testified at the arbitration hearing, she was still treating with Dr. Serushan. (Tr., November 13, 2013, at 101-103)

Petitioner testified with regard to the physical issues she experienced from October 2010 through March 2011. She had pain all over her whole body, fatigue, and sleep apnea. She could basically do nothing at all; just sit up in a chair or lay in bed. This is what she still did as of the date of her testimony, November 13, 2013. She cried "a lot" and got into arguments easily because of the pain. "It's gotten worse with the fibromyalgia." She testified that she contemplated suicide. Petitioner started seeing a therapist and was undergoing hypnotherapy. Medicare is paying for this treatment. (Tr., November 13, 2013, at 113-116)

On November 13, 2013, the date of her testimony, Petitioner testified that she still has right thumb and right hand pain. She testified to left hand pain. She wore braces on both of her hands, which she testified she wears 24 hours a day. (Tr., August 12, 2014 at 62)

Petitioner was awarded Social Security Disability on March 14, 2012 and a decision was entered that indicated she had been disabled since August 14, 2009. During the ten-month period of August 2009 through May 2010, Petitioner received Social Security Disability benefits, retroactively, and TTD from Respondent.

As of the date of Petitioner's cross-examination testimony, August 12, 2014, she continued to receive Social Security Disability benefits. Her attorney contacted Dr. Serushan and Dr. Jeff Lucas to write reports regarding her claim for Social Security Disability. (Tr., November 13, 2013, at 116-117; Tr., August 12, 2014, at 81-84)

Petitioner testified regarding previous employment with CBS. She started work there in May 1989 and worked through June 2003. She started as an accounting manager and worked her way up to assistant controller. There was a financial issue and Petitioner and her husband were charged with converting $2,000.000.00 from CBS. There were charges of felony theft by deception and money laundering. Petitioner pled guilty to the felony charge. She spent 2.5 years (July 2003 through January 2006) and her husband spent 1.5 years in state penitentiaries. (Tr., November 13, 2013, at 124-127; Tr., August 12, 2014, at 76, 78) Petitioner was released from the Illinois State Penitentiary five months prior to the date of loss at issue here.

Petitioner was also subsequently charged with stealing $40,000.00 from the Oak Forest Credit Union. She testified that this had to do with a loan for a vehicle. The criminal cases were combined and her original sentence was four years and six months. (Tr., August 12, 2014, at 76-77)

During Petitioner's testimony on November 13, 2013, video was viewed regarding surveillance of Petitioner on November 13, 2011, January 6, 2012, and February 1, 2012. (Tr., November 13, 2013, at 131-132; RX #3 is the surveillance report and #3a is a disc with the video file) Petitioner is seen getting into and out of a minivan without assistance and was able to get out of her wheelchair without assistance. (RX #3a)

At 4:40 on the video file counter, Petitioner used her right hand to not only open, but close a minivan passenger door when she got in. (Id.) At 6:20, Petitioner was shown holding her cane in her right hand as she exited the minivan. At 6:40, Petitioner held her cane in both hands and used it as a tool to assist her to lower the footrests on her wheelchair. (Id.) At 11:12, Petitioner exited from the back seat of a taxi unassisted. At 12:50, Petitioner places each of her hands on the respective arm rests of her wheelchair and used her hands to support her weight as she got up from her wheelchair unassisted. (RX #3 and #3a)

During cross-examination, Petitioner testified that her attorney has copied her (debcpafogarty@aol.com) on "dozens and dozens" of electronic correspondence that he sent to Respondent's Counsel going back to August 2010. Petitioner acknowledged that she told her attorney she would accept correspondence from him via electronic mail. (Tr., August 12, 2014, at 106-112; RX #34 and RX #36, which contain an assortment of electronic correspondence with Petitioner copied ranging from August 18, 2010 to June 20, 2014)

Petitioner was shown RX #30, which is electronic correspondence from the address debcpafogarty@aol.com to her attorney. At the end of this correspondence the words "Sincerely Debbie" appear. Petitioner testified she that she did not type this correspondence, but admitted it was from her. (Tr., August 12, 2014, at 113, 205; RX #30) Petitioner testified that she dictated her correspondence. (Tr., August 12, 2014, at 204)

Petitioner was shown RX #15, RX #16, and RX #17, which are typed lists of prescriptions, doctors, and bills respectively. She denied typing these documents. (Tr., August 12, 2014, at 114-119) In contrast to these denials, the Arbitrator notes that during Dr. Serushan's deposition, Petitioner's Counsel twice indicated on the record that Petitioner typed and provided the document marked as RX #15. (PX #16 at 41)

Petitioner further testified on cross-examination that she can barely use her right hand and cannot open a car door with it. She testified when she uses a cane, she always holds it in her left hand. Petitioner confirmed

that she can get out of her wheelchair unassisted, but that she does not use her hands. She testified that she uses one hand and her elbow. (Tr., August 12, 2014, at 120-127, 129-131)

Petitioner testified to medical issues and problems she has with body parts other than her right hand. She underwent right knee replacement surgery in 2001. She testified that her left knee needs to be replaced and that she needs revision surgery on her right knee. She testified that she needs bilateral hip replacements as well. (Tr., August 12, 2014, at 127-129) Petitioner has GERD and high blood pressure. (Tr., August 12, 2014, at 140-141)

Petitioner testified that she is involved in activities at her church and attends services there each week. Once in a while, Petitioner continued, she does a reading at church. (Tr., August 12, 2014, at 131)

On November 13, 2013, Petitioner testified with regard to the various medications that have been prescribed to her and which she takes each day. The list includes medications prescribed to her by Dr. Serushan, her rheumatologist, and Dr. Radzevicius, her psychiatrist. Petitioner testified that for fibromyalgia, she takes Lyrica, 100 mg., 3 times a day, and for fibromyalgia and arthritis, she takes Hydrocodone, 750 mg., 1 tablet every 4-6 hours. She also applies a Duragesic patch that has Fentanyl, 50 micrograms per hour, 24/7, as well as Voltaren gel, Pennsaid, and a Lidoderm patch. (Tr., November 13, 2013, at 34-38) Dr. Radzevicius has prescribed Zoloft, 100 mg., 1 time per day for her major depressive disorder, and Ambien, 10 mg., at night so that she can sleep. (Tr., November 13, 2013, at 38-39)

The arbitration hearing for this case took over 2 years to complete, during which time the Arbitrator made a record on 11 occasions. The Arbitrator assessed Petitioner's demeanor and notes that when she testified, she was lucid and intelligent. When she was not testifying, Petitioner was a keen observer and would sometimes confer with or pass notes to Petitioner's Counsel. On those occasions, the Arbitrator, as a layman, did not observe any outward signs of a person medicated with Hydrocodone, Lyrica, and a Fentanyl patch. Petitioner did not appear groggy or sleepy.

In addition to Deborah Fogarty, Nan Foster, Dr. Lucas, and Dr. Serushan, Petitioner called the following witnesses to testify: Jeanne Maggio, Elizabeth Eggers, Susan Kramer, Mario Reyes, and Catherine Cesiro.

CONCLUSIONS OF LAW

WITH REGARD TO ISSUE (F) "IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?", THE ARBITRATOR RENDERS THE FOLLOWING FINDINGS AND CONCLUSIONS:

The Arbitrator finds that by a preponderance of the evidence, Petitioner's current conditions of ill-being of her right thumb, right hand and person as a whole, due to the onset of fibromyalgia, are causally related to the accident of June 1, 2006.

Following Petitioner's June 1, 2006 right thumb/hand accidental injury, Petitioner presented to Dr. Fernandez for treatment on October 2, 2008. Dr. Fernandez's treating records indicate that Petitioner reported she sustained an injury on June 1, 2006, while working. She specifically reported that she "tripped on a computer cord and hit her right hand on the corner of a desk." She then experienced a significant amount of pain involving her thumb. Additionally, Petitioner noted significant swelling involving the hand and wrist.

Subsequently, Dr. Fernandez performed three surgeries on her right thumb/hand, including the hardware removal procedure. On November 11, 2010, at his last appointment with Petitioner, Dr. Fernandez wrote, in pertinent part, the following:

WORK CAPACITY: I believe that she is at maximum medical improvement. I believe that she would be restricted to only very light use on the right side with less than five pounds of use with minimal repetition or use of tools. This includes minimal exposure to typing, writing, or use of calculators and other manual activities requiring the right hand. It should be noted that she will have similar restrictions on the left side, but this is currently being treated as separate from the right side. This specifically has to do with the right side regarding her workers' compensation claim. (RX #13, Dep. Ex. #5)

Dr. Vender, Respondent's Section 12 physician, examined Petitioner on March 21, 2012 and diagnosed her with status post resection arthroplasty, right thumb carpometacarpal joint, and status post right thumb MP fusion. In his examination report, Dr. Vender wrote the following:

Ms. Fogarty's overall presentation, especially that related more specifically to her right upper extremity, would be considered non-physiologic. That is, the basis of this presentation would not be based on true objective pathology within the upper extremity. Instead, these presentations are more consistent with behavioral abnormality. This would be consistent with her significant psychiatric history. (RX #13, Dep. Ex. 2)

With regard to Petitioner's right thumb and hand, in this case the Arbitrator gives more weight to the opinions of treating physician, John J. Fernandez, M.D., than he does to the opinions of examining physician Michael I. Vender, M.D. Both are orthopedic surgeons who specialize in the hand and upper extremity. Dr. Vender examined Petitioner on only one occasion.

Even if one of the medical witnesses was equivocal on the question of causation, it is for the Commission to decide which medical view is to be accepted, and it may attach greater weight to the opinion of the treating physician. International Vermiculite v. Indus. Comm'n, 394 N.E.2d 1166, 31 Ill. Dec. 789 (1979) *citing* Holiday Inns of America v. Indus. Comm'n (1969), 43 Ill. 2d 88, 89-90 and Proctor Community Hospital v. Indus. Comm'n (1969), 41 Ill. 2d 537, 541.

With regard to Petitioner's condition of fibromyalgia, Majid Serushan, M.D., testified that the trauma of falling, the stress of the trauma, and the stress of going through three unsuccessful surgeries that did not relieve

Petitioner's pain will bring on fibromyalgia as well as depression. Dr. Serushan elaborated that Petitioner has fibromyalgia, which is a disease of the whole body. In response to being asked how surgery to the hand can cause fibromyalgia throughout the whole body, Dr. Serushan testified that fibromyalgia is the simulation (sic) of the body's pain receptions. So, one single, localized area of trauma would instigate and initiate fibromyalgia. That trauma could be physical, but could also come as a result of emotional trauma following several surgeries. In her case, he thought that the fall, the three surgeries and lack of response to those surgeries, her relationship to her employer, getting fired from her job all contributed to her fibromyalgia. Dr. Serushan testified that all of this is causally related to the initial insult, i.e., the June 1, 2006 accident, that started a chain reaction. Also, Dr. Serushan continued, mental problems contribute to fibromyalgia. He noted that fibromyalgia causes depression and depression causes fibromyalgia.

With regard to Petitioner's condition of fibromyalgia, Michael I. Vender, M.D., testified to the following:

Dr. Vender testified that fibromyalgia is a systemic condition, and if present, would not be related to her thumb injury. He defined fibromyalgia as follows: "It's a nebulous condition of significant controversy as to whether it actually represents a physiologic abnormality. And for some people it just represents multiple complaints of pain with little to no objective findings." Dr. Vender agreed with Petitioner's Counsel that Petitioner is taking a lot of medications, and much of it appears to be narcotic pain medication. He thought that that was "pretty pitiful." He further testified that he has had patients who have been diagnosed with fibromyalgia, but typically someone else like a rheumatologist or family doctor makes the diagnosis. Dr. Vender testified that the Mayo Clinic article that Petitioner's Counsel showed him is not a reference for physicians. He opined that articles such as this one are not peer reviewed and are written by someone who has very personal and potentially anecdotal [evidence]. Dr. Vender found that Petitioner's presentation is consistent with some form of psychological or psychiatric disorder.

The Arbitrator finds the opinions of Dr. Serushan, a rheumatologist, to be more persuasive that those of Dr. Vender, orthopedic surgeon, because the Arbitrator considers Dr. Serushan to be more qualified to diagnose fibromyalgia than Dr. Vender.

The Arbitrator finds the opinions of Dr. Radzevicius to be persuasive. At the initial evaluation on March 2, 2011, Dr. Radzevicius noted that Petitioner's past psychiatric history is entirely negative. There have been no psychiatric hospitalizations, no prior psychiatric treatment, and no history of assaultive or suicidal behavior. There is no history of depressions, anxiety attacks, or other common psychiatric symptoms. No psychotropic medications have ever been taken. There is no history of non-compliance with medication or treatment. This psychiatrist concluded that Petitioner developed symptoms of major depression and anxiety that were caused by the injury of June 1, 2006 and the related surgeries thereafter, and that such symptoms got worse with time as her health and overall medical condition deteriorated. Dr. Radzevicius has prescribed several psychoactive medications for Petitioner.

Dr. Ganellen was the only medical professional to administer neuropsychological testing to Petitioner. Notwithstanding this distinction, he opined that Petitioner's diagnosis of Major Depression was reasonable, but that linking the depression *entirely* to the effects to the June 1, 2006 incident was questionable. (Emphasis added.)

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 v. Indus. Comm'n, 37 Ill. 2d 123, 127, 227 N.E.2d 65 (1967)

The Arbitrator finds that no doctor diagnosed Petitioner with overuse syndrome of the left hand and wrist, and the evidence does not support a causal connection. Only Petitioner herself diagnosed overuse syndrome of her left hand and wrist. Therefore, the Arbitrator finds that the current condition of ill-being of Petitioner's left hand and wrist is not related to the accident of June 1, 2006.

The Arbitrator further finds that the carpal tunnel syndrome of Petitioner's right hand/wrist is not causally related to the accident of June 1, 2006. Although Dr. Light noted symptoms that were suggestive of carpal tunnel syndrome on July 31, 2006, he did not causally relate such symptoms to the June 1, 2006 accident. Petitioner worked as an accountant for 2 different employers after that, and filed a claim for bilateral carpal tunnel against Waldo Accounting Systems, Inc., with an accident date of June 30, 2008.

WITH REGARD TO ISSUE (K) "WHAT TEMPORARY BENEFITS ARE IN DISPUTE? TTD AND MAINTENANCE", AND WHETHER TEMPORARY TOTAL DISABILITY AND MAINTENANCE BENEFITS ARE OWED TO PETITIONER, THE ARBITRATOR RENDERS THE FOLLOWING FINDINGS AND CONCLUSIONS:

Petitioner claims that she is entitled to TTD benefits from November 14, 2008 through November 11, 2010, or 104 weeks, "and thereafter maintenance." (AX #1)

Respondent claims that Petitioner is entitled to TTD benefits from November 14, 2008 through May 22, 2010, or 79 weeks, and no maintenance benefits. Respondent seeks a credit in the amount of $35,814.65 in TTD benefits paid to Petitioner. (AX #1)

Petitioner testified that following the accident, in October 2006, she started working for Waldo Corporation where she did accounting work, keyboarded, and wrote. (Tr., November 13, 2013, at 56) She worked for Waldo through June 30, 2008 when its business closed. (Tr., November 13, 2013, at 56-57) Following the closure of Waldo Corporation, in July or August 2008, Petitioner started working for an accounting firm in Crestwood, Illinois. This lasted for approximately six weeks because she had to quit due to the emergency hysterectomy that she underwent in September 2008. (Tr., November 13, 2013, at 59, Tr., August 12, 2014, at 90-92)

On the following dates, Petitioner underwent three surgeries to her right thumb/right MP joint: November 14, 2008, August 14, 2009, and March 12, 2010.

Petitioner also underwent unrelated carpal tunnel release surgeries to her right and left hand/wrist on November 14, 2008 and August 27, 2010, respectively.

Respondent stopped temporary total disability benefits as of May 22, 2010. On or about that date, Dr. Fernandez shifted his treatment to Petitioner's left hand. Such treatment was alleged to be related to a separate workers' compensation claim against Waldo Accounting Systems, Inc. Petitioner settled all left and right hand carpal tunnel issues, including TTD, with Waldo Accounting Systems, Inc. for case number 08 WC 51204.

However, on March 16, 2010, Dr. Fernandez examined Petitioner and restricted her from work altogether, and wrote: "After the two-week visit, she will be able to return back to work in a one-handed capacity." (PX #3, Pp. 41-42)

On April 1, 2010, Dr. Fernandez examined Petitioner and allowed her to work in a one-handed capacity with no use of the right upper extremity. (PX #3, Pp. 43-44)

On May 11, 2010, Dr. Fernandez examined Petitioner and noted that, overall, her range of motion has improved, but appears to be reaching a plateau. She continues to have generalized pain to the right thumb along the basilar joint region and at the IPJ, particularly with increased use. She continues to have stiffness to terminal flexion of the right thumb. She feels "clumsy" as well as weak on that side. Dr. Fernandez also noted complaints referable to the left thumb along the basilar joint region. Dr. Fernandez restricted Petitioner from normal work activities with the right hand and arm. (PX #3, Pp. 45-46)

On July 20, 2010, Dr. Fernandez examined Petitioner and allowed her to return to work in a light-duty capacity with less than 10 pounds of force involving her left and right upper extremity. He also limited Petitioner to minimal repetitive use and no use of tools. (PX #3, Pp. 47-48)

On September 9, 2010, Dr. Fernandez examined Petitioner and stated that "she is technically on a no use of the left arm restriction or very light use around the house." (PX #3, Pp. 49-50)

On September 28, 2010, Dr. Fernandez examined Petitioner and stated that Petitioner is at maximum medical improvement from her carpal tunnel releases and allowed her to engage in light activities with up to 10 pounds of use, but with frequent breaks, particularly with more significant repetitive types of use through the wrist and hand. Dr. Fernandez noted that there are other issues relating to the thumbs bilaterally relating to a separate injury and that this is not related to her current symptoms. (PX #3, Pp. 51-52)

On October 5, 2010, Dr. Serushan saw Petitioner for the first time. Dr. Serushan wrote, in pertinent part, the following:

> *Deborah – 51 yrs. – 1st visit – She was referred by Dr. Luebbe –*
> *c/o joint pain all over, insomnia, abnormal labs –*
> *consult dictation*
> *Fibromyalgia*
> *Ⓡ knee prosthesis loosening*
> *previous hands*
> *dx of trauma –*
> *Ⓡ hand 4 years ago –*
> *multiple surg.* (PX #5)

On November 11, 2010, Dr. Fernandez issued the following permanent restrictions: "I believe that she is at maximum medical improvement. I believe that she would be restricted to only very light use on the right side with less than five pounds of use with minimal repetition or use of tools. This includes minimal exposure to typing, writing, or use of calculators and other manual activities requiring the right hand. It should be noted that she will have similar restrictions on the left side, but this is currently being treated as separate from the right side. This specifically has to do with the right side regarding her workers' compensation claim." (RX #13, Dep. Ex. #5)

The Arbitrator notes that the treatment Petitioner received for his right thumb and right hand was enmeshed with the treatment she received for unrelated bilateral carpal tunnel syndrome.

In a handwritten chart note dated September 21, 2011, Dr. Serushan assessed Petitioner with chronic pain, fibromyalgia, status post several surgeries of hand and unable to function. (PX #5)

On October 12, 2011, Dr. Serushan authored a "To Whom It May Concern" narrative report. He noted that prior to June of 2006, Ms. Fogarty was healthy, working and ambulating fine. She then tripped over a computer cord, tried to break her fall and struck her right thumb and hand on a desk. Dr. Serushan offered the following IMPRESSION:

1. Fibromyalgia, which evolved after traumatic fall / injury, multiple surgeries and major depression. Unfortunately, this could be a permanent problem and she could suffer with pain for the rest of her life. There are not too many medications to offer. Prognosis is generally poor, given the fact that she has gained weight which makes the problem worse.

2. Osteoarthritis in the hands, which could be secondary to trauma or repetitive work for many years.

3. Chronic depression and chronic pain. The pain is relentless and does not improve with medications.

4. Weight gain, partly due to fibromyalgia and lack of exercise / ambulation.

5. Right knee osteoarthritis and right knee total replacement. (PX #5)

The Arbitrator notes that Petitioner worked as an accountant for Waldo Accounting Systems, Inc., from October 2006 to July or August 2008, and then for an accounting firm in Crestwood, Illinois, for six weeks after she worked for Waldo. Moreover, the evidence indicates that Petitioner did not weigh 190 lbs. just prior to the accident and therefore did not experience a significant weight gain.

On March 21, 2012, at the request of Respondent and pursuant to Section 12 of the Act, Petitioner presented to Michael I. Vender, M.D., for an examination. He took a history, reviewed the x-rays, conducted physical examination and concluded that Petitioner was at maximum medical improvement and was capable of performing unrestricted work. (RX #13, Dep. Ex. 2)

The Arbitrator has found that Petitioner's current conditions of ill-being of her right thumb, right hand and person as a whole, due to the onset of fibromyalgia, are causally related to the accident of June 1, 2006. The Arbitrator has found the opinions of Doctors Fernandez and Serushan to be more persuasive than the opinions of Dr. Vender. The Arbitrator has found the opinions of Dr. Radzevicius to be persuasive.

After Petitioner was found to be at MMI and released to restricted work on November 11, 2010 by Dr. Fernandez, she did not conduct a self-directed job search.

Respondent did not offer Petitioner work within Dr. Fernandez's restrictions.

Respondent did not consult with Petitioner and did not prepare a written assessment of rehabilitation required to return Petitioner to employment, pursuant to Section 7110.10 of the Rules Governing Practice Before the Illinois Workers' Compensation Commission.

In a report dated February 7, 2013, Sharon Babat, C.R.C., performed a blind vocational assessment. (RX #24) Ms. Babat testified that in performing the assessment, she reviewed medical records and reports, but did not speak with Petitioner on the telephone or interview her in person. Ms. Babat did not review Dr. Serushan's records or Dr. Radzevicius' records (McGrath Clinic). Ms. Babat testified that she did take into consideration whether or not Petitioner, who is on morphine on a regular daily basis, could do the jobs that Ms. Babat says she

can do. Ms. Babat either was not aware or did not consider that Dr. Fernandez's permanent restrictions applied to both Petitioner's left and right hands.

Dr. Lucas testified that Ms. Babat did not address the psychological aspect of Petitioner's condition.

Ms. Babat conducted a labor market survey and indicated the results of such survey in a report dated March 1, 2013. Ms. Babat's overall conclusion with regard to Petitioner's ability to secure employment in her geographical area is that she would likely secure such employment in a pay range of $8.25 and $25.00 per hour, and that her past work experience and transferable skills may allow her to access positions at a higher level of pay.

The Arbitrator finds that the prospective jobs that Ms. Babat located for Petitioner exceeded her restrictions. The Arbitrator further finds that Ms. Babat's opinions are defective because she did not review the complete set of medical records for Petitioner.

The Arbitrator finds that the opinions of Dr. Jeff Lucas are more persuasive than those of Ms. Babat. Dr. Lucas is better qualified than Ms. Babat and reviewed a more complete set of medical records for Petitioner than Ms. Babat did. Dr. Lucas testified that there is no place for Petitioner's condition and her medical situation in the labor market. With the exception of a sheltered workshop, he found that she just would not be hired because there are no jobs that would fulfill the requirements set forth by the medical doctors. There is no way she would be able to perform the necessary tasks involved in the jobs she has done in the past or jobs that he has looked into for Petitioner for the future.

Based on the foregoing, the Arbitrator finds that Petitioner is entitled to TTD benefits at a rate of $453.33/week from November 14, 2008 through November 11, 2010, or 104 weeks, and is entitled to maintenance benefits at a rate of $453.33/week, from November 12, 2010 through June 25, 2015, or 241 weeks.

WITH REGARD TO ISSUE (L) "WHAT IS THE NATURE AND EXTENT OF THE INJURY?", THE ARBITRATOR RENDERS THE FOLLOWING FINDINGS AND CONCLUSIONS:

Petitioner testified that she has a Bachelor of Arts Degree from Lewis University and a Certified Public Accountant's degree from University of Illinois.

Petitioner is a Certified Public Accountant and worked as one for over 20 years. Petitioner testified regarding her resume' and her experience in budgeting, general ledger, payroll, and human resources. As of 2003, she was making approximately $75,000.00 per year. Dr. Lucas testified that Petitioner could use voice recognition software.

Petitioner is also certified in food service sanitation and has a certification regarding courses in computer technology.

Petitioner testified that she is in a wheelchair. She further testified that she does not drive because of her condition. She testified that there is no way she can maneuver a vehicle with fibromyalgia, the conditions of her hands and legs, and the pain she is in.

Dr. Vender testified Petitioner's overall medical presentation was nonphysiologic: it was not based on real physical disease in the body. Her presentation was consistent with a personal psychological or psychiatric

disorder. Dr. Vender indicated Petitioner would be able to return to work as an accountant following the type of treatment she underwent to her right thumb. Even with a bad result from the surgeries she underwent, he opined, there would be no reason to suspect a need for restrictions, let alone extreme restrictions. Dr. Vender further opined that any claim of an inability to work would not be related to her right thumb and the surgeries she underwent. Dr. Vender elaborated on the reason he thought Petitioner's list of medications was pitiful. He cited the Mayo Clinic blurb that indicated very benign treatment such as stress reduction and exercise. Dr. Vender opined that nowhere would they [Mayo Clinic] ever recommend treating fibromyalgia with narcotic medication, which can be habit-forming.

Yet, the Arbitrator relies on the opinions of her treating rheumatologist, Dr. Serushan, that Petitioner is a medically permanently and totally disabled. Dr. Serushan testified that "pain" is the basis of his opinion that Petitioner is unable to perform gainful employment. He noted that Petitioner has a loss of function of the thumb that is fused and development of osteoarthritis in the base of the hand. Dr. Serushan testified that he believed Petitioner was permanently and totally disabled based upon the problems to both of her hands, and that the medication that she takes for pain management - - such as the Fentanyl patch - - contributes to this disability.

Moreover, Dr. Radzevicius, Petitioner's treating psychiatrist, found that although Petitioner is somewhat better with treatment, she is still severely impaired even with current treatment that includes medications and psychotherapy. In Dr. Radzevicius' opinion, Petitioner is totally disabled and will be unable to function in any work setting in the foreseeable future. He found that continuing psychiatric treatment and psychological treatment are indicated for her conditions.

As discussed above, the Arbitrator finds the opinions of Dr. Jeff Lucas to be more persuasive than those of Ms. Sharon Babat and therefore finds that Petitioner is vocationally permanently and totally disabled.

Therefore, based on the foregoing, the Arbitrator finds that as a result of the June 1, 2006 accident, Petitioner is permanently and totally disabled.

Respondent is entitled to a credit in the amount of $9,302.40 for a PPD advance, which is equivalent to 30% loss of use of the right thumb.

WITH REGARD TO ISSUE (M) "SHOULD PENALTIES OR FEES BE IMPOSED UPON RESPONDENT?", THE ARBITRATOR RENDERS THE FOLLOWING FINDINGS AND CONCLUSIONS:

Petitioner claims she is entitled to Section 19(k) and 19(l) penalties on late payment of medical bills and on unpaid TTD benefits, and that her attorney is entitled to attorney's fees.

When the arbitration hearing began on June 13, 2013, Petitioner's Counsel stated for the record that there are no outstanding medical bills. However, Petitioner's Counsel stated that the medical bills were paid 1-3 years late and relied on a June 7, 2010 fax from Respondent's Counsel wherein Respondent's Counsel stated: "To my knowledge, all lost time and medical bills are paid in full. Please accept this as notice under Rule 7110.70 that no further lost time or medical bills will be considered or paid in the future." (Tr. of June 13, 2013, Pp. 5-6; PX #8)

In the Second Amended Petition for Penalties for 19(k), 19(l) Penalties and Section 16 Attorneys' Fees, Petitioner's Counsel claimed that as of July 19, 2011, the unpaid medical bills totaled $58,613.35. (PX #8)

In Respondent's Response to the Second Amended Petition for Penalties for 19(k), 19(l) Penalties and Section 16 Attorneys' Fees, he stated, *inter alia*, that Petitioner failed to attach complete medical records and complete documentation of any alleged unpaid amounts to her Petition. (RX #19)

After Petitioner sustained the accident at bar on June 1, 2006, she worked for 2 different employers from October 2006 to September 2008. The reason that she stopped working at the accounting firm in Crestwood, Illinois, in September 2008 was to undergo an emergency hysterectomy.

On August 20, 2007, Petitioner fell down half of the escalator stairs at One Financial Place. She was not employed by either Respondent listed on the current Application when this event occurred. She was taken to Northwestern Hospital by ambulance. Medical records from this visit indicate injury to Petitioner's face, right hand, right forearm, left leg, left shoulder, and neck. She hired attorneys to represent her for this incident and received a settlement. At the arbitration hearing for the case at bar, Petitioner denied that the condition of her right hand/right thumb or left hand was affected by the fall down the escalator.

The Arbitrator refers to a transcribed telephone conversation of November 10, 2008 between Dr. Fernandez and Petitioner. Petitioner was not in agreement with Dr. Fernandez that her right thumb arthroplasty would be covered under workers' compensation but her right carpal tunnel syndrome surgery would not be covered under workers' compensation. She told Dr. Fernandez that if she was not having her carpal tunnel surgery performed on the same day as her arthroplasty, she will "not have any surgery at all." (PX #3, p. 80)

Both surgeries were billed together and the combined bill was paid by Blue Cross/Blue Shield. Petitioner had this insurance through her husband. (Tr., June 20, 2013, at 37; Tr., August 12, 2014, at 53-57, 195, 208; RX #28, which is correspondence from BC/BS to Gallagher Bassett with a Consolidated Statement of Benefits attached)

On November 19, 2008, Petitioner filed an Application for Adjustment of Claim in the matter of Deborah M. Fogarty v. Waldo Accounting Systems, Inc., 08 WC 51204. In such Application, Petitioner alleged that on June 30, 2008, she sustained carpal tunnel syndrome of her left and right hands due to repetitive trauma.

Subsequently, Petitioner requested the charges for the November 14, 2008 surgery be split. Rush Oak Park sent her a letter dated November 1, 2010 indicating the line item payment request could not be calculated. (Tr., August 12, 2014, at 58-59; RX #27)

On February 13, 2009, Petitioner presented for treatment at Athletico and stated she jammed her right thumb into a desk again, causing pain. Petitioner testified she was probably at home and jammed her right thumb into her own desk.

Petitioner's treatment for unrelated bilateral carpal tunnel syndrome (for which she later received a lump sum settlement from Waldo Accounting Systems, Inc. [RX #6]) is enmeshed with her treatment for the causally related right thumb/right hand condition. Petitioner settled her claim with Waldo for $39,114.00 for disputed claims for medical, TTD and PPD benefits.

From Respondent's point of view, absent the unrelated, operated, bilateral carpal tunnel syndrome, Dr. Fernandez would have issued less severe restrictions that may have allowed Petitioner to return to work as an accountant. Dr. Fernandez was not deposed.

Moreover, Petitioner had pre-existing osteoarthritis.

Nineteen separate HCFA formatted bills for Dr. Serushan's treatment are included in PX #5 and indicate Petitioner's condition is not related to her employment, not related to an auto accident, and not related to any other accidents. (PX #5)

Although Dr. Serushan authored the "To Whom It May Concern" narrative report dated October 12, 2011, there is no evidence that such report was sent to Respondent before Dr. Vender's IME.

On March 14, 2012, at the request of Respondent and pursuant to Section 12 of the Act, Petitioner presented to Michael I. Vender, M.D., for an examination. Following the exam, Dr. Vender authored a report of his findings and conclusions. Dr. Vender diagnosed Petitioner with status post resection arthroplasty, right thumb carpometacarpal joint, and status post right thumb MP fusion. Dr. Vender found that Petitioner's overall presentation would be considered non-physiologic. He further found that she did not need any more treatment for the thumb and needed no work restrictions. Dr. Vender concluded that Petitioner's current inability to work is not based on any injury she sustained to her right upper extremity.

Based on the foregoing, the Arbitrator finds that neither penalties nor attorney's fees are warranted in this case.

Brian T. Cronin
Arbitrator

December 2, 2016
Date

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

Mark T. Weyers,

Petitioner,

vs. NO: 11WC003841

Wal-Mart Supercenter,

18IWCC0073

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 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.

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: JAN 31 2018

Stephen J. Mathis

SJM/sj
o-1/25/2018
44

David L. Gore

Deborah L. Simpson

Deborah L. Simpson

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

WEYERS, MARK T
Employee/Petitioner

Case# **11WC003841**

18IWCC0073

WAL-MART SUPERCENTER
Employer/Respondent

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:

0452 PIGNATELLI & ASSOCIATES
LOUIS F PIGNATELLI
102 E ROUTE 30
ROCK FALLS, IL 61071

0560 WIEDNER & McAULIFFE LTD
MARY C SABATINO
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

18IWCC0073

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)

Mark T. Weyers
Employee/Petitioner

Case # 11 WC 03841

v.

Consolidated cases: n/a

Wal-Mart Supercenter
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 William R. Gallagher, Arbitrator of the Commission, in the city of Rock Island, on August 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, January 18, 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 not causally related to the accident.

In the year preceding the injury, Petitioner earned $15,148.64; the average weekly wage was $291.32.

On the date of accident, Petitioner was 23 years of age, single with 1 dependent child(ren).

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

Respondent shall be given a credit of $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 reasonable and necessary medical services from January 18, 2011, through January 21, 2011, as identified in Petitioner's Exhibits 10 and 11, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Based upon the Arbitrator's Conclusions of Law attached hereto, Petitioner's petitions for prospective medical treatment and temporary total disability benefits are 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.

William R. Gallagher, Arbitrator
ICArbDec19(b)

September 5, 2016
Date

SEP - 7 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 January 18, 2011. According to the Application, a pallet jack struck Petitioner's right foot which caused an injury to the "Right Foot/Leg/Person as a Whole" (Arbitrator's Exhibit 2). This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of medical bills and temporary total disability benefits as well as prospective medical treatment. Respondent disputed liability on the basis of accident and causal relationship (Arbitrator's Exhibit 1).

Petitioner began working for Respondent in August, 2010, and he worked in the grocery section of Respondent's "Supercenter." Petitioner's job consisted primarily of stocking and restocking frozen food. At trial, Petitioner testified that on January 18, 2011, he was pushing a long cart while simultaneously pulling a pallet jack which Petitioner stated he had approximately 200 to 300 pounds of frozen food product on it.

While Petitioner was pushing the cart and pulling the pallet jack, there was an intercom announcement made which directed the employees to move their vehicles. When Petitioner heard the announcement, he stopped pushing the cart and pulling the pallet jack; however, the pallet jack did not stop and it struck the back of Petitioner's right heel. Petitioner thought that the accident occurred sometime between 1:00 AM and 2:00 AM.

Petitioner reported the accident in a timely manner to Respondent. Petitioner also prepared and signed a written statement that same day. The statement was received into evidence at trial. In regard to the circumstances of the accident of January 18, 2011, the written statement prepared and signed by Petitioner was consistent with his testimony at trial (Respondent's Exhibit 1).

Petitioner also gave a recorded statement regarding the accident on January 21, 2011. This recorded statement was also received into evidence at trial. In the recorded statement, Petitioner stated that he stopped pushing/pulling when the announcement came over the intercom directing people to move their cars. After the pallet jack rolled up his right foot, Petitioner said he "Leaned on the cart for a few minutes because it really hurt. I continued and moved to the aisle then went to move my car and then return to freight." (Respondent's Exhibit 2).

Nathen Vock testified on behalf of Respondent when this case was tried. At the time of trial, Vock was the Store Manager; however, in January, 2011, Vock was the Asset Protection Coordinator of the store. Vock testified that when an accident occurs at work, the Asset Protection Coordinator is notified of the time and place of the accident so that the video can be located and reviewed. In this case, because Petitioner reported the accident in a timely manner, Vock was able to locate the video of the accident.

Respondent tendered into evidence a video of the Petitioner that was taken on January 18, 2011, at approximately 12:38 AM. Petitioner's counsel objected to the admission of the video into evidence. After hearing the argument of counsel for Petitioner and Respondent, the Arbitrator overruled the objection of Petitioner and the video was received into evidence. The video was

watched at trial by the Arbitrator and counsel for Petitioner and Respondent. Respondent's counsel then tendered a copy of the video into evidence as Respondent's Exhibit 10.

While reviewing the records so that he could write his Decision, the Arbitrator attempted to play the video that was entered into evidence, but was unable to do so. The Arbitrator made numerous attempts to play the video on three different computers using different programs. This situation was communicated to counsel for Petitioner and Respondent. The Arbitrator advised counsel that it would be necessary for them to reach an agreement if they wanted the Arbitrator to watch another copy of the video. This resulted in a series of e-mails over a week between both counsel and the Arbitrator regarding this issue. No agreement in respect to this issue was forthcoming. Accordingly, the Arbitrator's statements contained herein in regard to the video are based upon his best recollection of what he observed in the video at the time of trial.

In the video, Petitioner was observed coming down an aisle pushing a cart and pulling a pallet jack at approximately 12:38 AM on January 18, 2011. The cart in front of Petitioner had cardboard boxes which partially obstructed the view of Petitioner. At one point in time, Petitioner stopped and proceeded to lift up his right foot. It was not possible to see if, in fact, the pallet jack struck Petitioner's right foot because the view was obstructed by the boxes on the cart in front of Petitioner. Afterward, Petitioner turned, picked up his jacket and walked away from the cart and pallet. On the video, Petitioner was only observed for very brief period of time because he proceeded to go down an aisle adjacent to the cart and pallet which was not included in the video. Contrary to his recorded statement, Petitioner did not lean on the cart afterward (Respondent's Exhibit 10).

Vock testified that he had been directed to review footage both before and after the video of Petitioner to ensure that the video presented was, in fact, of the incident in question. Vock testified that the only time Petitioner was observed pushing a cart and pulling a pallet jack in the frozen food section was what was observed in the video that was tendered into evidence.

Mallory Vancil testified on behalf of Petitioner when this case was tried. Vancil also worked for Respondent in the frozen food department. She stated that she observed Petitioner limping and assisted him out of the building to his car so that he could move it. She also assisted Petitioner to get back in the building. On cross-examination, Vancil agreed that she was not present at the time the accident occurred.

Trista Miller testified on behalf of Respondent when this case was tried. Miller was Petitioner's immediate supervisor at the time of the accident and she confirmed that Petitioner reported it to her shortly after its occurrence. Miller testified that she observed some slight bruising of Petitioner's right foot at that time. Miller also prepared a written report dated May 4, 2011, almost four months post-occurrence, which was received into evidence at trial. In that report, Miller noted that she observed Petitioner's right ankle and that she saw slight bruising but no swelling. She offered Petitioner an icepack, if he thought he needed it, and she advised him what he needed to do if he sought medical care (Respondent's Exhibit 9).

Petitioner initially sought medical treatment at CGH Medical Center at 3:04 PM on January 18, 2011. At that time, Petitioner complained of right ankle/heel pain as a result of a pallet that he

was pulling running into him. X-rays were taken which were negative for any acute fracture dislocation; however, the radiologist noted that there was an os trigonum posteriorly which can be associated with significant ankle pain. The radiologist also noted that the same appearance might be simulated by a lateral talar process fractures which may be chronic or acute. He suggested MRI imaging. His impression was "Os trigonum versus lateral talar process fracture." (Petitioner's Exhibit 1; pp 15, 17-18).

Petitioner was evaluated by Dr. Eric Riley, a podiatrist, on January 21, 2011. Dr. Riley examined Petitioner and reviewed the x-rays. He opined that Petitioner had sustained a traumatic event about his os trigonum with a dislocation of partial or fibers union of the posterior lateral. He authorized Petitioner to be off work (Petitioner's Exhibit 2; pp 30-32).

Petitioner was again seen by Dr. Riley on February 7, 2011. At that time, Petitioner continued to complain of pain in the Achilles area of the ankle. Dr. Riley opined that Petitioner had os trigonum syndrome versus fracture and anticipated that a surgical intervention might be required. He recommended that Petitioner have an MRI scan and authorized Petitioner to remain off work (Petitioner's Exhibit 2; pp 27-28, 32).

An MRI of Petitioner's right ankle was performed on March 31, 2011. According the radiologist, the MRI revealed a prominent os trigonum with mild edematous changes of the bone marrow consistent with os trigonum syndrome. There were no post-traumatic changes of ankle ligaments or tendons (Respondent's Exhibit 8).

Petitioner continued to be treated by Dr. Riley. When Dr. Riley saw Petitioner on April 5, 2011, he reviewed the MRI scan. He opined that surgery was appropriate because of the lack of satisfactory results with conservative treatment (Petitioner's Exhibit 2; p 67).

On May 11, 2011, Dr. Riley performed surgery on Petitioner's right foot. The procedure consisted of an excision of the posterior lateral talar process. The surgical report noted that the sural nerve was completely intact (Petitioner's Exhibit 2; pp 72-73).

Dr. Riley saw Petitioner on May 19, 2011, and he noted that Petitioner was doing well. Dr. Riley informed Petitioner that the sural nerve was manipulated during the surgery and that Petitioner would have paresthesias and/or anesthesia as a result of the manipulation of the sural nerve (Petitioner's Exhibit 2; p 47).

At the direction of Respondent, Petitioner was examined by Dr. George Holmes, an orthopedic surgeon, on July 5, 2011. In connection with his examination of Petitioner, Dr. Holmes reviewed medical records provided to him by Respondent. On examination, Dr. Holmes noted a decreased range of motion because of complaints of pain and numbness along the course of sural nerve. He obtained x-rays and noted that there was a fragment in the posterior lateral aspect of the ankle. Dr. Holmes' could not determine if it was an os trigonum or lateral process fracture, but stated that it appeared to be a large os trigonum with the fragment continuing to be present in the posterior aspect of the ankle (Respondent's Exhibit 3).

Dr. Holmes opined that Petitioner sustained an injury as a result of the accident of January 18, 2011, and that it was either persistent os trigonum or persistent lateral process fracture of the talus. He also made a secondary diagnosis of sural nerve neuroma along the site of the surgical incision. He opined that Petitioner's current symptoms were related to the accident of January 18, 2011, or the surgery. He opined that Petitioner was not at MMI and that further surgery to remove the bone fragment was indicated. Dr. Holmes did state that he wanted to review the pre-operative x-rays and MRI scan (Respondent's Exhibit 3).

Dr. Holmes subsequently reviewed the report of the x-rays obtained on January 18, 2011, and the MRI scan of March 31, 2011, and prepared a supplemental report dated July 26, 2011. In his review of the x-ray report and MRI scan, Dr. Holmes noted that the os trigonum did not appear to be an acute process or injury that occurred as result of the injury of January 18, 2011. He specifically noted that the MRI showed a well-corticated margin around the loose body in the posterior aspect of the ankle. He stated that "Such a well-corticated margin is absolutely indicative of an old or pre-existing condition rather than an acute process. The MRI does not also show any evidence of an acute lateral process or fracture of the talus." He opined that the preceding findings were not created or aggravated by the accident of January 18, 2011 (Respondent's Exhibit 4).

Dr. Riley saw Petitioner on July 19, 2011, and noted that Petitioner's pain was out of proportion for the natural history of an os trigonum excision. He recommended referral to a pain management specialist and suspected chronic regional pain syndrome (Petitioner's Exhibit 2; p 35). Dr. Riley subsequently referred Petitioner to Dr. Robyn Vargo, an orthopedic surgeon.

Dr. Vargo saw Petitioner on August 15, 2011. On examination, Dr. Vargo noted posterior impingement pain with plantar flexion, decreased range of motion and hypersensitivity along the scar in the sural distribution. She ordered a CT scan and ultrasound to make certain the os trigonum was completely excised (Petitioner's Exhibit 4).

The ultrasound was performed on August 25, 2011. According the radiologist, the ultrasound revealed a longitudinal split tear involving the right peroneus brevis tendon and fibrosis posterior to the right ankle capsule (Petitioner's Exhibit 7). A CT scan was also performed, but the radiologist's report regarding it was not tendered into evidence at trial. However, when Dr. Vargo saw Petitioner on September 9, 2011, she reviewed both the ultrasound and CT scan and opined that they revealed some fragmentation of the os trigonum as well as some sural nerve entrapment (Petitioner's Exhibit 4).

Dr. Vargo again saw Petitioner on January 26, 2012. At that time, Petitioner complained of extreme pain. On examination, Dr. Vargo noted skin color and temperature changes consistent with complex regional pain syndrome. She recommended referral to pain management. Dr. Vargo did not see Petitioner again until October 2, 2013. At that time, Petitioner's condition was essentially the same as it had been previously (Petitioner's Exhibit 4).

Petitioner was seen by Dr. Scott Glaser, a pain management specialist, on February 14, 2014. Dr. Glaser opined that Petitioner had complex regional pain syndrome and recommended Petitioner undergo lumbar paravertebral sympathetic nerve blocks. Dr. Glaser performed right lumbar

paravertebral nerve blocks on April 3, April 10, and April 17, 2014. The nerve blocks did not provide any relief of Petitioner's symptoms. Dr. Glaser subsequently recommended that Petitioner have a spinal cord stimulator surgically implanted. Dr. Glaser continued to see Petitioner through October, 2015 (Petitioner's Exhibit 6).

Dr. Holmes was deposed on March 20, 2012, and his deposition testimony was received into evidence at trial. Dr. Holmes' testimony was consistent with his medical reports and he reaffirmed the opinions contained therein. He testified that subsequent to his examination, he reviewed the report of the x-rays obtained on January 18, 2011, and the MRI scan of March 31, 2011. Dr. Holmes specifically noted that the x-ray report suggested that the os trigonum was an old or chronic injury and the MRI scan indicated that it was an old injury. In explaining his opinion, Dr. Holmes noted that the MRI scan revealed a "hard shell" around the bone which demonstrated a completely healed process which would not have occurred two months after the injury. Dr. Holmes's stated that it would take six to seven months for that hard shell formation to occur. He also observed that the MRI did not reveal any inflammatory process around the os trigonum (Respondent's Exhibit 5; pp 18-20).

Dr. Holmes testified that he changed his opinion regarding causal relationship after his review of the MRI scan. In regard to whether there was an exacerbation of the os trigonum, he stated that "There should be fluid around the os trigonum, there should be bruising of the os trigonum, the tendons around the os trigonum should show some evidence of injury as well. None of this was noted on the MRI scan of 3/31/2011." (Respondent's Exhibit 5; pp 21-22).

Dr. Holmes also testified that the surgical excision of the os trigonum was not necessary. In regard to the sural nerve injury, he testified this was related to the surgery that was performed, not the injury of January 18, 2011. In regard to the pathology observed in the ultrasound of August 25, 2011, Dr. Holmes testified that this was not related to the accident because none of the findings noted in the ultrasound were present in the MRI scan (Respondent's Exhibit 5; pp 22, 25- 26).

Dr. Vargo was deposed on February 8, 2013, and her deposition testimony was received into evidence at trial. Dr. Vargo reaffirmed her opinion that Petitioner's right foot condition was related to the accident of January 18, 2011 (Petitioner's Exhibit 18; pp 14-18).

On cross-examination, Dr. Vargo agreed that her causality opinion was based upon the information regarding the accident as communicated to her by Petitioner. Further, Dr. Vargo agreed that she did not review any of the pre-operative x-rays or MRI scans (Petitioner's Exhibit 18; p 27).

At the direction of Respondent, Petitioner was examined by Dr. Kenneth Candido, an anesthesiologist, on December 2, 2014. In connection with his examination of Petitioner, Dr. Candido reviewed medical reports provided to him by Respondent, as well as the transcripts of the depositions of Dr. Holmes and Dr. Vargo. Dr. Candido opined that Petitioner had three of the four subjective criteria for complex regional pain syndrome and did meet the minimum criteria for that diagnosis. In regard to causality, he deferred to Dr. Holmes' opinion/testimony that the sural nerve neuroma or neuropathic pain was related to the surgery, which Dr. Holmes opined

was unnecessary. He also noted that Dr. Holmes and Dr. Vargo disagreed as to the etiology of the os trigonum, and deferred to them because this was an orthopedic issue (Respondent's Exhibit 6).

Dr. Candido was deposed on November 17, 2015, and his deposition testimony was received into evidence at trial. Dr. Candido's testimony was consistent with his medical report and he reaffirmed the opinions contained therein (Respondent's Exhibit 7).

At trial, Petitioner testified that he still has significant complaints of pain in regard to the right foot/ankle as well as his back. He has not been able to work since shortly after the accident. He does want to proceed with the surgical implantation of the spinal cord stimulator.

Conclusions of Law

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

The Arbitrator concludes that Petitioner sustained an accidental injury arising out of and in the course of his employment for Respondent on January 18, 2011.

In support of this conclusion the Arbitrator notes the following:

Petitioner's testimony that he was pushing a long cart and simultaneously pulling a pallet jack that contain frozen food product was consistent with the video of him tendered into evidence.

When Petitioner stopped pulling the pallet jack and pushing the long cart, he was observed in the video picking up his right foot, turning, picking up his jacket and walking away from the cart and pallet. As was noted herein, it was not possible to determine if the pallet jack struck Petitioner's foot because the view of Petitioner was partially obstructed by the boxes on the cart in front of him.

The handwritten statement prepared by Petitioner on the same day as the accident was consistent with his testimony and the video.

The Arbitrator does note that in Petitioner's recorded statement of January 21, 2011, he stated that after the pallet jack struck his right foot, Petitioner leaned on the cart for a few minutes because of the pain he was experiencing. This was inconsistent with what was observed in the video.

Mallory Vancil, another employee of Respondent, testified that on the day of the accident she observed Petitioner limping and assisted him to the car so that he could move the vehicle.

Trista Miller, Petitioner's immediate supervisor, testified that Petitioner reported the accident to her that same day and she personally observed some bruising of Petitioner's right foot.

Based upon the preceding, the Arbitrator finds that Petitioner sustained an injury to his right foot on January 18, 2011, when it came in contact with the pallet jack that Petitioner was pulling. In

spite of the inconsistency noted herein, Petitioner required assistance to his car afterward and Respondent's witness personally observed some bruising of Petitioner's right foot.

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 not causally related to the accident of January 18, 2011.

The Arbitrator has determined that Petitioner sustained a work-related right foot injury on January 18, 2011, when he came in contact with the pallet jack that Petitioner was pulling.

Petitioner was subsequently diagnosed with os trigonum syndrome or fracture, underwent surgery, and developed a paresthesia in regard to the sural nerve.

When Respondent's Section 12 examiner, Dr. Holmes, saw Petitioner, he initially opined that Petitioner's right foot condition was related to the accident of January 18, 2011. However, after reviewing the x-ray report of January 18, 2011, and the MRI scan of March 31, 2011, Dr. Holmes opined that Petitioner's right foot condition was not work-related. When he was deposed, Dr. Holmes explained that the primary basis for the change in his opinion in regard to causality was his observation of a "hard shell" around the bone which could not have developed in just two months post injury.

Dr. Vargo opined that Petitioner's right foot condition was work-related; however, Dr. Vargo did not review the x-ray report of January 18, 2011, and, more critically, did not review the MRI scan of March 31, 2011. Accordingly, Dr. Vargo's opinion that there was a causal relationship was without the benefit of reviewing either the x-ray report or MRI scan.

Based upon the preceding, the Arbitrator finds that the opinion of Dr. Holmes was more persuasive than that of Dr. Vargo.

In regard to the pathology involving the sural nerve, Dr. Holmes opined that this was as a result of the unnecessary surgery performed by Dr. Riley.

Based upon the preceding, the Arbitrator finds that Petitioner sustained a right foot/ankle contusion as a result of the accident of January 18, 2011.

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

The Arbitrator concludes that the medical care provided to Petitioner from January 18, 2011, through January 21, 2011, was reasonable and necessary and Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services from January 18, 2011, through January 21, 2011, as identified in Petitioner's Exhibits 10 and 11, 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:

Those medical services were provided to Petitioner shortly after the accident.

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

Based upon the Arbitrator's conclusion of law in disputed issue (F), Petitioner is not entitled to prospective medical treatment.

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

Based upon the Arbitrator's conclusion of law in disputed issue (F), Petitioner is not entitled to temporary total disability benefits.

William R. Gallagher, Arbitrator